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Research that matters

StandBy Feedback Project

FINAL REPORT 25 AUGUST 2021

StandBy Support After Suicide Service

07 5309 5588

www.thescienceofknowing.com.au

info@thescienceofknowing.com.au

About us

The Science of Knowing Pty Ltd is a strategic insight consultancy that specialises in research, policy and evaluation. A full-service, independent company, we maintain a history of success for our clients and projects through a professional, ethical and scientific approach to our work. Our aim is to deliver research that matters, which provides tangible benefits for our clients and contributes to a fair and healthy society.

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The key to successful research, policy and evaluation is reliably sourcing and understanding the correct information. Making the knowledge process easy, accurate and cost-effective truly is a science – the science of knowing…

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Acknowledgements

Understanding the voice of people with lived experience of suicide bereavement is critical to reducing the impact of suicide and also reducing the risk of further suicides. Many people contributed to the success of this project, so we would like to thank them for their time, efforts and contribution.

First and foremost, we would like to thank the people bereaved by suicide who participated in the survey for their courage in sharing their experience of suicide bereavement. We greatly appreciate their time and willingness to participate to help us better understand the support needs of people bereaved by suicide.

We would also like to thank the StandBy coordinators, managers and teams for continuing to provide their feedback and knowledge and efforts during the data collection phase. Your ongoing support and commitment helps countless people across Australia.

Thank you to the organisations and stakeholders who helped to share information about the project, encouraging people to share their stories and have their voices heard.

Finally, thank you to the national StandBy team – Karen Phillips, Geoff Timm, Susan Vaughan, Hanna Raun, Lisa Wan, Trent Harvison, and Travis Shorey for their support, insights, and guidance throughout the project.

Research partners

The Science of Knowing Pty Ltd

Victoria Visser – Director

Rebecca Tretheway – Senior Research and Evaluation Officer

Suggested citation

Visser, V. & Tretheway, R. (2021). StandBy Client Feedback Project – Final Report, The Science of Knowing, Buddina, QLD, Australia.

Executive summary

Background and context

StandBy has been extensively evaluated, with several studies showing that people who have received support from StandBy report lower levels of suicidality and loss of social support than people bereaved by suicide who did not access StandBy's support. However, little is known about the effectiveness of suicide bereavement services in maintaining these improved outcomes of people bereaved by suicide over time. (e.g. grief experiences, suicidality). The current study aimed to measure changes in grief experiences and levels of suicidality for people who have accessed StandBy's support, comparing those with people bereaved by suicide who did not access StandBy. The study also measured people's opinions about the support provided by StandBy and to better understand how to best support people bereaved by suicide. This information will be used to develop a continuous improvement tool that can be used on an ongoing basis to garner feedback from people who have received support from StandBy.

The study also aimed to respond to the need for more in-depth insights into how Aboriginal and Torres Strait Islander people perceived the StandBy service and gather their feedback.

Project methodology

The study approach involved two separate methodologies:

1. Part A – An observational longitudinal design using online surveys and recruiting people bereaved by suicide who had accessed StandBy and those who had not.
2. Part B – A qualitative storytelling process for Aboriginal and Torres Strait Islander people who had accessed support from StandBy.

Participants in Part A were asked to complete two surveys, three months apart. The first survey included three validated instruments:

1. Suicide Behaviours Questionnaire-Revised (SBQ)
2. Grief Experience Questionnaire (GEQ), and
3. De Jong Gierveld Loneliness Scale (DLS).

The initial survey also included numerous bespoke questions relating to closeness and impact of the death, support service usage (comparison group), satisfaction with support from StandBy (StandBy group), and demographic questions (both groups). The follow-up survey only included the three validated instruments.

Participants were recruited via telephone through StandBy's site coordinators, via text message from StandBy National, or through a national Facebook campaign.

Data was collected for Part B using a storytelling process over the phone, supported by a short interview protocol to prompt participants, when needed. There were significant challenges in recruiting Aboriginal and Torres Strait Islander people to Part B of the study and there was not sufficient data to provide reliable and valid analysis. As such, the results for Part B are not included in this report.

The study received ethical approval through UnitingCare Queensland Human Research Ethics Committee on the 14th July 2020 (Approval #09042020 Part A and B).

Results

In total, 499 people completed the first study survey, with 174 being in the StandBy group and 325 being in the comparison group. And, 73 people in the StandBy group and 96 people in the comparison group completed a survey at both timepoints (42% and 30% response rate, respectively). The StandBy and comparison groups were demographically similar in almost all respects, with the exception of relationship to the deceased. The StandBy group was more likely to have lost a partner/spouse, child or other relative, while the comparison group was more likely to have lost a close friend. These differences were accounted for in the analysis.

In terms of how StandBy may impact on people's experiences after a loss through suicide, the findings from this study support those from previous evaluations, showing that, within 12 months after the loss, people who received StandBy's support reported significantly lower levels of suicidality and loneliness than people who had not received their support. The results for grief reactions have been less consistent, but in this study the StandBy group reported significantly lower feelings of

shame than the comparison group. It is perhaps not surprising that people who had accessed StandBy did not have significantly different grief reactions from other people bereaved by suicide – StandBy may not have the ability to change people's reactions to the death. But it does appear to have an impact on people's response to those reactions in the form of reduced suicidality. And it seems to help people feel less alone and more supported – a result that was confirmed through the open-ended comments. Also similar to the previous evaluation, the results for people whose loss was more than 12 months ago showed limited differences between the groups. These people (StandBy and comparison groups) were not typically doing substantially better than people whose loss was within the past 12 months, suggesting that the impact of suicide stretches well beyond the first 12 months after the loss.

In terms of how people's experiences changed over time, for people whose loss was within the first 12 months, the results showed that, in general, people's loneliness, suicidality and grief reactions remained relatively stable over a three-month period. Loneliness remained stable over time, but the StandBy group still reported significantly lower levels of loneliness than the comparison group. For suicidality, the StandBy group showed a slight decline over time, while the comparison group showed an increase in their average score. The difference between the StandBy's decline and the comparison group's increase was statistically significant. This suggests that support from StandBy may help to continue reducing the risk of suicidality for bereaved people, while others' risk may continue to rise over time. This is a significant finding and further supports the consistent finding that StandBy plays a role in preventing further suicides amongst bereaved people.

The results for grief reactions also tended to remain stable, with neither group showing any significant changes. However, again, the StandBy group tended to decline slightly over time, while the comparison group tended to remain stable or increase slightly.

For people whose loss was more than 12 months ago, the results showed very few differences, either over time or between the groups. The percentage of people who found to be at risk of suicidality in both groups was far lower for people whose loss was more than 12 months ago, compared with people whose loss was within the last 12 months. This is not particularly surprising, but does suggest that the risk of suicidality is greatest in the initial period after the loss and may reduce over time. However, overall, the levels of grief reactions, loneliness and suicidality remained high for people whose loss was more than 12 months, suggesting that the grief process for people bereaved by suicide is ongoing and non-linear.

When different types of support were compared, people who had received support from StandBy showed lower levels of loneliness, suicidality and grief reactions (with the exception of stigmatisation). For people who didn't access support from StandBy, people who did not access any support tended to show the highest levels of loneliness and suicidality, followed by people who only accessed formal support from a health professional. The results suggest that accessing a range of formal and/or informal supports is most likely to result in better outcomes.

There are likely many factors that influence how people respond to the death of a loved one through suicide. In this study, the relationship with the person who died had a significant impact on people's grief reactions, but not on their levels of loneliness or suicidality. However, the most influential factors were how close the bereaved person thought they were to the person who died and how much impact they felt the death had had on their life. The perceived closeness of the relationship had a significant effect on grief reactions and levels of loneliness, while the perceived impact of the death significantly influenced suicidality as well.

Overall, satisfaction with StandBy remains very high (similar to previous studies). In particular, people felt that they would recommend StandBy to others, that they couldn't have gotten equally good support elsewhere and that they couldn't have easily coped with StandBy. Although still scoring very high, there may be benefits in providing additional assistance in relation to the stigma around suicide. Stigmatisation is an area where people who accessed StandBy still scored highly, so further addressing this need may help to reduce feelings of stigma and judgement.

“I am forever grateful for their help and advice… I truly believe they help save the lives of the people left behind.”

Background and context

Suicide and suicide bereavement in Australia

Over 2,000 deaths by suicide occur each year in Australia, and in 2019, the number rose to over 3,300.[1] Conservative estimates suggest that for every death by suicide, at least six people are significantly affected by intense and complex grief.[2,3] More recent literature suggests that approximately 50 people are exposed and significantly impacted by each suicide.[4] Based on these estimates, in 2019 over 165,000 Australians were bereaved by suicide. Moreover, individuals bereaved by suicide are at an increased risk of experiencing suicide ideation, suicide attempts, depression, poor social functioning, stigma, and complicated grief compared to non-suicide bereavement individuals.[5,6]

Bereavement services and programs offer various forms of support to individuals who have experienced the loss of a loved one. However, there are mixed findings on the effectiveness of bereavement services in helping people recover or live with their grief,[7] and research specifically evaluating the effectiveness of suicide bereavement services is limited.[8]

Previous research on suicide bereavement services have found such services to be cost-effective,[9] provide important information materials designed to help facilitate recovery,[10] and people who access such services have positive views about the support they received,[11,12] and may experience lower levels of suicidality,[13,14] be less likely to experience the grief reaction of a loss of social support, or experience social loneliness.[13]

However, little is known about the effectiveness of suicide bereavement services in maintaining these improved outcomes of people bereaved by suicide over time. (e.g. grief experiences, suicidality). To our knowledge, only one longitudinal study has been conducted in Australia that analysed changes in grief reactions over time, however; this study was primarily focussed on a comparison with those bereaved by other forms of sudden death rather than the type of support received after the loss (the focus of this study).[15-18]

StandBy Support After Suicide service

StandBy Support After Suicide (hereafter referred to as StandBy) is a program of Youturn Ltd (formerly United Synergies), established in 2002 to meet the need for a coordinated community response to suicide. StandBy is now recognised as Australia's leading suicide postvention program dedicated to assisting people and communities impacted by suicide. They support individuals, families, friends, witnesses, schools, workplaces, first responders, communities and service providers who have been bereaved or impacted by suicide.

StandBy provides free telephone or face-to-face support by local caring staff, committed to the wellbeing of the person or group impacted by a loss. The program provides a central point of coordination, connecting people to the various supports they may need through connections to services, groups and organisations within their local area.

The StandBy service model is centred around ongoing support for up to 24 months, which typically includes an initial support shortly after a death by suicide, and follow-up and coordination support provided at 1 week, 3 months, 12 months and 24 months after initial contact.

StandBy's follow up model is important to ensure that each individual's personalised support plan is still on track and that they remain connected to the resources identified within the plan and supported on an ongoing basis.

During each follow up the Coordinator checks in with the individual's plan, their supports, checks their safety, and provides further information and personalised pathways for support as required. They also communicate when the next scheduled follow-up will occur, and organise additional follow-up if greater frequency is requested/required, they also invite the person to call prior to the follow-up as required.

StandBy operates nationally by partnering with local organisations, engaging their expertise within the community to deliver the most effective and culturally suitable support for each individual circumstance. Locally tailored community workshops and education programs are provided to increase awareness of suicide and suicide bereavement to help enable communities to support one another.

Project objectives

StandBy has been extensively evaluated, with several studies showing that people who have received support from StandBy report lower levels of suicidality and loss of social support than people bereaved by suicide who did not access StandBy's support.[9,13,14] Results from a previous study conducted by The Science of Knowing suggested that the positive benefits of StandBy were only evident within the first 12 months following a loss.[13] After this time, there were limited differences between people bereaved by suicide who had accessed support from StandBy and those that hadn't.[13] As such it was recommended that StandBy monitor people's experiences over time to better understand people's changing support needs.

In addition, StandBy were keen to develop an ongoing individual feedback tool and process that could be used to monitor the outcomes of the support provided and satisfaction with the service.

The current study aimed to measure changes in grief experiences and levels of suicidality for people who have accessed StandBy's support, comparing those with people bereaved by suicide who did not access StandBy. The study also measured people's opinions about the support provided by StandBy and to better understand how to best support people bereaved by suicide. This information will be used to develop a continuous improvement tool that can be used on an ongoing basis to garner feedback from people who have received support from StandBy.

Project methodology

Project approach

In 2018, our research demonstrated that StandBy was able to improve outcomes related to grief experiences, suicidality and loneliness for those bereaved by suicide who accessed their services (StandBy group).[13] This project aimed to identify whether these outcomes were sustained over time and compare those outcomes with those of suicide bereaved people who had not received support from StandBy (comparison group).

This study also aimed to address the methodological limitations of the previous study, specifically the lower response rate for people who received support from StandBy (primarily owing to UnitingCare clients not receiving an invitation to participate in the previous study), and lower representation of Aboriginal and Torres Strait Islander peoples.

In order to respond to the need for more in-depth insights into how Aboriginal and Torres Strait Islander people perceived the StandBy service and gather their feedback, it was crucial that a culturally appropriate study design was adopted for this group. The methodology devised for measuring individual outcomes over time was deemed culturally inappropriate for some Aboriginal and Torres Strait Islander people. As a result, the data collection process for this group focused on capturing their outcomes and feedback at a single point in time rather than an 'objective' measurement of changes in outcomes over time.

For simplicity, the two parts of the study are separated in this report, as follows:

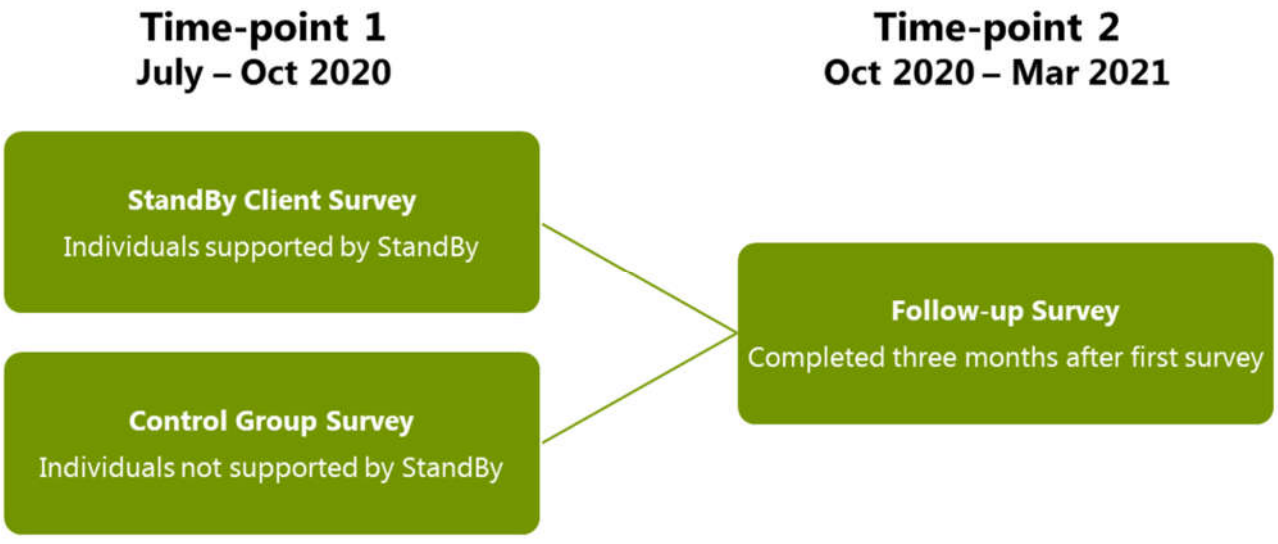
- Part A – quantitative mainstream longitudinal study, and
- Part B – qualitative study of Aboriginal and Torres Strait Islander people who had received support from StandBy.

Study design

Part A used an observational longitudinal study design. Data was collected using three online surveys:

1. A survey offered to people who received support from StandBy at their scheduled follow-up calls (3 and 12 months)
2. A survey shared via social media and professional networks for participation by those bereaved by suicide, but who had not received support from StandBy, and
3. A follow-up survey for both the above groups who provided their contact details, sent three months post the initial survey.

Figure 1: Part A study design



Part B of the study was designed as a cross-sectional study design. Data was to be collected through a qualitative storytelling process. The storytelling was identified as the most appropriate method for Aboriginal and Torres Strait Islander StandBy people. This method allows for more meaningful and rich stories of individuals' and communities' experiences after a loss by suicide and the support provided through StandBy. "*Storytelling or 'yarning' is embedded within the processes and structure of Aboriginal society. Stories are empowering and uplifting, giving access to layers of deep cultural and historical knowledge that make up the social and cultural identity of Aboriginal people.*"[19]

Recruitment

Survey participants were recruited using three methods:

1. Verbal invitation by StandBy Coordinators during scheduled follow-up calls (3 and 12 months) to people who had previously received support from StandBy. Those that consented to participate were sent the survey link via text message.
2. A text message sent directly to all people who had received support from StandBy from 2019 and those from January to April (inclusive) 2020. This text message was sent to 878 people on 21st October 2020.
3. Facebook posts and advertising campaign to recruit both people supported by StandBy and those bereaved by suicide who had not been supported by StandBy.

A range of service providers and Facebook support groups for suicide bereaved were contacted and asked to share the Facebook post for the study. Data for Part A of the study was collected between 15th July 2020 and 31st March 2021.

Participants were recruited for Part B via a verbal invitation to Aboriginal and Torres Strait Islander StandBy people during the scheduled 3 and 12 month follow up calls.

Data collection instruments

The online surveys were a revised version of the surveys used in the 2018 research project. Key findings from the 2018 project enabled us to reduce the length of the surveys to focus on areas where StandBy was having a significant impact on individual outcomes. This included the inclusion of three validated survey instruments:

1. **Suicide Behaviours Questionnaire-Revised (SBQ)** – The SBQ measures different dimensions and frequency of suicidality (e.g. suicide ideation, suicide attempt). Scores on SBQ range from 3-18, with scores equal to or above 7 indicating being at high risk of suicidality.[20]
2. **Grief Experience Questionnaire (GEQ)** – The GEQ measures grief reactions associated with bereavement in general as well as grief reactions unique to suicide bereavement. A revised (2019) version of the GEQ was used in this study and reduced to only four constructs reported to be elevated in people bereaved by suicide (Stigma, Responsibility, Shame and Rejection). Scores on the GEQ range from 5-25, the higher the score the more likely the presence of that particular grief experience.[17]
3. **De Jong Gierveld Loneliness Scale (DLS)** – The DLS measures social and emotional loneliness and provides a measure of social isolation. Overall scores range from 0-6 (0 = least lonely, 6 = most lonely).[21]

The initial survey also included numerous bespoke questions relating to closeness and impact of the death[22], support service usage (comparison group), satisfaction with support from StandBy (StandBy group), and demographic questions (both groups).

The follow up survey sent to both the StandBy and comparison groups were identical and only included the three validated survey instruments identified above.

Data was collected for Part B using a storytelling process over the phone. Aboriginal and Torres Strait Islander people who consented to participate were contacted by a StandBy National Team member. Once a convenient time was arranged, the person was called back to audio record their story. The process was also supported by a short interview protocol to prompt participants, when needed.

Data analysis processes

Based on the StandBy service model, comparisons between the StandBy group and the comparison group were completed in two separate analyses – those whose most recent loss was within the past 12 months, and those who most recent loss was more than 12 months ago.

To compare the results between the StandBy groups and the comparison group at the first timepoint, statistical

analyses included the Chi-Square statistic and one-way multivariate analysis of covariance (MANCOVA). The Chi-Square statistic was used to test differences in proportions between the StandBy and comparisons groups (e.g. percentage at risk of suicidality). A one-way MANCOVA was used to test differences in average scores of outcome measures between the StandBy and comparison groups, and to account for the differences in demographic characteristics between the two groups. A one-way MANCOVA is used when there are multiple outcomes measures that need to be compared between two or more groups (e.g. StandBy group and comparison group) and allows for other variables to be controlled for (e.g. variables such as the relationship with the deceased that may influence the results).

In order to test for changes in the outcome variables over time (i.e. datapoint 1 and datapoint 2), a linear mixed-effects modelling for repeated measures (MMRM) was conducted. This analysis allows comparisons between outcomes for the same person at different timepoints as well as comparisons between groups (i.e. StandBy group versus comparison group).

Descriptive statistics (e.g. frequencies, percentages, means) were conducted for the bespoke questions relating to satisfaction and support service usage.

There were significant challenges in recruiting Aboriginal and Torres Strait Islander people to Part B of the study, which resulted in only one person participating in a qualitative interview. This did not provide sufficient data to provide reliable and valid analysis. As such, this data was not analysed and results for Part B are not included in this report.

Ethical review

The study received ethical approval through UnitingCare Queensland Human Research Ethics Committee on the 14th July 2020 (Approval #09042020 Part A and B).

Results

Participants

Sample sizes and response rates

In total, 499 people completed the first study survey, with 174 being in the StandBy group and 325 being in the comparison group. There were numerous additional responses that were incomplete and responses from people based overseas, which were removed to ensure both groups were from Australian respondents and contained adequate data for analysis.

Respondents from the StandBy group were recruited in one of three ways – invitation by the StandBy site coordinator/team member, text message from StandBy National, or through the Facebook advertising.

Table 1 shows the total number of people invited through each method, the number of respondents and the response rate by method of distribution. Response rates were quite low for the StandBy group, no matter which distribution method was used. In fact, more than one-third of the StandBy group was recruited via the Facebook advertising, rather than through direct contact from StandBy. This has resulted in a relatively high margin of error for the StandBy group (8.85%), which means that the results may lie approximately 9% above or below the levels reported. The margin of error for the comparison group is an estimate only (based on an estimate of the number of bereaved people in Australia in 2019), but is relatively high (5.43%), especially considering it is a self-selected convenience sample.

Participants were asked if they would like to participate in the follow-up survey three months following the completion of their first survey. In total, 73 people in the StandBy group and 96 people in the comparison group completed a survey at both timepoints. Table 2 shows the follow-up response rates for the StandBy and comparison groups (42% and 30% respectively).

Participant characteristics

The StandBy and comparison groups were similar on most demographic characteristics. A summary of the demographic characteristics of the participants in both groups is shown on page 17. Their averages ages were almost identical (50 years for both groups) and both groups were majority female (86% female for the StandBy group and 84% female for the comparison group). A small proportion of people within each group identified as Aboriginal and/or Torres Strait Islander (6% StandBy group and 4% comparison group). A similar proportion from each group experienced their most recent loss through suicide in the past 12 months (46% for the StandBy group and 39% for the comparison group). Almost half of all participants in the StandBy group resided in Queensland at the time of their most recent loss (46%), which was substantially higher than the comparison group (22%). This is likely because many of StandBy's higher volume sites are based in Queensland. The comparison group were more evenly spread across Australia and were much more likely to reside in Victoria (22% compared with only 7% for the StandBy group). However, the comparison group had no one who resided in the Northern Territory, compared with 5% of the StandBy group.

The main difference between the StandBy and comparison groups was the relationship participants had with the person who died by suicide. Participants from the StandBy group were significantly more likely to have lost a partner/spouse, child or other relative and significantly less likely to have lost a close friend than the comparison group. These differences have been accounted for in the analysis later in this report.

When only those participants who completed both surveys are compared, the groups were very similar. There were no significant differences by age, gender, Aboriginal and Torres Strait Islander status, perceived closeness of the relationship with the deceased or the perceived impact of the death. The only differences were that people in the StandBy group were significantly more likely than the people in the comparison group to have lost a partner/spouse (27% for the StandBy group, 14% for the comparison group, p=0.032) while people in the comparison group were more likely to have lost a close friend (4% for the StandBy group, 18% for the comparison group, p=0.005).

Table 1: Response rates by method of distribution

Recruitment strategy	Sample (n)	Surveys completed (n)	Response rate (%)	Margin of error (%)
Invitations by StandBy Coordinators	**281**	**47**	**16.7%**	**8.85%**
Bulk text message to people who accessed StandBy in 2019 or between Jan-Apr 2020	**878**	**64**	**7.3%**	
Facebook campaign – StandBy group	**-**	**63**	**-**	**-**
Facebook campaign – Comparison group	**165,000***	**325**	**-**	**5.43%**

** Based on approximate number of people bereaved by suicide across Australia in 2019*

Table 2: Follow-up response rates by group

Group	Surveys completed at Time 1 (n)	Surveys completed at Time 2 (n)	Follow-up rate (%)
StandBy group	**174**	**73**	**42%**
Comparison group	**322**	**96**	**30%**
Total	**496**	**169**	**34%**

Participant demographics

StandBy Group - 174	Comparison Group - 325

Participants' gender, age and ethnicity

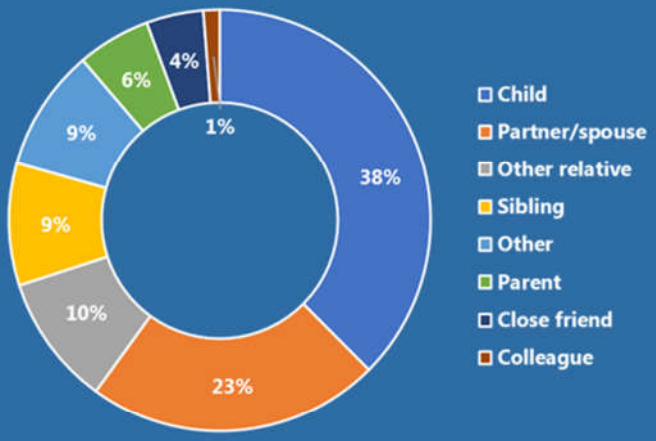
StandBy Group - 174

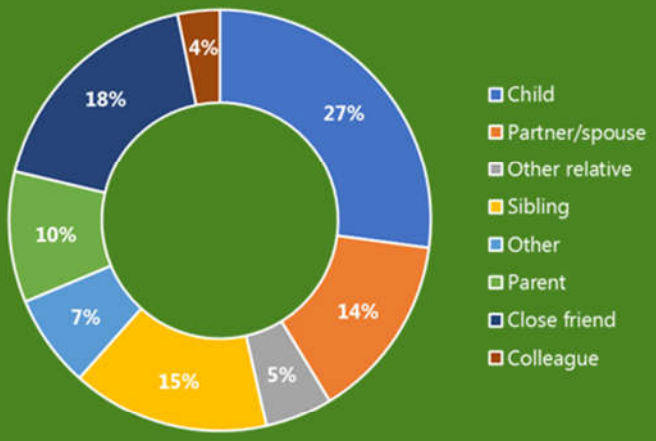
- Male 13%
- Average age 50
- Female 86%
- Other 1%
- Aboriginal and/or Torres Strait Islander 6%

Comparison Group - 325

- Male 14%
- Average age 50
- Female 84%
- Other 2%
- Aboriginal and/or Torres Strait Islander 4%

Participants' relationship with the person who died by suicide





Time since most recent loss

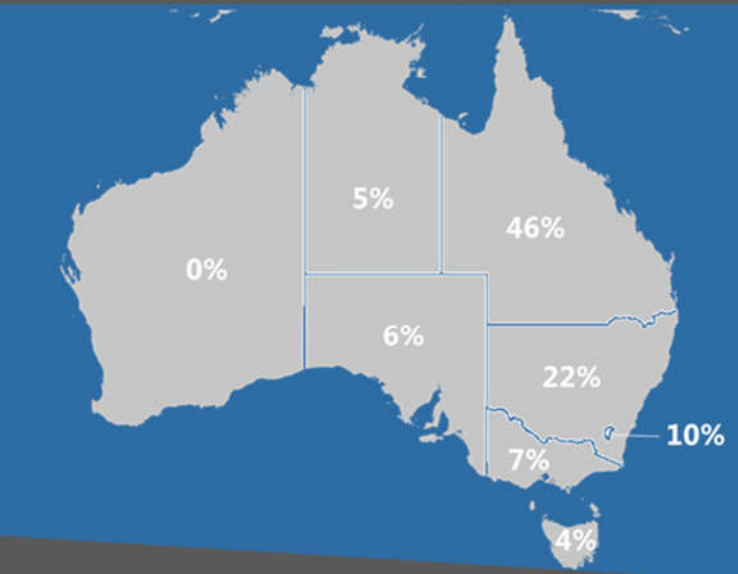
StandBy Group - 174

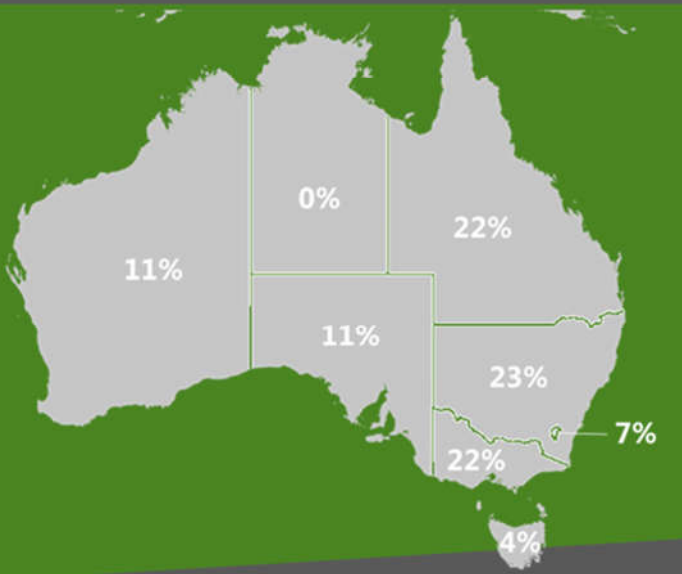
- 46% n=74 Less than 12 months ago
- 54% n=86 More than 12 months ago

Comparison Group - 325

- 39% n=122 Less than 12 months ago
- 61% n=187 More than 12 months ago

State or territory participants resided at the time of their loss





Closeness of relationship and impact of the death

Recent research has shown that approximately 50 people are significantly impacted by each death by suicide.[4, 22] We replicated questions from this research in our survey to determine the perceived closeness of the relationship participants had with the person who died and the impact of the death on their lives. Participants in this study overwhelmingly reported a high level of closeness with the person who died and that the death had a significant or devastating impact on them and their lives. Regardless of the type of relationship they had with the deceased person, at least three-quarters of people in both the StandBy group and the comparison group reported that their relationship with the person who died by suicide was either 'close' or 'very close' (75% and 78% respectively) (Figure 2). And, almost all participants in the StandBy group (93%) and 85% of participants in the comparison group reported that the death either 'disrupted their life in a significant or devastating way, but they no longer feel that way' or it 'had a significant or devastating effect on them that they still feel' (Figure 3). These results suggest that suicide often has a very significant and distressing impact on people's lives, regardless of whether they were a close relative, friend, colleague or another type of relationship. However, it is important to note that these results do not suggest that the death of a loved one by suicide always has a significant impact on people's lives. It is more likely that people who participate in research on suicide bereavement are more likely to feel this way.

Figure 2: Perceived closeness of relationship with the deceased person

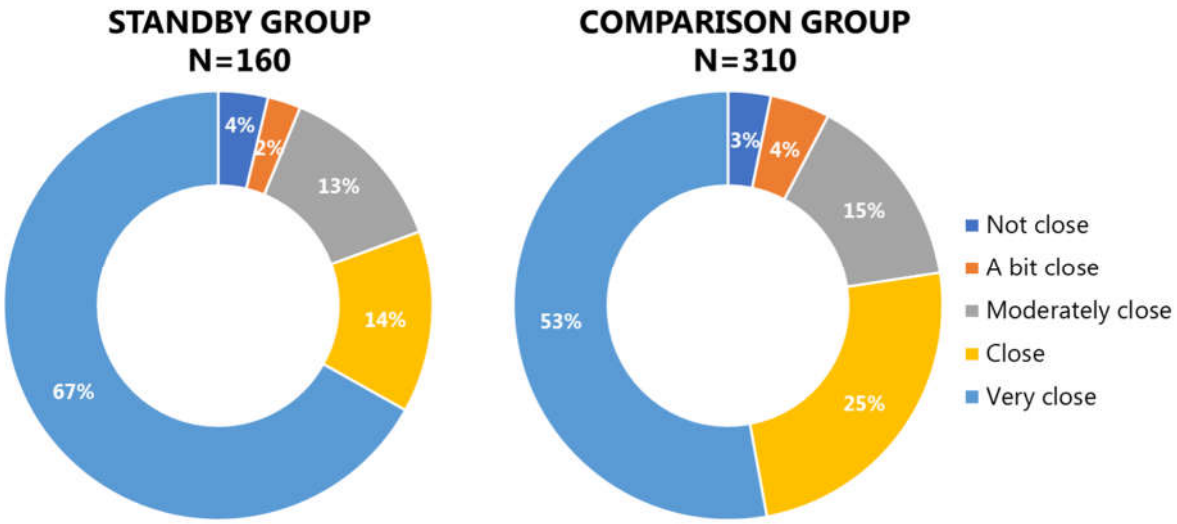
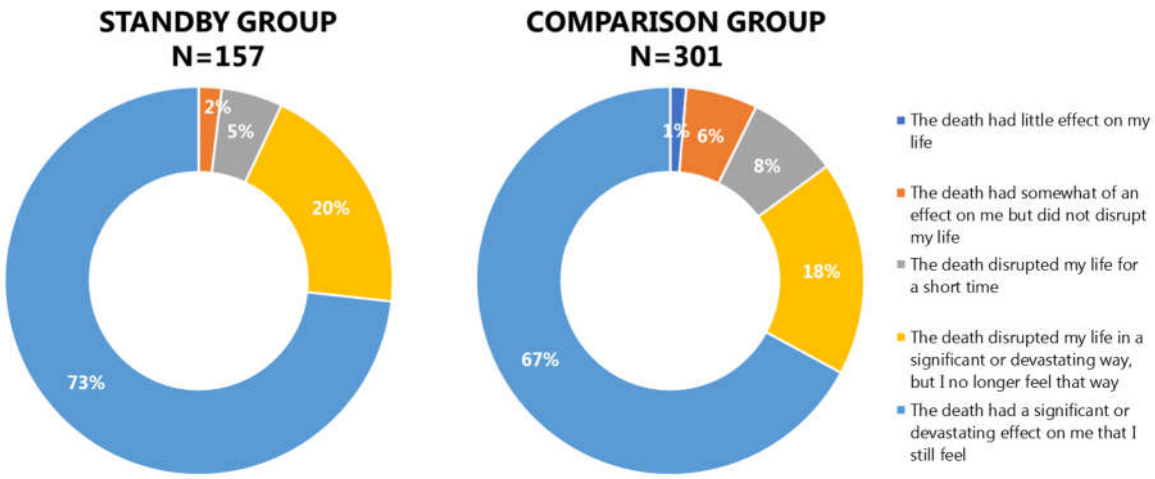


Figure 3: Impact of death on participants' lives



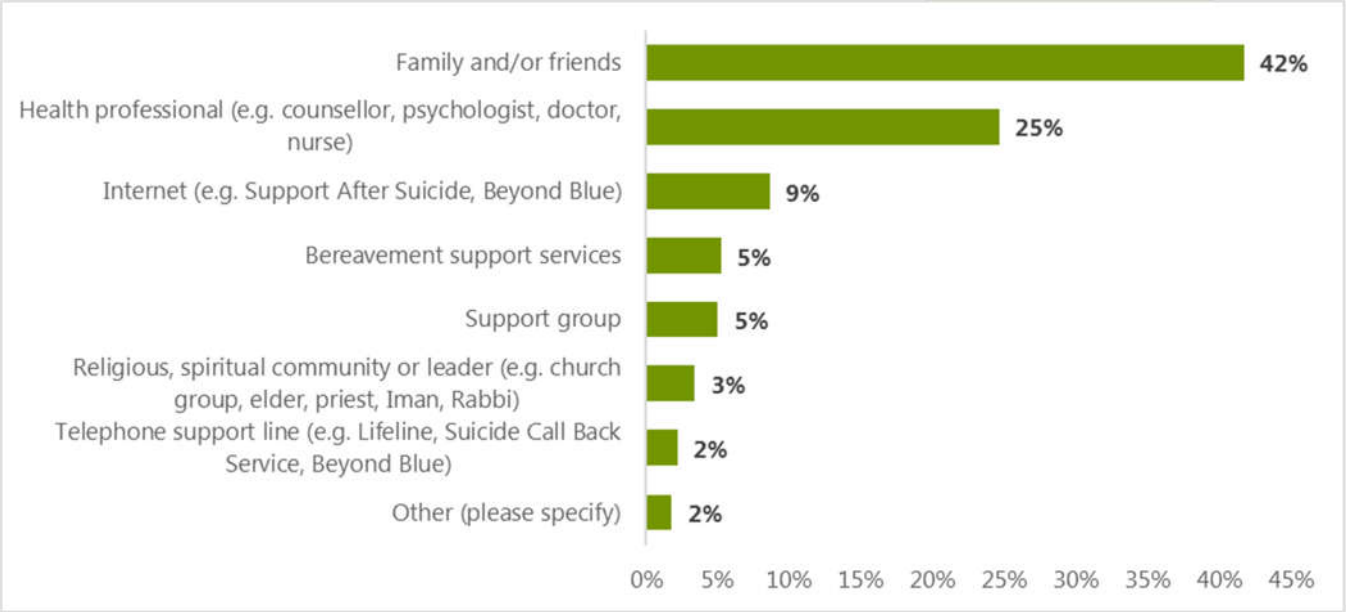
Types of support received

People in the comparison group were asked to indicate what types of support they had received following the loss of their loved one. More than one-third of participants (34%) reported that they had accessed one or more types of informal support, another quarter (24%) indicated that they had accessed both formal support (i.e. from a health professional) and informal support, while 7% indicated that they had only sought support from a health professional. Twelve percent of the comparison group indicated that they had not accessed any type of support.

Figure 4 shows the different types of informal and formal supports accessed by the comparison group following their loss through suicide. A large proportion of participants (42%) indicated that they had accessed support through family and/or friends, while a quarter indicated that they had accessed formal support through a health professional. Other types of informal support were less commonly accessed, such as information on the internet (9%), bereavement support services (5%), support groups (5%) and telephone support lines (2%).

The comparison group were also asked why they didn't receive support from StandBy. The vast majority (86%) reported that they hadn't accessed StandBy because it was never offered to them. A further 13% reported that they may have been offered support from StandBy, but they couldn't remember. Only three people reported that they were offered support from StandBy, but they declined. These people reported that they didn't accept StandBy's support because they didn't need it or because they didn't know how to reach out for help. Only one of these people indicated that they would have accessed support from StandBy if they had attempted to contact them again.

Figure 4: Types of informal and formal supports accessed by the comparison group (n=400)



Key outcomes

Comparing outcomes between groups at Time 1

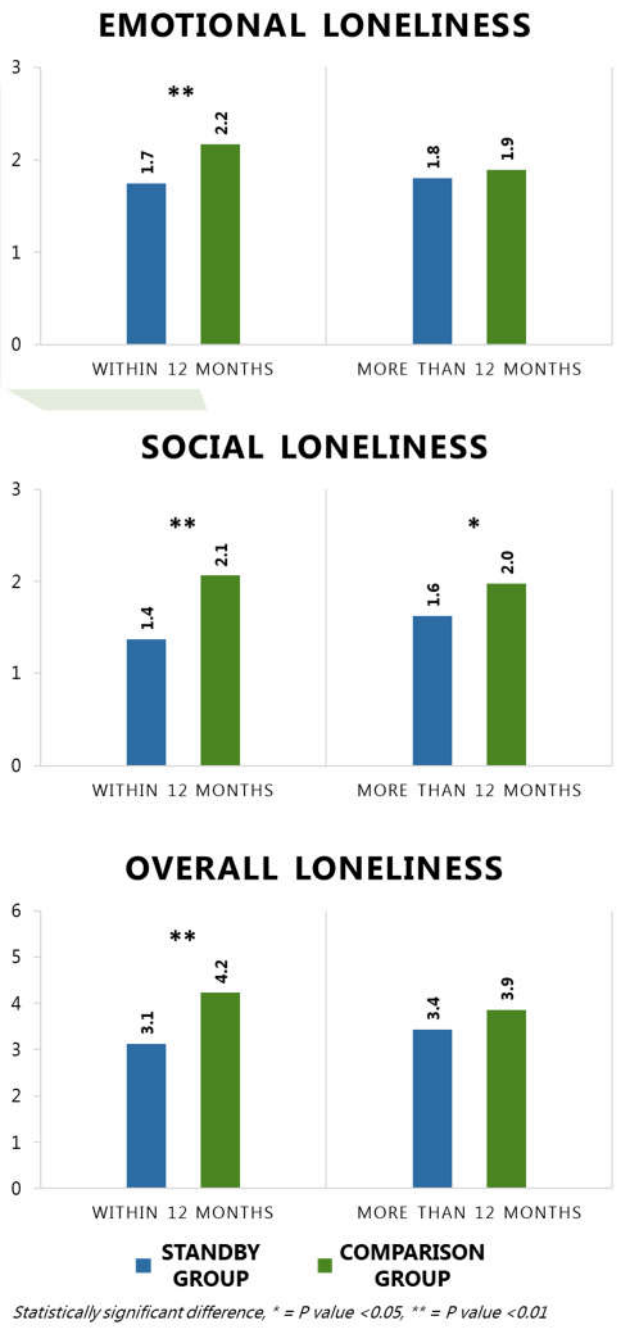
Similar to the study completed in 2018[13], this study showed that, at the first datapoint, there were differences in some outcomes for people who have accessed StandBy's support (StandBy group) and people bereaved by suicide who have not accessed support from StandBy (comparison group). Note that this analysis includes the results for the 496 people who completed the survey at Time 1.

For people whose most recent loss was within the past 12 months, the StandBy group had significantly lower levels of loneliness (including Social Loneliness, Emotional Loneliness and Overall Loneliness) and suicidality than the comparison group (see Figure 5 and Figure 6). Half of the StandBy group scored above seven in the SBQ scale, indicating a high risk of suicidality, compared with 64% of the comparison group. This difference was approaching statistical significance (p=0.055). There was only one statistically significant difference between the groups on the grief reactions measured through the GEQ, which was Shame (p=0.044). There were no statistically significant differences for the grief reactions of Stigmatization, Responsibility or Rejection (see Figure 7). As Figure 7 shows, Shame is lowest scoring grief reaction, while Stigmatization is the highest scoring grief reaction. In fact, people from the StandBy group scored slightly higher than the comparison group on Stigmatization at Time 1, but this difference was not statistically significant.

For people whose most recent loss was more than 12 months ago, there was only one significant difference – the StandBy group scored significantly lower on Social Loneliness than the comparison group (p=0.027) (Figure 5). The StandBy group also scored slightly lower on Emotional Loneliness, Overall Loneliness and Suicidality, but these differences were not statistically significant. Grief reactions tended to be similar for both groups.

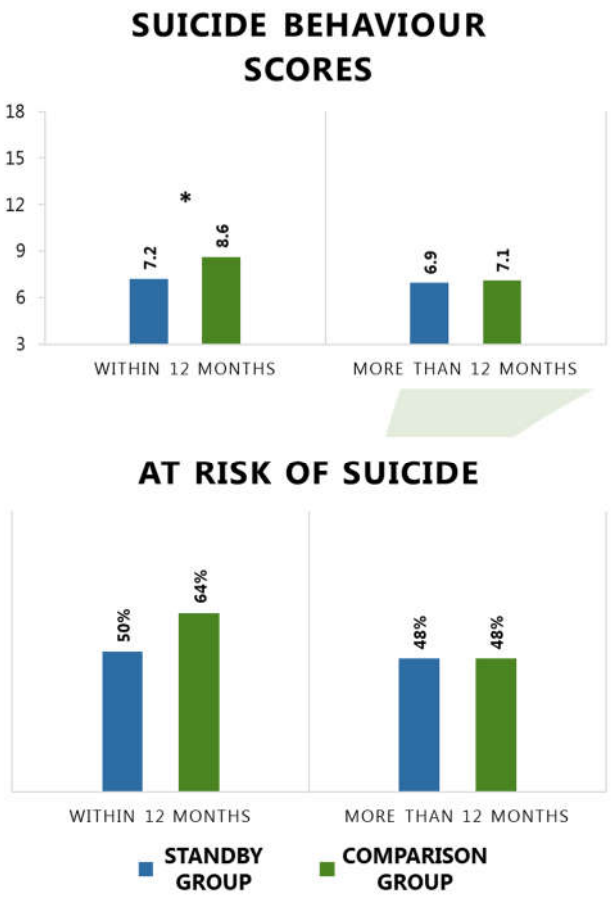
These results are similar to those found in our previous research, whereby people who received support from StandBy tended to show lower levels of loneliness and suicidality than people who did not receive StandBy's support, particularly within the first 12 months after their loss.

Figure 5: Experiences of loneliness at Time 1, as measured by the DLS



*Statistically significant difference, * = P value <0.05, ** = P value <0.01*

Figure 6: SBQ scores and percentage of participants at risk of suicidality at Time 1



*Statistically significant difference, * = P value <0.05*

Figure 7: GEQ scores at Time 1

*Statistically significant difference, * = P value <0.05*

Changes in outcomes over time

The primary aim of this study was to better understand how people's grief reactions changed over time. Participants were asked to complete the same standardised measures three months after their initial survey completion in order to track their short-term grief trajectory. Analysis determined whether there were differences in the StandBy or comparison groups' results over that time and also if there were differences between the two groups. This analysis only includes the 169 participants who completed both the Time 1 and Time 2 surveys.

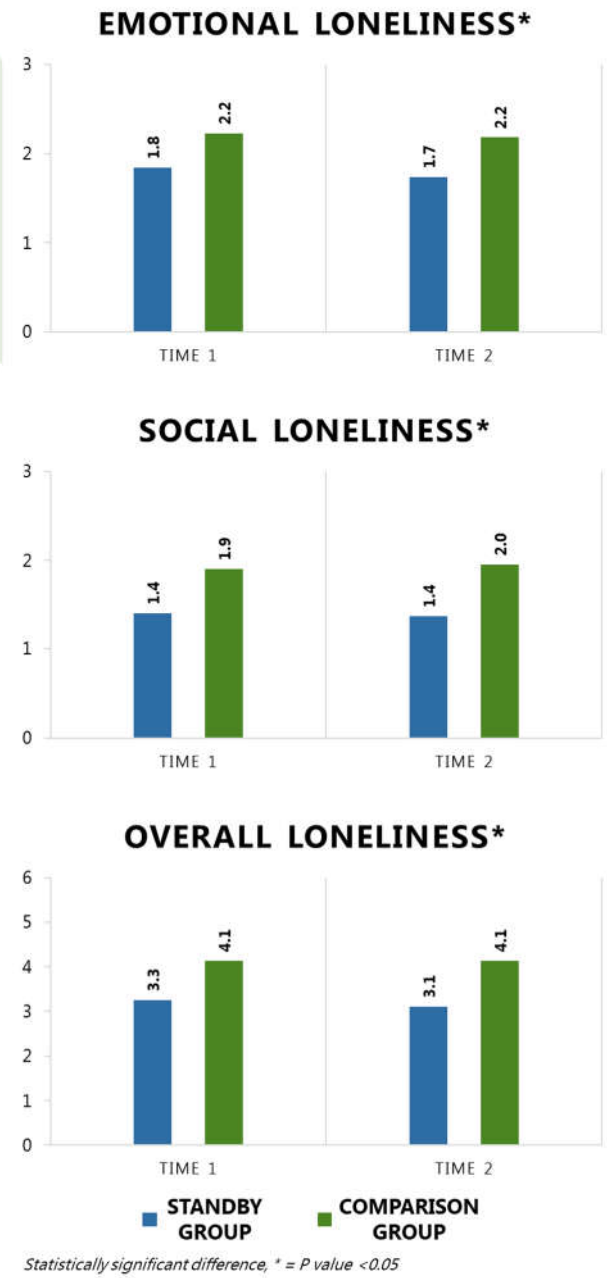
Loneliness

For participants whose loss was within the past 12 months, the results showed that the StandBy group scored significantly lower than the comparison group on Emotional Loneliness, Social Loneliness and Overall Loneliness (Figure 8). However, there were no significant changes between Time 1 and Time 2 for either group. Both groups remained relatively stable across the three measures over time.

For participants whose loss was more than 12 months ago, there were no statistically significant differences between the StandBy group and the comparison group on Emotional Loneliness, Social Loneliness or Overall Loneliness. Similarly, there were no significant differences for either group between their scores at Time 1 and Time 2. The results for both groups remained relatively stable over time (see Figure 9).

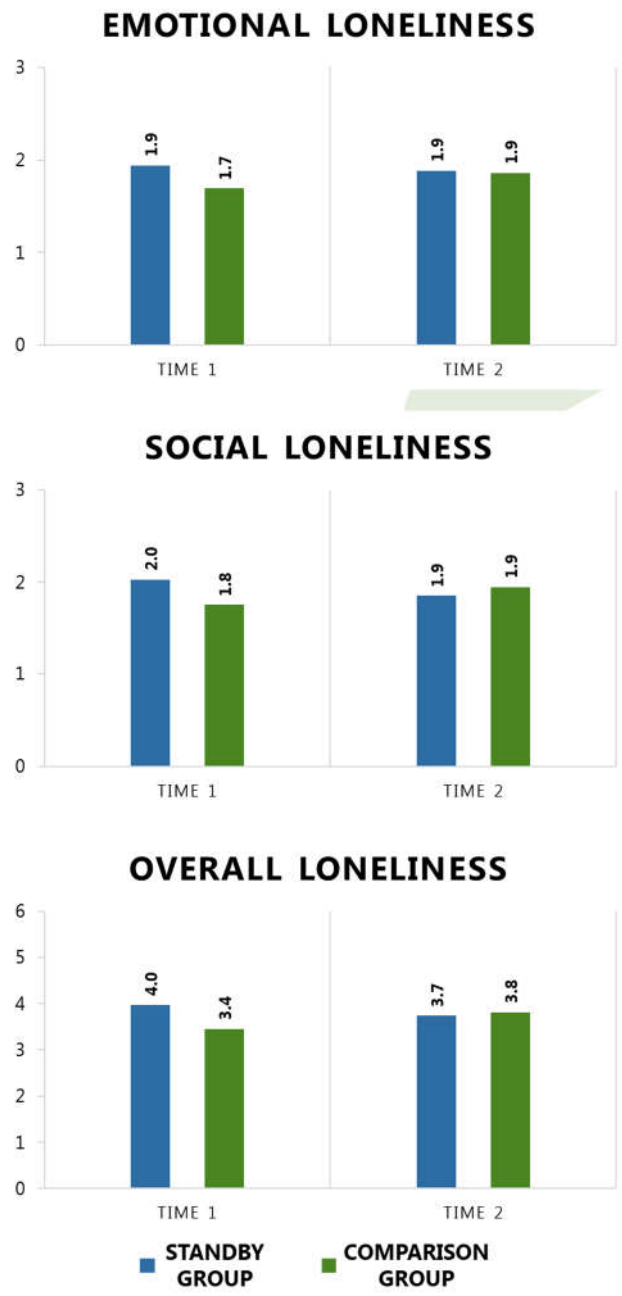
Interestingly, the average scores for the StandBy group were higher (i.e. more lonely) for participants whose loss was more than 12 months ago than those whose loss was within the past 12 months. But, for the comparison group, average scores across the three measures were slightly lower for participants whose loss was more than 12 months ago, compared with participants whose loss was within the past 12 months.

Figure 8: DLS scores - changes over time for participants whose loss was in the past 12 months



*Statistically significant difference, * = P value <0.05*

Figure 9: DLS scores - changes over time for participants whose loss was more than 12 months ago



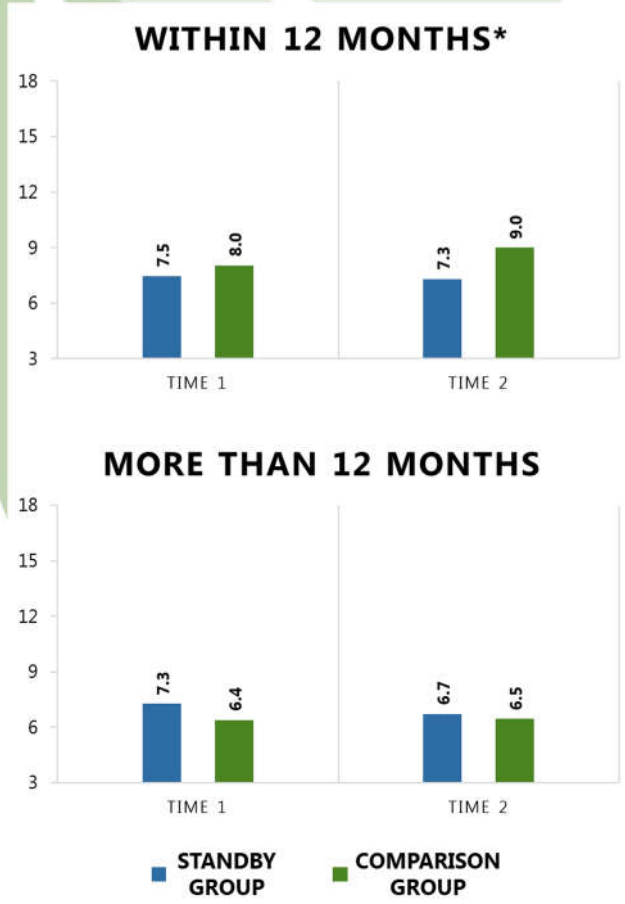
Suicidality

The results showed that for people whose loss was within the last 12 months, the average scores on the SBQ were above the cut-off indicating a high risk of suicidality for both groups at both time points (see Figure 10). However, the average score for the StandBy group declined slightly over time, while the score for the comparison group increased. However, neither of these changes were statistically significant. Similarly, although the StandBy group scored lower than the comparison group at both time points, these differences were not significant. However, there was a significant difference in the *changes in scores* between the two groups. For participants whose loss was more than 12 months ago, there were no statistically significant differences between the StandBy and comparison groups or within each group over time. However, the StandBy group still showed a slight decline in their average score over time, while the comparison group remained stable over time.

The average scores for the StandBy group were relatively similar regardless of when their loss occurred. However, participants from the comparison group whose loss was within the last 12 months showed substantially higher scores than participants whose loss was more than 12 months ago.

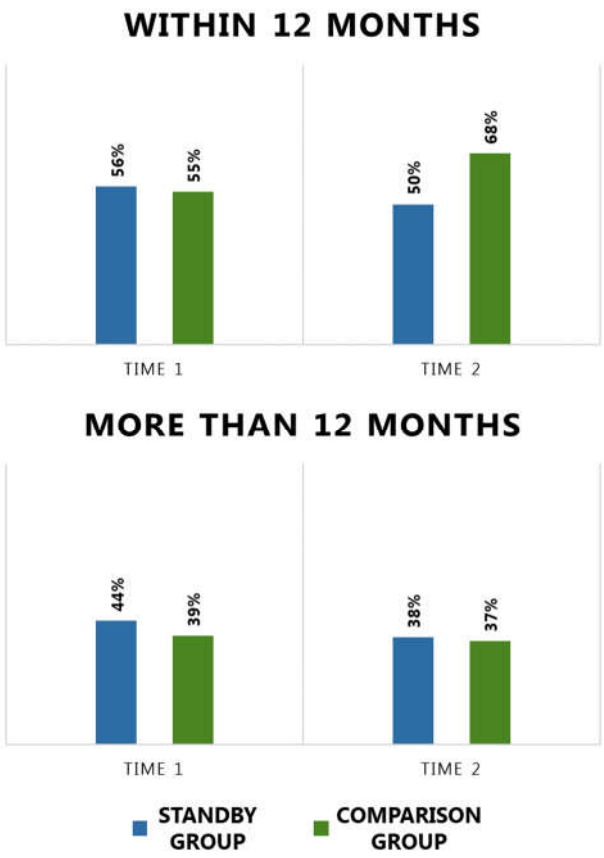
In terms of the proportion of participants who scored above seven on the SBQ (the cut-off for high risk of suicidality), there were no statistically significant differences between the StandBy group and the comparison group, no matter when their loss occurred (see Figure 11). However, for participants whose loss was within the last 12 months, the proportion of participants in the comparison group at high risk of suicidality increased significantly between Time 1 and Time 2 (from 55% at Time 1 to 68% at Time 2).

Figure 10: SBQ scores - changes over time



*Statistically significant difference, * = P value <0.05*

Figure 11: Proportion of participants at risk of suicidality, based on SBQ scores over 7

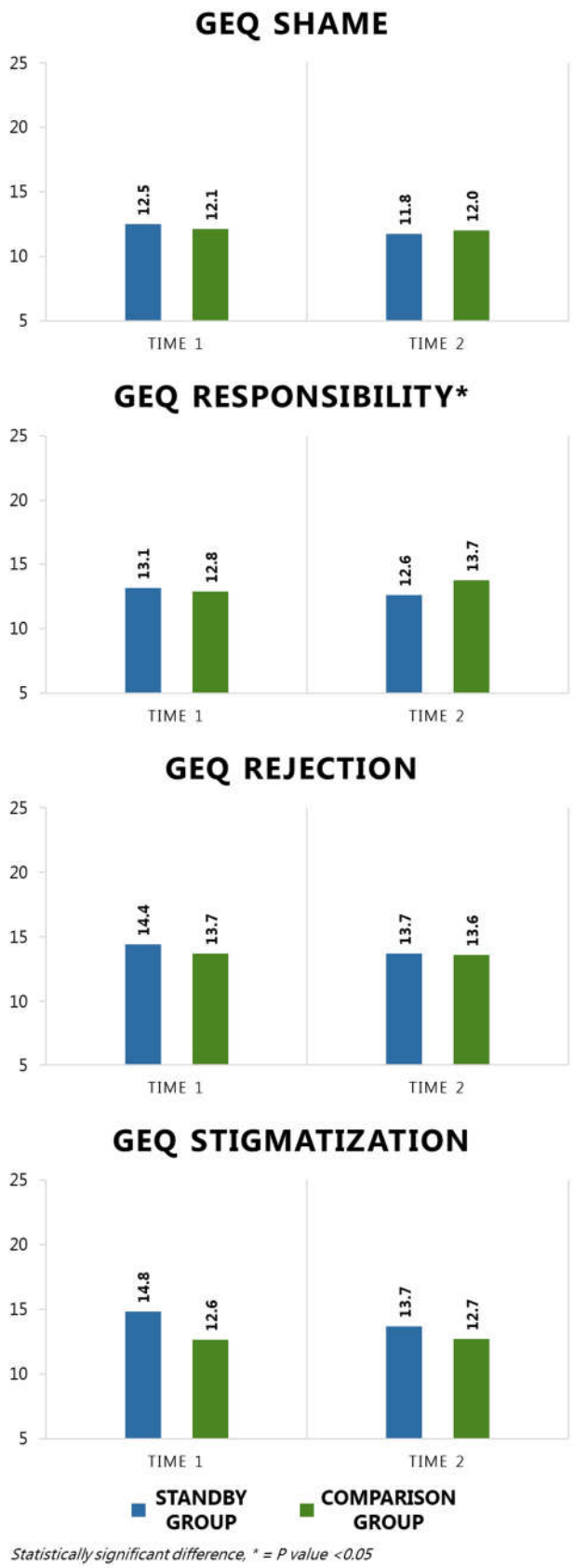


Grief reactions

In terms of the grief reactions measured by the GEQ, there were limited differences between groups or over time that were statistically significant. That is, the results for participants in the StandBy group tended to be relatively similar to those for the comparison group and neither group tended to show any significant changes over time.

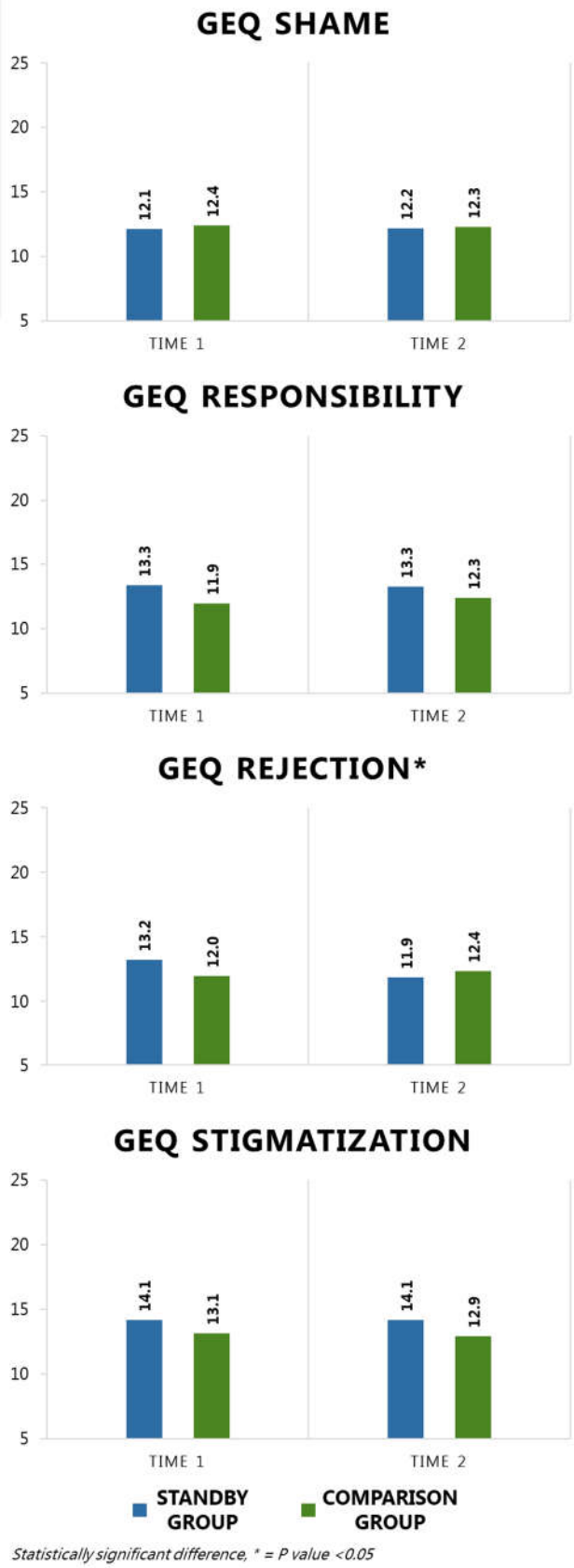
However, for participants whose loss was within the past 12 months, participants in the StandBy group showed a slight decline in their average score on the Responsibility grief reaction, while the average score for comparison group participants increased. The difference between the two groups' change in scores was significant. Similarly, for participants whose loss was more than 12 months ago there was a statistically significant difference between the change in average scores for the grief reaction of Rejection.

Figure 12: GEQ scores - changes over time for participants whose loss was in the past 12 months



*Statistically significant difference, * = P value <0.05*

Figure 13: GEQ scores - changes over time for participants whose loss was more than 12 months ago



*Statistically significant difference, * = P value <0.05*

Impact of demographic characteristics and types of support on outcomes

Additional analyses were conducted using the whole sample (i.e. people who had had support from StandBy and those who hadn't) to gain further insights about outcomes for people bereaved by suicide. These analyses focused on the impact of different types of support, the relationship to the deceased, the perceived closeness the relationship and the perceived impact of the death on people's lives. These analyses can help in understanding how bereavement through suicide is experienced differently depending on people's circumstances and best to deliver support.

StandBy compared with other types of support

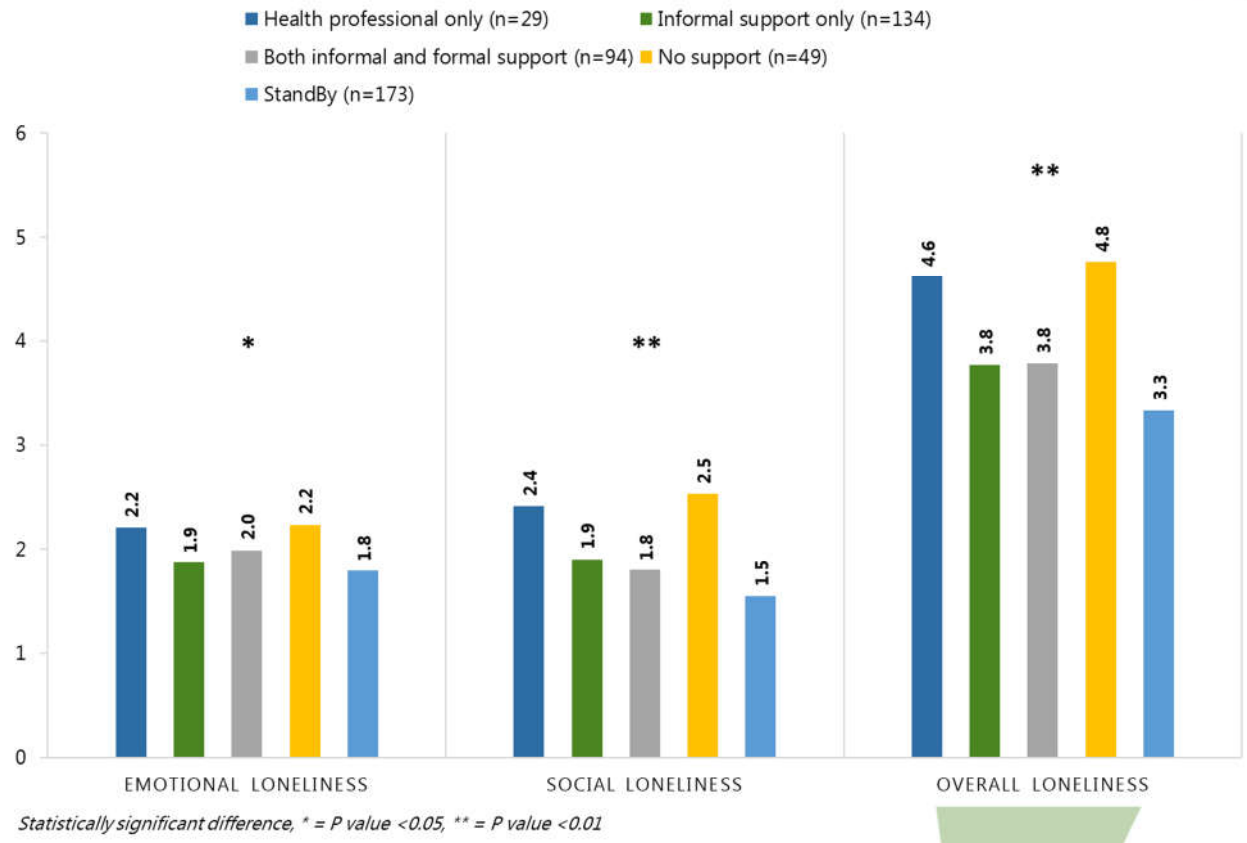
As discussed earlier in this report, the survey asked the comparison group which types of support they had received following the death through suicide. The figures below show the results for key outcomes for all participants at Time 1 (n=479).

Figure 14 shows the results for the DLS at Time 1 by the different types of support received by participants after their loss. Participants who had received support from StandBy had significantly lower levels of loneliness compared with other types of support (including Emotional Loneliness, Social Loneliness and Overall Loneliness). People who had received no support had the highest levels of loneliness, followed by people who had only received formal support from a health professional. Participants who reported receiving either only informal support or both informal and formal support tended to have lower levels of loneliness, although not as low as the StandBy group.

As shown in Figure 15, participants who received support from StandBy tended to score lower across most grief reactions (with the notable exception of Stigmatization). Participants who received support only from a health professional (i.e. formal support) tended to score the highest across the GEQ grief reactions. Conversely, participants who reported having only received informal support tended to have lower scores. People who did not access any support had somewhat mixed results.

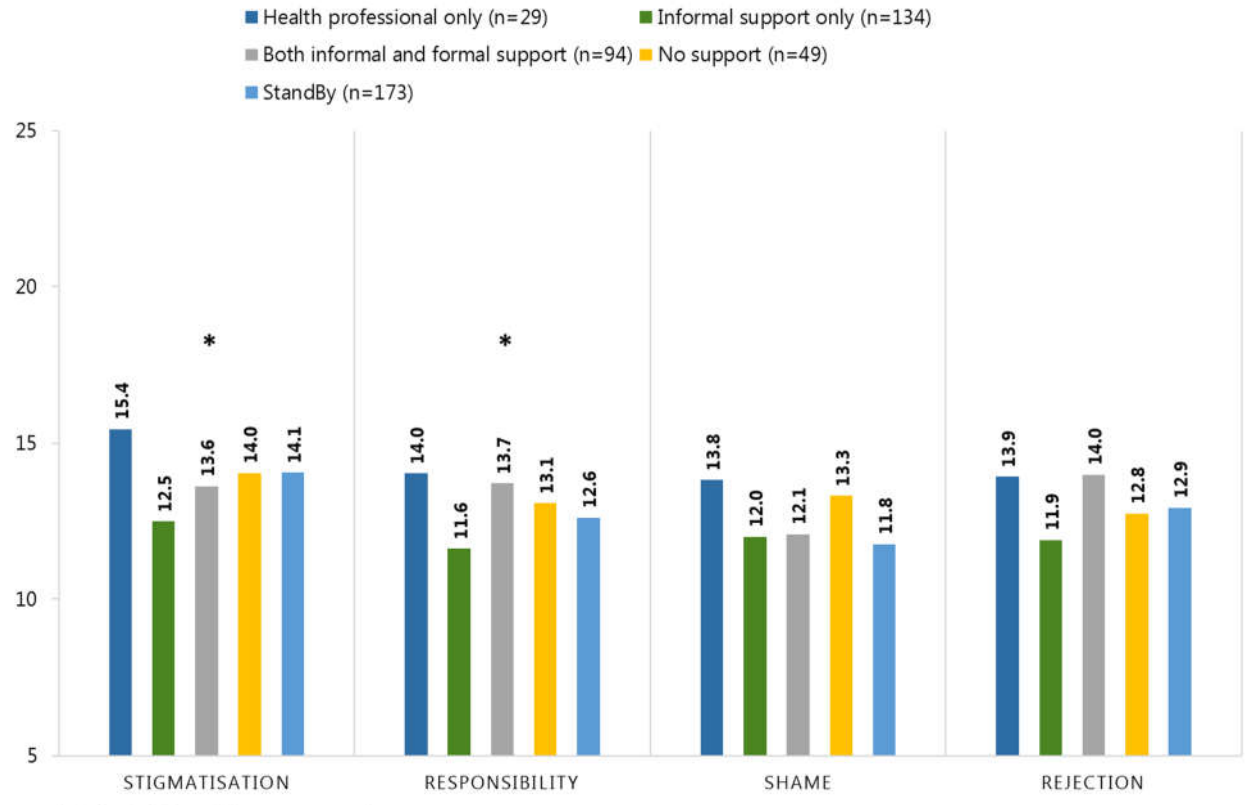
The results from the SBQ (Figure 16) show slightly lower scores for people who accessed support from StandBy when compared to people who accessed other types of formal and informal support, but these differences were not significant. People who did not access any support had a higher average score on the SBQ than other groups, but again this difference was not significant. Similarly, there were no significant differences between the proportion of participants at risk of suicidality based on the types of support they received. However, it can be seen that people who accessed StandBy had lower risk of suicidality, particularly when compared with people who accessed no support or only formal support from a health professional.

Figure 14: DLS scores at Time 1 by type of support received



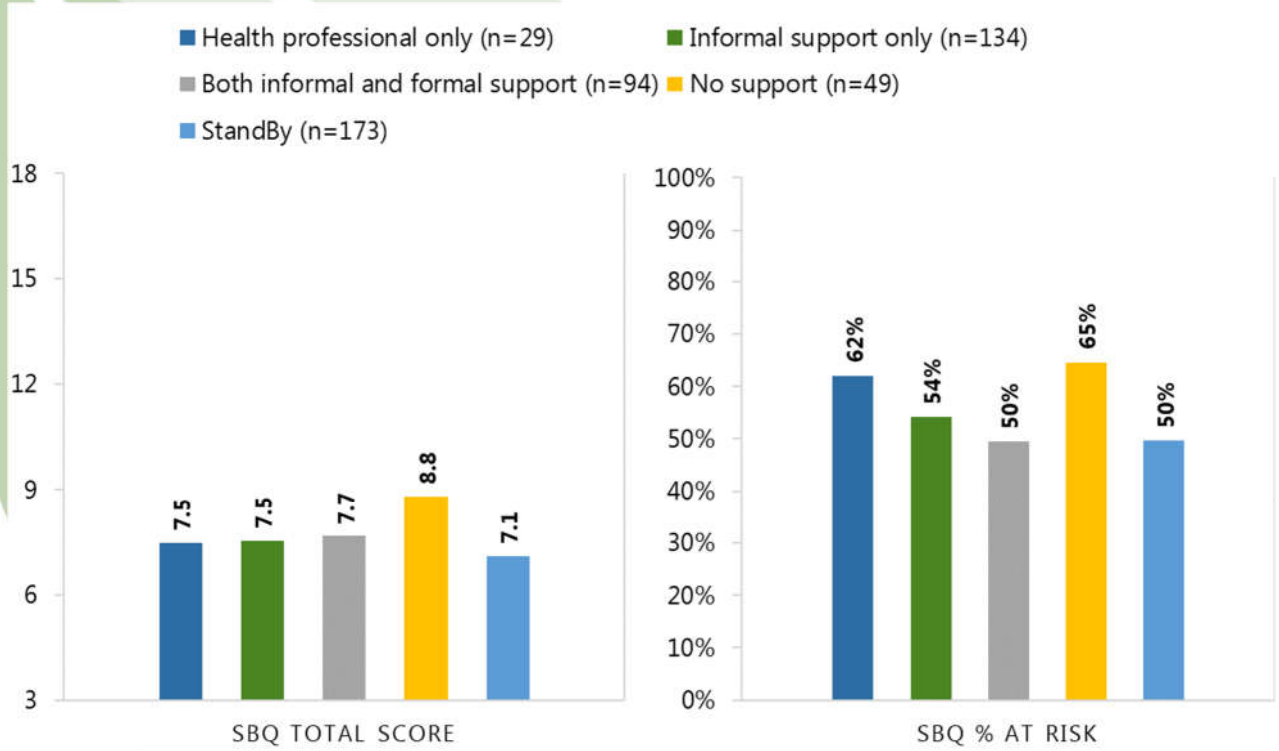
*Statistically significant difference, * = P value <0.05, ** = P value <0.01*

Figure 15: GEQ scores at Time 1 by type of support received



*Statistically significant difference, * = P value <0.05*

Figure 16: SBQ total scores and percentage at risk of suicidality at Time 1 by type of support received

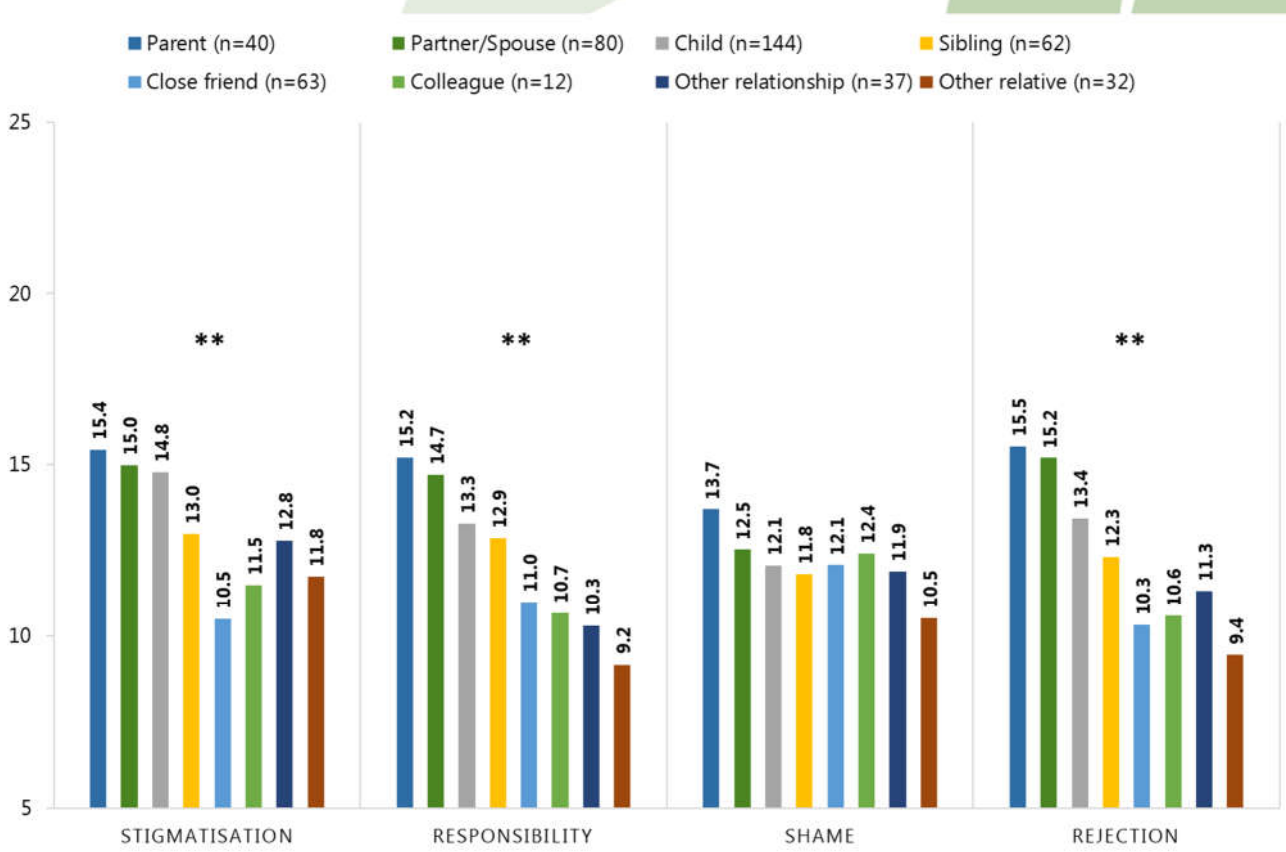


Relationship to the deceased

Several studies have shown that the relationship someone has with the person who dies by suicide has a substantial impact on their grief response. This analysis shows the results for key outcomes for all participants at Time 1 (n=470), comparing the key outcomes by the relationship with the deceased person.

Interestingly, there were no significant differences in the average scores for loneliness as measured by the DLS (Emotional Loneliness, Social Loneliness or Overall Loneliness) or suicidality as measured by the SBQ. However, there were significant differences in three of the four grief reactions measured by the GEQ – Stigmatization, Responsibility and Rejection (see Figure 17). Participants who lost a parent, partner/spouse or child tended to have higher scores than other participants. This result is consistent with other research on the impact of relationship on grief outcomes.

Figure 17: GEQ scores at Time 1 by type of relationship



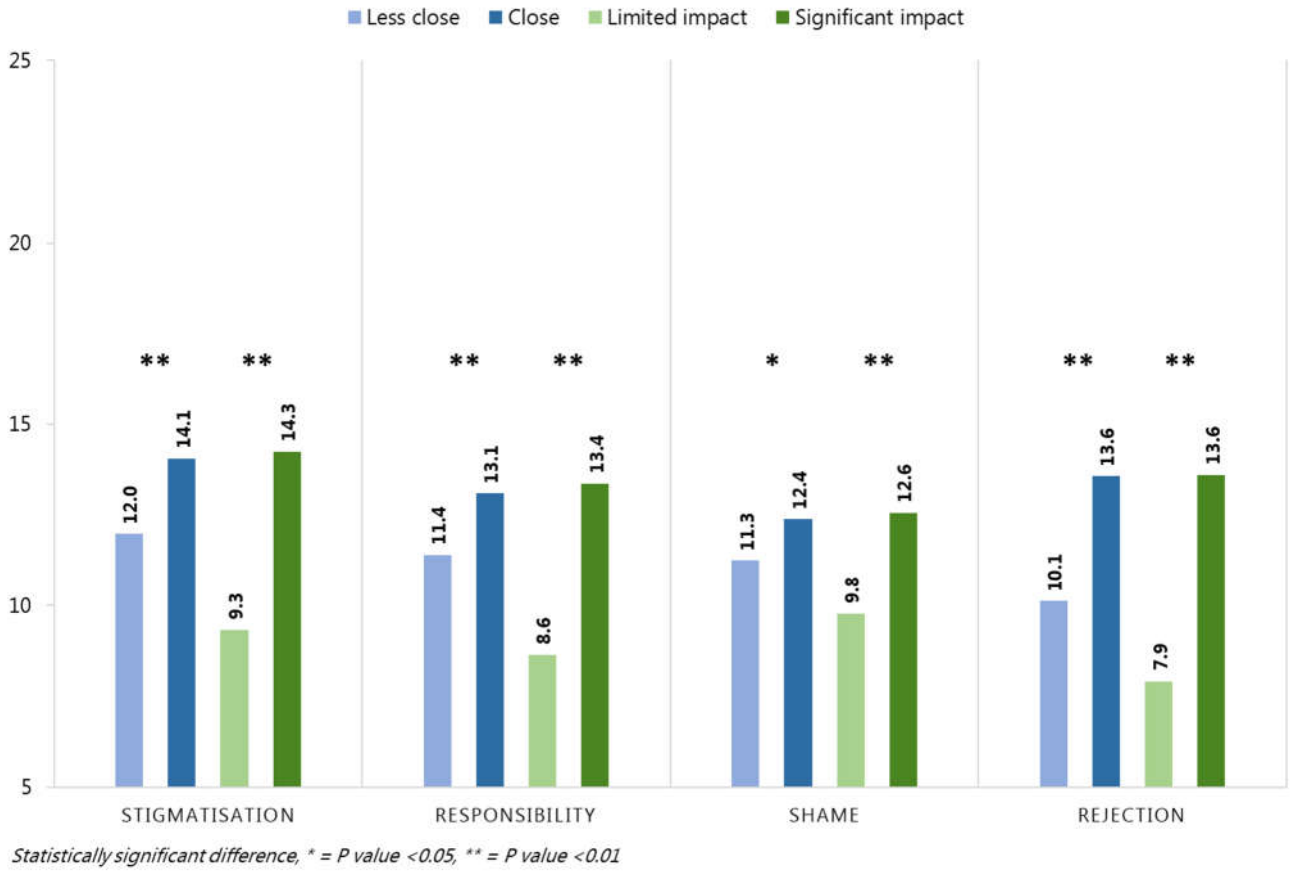
*Statistically significant difference, ** = P value <0.01*

Closeness of relationship and impact of the death

As previously discussed, participants were asked to indicate the level of closeness they had with the person who died, as well as the impact they felt the death had had on their lives. This analysis looked at differences in the key outcomes based on the level of closeness and the perceived impact of the death, using data from those participants who completed the survey at Time 1 (n=470 for closeness and n=458 for impact). The results for level of closeness were categorised into two groups – *close relationship* ('close' or 'very close') or *less close relationship* ('not close', 'a bit close', 'moderately close'). Similarly, level of impact was categorised into two groups – *significant impact* ('the death disrupted my life in a significant or devastating way, but I no longer feel that way' and 'the death had a significant or devastating effect on me that I still feel') and *limited impact* ('the death had little effect on my life', 'the death had somewhat of an effect on me but did not disrupt my life' and 'the death disrupted my life for a short time').

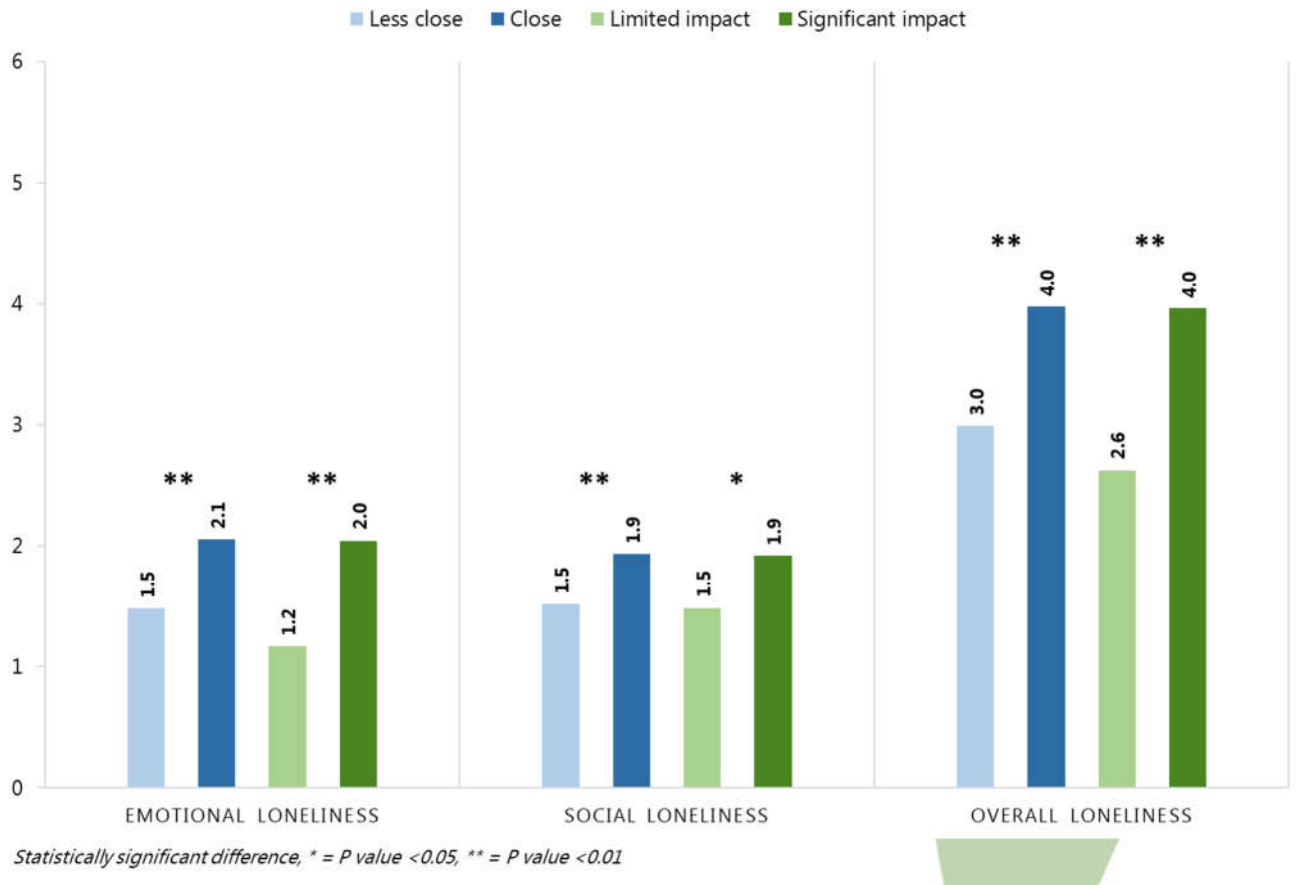
The results showed that there were significant differences across almost all key outcomes, depending both on the perceived closeness of the relationship and the perceived impact of the death on participants' lives. People who perceived their relationship with the deceased person to be close or that the death had a significant impact on their life had significantly higher scores on the GEQ grief reactions (Figure 18) and significantly higher levels of Emotional Loneliness, Social Loneliness and Overall Loneliness (Figure 19). Interestingly, only the perceived level of impact of the death had a significant influence on the level of suicidality and the proportion of participants at risk of suicidality (Figure 20). Fifty-four percent (54%) of participants who rated the impact of the death as significant were at risk of suicidality, compared with only 39% of people who rated the impact of the death as limited.

Figure 18: GEQ scores at Time 1 by level of closeness and level of impact



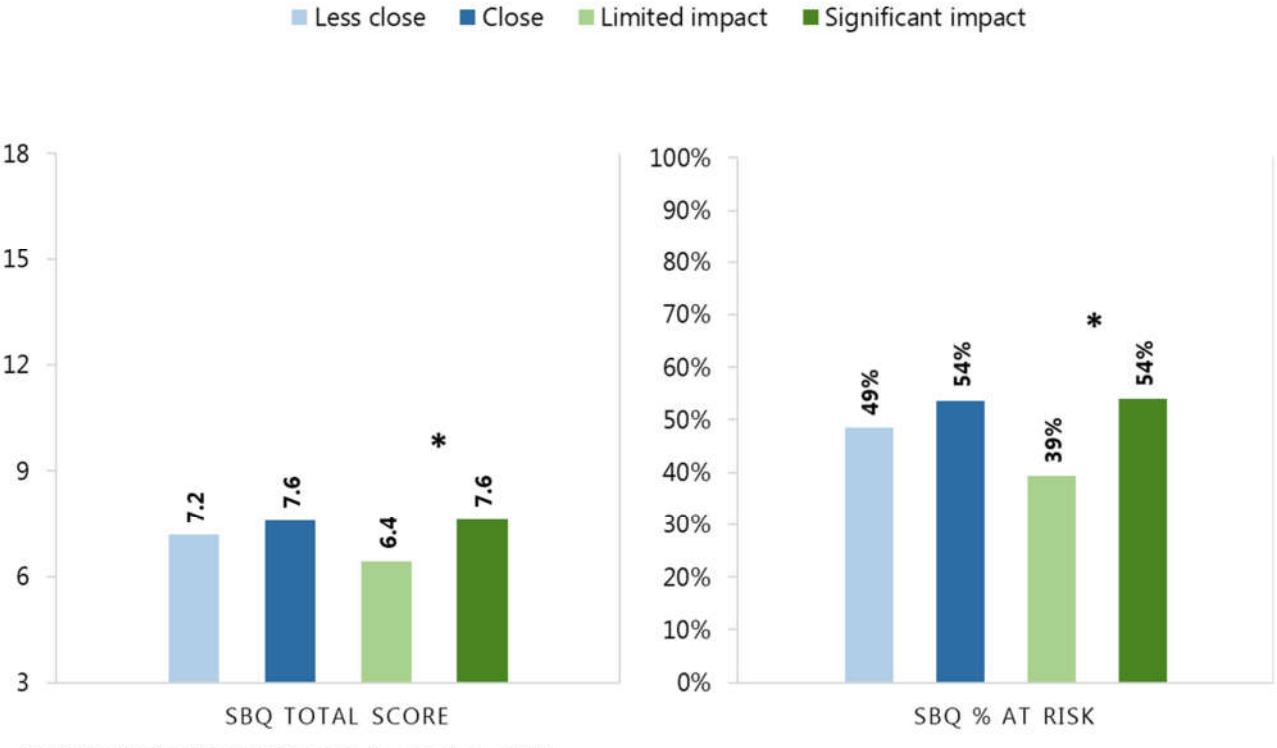
*Statistically significant difference, * = P value <0.05, ** = P value <0.01*

Figure 19: DLS scores at Time 1 by level of closeness and level of impact



*Statistically significant difference, * = P value <0.05, ** = P value <0.01*

Figure 20: SBQ total scores and proportion at risk of suicidality at Time 1 by level of closeness and level of impact



*Statistically significant difference, * = P value <0.05*

Experiences with StandBy

Support received

Participants from the StandBy group provided information about the support they received from StandBy, including which site they accessed support from, how they found out about StandBy, when they accessed support and their opinions about when the best time to receive support is. A large proportion of participants (45%) accessed support from Queensland-based sites – Brisbane, East Coast Queensland, North Queensland and North West Central Queensland. An additional 15% accessed support from the North Coast NSW site. An additional quarter of participants accessed support from other sites, while 16% did not report which site they accessed support from (see Table 3).

One-third of participants heard about StandBy through first responders (Figure 21), while a further quarter heard about the service through family or friends. Almost one-quarter (23%) found out about the service through other means, which included Facebook, the Coroner's office, the hospital, their school or workplace, or another person, such as the funeral director. A small number of people also indicated that StandBy contacted them directly or simply 'showed up' at their house. A small proportion of people (8%) indicated that they found StandBy on the internet, while a similar proportion (7%) reported that they already knew about StandBy. Only three percent reported that they found out about StandBy through their doctor.

In terms of when people accessed support through StandBy, just over 40% of participants accessed support within days of their loss and 70% accessed support within the first two weeks after their loss (see Figure 22). Further, participants tended to think that this was the best time to access support, with almost half of participants believing that it was best to be contacted by StandBy straight away (see Figure 23). An additional quarter of participants thought that the best time to be contacted by StandBy was about a week after the loss. The majority of participants (66%) were ready to speak to StandBy on the first call, but a small proportion either needed more than one call (8%) or couldn't remember (12%) (see Figure 24). Thirteen percent of participants reported that they had to contact StandBy themselves or accessed support in another way (e.g. through a family member or StandBy just 'showed up' at their house).

Table 3: Site where survey respondents from StandBy group received support

StandBy site	Number	Percentage
Brisbane	27	16%
East Coast Queensland (e.g. Sunshine Coast, Wide Bay, Central Qld)	26	15%
North Coast (New South Wales) (e.g., Tweed Heads, Byron Bay, Port Macquarie)	26	15%
North Queensland (e.g., Cairns, Townsville, Mackay)	23	13%
Canberra	11	6%
Tasmania	9	5%
Murray (Victoria)	8	5%
South Australia – Country South	8	5%
Northern Territory	6	3%
South Australia – Country North	2	1%
North West Central Queensland (e.g., Mt Isa, Longreach, Boulia, Birdsville)	1	0.6%
Kimberley	0	0%
Perth	0	0%
Pilbara	0	0%
No response	27	16%
TOTAL	**174**	**100%**

Figure 21: How participants found out about StandBy (n+155)

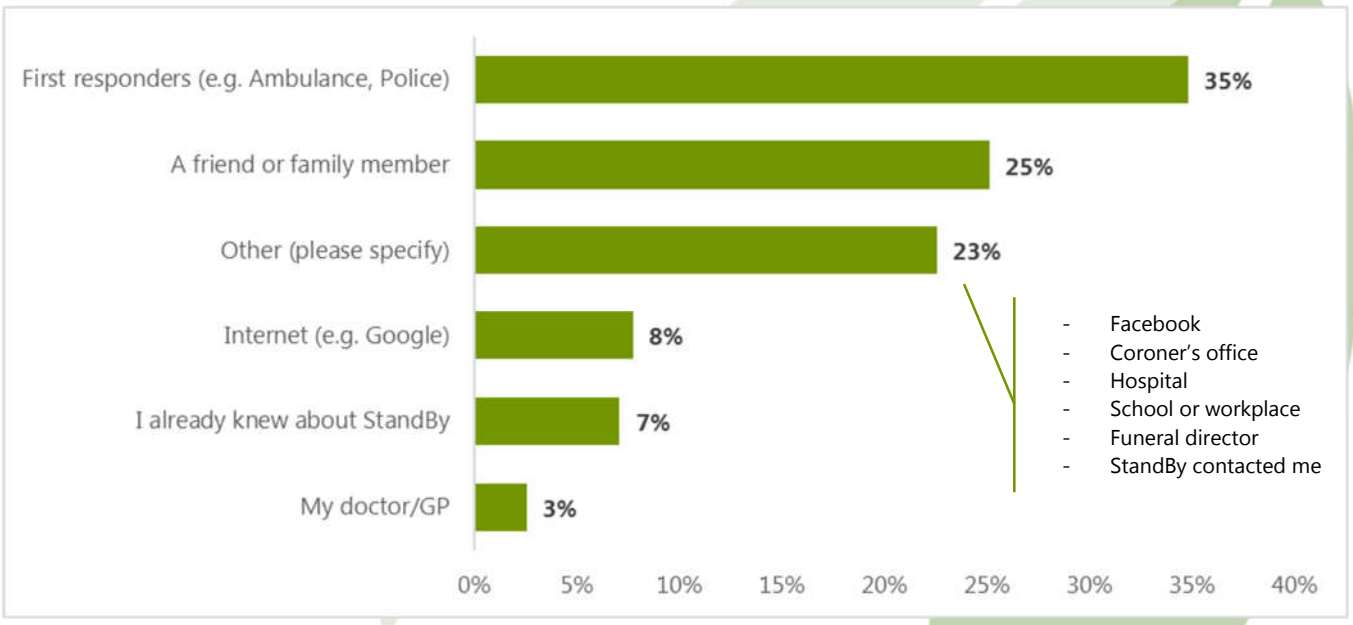


Figure 22: Length of time after loss when respondents accessed support from StandBy (n=151)

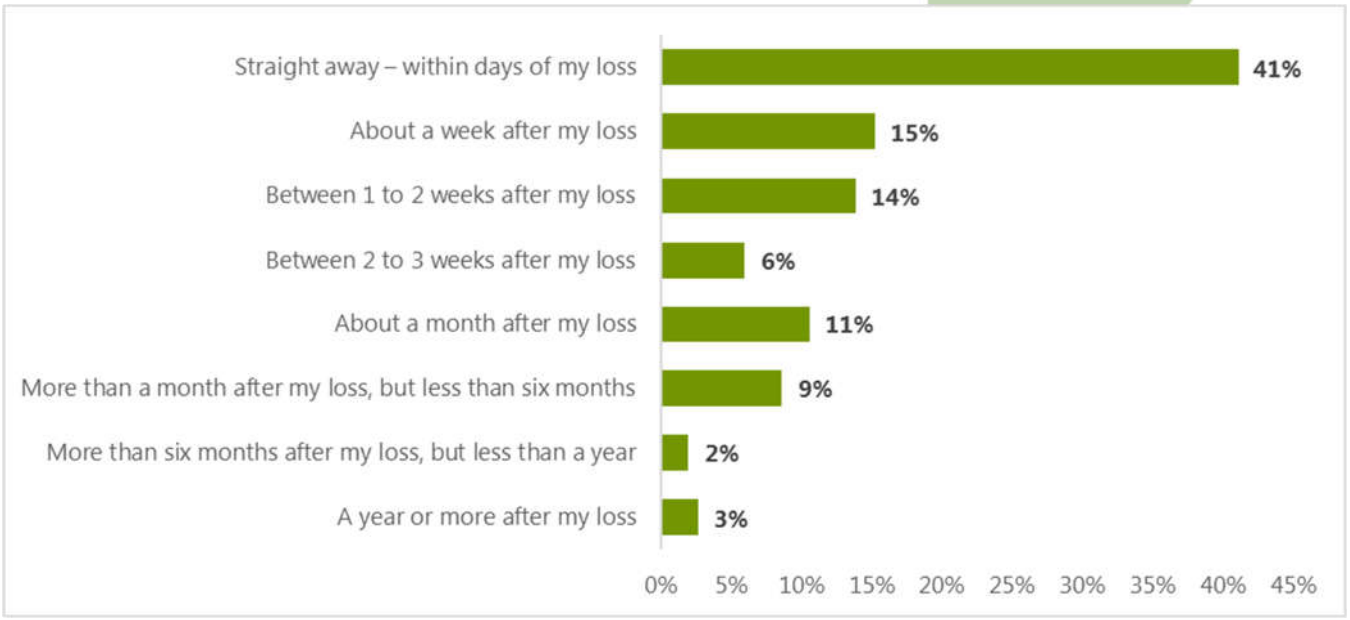


Figure 23: Best time reported by respondents to be contacted after their loss (n=153)

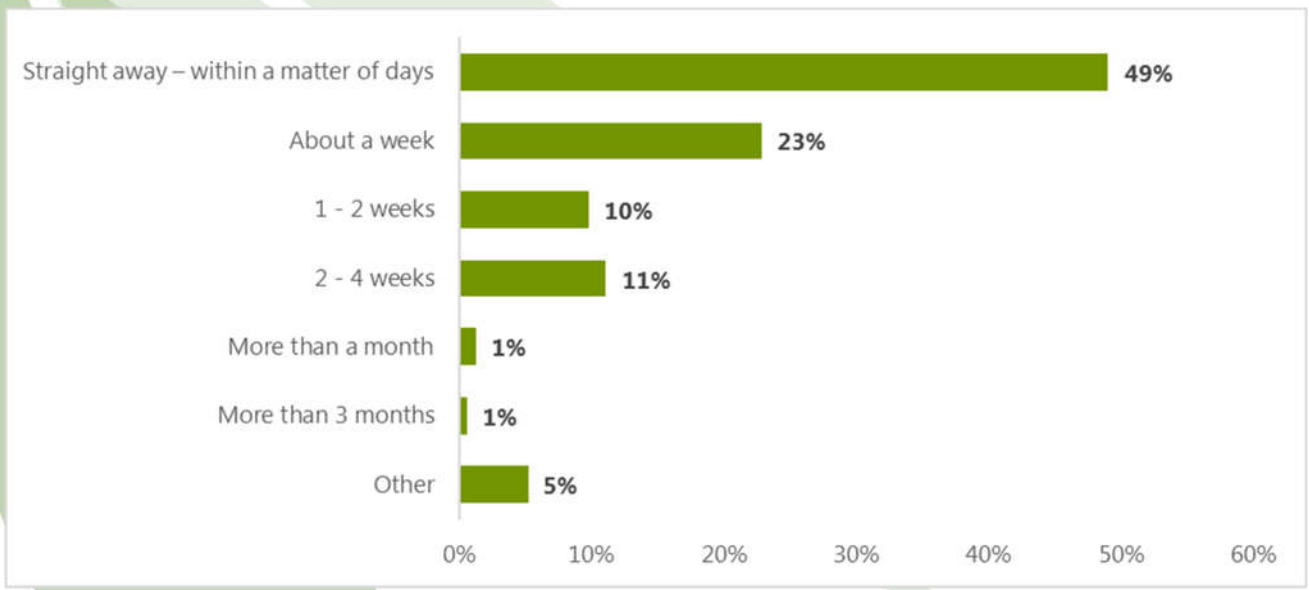
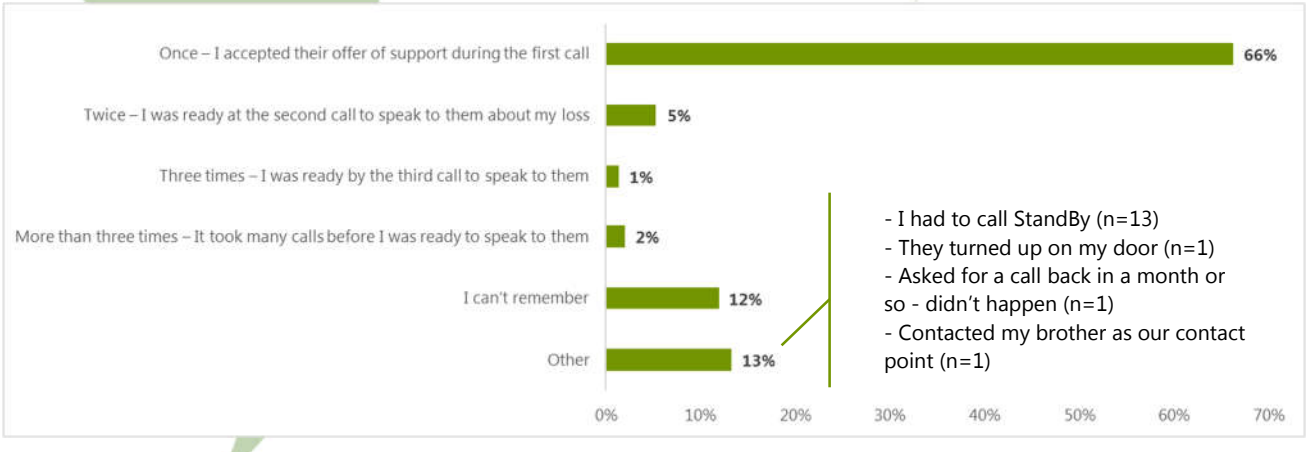


Figure 24: Number of times StandBy contacted respondents before they were ready to speak (n=151)



Satisfaction with StandBy

Participants in the StandBy group were asked to indicate their satisfaction with various aspects of the support they received from StandBy. There were 12 satisfaction questions, which used a five-point Likert scale (*strongly disagree* to *strongly agree*) with a 'don't know/unsure' response option available.

The results have been colour-coded using a traffic light system (i.e. green, amber, red) to provide an indication of the level of satisfaction and to allow results to be easily differentiated between different groups. The cut-off points for each colour code are:

- Green zone – average score of 4.0 or more out of 5. This generally equates to approximately 80% or more of participants satisfied.
- Amber zone – average score of between 3.7 and 3.9 out of 5. This equates to approximately 67%-79% of participants satisfied.
- Red zone – average score of 3.6 or below. This equates to approximately less than 67% of participants satisfied.

Areas in the green zone are those that are doing well where participants are generally satisfied. Areas scoring in the amber zone may require some attention and improvement. And areas in the red zone should be immediately addressed.

Overall, participants reported being very satisfied with the support they received from StandBy (Figure 25). Based on the average score, nine of the questions scored in the green zone (average score of 4 out of 5 or above) and three questions scored in the amber zone. No questions scored in the red zone. The three highest scoring questions related to participants' willingness to recommend StandBy to others in similar situations, their overall satisfaction with the service and the timeliness of the StandBy's support (top of Figure 25). The three lowest scoring questions related to participants' feeling overwhelmed by all the information provided by StandBy, the usefulness of the information about Lifeline and the Suicide Call Back Service, and participants' opinions about whether StandBy helped to reduce the stigma they felt (bottom of Figure 25). However, it is some of the other mid-scoring questions that perhaps are most telling of the impact of StandBy's support on people's lives. For example, 87% of participants agreed that StandBy encouraged them to connect with family, friends or other social support and 82% believed that StandBy provided the practical support they needed after the loss. Almost four out of five people agreed that StandBy helped them cope better with the emotions they experienced and 76% agreed that they could not have easily coped with StandBy or have gotten equally good support from other professionals. These results show that the types of support StandBy provides are delivering real, tangible benefits for the majority of people who access the service, helping them to cope in such a difficult and emotional time in their lives. These results also corroborate the other findings outlined in this report – such as decreased feelings of loneliness and some grief reactions.

Figure 25: Satisfaction with StandBy

Comments about StandBy

Participants who accessed support from StandBy were asked three open-ended questions in the survey:

1. What are the top 3 most vital things that StandBy did for you?
2. What else could StandBy have provided that would have made a big difference?, and
3. Do you have any other comments or feedback to provide about the service you received?

One hundred and thirty-nine people provided comments on what the most vital things that StandBy did for them were. There was considerable overlap in participants' comments, with a dozen themes raised across all the feedback. The mostly commonly mentioned themes were:

- Listening (80 mentions)
- Providing practical support, information and resources (74 mentions), and
- Having a good understanding of suicide bereavement and being able to normalize their feelings (67 mentions).

Other themes included StandBy staff being kind, caring and compassionate (36 mentions), providing continuity, ongoing support and follow-up calls (34 mentions), availability in-home or over the phone and 24/7 support (23 mentions), providing or encouraging connections with other supports (20 mentions), supporting people to move forward in their lives (19 mentions), reducing stigma and being non-judgmental (10 mentions), providing an external, confidential support (9 mentions), ensuring people didn't feel alone (8 mentions), and providing a safe space (6 mentions).

Some examples of participants' comments are below.

"Gave me confidence that I was handling things the right way for me and my family."

"Speaking to the same person helped reduce telling the story, so a consistent channel of communication."

"Help to navigate the systems for other supports."

"Provided information about how to explain my husband's death to our young son."

Fifty-one people provided additional comments on what else StandBy could have provided that would have made a big difference. More regular follow-up and follow-up beyond 12 months was a common theme in these suggestions, as well as more linkages with ongoing counselling services and support groups. In particular, several people would have liked more information on supporting children. One person suggested that StandBy establish its own support groups for people bereaved by suicide. Another suggested that StandBy needed some more culturally appropriate resources. The other main theme raised in these comments was the need for more practical assistance, such as financial support, assistance with attending appointments, etc. There were a small number of comments related to individual staff members who participants did not connect well with. However, some of these were followed by comments about how this was appropriately addressed by the service.

Other comments provided by participants mirrored the themes highlighted in the most vital things StandBy does, with most expressing thanks for the support and elaborating on their personal stories.

Study limitations

A longitudinal observational study design with an online survey was selected as an appropriate data collection method to compare outcomes between the StandBy group and the comparison group and to observe changes over time, as an experimental design with randomisation is difficult and potentially unethical with the target population (people bereaved by suicide).

However, there are several limitations to the study design that should be considered when interpreting results. The study used a convenience sample for the comparison group, and all participants self-selected to participate in the study. This may have led to selection bias, whereby people bereaved by suicide who chose to participate may not be representative of the whole population of people bereaved by suicide in Australia. The survey is also a self-report measure, which relies on people responding accurately and truthfully.

The time between data collection points was relatively short (three months) to detect changes in the key outcome variables. Ideally, participants would be followed up at least twice after the initial baseline measure to establish a clear trend of any changes in the outcomes. Other recent research has followed up participants at six months, 12 months and 24 months. However, for this project, the project timeframe and the risk of attrition (i.e. drop-outs) was deemed too high to lengthen the time between datapoints. In this study, the follow-up response rate was 34%, meaning that 66% of participants who completed the first survey did not go on to complete the second survey.

Finally, an observational design cannot establish cause and effect – that is, it cannot confirm that receiving support from StandBy is the sole or partial reason underlying any differences between the StandBy group and the comparison group. There are many variables that may have contributed to these differences that are difficult to control for. Indeed, there were some significant differences between the demographic characteristics of the StandBy group and the comparison group, but these differences were accounted for, where possible.

“Provided intelligent, compassionate and ongoing support to our large family and armed us to face a future without our loved one.”

Summary of findings

StandBy processes and service delivery

The response rates that were achieved in the study from people who had accessed StandBy's support were relatively low (approximately 10%), no matter which survey distribution method was used. Our experiences during the data collection phase of the project suggest that the approach of inviting people to participate during follow-up calls was not very effective in practice. Some coordinators felt that the process was quite burdensome amongst an already busy workload. Further, bias may have been inadvertently introduced through this process, as there was evidence that some people bereaved by suicide were not invited to participate, rather than being empowered to make their own decision on whether to participate.

It is apparent from this and previous studies that StandBy primarily supports close family members after a suicide. The StandBy group in this study were more likely to have lost a partner/spouse, child or other relative, while the comparison group were more likely to have lost a close friend. There may be opportunities in the future for StandBy to more actively engage with close friends of people who suicide. There is also evidence that women are more likely to engage with StandBy than men, supporting the common finding that women are more likely to display help-seeking behaviours than men. This may not be an issue, however, as the women may simply be the ones to arrange support, while the men may still receive support through those women. However, what it does mean is that client feedback may not provide a full picture of men's experiences of support.

People who accessed StandBy's support found out about it through a variety of different means, but primarily through emergency services, family and friends. Other means of advertising StandBy's service (e.g. social media) may attract more people to the service, particularly bereaved people who are not directly related to the person who died.

Overall, satisfaction with StandBy remains very high (similar to previous studies). In particular, people felt that they would recommend StandBy to others, that they couldn't have gotten equally good support elsewhere and that they couldn't have easily coped with StandBy. Although still scoring very high, there may be benefits in providing additional assistance in relation to the stigma around suicide. Stigmatisation is an area where people who accessed StandBy still scored highly, so further addressing this need may help to reduce feelings of stigma and judgement.

The open-ended comments were consistent with other findings from this report, highlighting the key benefits of StandBy as being good listening, providing practical support and information/resources, having a good understanding of suicide bereavement and normalising feelings. People's main suggestion for improvement was for more support over a longer period of time.

It is unfortunate that recruitment for Part B of this project – qualitative storytelling with Aboriginal and Torres Strait Islander peoples – was not successful. The experiences of this group of people who have accessed StandBy's support are not well understood and is a significant gap in knowledge for StandBy and the broader suicide prevention sector. As such, future research in this area would be highly beneficial.

For those people who had not accessed StandBy, the majority had accessed some other type of support, either formal or informal. However, there was still a sizeable group (more than 10%) who had not accessed any support after their loss. StandBy's current expansion into new regions across Australia will hopefully mean that the majority of Australians who become bereaved by suicide will have access to support going forward.

StandBy's impact

In terms of how StandBy may impact on people's experiences after a loss through suicide, the findings from this study support those from previous evaluations, showing that, within 12 months after the loss, people who received StandBy's support reported significantly lower levels of suicidality and loneliness than people who had not received their support. The results for grief reactions have been less consistent, but in this study the StandBy group reported significantly lower feelings of shame than the comparison group. It is perhaps not

surprising that people who had accessed StandBy did not have significantly different grief reactions from other people bereaved by suicide – StandBy may not have the ability to change people's reactions to the death. But it does appear to have an impact on people's response to those reactions in the form of reduced suicidality. And it seems to help people feel less alone and more supported – a result that was confirmed through the open-ended comments. Also similar to the previous evaluation, the results for people whose loss was more than 12 months ago showed limited differences between the groups. These people (StandBy and comparison groups) were not typically doing substantially better than people whose loss was within the past 12 months, suggesting that the impact of suicide stretches well beyond the first 12 months after the loss.

In terms of how people's experiences changed over time, for people whose loss was within the first 12 months, the results showed that, in general, people's loneliness, suicidality and grief reactions remained relatively stable over a three-month period. Loneliness remained stable over time, but the StandBy group still reported significantly lower levels of loneliness than the comparison group. For suicidality, the StandBy group showed a slight decline over time, while the comparison group showed an increase in their average score. The difference between the StandBy's decline and the comparison group's increase was statistically significant. This suggests that support from StandBy may help to continue reducing the risk of suicidality for bereaved people, while others' risk may continue to rise over time. This is a significant finding and further supports the consistent finding that StandBy plays a role in preventing further suicides amongst bereaved people.

The results for grief reactions also tended to remain stable, with neither group showing any significant changes. However, again, the StandBy group tended to decline slightly over time, while the comparison group tended to remain stable or increase slightly.

It is important to keep in mind that people in this group (within the first 12 months) were mostly asked to participate in the study at their 3-month follow-up call. As such, most were approximately 3-9 months post-loss. It is probably reasonable to expect that there wouldn't be too much change in their feelings during this time. As it's almost impossible to gather a 'baseline' measurement (i.e. immediately following the loss), it has not been possible to compare how their feelings change over the first few months. Nor have we been able to track changes over a longer period of time (e.g. 1-2 years). However, other recent research showed that several grief reactions (e.g. stigmatisation, rejection) declined significantly over six, 12 and 24 months for people bereaved by suicide.[15]

For people whose loss was more than 12 months ago, the results showed very few differences, either over time or between the groups. The percentage of people who found to be at risk of suicidality in both groups was far lower for people whose loss was more than 12 months ago, compared with people whose loss was within the last 12 months. This is not particularly surprising, but does suggest that the risk of suicidality is greatest in the initial period after the loss and may reduce over time. However, overall, the levels of grief reactions, loneliness and suicidality remained high for people whose loss was more than 12 months, suggesting that the grief process for people bereaved by suicide is ongoing and non-linear. Feelings of grief may wax and wane over time, perhaps continuing for many years.[15] As such, ongoing support for some people following a loss through suicide is warranted.

StandBy compared to other types of support

When different types of support were compared, people who had received support from StandBy showed lower levels of loneliness, suicidality and grief reactions (with the exception of stigmatisation). For people who didn't access support from StandBy, people who did not access any support tended to show the highest levels of loneliness and suicidality, followed by people who only accessed formal support from a health professional. This may seem counter-intuitive, perhaps suggesting that receiving formal support (e.g. from a psychologist or other health professional) doesn't help people bereaved by suicide to reduce their feelings of loneliness or grief reactions. However, it may, in fact, suggest that people who were more impacted by the death sought more formalised support from a health professional, compared with people who were less impacted, who may not have required or chosen to access formal support. However, the results suggest that accessing a range of formal and/or informal supports is most likely to result in better outcomes.

Other factors that influence outcomes

There are likely many factors that influence how people respond to the death of a loved one through suicide. In this study, the relationship with the person who died had a significant impact on people's grief reactions, but not on their levels of loneliness or suicidality. However, the most influential factors were how close the bereaved person thought they were to the person who died and how much impact they felt the death had had on their life. The perceived closeness of the relationship had a significant effect on grief reactions and levels of loneliness, while the perceived impact of the death significantly influenced suicidality as well. These results support other research that showed that closeness of the relationship and impact of the death are better predictors of grief and mental health outcomes than other factors traditionally seen as important, such as the relationship to the person who died.[22]

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