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Suicide Survivors Support Services and Postvention Activities

The availability of services and an intervention plan
in Brazil

Author: Karen Scavacini

Supervisor: Britta Alin-Åkerman, PhD, Nationell Prevention av Suicid och Psykisk Ohälsa (NASP), Karolinska Institutet.

Examiner: Anna Månsdotter, PhD, Department of Public Health Epidemiology, Karolinska Institutet.

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Tanja Tomson
Programme Director



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Abstract

Aim: This study aims to address the need of suicide survivor support services and postvention activities in Brazil.

Background: Suicide survivors, referring to the people that lost someone or those affected somehow from other person suicide, tend to experience a more complicated bereavement and psychological morbidity, as well as increased suicidal behaviour. Postvention activities and programmes are currently underway in many countries to decrease these outcomes.

Methods: Literature review of interventions, services and postvention activities available to suicide survivors in their bereavement, along with some other country-specific services, identify the current practices that support the design of a research-based intervention plan.

Results: The services available could be divided into one-to-one, psychosocial and Web based services, at active or passive type of provision and offered immediately, after a short or long period after the suicide. A wide range of services, policies and guidelines are available in some countries. Brazil has any service available for suicide survivors.

Conclusions: Suicide survivors need support and services available for them to decrease the complicated grief outcomes that they usually face. Furthermore, suicide postvention can also be suicide prevention. A suicide postvention multi service center is the proposed solution for the lack of this type of services in the country.

Key words: suicide, bereavement support, grief, survivor, prevention, postvention, public health intervention, mental health promotion.

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1 – INTRODUCTION

“A person’s death is not only an ending:
it is also a beginning for the survivors” (Shneidman, 1973)

Suicide invariably results in pain and grief to those who are left behind; poor outcomes, psychological morbidity and increases of suicidal behavior can be seen in suicide survivors all around the world. In Brazil similar mental health issues are seen in survivors of people who have completed suicide, however, services available for them are particularly difficult to find in this country.

Even though suicide survivors deal with their grief with or without professional help, postvention care, that is actions and activities, like interventions, support and assistance for those affected by a completed suicide is increasingly recognised as an important component of mental health care systems. Interventions aims at modify an outcome for prevention, treatment or rehabilitation. Postvention aims at helping survivors address the traumatic effects of their loved ones’ deaths (Yufit and Lester, 2004), and is defined by Shneidman, who coined this term, of appropriate and helpful acts that come after a dire event. (Shneidman, 1972, cited by Campbell et al., 2004). Postvention services are a very important tool for suicide survivors and, ultimately, for suicide prevention, and given the suicide rates in Brazil, such services should be more broadly available. Without proper care, suicide survivors, especially children, can experience traumatic and complicated grief outcomes. Postvention services allow suicide survivors to have access to specialized and appropriate bereavement care, and reduce the risk for follow-up suicides in this vulnerable group.

Although suicide bereavement support services are included in postvention activities, to be clear about which type of service it was proposed or explained in this study and give more emphasis in bereavement support when needed, both terms were used.

This study will examine the impact of suicide, the number of suicide survivors, the suicide bereavement outcomes, the predictors of poor response, the morbidity, the need of services, the history of response to suicide survivors overseas and in Brazil followed by the most common suicide bereavement support services found in the literature, a service delivery model and what some countries and Brazil have available for this population.

Finally, a recommendation of what could be accomplished in Brazil to effectively support suicide survivors and raise the suicide postvention activities, concurrently with a reasonable solution to provide those services in an ideal model of suicide postvention center, based on the literature review, in order to improve mental health and prevent suicides among suicide survivors in Brazil will be provided. How to get there, the goals, the potential barriers, the strengths and limitations, the implications of the findings and the ethical considerations will also be discussed in chapter 6. The acronyms, terms and definitions used in this research are available at the Appendices I.

2 – BACKGROUND

2.1 - The impact of suicide on World mental health

Every year, approximately one million people commit suicide. Completed suicides result in a mortality rate of 16 per 100.000 people, or one death every 40 seconds. Suicide is the world's 13th leading cause of death, and the 3rd most frequent cause of death among people aged 15 to 34 years old. In some countries, (i.e. EUA, China, Australia, etc.) suicide comprises either the 1st or the 2nd leading cause of for people 15 to 19 years old of both sexes. (WHO, 2010)

Even though usually the male elderly have the highest suicide rates, in a third of the countries, the young people is now at the highest risk, as their rates have been increasing in a large extend. (WHO, 2010)

Suicide rates have increased globally by 60 % over the past 45 years and are expected to continue to increase. These data do not include suicide attempts, which, according WHO (2010) can be 20 % higher than completed suicides.

Suicide is a multifaceted outcome of various, inter-related factors. Suicide risk factors can be categorized as biopsychosocial (mental disorders, alcohol and substance abuse, hopelessness, history of trauma, family history of suicide, etc); environmental (job or financial loss, relational or social loss, contagious influence, etc.) and socialcultural (lack of social support and sense of isolation, difficulties to access health care, stigma, some cultural and religious believes, influence of others that have died by suicide, etc.). (SPRC, 2001)

2.2 – The impact of suicide on Brazil's mental health

Nowadays Brazil has almost 197 million people and although the national suicide rate is fairly low on comparison of others countries (4,9 per 100.00 habitants) the total suicide rates increased 33,5% in 10 years (1998-2008). In absolute numbers this places the country in the 9th global rankings for suicide deaths. (Mello-Santos et al., 2005) On average, official statistics show that 24 people commit suicide every day in Brazil (1 per hour) but the actual number of suicide deaths can be 20% higher because of non registered cases and low quality of information in death certificates. (Mello-Santos et al., 2005, Botega, 2010, Meneguel et al., 2004)

In the last ten years in Brazil, the rates of death by suicide (33,5%) have increased more than the rates of death by traffic accidents (26,5%) and homicides (19,5%), being the males at higher risk, as men committed 2,3 to 4 times more suicide than the women (IPEA, 2010, Waiselfisz, 2011). Although suicide rates are highest in men over 75 years old (15 per 100.000), suicide rates for young adults males (between 15 to 24 years old) have increased the impressive 1900% over the past two decades, (from 0.3 to 6.0 per 100.000). Suicide deaths for young adult women have increased 300% (from 0.5 to 2.0 per 100.000) over the same period. (Mello-Santos et al., 2005, Botega, 2010, Meneguel et al., 2004)

As seen in other countries, Brazilian cities usually demonstrate higher rates than the capitals. Several researchers have noted the range of different suicide rates within and between Brazilian states, and speculate that this variation may be due, in part, to differences in levels of development and public health policies available in each one. (Waiselfisz, 2011, Lovisi et al., 2009)

Some areas in Brazil present higher suicide rates, particularly the South (8,2) and the Centre-West regions (6,3). There are cities however with exceptionally high suicide rates: Amaraí and Paranhos, both in the state of Mato Grosso do Sul have rates of 49,3 and 35 per 100.00 inhabitants respectively, with are among the highest rates in the world. The majority of suicides in these locations are among native tribes. (Waiselfisz, 2011)

It is estimated that in 2001 alone, the economic cost of production loss due to the suicide deaths, adjusted for survival rates in Brazil was US\$0,6 billion, or US\$75.000 per victim, and the YLL, which means the years of life lost due premature death due suicide was 1,57 million of years. (Carvalho et al., 2007)

2.3 – Number of Suicide Survivors

In 2008 Brazil reported 9.328 deaths by suicide (Waiselfisz, 2011), Data from the World Health Organization (2008), estimates that, for every suicide, there are on average five to ten people who are severely affected by the suicide (WHO, 2008). Other studies estimate that the number of affected people can reach over 28 individuals per suicide (Bland, 1994). Coleman (2005) states that in some families the estimated numbers exceed 50 people. Using the most conservative estimates of WHO, each year in Brazil, at least 55.968 people are directly affected by suicide deaths.

2.4 - Suicide Bereavement Outcomes

Although suicide is an individual and solitary act, it can be considered the most painful type of death for families to deal with, as survivors, and those effects can be devastating for those left behind (Jaques, 2000, Cerel et al., 2008).

Researchers studying bereavement have assessed if there are differences in grief suffered by suicide survivors, compared to survivors who have lost friends or family to other types of death. Van der Wal (1989-90) states that there is no empirical evidence that suicide survivors have a more pathological grief than other survivors. McIntosh (1993) shows that there are many more similarities than differences in bereaved processes between suicide survivors and other types of bereavement groups, than there are differences.

Nevertheless other studies have found that suicide survivors, compared to mourners of accidental, expected, and unexpected natural modes of death, can have different or more severe grief reactions (Jordan, 2001, Jaques, 2000, Ellenbogen and Gratton, 2001, Ness and Pfeffer, 1990). Differences are seen in the thematic content expressed by suicide survivors when they discuss their grief, and the social processes surrounding the survivors. Suicide deaths also differ in

the impact such deaths have on family systems. Research has found that survivors have heightened feelings of responsibility and rejection, greater difficulty in making sense of the death, and greater overall grief reactions (WHO, 2008, Jordan, 2001). There are clear differences in the length, intensity of grief as well as an increase in depressive symptoms for these survivors when compared with other types of bereavement. (Dunne and Dunne-Maxim, 2009, Wasserman, 2001)

Suicide bereavement tends to be a lonely road: people (including family members) who usually would give support and comfort for other types of death distance themselves, leaving suicide survivors alone to deal with the situation. (Jaques, 2000, Tzeng et al., 2010) Isolation may also be selected as a coping reaction by survivors, resulting in them feeling distance from other people and not perceiving offered help, feeling more isolated and stigmatized that they really are (Jordan, 2001).

The social outcomes for suicide survivors often result in changes in family dynamics, changes in social dynamics and relationships, social ostracism and self-isolation. Suicide survivors are also vulnerable to increased use of sick-leave, experience of legal and financial difficulties, academic failure and changes in social identity, or group membership (belonging now to suicide survivors group), etc (Cerel et al., 2008).

The psychological outcomes for suicide survivors may include increased risk of anxiety disorders, mood disorders (especially depression), traumatic grief, sleep disorders, PTSD, anhedonia, substance abuse, and, sadly, increased risk for self-harm and suicidal ideation/attempts (Grad, 1996).

The most common emotions described under the thematic content of the grief by suicide survivors include shock, denial, pain, confusion, despair, continuous searches to understand why the loved one completed a suicide, blame, shame, guilt, anger, disbelief and yearning. The stigma of a loved one's death through suicide can be an additional burden on the bereaved, (Wilson and Clark, 2005) and becomes intertwined with other emotional reactions to grief. (Jordan, 2001, Cerel et al., 2008, Sveen and Walby, 2008, Dunne and Dunne-Maxim, 2009)

During bereavement, gender differences in grief coping styles can be observed both in family members suicide survivors as in reactions of therapists that lost a patient for suicide. Murphy (2000) observed that over 5 years period after the suicide death, fathers presented deterioration in health and PTSD symptoms, when mothers usually demonstrate and improvement in health and functioning. Women respond differently and more positively to interventions than men. (Jordan and McMenemy, 2004) For the therapists that had lost a patient for suicide, women had an increased feeling of shame and guilt and were not confident about her professional capacity. (Grad et al., 1997)

For the *families left behind after suicide deaths*, relationships and can be seriously affected, including the connection with the children, problems related to different grief and coping styles, disturbance of the family role functioning, deterioration of family ties and intergenerational boundaries, interference of the relationships between and outside the family. There are also the "sleeping effects",

that is the long-term effect of losses, like changes in the family developmental processes and communication patterns, leading to the spread of a family world view to the future generations, or a negative intergenerational impact of such losses in the family system and which can appear long time after the death. (Jaques, 2000, Jordan, 2001)

The exact effects on *children* after suicide of a parent are not well studied to date. One study posits that the parental suicide is such a terrible experience that could be compared to a child abuse. (Wright and Partridge, 1999) Studies show that children and adolescents who are suicide survivors have greater incidences of psychological morbidity when compared to controls. For children experiencing suicide bereavement, some effects have been documented from the suicide death to 25 months after the suicide, nevertheless those effects can continue during lifetime, including mental health problems, post traumatic stress disorders (PTSD), traumatic grief, behaviour problems, aggressiveness, mood and anxiety disorders, suicidal behaviour), functional problems (academic difficulties, impaired social adjustments...), negative emotions (anger, sadness, guilt, anhedonia) and somatic distress (stomach pain, headaches...), reactions that are similar to those found in adults. (Cerel et al., 2008, Pfeffer et al., 1997, Cerel et al., 1999, Sethi and Bhargava, 2003, Melhem et al., 2004b, Melhem et al., 2004a)

Furthermore, the *siblings* can also be the “forgotten mourners”. (McIntosh and Wroblewski, 1988) Many surviving siblings tend to protect their parents from their pain and delay their own grief. They may also blame or support each other. (Jaques, 2000) Feelings of guilt, sadness, identification and grief can also be observed in other groups of survivors, like the siblings of schizophrenic individuals and siblings of mentally retarded children. (Titelman, 1991)

The *significant others*, which means people other than the family members that had a meaningful relationship to the deceased, tend to be the most neglected in the grief process because they lack legal and social status that family members have to the deceased. These survivors are often left to learn by themselves to cope with the loss and distress while, at the same time, they are commonly also called upon to help survivors who are family members. Such events can be very problematic for younger people. (Grad, 1996)

Service Providers, who have treated people who complete suicides are also affected, grief over the loss of a patient is often combined with the fear of facing the surviving family and the thoughts that they should have done better, which may increase their senses of failure and guilt. The reactions of a therapist to patient suicide can be affected by the circumstances in which the death occurred, the relational factors in the therapy, the personal history of the therapist regarding grief and death, the therapist’s personality and the social factors involved. (Grad, 1996) Almost 30 % of medical residents beginning their professional career will experience patient suicides. (Goldstein and Buongiorno, 1984) Among psychiatrists who experience patient suicides, post trauma symptoms are reported by 57 % (Chemtob, 1988 at Grad, 1996). Brown cited at Grad (1996) states that there are two types of therapists: “the ones that had already experienced a suicide of a patient and the ones who will” (pg 139).

2.5 – Predictors of Poor Outcome

There are a number of circumstances that can lead to complicating or even derailing the recovery process for suicide survivors.

The characteristics of the loss, the family resources, vulnerability, gender roles and belief systems (like religion, cultural, societal and scientific ideas, etc) about suicide will influence the adaptation of family members to the death. (Murray, 1994) Others predictors of poor outcome are the timing and concomitant stressors in the family cycle, the role and situation of the family member before the suicide and the presence of conflicted relationship with the person prior to their suicide. (Jaques, 2000, Ellenbogen and Gratton, 2001)

In some families a phenomenon called “relief effect”, or the reduction of the overall stress levels in the family after the suicide, can be observed, especially if the person who committed suicide had one or more severe psychiatric disorders or long-term illnesses before death. This sense of relief can contribute to an increase of mixed emotions during the grief period. (Reed, 1998 at Jordan, 2001)

The predictors/mediators of the suicide-caused grief outcomes for children include demographic factors (age, sex, race, income); the time that has passed since the loss; the type of relationship experienced with the deceased; the death itself (whether or not the child knows about the suicide, saw the body, witnessed previous attempts, attended the funeral, among other factors); the family dynamics before and after the death; the integration of the child/family with the society and the community; the offered and received support, and previous psychopathology in the survivors and in the deceased. (Cerel et al., 2008, Melhem et al., 2004b)

Factors that lead to prolonged or atypical grief reactions in children include the presence of family disruption, generational family dysfunction, stressful and abnormal home life because of mental illness before the suicide, the nature of the death, the effects of bereavement during formative periods and social and economical difficulties after the loss of parents. (Shepherd and Barraclough, 1976, Ratnarajah and Schofield, 2008, Cerel et al., 1999)

2.6 – Morbidity

An ongoing study at the St. Göran Hospital (Sweden) investigating the mental health of parents and siblings suicide survivors has shown that 18 months after a suicide, 62% of the parents had high scores of psychosocial stress, 52% had high levels of posttraumatic distress and 78% had high scores of complicated grief. Among surviving siblings, 73% of the siblings living in the same household of their parents, otherwise 39% of the siblings, demonstrated high levels of posttraumatic reactions. (Stain, 2010)

Another study (Prigerson et al., 1997) found that after one year of a child’s suicide, mothers continued to show high rates of depression, and siblings still had high grief rates at 12 and 37 months after the death. Begley and Quayle (2007) found that even though the family suicide survivors were able to find a sense of “purposefulness” in their lives following the suicide death, five years after the

death of loved ones they were still experiencing symptoms of mental distress.

Psychiatric, physical morbidity and premature death (especially through suicide) are increased, compared to other groups, among grandchildren of individuals who died by suicide. (Cain, 2006)

Parental suicide is often linked to the presence of severe mental illness in a family. The mode of parental death and offspring age at parental death are associated with offspring long-term risk for suicide and hospitalization for specific psychiatric disorders. In one study, children and adolescents whose mothers have died from suicide exhibited a threefold increased risk for bipolar disorder and, in the case of paternal suicide, had a twofold increased risk for being diagnosed bipolar. (Kuramoto et al., 2009)

Suicidal Behavior of Suicide Survivors

One strong concern is the finding that suicide survivors, including family members and social groups, experience their own increased risk of suicidal behaviour, a phenomenon identified as intergenerational and transgenerational transmission trauma. Transfer of elements of the historical trauma and reactions may occur between generations (intergenerational trauma) and across successive generations (Trans generational trauma), until redressed by individual, family and community healing. (Fonagy, 1999) For Cain (2006) this transmission can reach up to a third generation after a parent suicide and may affect not only the relatives, but also friends, professionals involved and the individual's community.

Another hypothesis, the so-called "suicidal diathesis", describing a propensity of suicide survivors to respond with their own suicidal behaviour during stress periods, could be related to a familial vulnerability both for environmental and genetic factors. (Jordan, 2001, Waern, 2005)

A family history of suicide increases suicide risk independently of the psychiatric illness (Qin et al., 2002); studies indicated that this risk can be two times higher, (Runeson and Asberg, 2003), or even three times higher when compared to controls (Kuramoto et al., 2009).

Suicide risks in later life can be increased fourfold if the person has a first-degree relative who has completed suicide. (Rubenowitz et al., 2001) Suicide survivors who are diagnosed with complicated grief have nearly ten times the likelihood of suicidal ideation, compared to others, after controlling for depression (Mitchell et al., 2005).

It is known that suicide usually runs within families, however heredity factor findings are inconclusive, nowadays studies about the genetics inheritance and environment interactions are trying to fill this gap. The science behind the research to explain increased suicide risks in suicide survivors is currently exploring the interactions between genetics and environment, but the available research on the increased risks of suicide for suicide survivors poses its own concern, as this knowledge may increase the fear in suicide survivors of finding themselves or someone close to them engaging in suicidal ideation or attempts (Cerel et al., 2008).

2.7 – The Need of Interventions

Recent studies have described the needs and benefits of suicide postvention for suicide survivors. Because of difficulties in evaluating these support programmes (lack of measurements, evidence of their effectiveness and insufficient studies on empirically based interventions), generally, unclear writings regarding the studies, more research is needed to define best practices in postvention programming, to prevent the negative outcomes, reduce the incidence of future suicides and promote better mental health in suicide survivors. (Wilson and Clark, 2005, Flexhaug and Yazganoglu, 2008)

Unfortunately many suicide survivors do not receive any postvention help. Certainly it is the case that some suicide survivors don't want or don't need any help outside family and social networks. It is estimated that only 1 in 4 survivors seek for the help desired, but within this group, 75% wished to have more formal postvention services. (Aguirre and Slater, 2010, Provini et al., 2000)

Many suicide survivors do not receive any help for their bereavement. The number of untreated survivors ranges from 15% in Norway, 50% in Australia to 76% in New York. Reasons for lack of treatment from postvention programmes also vary: even though they desired the help, the support was not provided in some cases. In other circumstances, survivors do not know about available services. In other cases, postvention support was perceived as insufficient or even harmful (Dyregrov, 2002, Wilson and Clark, 2005, Provini et al., 2000).

Regrettably, services specialized in treating children who are bereaved by suicide are scarce or missing in many countries.

Ideally, recent studies suggest that postvention services should be offered to survivors from the 1st week after a suicide occurs, and these services should be continued up to two years after a death. There are multiple types of assistance needed, including counselling, individual and group therapy, support groups, practical assistance, legal and financial advice, information of services availability, referral, and information about the facts involved in the grieving process. (Andriessen, 2004b, Clark, 2001)

The most common type of help offered for suicide survivors is the support group. Support groups can provide the connection with other survivors, promoting a sense of community and support, the hope to feel better, sense of belonging, a possibility to learn new behaviours of approaching problems, sharing the grief and provide survivors with a place to openly express the feelings. (WHO, 2008)

Wilson and Clark (2005) recommend that postvention programmes need two-prolonged approaches, one to provide support for the bereaved and other to support and give appropriate measures for professionals and service providers. Jordan and McMenany (2004) states that the design of interventions should take the gender differences into account, as women grief differently than men.

To avoid psychological morbidity in suicide survivors, including future suicide attempts, active and passive postventions are needed. Appropriate suicide postvention programmes serve as suicide prevention programmes, reducing this risk in survivors. (Baro et al., 2009, Cerel et al., 2008)

2.8 – History of Responses

International

The history of the suicide survivor movement started in 1970s in North America with the foundation of the first suicide bereavement group and the Cain's book, "Survivor of Suicide" published in 1972, wherein a preface authored by Dr. Edwin Shneidman described the concept of "postvention as prevention for the next generation". This call for postvention services and support for suicide bereavement was then taken up by multiple books and studies about suicide survivors. Suicide bereavement groups were established in a number of countries like Canada, USA, England, etc. In 1989 the American Association of Suicidology (AAS) sponsored the first Healing after Suicide conference to identify the "impact of suicide in individual family members, family dynamics and social networks" (Cerel et al., 2008) and increasing the awareness and importance of suicide postvention for suicide survivors. (McIntosh, 2008)

Many suicide survivors developed programs for other suicide survivors, influencing not only suicide prevention organizations but also promoting the development of policies regarding suicide prevention. The suicidology academy and the suicide survivors are both trying to find ways of helping each other, combining the academic rigor with the lived-wisdom of the survivors, because both are essential to advance the understanding and prevention of suicide. (Cutcliffe and Ball, 2009)

In 1992 the AAS published the "Survivors of Suicide Support Group Guidelines" and in 2008 the WHO in collaboration with the International Association of Suicide Prevention (IASP) published "Preventing Suicide: How to Start a Survivors Group" and translated it to multiple languages, distributing the document globally. (WHO, 2008)

An annual International Survivors of Suicide Day occurs each 20th of November, with multiple conferences in the USA and around the world to help survivors connect with each other, and share their experience. (AFSP, 2010)

The IASP has a permanent postvention taskforce, created in 1999 to improve and promote the activities in this area. Suicide survivors groups and organizations are now present around the world. Some countries that provide suicide bereavement services include Australia, Austria, Belgium, Canada, Denmark, Estonia, Finland, France, Germany, Ireland, Lithuania, Netherlands, Norway, Russia, Slovenia, South Africa, Sweden, Switzerland, Turkey, UK and USA (with more than 500 support groups around the country). However postvention policies and services per se are still limited.

Brazil

Although Brazil has been monitoring suicide deaths for years, there are only a few services directed towards prevention of such deaths, suggesting that suicide prevention is not prioritized in Brazil. This may be in part because of the high

occurrence of the urban violence in the country (seven times higher than suicide), with public health priorities being directed towards interpersonal violence prevention. Suicide rates are increasing more than urban violence rates in the last 10 years. Brazil does not have a suicide prevention association. Furthermore, postvention activities are almost inexistent. (IPEA, 2010, Waiselfisz, 2011)

The Brazilian Ministry of Health cooperated with the Pan American Health Association, (Organização Pan Americana da Saúde, in Portuguese, also known as the OPS) created a national strategy for suicide prevention called “Amigos da Vida”, or Friends of Life. As part of a jointly developed strategy to address suicide prevention, the “Projeto ComViver” or With Life Project, was established in Rio de Janeiro, to give support to suicide survivors and promote awareness about the needs of survivors; more detailed information about this project will be made in the chapter 5. The project ended in 2008. Nowadays there are just few institutions around the country (most of them in the big cities) that give support for grief and bereavement, none of them with interventions exclusive to suicide survivors. There is no suicide survivors support group activities currently underway in Brazil.

According to Botega at Fontanelle (2008) and Hetem (2010), indicates that almost nothing has been done in Brazil since august 2006 regarding suicide prevention. The National Strategy for Suicide Prevention was never fully implemented. Nowadays there are 13 universities that have research groups that include studies related to suicide prevention, with only a few of these groups specialising in suicide prevention. These smaller groups do not include suicide survivor’s issues or evaluation of suicide postvention services in their studies.

2.9 – Why Is This Research Needed?

There is ample research to demonstrate that suicide survivors have special mental health needs. This poses an important challenge for agencies and public health authorities, and mental health care providers who work with mental health promotion and suicide prevention strategies in Brazil. These authorities are well ward that suicides in Brazil produce not only economic losses, but also incur tremendous social costs due to the life lost and the subsequent poor mental health of many survivors.

Suicide survivors in Brazil need help, the specific issues related to complicated grief, and other mental health problems that result after the suicide death of a loved one, should to be addressed with knowledge, policy and interventions, not only to reduce the morbidity, poor outcomes and the long-term effects of this condition, but also to prevent more suicides, promote mental health and relieve their suffering, helping them to heal and function again. Interventions are essential for this population and need to be specifically designed to them, including active and passive prevention programs. (Baro et al., 2009)

3 – AIM

This study aims to address the need of suicide survivor support services and postvention activities in Brazil through three main objectives:

- 1) Identify suicide bereavement interventions and suicide postvention activities described in the literature and categorize the various types of services, policies and guidelines offered around the world;
- 2) Compare those current approaches and best practices with Brazil's current provision of support while considering cultural differences;
- 3) Suggest an improved model of services to increase suicide survivors support and postvention activities in Brazil.

3.1 – Questions

- 1) What suicide postvention services and activities are currently offered in Brazil?
- 2) Based on best practices described in peer-reviewed literature, current understandings, guidelines and national policies directed at suicide postvention, what could be done in Brazil to effectively address the suicide survivors needs?

4 – METHODS

Study design:

Articles published in scientific journals since 1976 on topics relevant for suicide bereavement support services and postvention activities were considered. Furthermore, a wide variety of websites, grey literature, snowball references, government and non-government documents were referred. Evidence recommended by experts in the field as significant or relevant to this study was considered for inclusion in the literature review.

After the literature review, the interventions and solutions presented by the articles for provide support for the suicide-bereaved people were combined to obtain a more complete description of the range of services available for suicide survivors. The first six countries cited in the articles plus Brazil was chosen to exemplify what they offer in terms of suicide bereavement support and postvention activities. The guidelines and postvention laws of those countries were researched in greater detail.

The development of an ideal model, i.e., a model that offered a full range of services, was inspired by an ideal model of suicide postvention services proposed by Wilson and Clark (2005, pg 162), as the aim of this research was not to describe a full-range programme, but also to propose an intervention strategy

adapted to Brazil situation as a combination of a literature review and a country study (Brazil). Flexhaug and Yasganoglu (2008) state that the use of a perfect model derived from the existing literature can offer "advice as how services should be developed and the components that need to be included." (Pg. 28)

Inclusion criteria

All the articles that addressed some aspect of the suicide bereavement, suicide survivors interventions and postvention activities were selected. Regarding the suicide survivors, there was no restriction about the relationship with the person that died, the time of the death, the type of service offered (professional or not) and for whom it was design (adults, children, teenagers or service providers bereaved by suicide). Both qualitative, quantitative studies and literature reviews were considered relevant if related to intervention. The interventions found at the literature review included evidence-based programs and expert consensus statements. The articles were published since 1976 in English or Portuguese language.

Literature search

Three searches were conducted, one in the literature, another with Internet search engine and the last in the national organization websites link suggestions.

In the first, databases and other resources were computer based searched up to 20 of December of 2010, another search was conducted in March 2011 to update the literature previously found. PubMed, Easysearch (SveMed+, CINAHL, Web of Science, PsycINFO) and BIREME (Brazil) were used, as well as sources of grey literature. No language restriction was applied during the search but the terms were searched in English and Portuguese. All the articles used were available online, most of them from the KI Library Website.

The *key words* used for the search in English were: suicide survivors, suicide postvention, suicide bereavement and suicide grief, in Portuguese: luto e suicídio, sobreviventes de suicídio e posvenção.

Articles of interest suggested by the Karolinska Institutet library website were also included if they met the inclusion criteria. Reference lists of all potentially relevant papers were checked and some experts in the field were contacted. The lists of contacts are found in the appendices of this document.

In the second wave of research, suicide survivors organizations, guidelines, reports and policies were searched using Google. The results were limited to the first five hints, as the objective of this study is not to relate all the organization, policies or countries with suicide postvention, but to use some of them as a reference of what is being done overseas. The national organizations were chosen based on the recognized credibility of each organization.

The *key words* used in this research wave were suicide survivors, suicide prevention policies, suicide prevention laws, suicide survivors guidelines, luto por

suicídio Brasil, prevenção ao suicídio Brasil, sobreviventes de suicídio Brasil e posvenção Brasil.

In the third wave of research, links suggestions made in the websites visited, especially at IASP (International Association of Suicide Prevention) website were checked to find guidelines and interventions suggestions. The same was done related to suicide prevention laws, reports and policies in different countries.

In total 114 information sources were relevant based on the research criteria and were included in this study. They were: 4 books; 12 articles indicated by experts in the field, 9 articles retrieved after snowball references, 48 articles by the literature review, 39 sources retrieved by Internet (25 websites, 6 guidelines, 8 reports).

Data synthesis:

From the review of the literature, 88 studies were reviewed for this research. These documents were categorized by the themes that they described, including: suicide grief and bereavement; history of responses to suicide survivors; policies, reports or guidelines; suicide survivor services, treatment or interventions; postvention activities; survivor organizations and associations.

A narrative review was used to synthesize the findings in a compilation of the interventions and postventions activities available. The intervention plan was a combination of the model proposed by Wilson and Clark (2006) together with the analysis of the results found in the literature review to create an ideal solution, adapted for the culture and the country for the lack of services for suicide survivors in Brazil.

Ethics considerations:

In a wider perspective this research could stigmatize suicide survivors: pathologizing unnecessarily the suicide bereavement and not allowing the grief process to be done naturally. Because of this, it is essential to demonstrate that suicide survivors are different and so are their grief and their needs, some of them will need those types of services or have a complicated grief, others don't. However for the ones that need and desire help, the support will be available. There is no recipe that will fit for all, and this can be seen in a range of services proposed targeting these differences. The individuality and freedom of choice need to be preserved.

5 – RESULTS

This section includes two parts, both of them based on a compilation of the interventions that have been used in different countries. The first part refers to the most common approaches in suicide bereavement found in the literature review, described in table 1, and a service delivery model, described in figure 1. Another table is included in Appendix II - table 3, with the explanation and examples of

services cited in table 1. The second part presents what some countries have available for suicide survivors, described in table 2 and followed by the explanations. The services available in Brazil are presented at the end of this chapter.

5.1 – Suicide Bereavement Services

Table 1 – Bereavement Services

Intervention/service		Type		Time		
		Active	Traditional	Immediately	Short Term	Long Term
One to One	Help Lines		X		X	X
	Counselling		X		X	X
	GP's		X		X	X
	Clinical Therapy		X			X
	Critical Incident Debriefing (CDI)	X	X	X		
	Outreach Services	X		X	X	
Psychosocial	Self help Groups		X			X
	Bereavement groups		X			X
	Involvement Therapy or Survivors Activities		X			X
Internet based			X	X	X	X

Table 1 – Comparison of the interventions available with the type and the time of their provision/utilization.

The interventions and services presented in the table 1 can be needed and offered at different times with two types of approach, providing support and services to suicide survivors. The services are divided in three types:

1) *One to One support*: is based on when and how the survivor needs a particular service, includes the help lines, counselling support, clinical therapy, CDI, outreach services and General Practitioners support (GP'S). (Flexhaug and Yazganoglu, 2008, Beautrais, 2004, Scocco et al., 2006, Hawton and Simkin, 2003, Bates et al., 2008, Franz Baro, 2008, Baro et al., 2009)

2) *Psychosocial support*: is related to activities that combine social and psychological aspects, consisting of self-help groups, bereavement groups and involvement therapy or survivor activities. (WHO, 2008)

3) *Internet based services*: refers to a range of activities, information and services available electronically. Offers both one to one support and psychosocial activities. (Flexhaug and Yazganoglu, 2008, Beautrais, 2004, Wilson and Clark, 2005)

As shown in the table 1, the service delivery (type) can be divided in active and traditional, influencing the form that survivors link with the services available, affecting the service utilization and efficacy.

The *active* type of provision of support is becoming more popular and it can be seen particularly in outreach services. They aim to diminish the time between the suicide death and the survivor getting in touch with the service. As depression and other factors can influence the help seeking behaviour, offering support can be an essential link to suicide support services. One example of this type of provision of support can be seen at the Campbell's Active Postvention Model (1997). (Aguirre and Slater, 2010)

The *Traditional* type of provision of service is when the survivor is the responsible to find and contact the support desired. It can take an average of 4,5 years for the survivors to find and join those services. (Campbell et al., 2004, Aguirre and Slater, 2010)

According to some authors and presented at the table 1, the service provision (time) for suicide bereavement can be divided in three phases: immediate support services (after death and first months), short term (2-6 months) or long term support services. (Jordan, 2001, Flexhaug and Yazganoglu, 2008)

Immediate services are usually provided by the first responders (police, emergency department staff, funeral directors, emergency service personnel), religious leaders and volunteers (mostly former suicide survivors). They include from cleaning the suicide site, helping the funeral arrangements, offering survivor support to providing practical information about suicide, suicide communication, etc. (Beautrais, 2004)

Some postvention services and institutions, like fire fighters and police offices can use a Critical Incident Debriefing (CID) as immediate support service. CID is a semi- structured conversation, in a single session with the individual who had just experienced the suicide of another person. Some studies states that CID help to decrease PTSD and others traumatic situations for the people involved in the death, although there is no agreement regarding the benefits of using it (Beautrais, 2004) and a systematic review of suicide postvention services made in Nova Scotia recommends to even not use it. (Sun Life Financial Chair in Adolescent Mental Health Team et al., 2010)

Short-term services target individuals, families, maybe schools, workplaces and institutions if needed. The programs involve the provision of information about the particular suicide, suicide in general, and grief reactions in one-to-one or psychosocial activities; offering a supportive environment and the opportunity to talk and check how the suicide is affecting the people involved, as the beginning of the road, sometimes long, to the personal understanding and acceptance of the suicide, if this is possible. (Aguirre and Slater, 2010, Beautrais, 2004)

The majority of services are included in the *Long Term support services*, this can be partly explained by the difficult to "become ready" presented in some studies: a delay of the survivor help seeking behaviour, as this is something that requires energy, desire and usually can takes place some time after the suicide.

Some other reasons observed to postpone the access to the services are difficulties to find information and low availability of the postvention services (Clark, 2001). Some examples of possible long-term interventions are: support groups, suicide survivor's networks, GP'S support, professional counselling, clinical therapy, etc.

Recent studies observed that every grief process is unique. For Resnik Psychological Resynthesis (1969) at Grad (1996, pg 138), the services offered should provide the "Resuscitation: breathing life into the survivors with serious psychological wounds; Rehabilitation: helping survivors through mourning; and Renewal: giving up grief and the bondage to the deceased". Consequently it is essential to provide a range of services to target the multiple needs that suicide survivors can have in different stages of their bereavement. Flexibility in the service design (type) and provision (time) is required as people grief in several ways. Some survivors will attend some interventions almost immediately, as others can wait years until they reach one of those, and some will need no support. For the most of survivors, it can take several years for the person start to experience a feeling of resolution. (Flexhaug and Yazganoglu, 2008, Jordan, 2001, Grad et al., 2004)

For Jordan and McMenemy (2004) the treatment planning should also take into account the distinct coping styles, specially in relation of the gender, personality and cultural differences.

Some studies demonstrated that another significant feature is the availability of special support for children, schools or institutions and minorities. (Flexhaug and Yazganoglu, 2008, Beautrais, 2004)

It is clear the need for interventions targeting children suicide survivors from parental suicide, sibling suicide or peer suicide. Children can have unique service needs (Mitchell et al., 2006). Bereavement support and self help groups can provide assistance for the parents to help their children in their suicide grief. (Pfeffer et al., 1997)

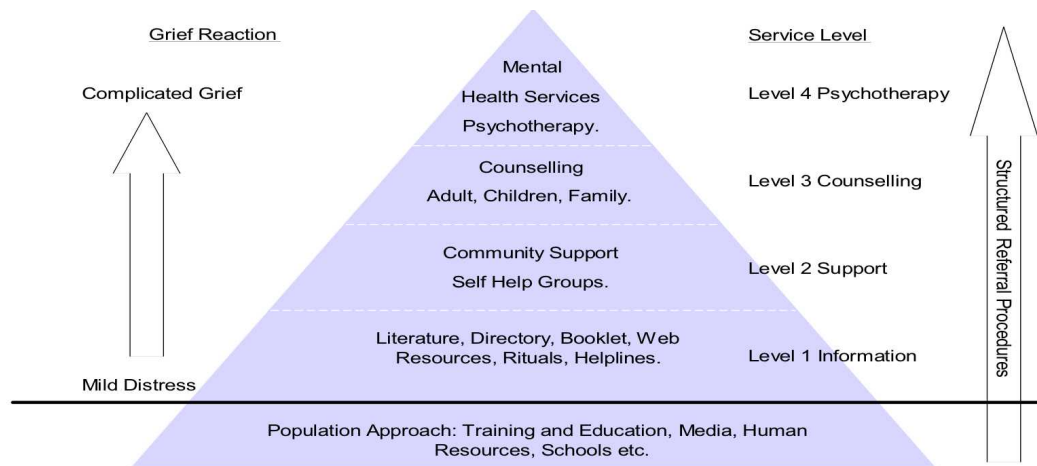
In schools and institutions the postvention services target two objectives – minimize distress and psychiatric disorders by responding and managing the crisis of a suicide death AND diminish the risk of suicide clusters. This can be reached by offering supportive counselling, psychological debriefing and a crisis/gatekeeper training. Especially in schools those programs need to be carefully planned and constantly evaluated to not produce negative effects. (Beautrais, 2004, Flexhaug and Yazganoglu, 2008, Melhem et al., 2004a, Callahan, 1996)

The minorities, like native tribes refugees, also need a postvention service specially designed for them, with culturally adapted interventions, as this population tends to have special needs. (Beautrais, 2004)

Media guidelines for reporting suicide and suicide attempts can be part of some postvention activities around the world. Special details about the suicide and how the death was communicate thru media for the community can influence the grief and mourning of survivors.

According to the Review of General Bereavement Support and Specific Services Available Following Suicide Bereavement from Ireland (2008, pg 3) the services delivery can be divided as follow:

Figure 1: Service Delivery Model



(Bates et al, 2008)

The figure 1 suggests that four levels of service are required to attend bereavement outcomes. As the grief reactions get more complicated, specialized services are required; however, the number of people that need those services decreases, as complicated grief is not so common in the general population. For suicide survivors, though, complicated grief reactions can be a regular outcome influencing the service provision and design for this population.

Studies shows that it is essential for the service to have strategies coherent with the model proposed, be accessible (either by phone, internet or in-person), known (people be aware about them), evaluated (have clear goals, objectives and measurable outcomes), be in balance with the government policy and have the proper training, infrastructure and staff. (Flexhaug and Yazganoglu, 2008, Taylor et al., 1997)

For Andriessen et al (2007), the biggest challenge in postvention services is the promotion of effective communication among all the individuals involved (survivors, significant others, peer supporters, clinicians, researchers, policy makers) to build up evidence-based approaches, evaluate the services available and implement good practices.

Jordan and McMenemy (2004) stated that the lack of evidence-based interventions can be explained by the lack of proper instruments to measure it, the short duration of the studies with few samples. This can influence the measurable impact, produce weakness in the methodological rigor and lead to a necessity of most careful study designs. According to this study, “The efficacy of formal interventions for survivors has yet to be scientifically established.” (Pg. 345)

Despite of this, the literature review shows an increasing number of countries that have suicide postvention activities available.

5.2 – Countries

From the 52 countries that are IASP members, only 14 have suicide survivors specific programs. Those services are available mostly in the US, Canada and some countries in Europe. Government support can be seen in most of these countries (Andriessen et al., 2007, Clark, 2001).

Wilson and Clark (2005) presents that in countries like Norway, New Zealand, Ireland and Belgium the suicide postvention has been systematically researched and supported to increase and offer “targeted services, professional infrastructure including pathways to care, educational pathways for professionals and professional support” (pg. 10).

According to the literature review, there is still no agreement within the countries if the suicide bereavement services should be a separate national organization or should be a subsection inside general bereavement support services. Bates et al (2008) support that instead of emphasize the type of death, the services should “concentrate in the bereaved person and the consequences of their loss, and screen for complicated grief” (pg 53). Jordan (2001) suggests that on a practical level suicide survivors specific support groups and psycho educational services are needed. Both approaches can be seen worldwide.

The table above is an example of what some countries have available for suicide survivors, including if they have public policy and guidelines to support suicide postvention at national, regional and local levels.

Table 2 – Countries

		USA	UK	Belgium	Canada	Australia	New Zealand	Brazil
Public Policy	National level	X	X	X		X	X	X
	Regional level		X	X		X	X	
	Local level	X	X	X		X	X	
Guidelines		X	X	X	X	X	X	
General Bereavement Support Services		X	X	X	X	X	X	X
Outreach Programs		X	X	X		X	X	
Suicide Survivor	Programs	X	X	X	X	X	X	
	Associations	X	X	X	X	X	X	
	Websites	X	X	X	X	X	X	
	Support Groups	X	X	X	X	X	X	
National Survivor Organization		AAS, AFSP, SPAN	SOBS	Flemish working group in Suicide Prevention	CASP	SPA, Wings of Hope, Lifeline	SPINZ	
Postvention Services	Large number	X	X	X	X	X	X	
	Moderate to low number							
	One Agency							
	Plans to start							X
	No activity							

According to the table 2 (page 22), almost all of the countries included have a large availability of general bereavement services, which can be combined to other suicide specific services to attend survivor needs. Suicide survivors activities are quite common in the countries presented in the table 2. Some National Survivors Organizations are cited as the reference of what can be found in each country. The number of postvention services available was retrieved from the survey carried out by the IASP European Directory in 2002 (Andriessen, 2009).

Commonly the policies regarding suicide postvention are included at the National Suicide Prevention Strategies in each country. Guidelines and distribution of practical information and support pack for survivors can be seen in all the countries in the table except for Brazil. The guidelines can be provided by the government or by the survivor associations. Some examples of guidelines available are:

After a suicide: a toolkit for schools (AFSP, 2011); Suicide: Coping with the Loss of a Friend or Loved One (SAVE, 2010); Towards Good Practice: Standards and Guidelines for Suicide Bereavement Support Groups (Lifeline, 2009b); Guidance for community organizations involved in suicide postvention (Ministry of Youth Development, 2005); After a Suicide: Recommendations for Religious Services & Other Public Memorial Observances (Litts, 2004).

The impact and importance of suicide survivors associations, programs, websites and self-help groups are notable in all of the countries. Some of them are from or have some funding by the government. There is an increasing participation of Non Governmental Organization's (NGO'S) and volunteer organizations in this field. Furthermore, outreach programs are increasing in the countries as an active model of postvention service.(Andriessen, 2004b)

There is a range of services available electronically for suicide survivors in websites. The activities offered varies from: chat rooms, bulletin boards, email support groups, discussion boards, websites of interest, recommended bibliography, download of guidelines, survivor e-networks, support groups, help lines 24/7, charters of "the rights of suicide survivors" (available at the appendix II, index I), etc. Some of the organizations also have advocacy to survivor's rights, involvement in political roles, awards for survivor's initiatives, postvention research support and funding. (Andriessen, 2004b, Andriessen, 2004a, Hawton and Simkin, 2003, Clark, 2001)

BRAZIL

The Brazilian activities regarding suicide postvention are limited to the development of the National Strategy for Suicide Prevention in Brazil in 2006, when the "Projeto ComViver", a special project targeting the research about suicide survivors was launched in Rio de Janeiro city.

After that, the Ministry of Health released the National Strategy for Suicide Prevention in Brazil, in the ordinance 1.876 from August 14th, 2006. Among

other things, this strategy comprised postvention training and care for the whole country.

The "Projeto ComViver" organized a report about the hospitals, regional and local public health services, universities and non-profit grief and bereavement support institutions that offered support to suicide behaviour in Brazil. In their report, from the 105 institutions contacted 26 answered the questionnaire and 18 were included in the study. They identified in the whole country: 8 institutions at public health services, 6 universities and 4 non-profit organizations that have some suicide behaviour related service in the whole country. Two states (Acre and Rondonia) declared that they don't have any service available for the treatment of suicide behaviour. From the services identified, 14 were available in the South and Southeast areas, 3 in the Northeast area and 1 in the Center-West area. The institutions provided assistance (17 from 18), research/epidemiologic studies (12 from 18), information brochures (3 from 18) and professional qualification (7 from 18). From the institutions that had research studies, just three of them developed studies related to general grief and bereavement. (ComViver, 2006)

Regarding support for the bereaved and during suicide crisis, the CVV (Centro de Valorização a Vida – Life recovery center) a helpline volunteer organization, was the one covering most states, their services are present in 18 from the 26 states plus a federal district existing in the country.

The "Projeto ComViver" was the only reference found in the entire country regarding suicide survivors support services. This project finished in 2008. (Ferrara, 2010) Currently, Brazil does not offer any public or private suicide survivor specific program or service.

6 – DISCUSSION

" Dealing with the death involves a
process, and not an event"
(Klass & Marwit, 1988 at Clark, 2001)

This chapter is divided in two sections: 6.1) the discussion of the results, aiming at proposing a possible solution for the lack of support services to suicide survivors in Brazil; exploring what would be the better form to promote and maintain suicide bereavement and postvention activities in the country; and 6.2) the discussion of the methodology, that presents the strengths and limitations of this study; considerations concerning the methods choice; the implication of the findings to suicide prevention and mental health promotion; the ethics considerations regarding the center proposed and the transferability of the results.

6.1 - Discussion of the results

Suicide bereavement services and postvention activities are a field that is growing although lacking evidence of efficacy and cost-effectiveness. A range of services and activities can be seen around the world. The situation of suicide survivors and their need of help justify interventions for the promotion of mental health and suicide prevention, respecting to the uniqueness of the grief process. As seen in the literature review, Brazil does not offer any specialized support for suicide-bereaved people. For the development of a possible solution in Brazil to address suicide survivors' needs of support and postvention activities; the interventions, the service delivery model and what some countries have available were analyzed and culturally adapted, leading to a suggestion of an improved model of services to be implemented in the country.

Because of the size of the country, the lack of specialized professionals in non-central areas, economic issues and a possible disinterest from the government for this topic, the centralization of the postvention activities in a multi-services center as the beginning of a postvention culture and support is the solution proposed by this study. Some similar type of multi-center can be seen in Australia and Belgium.

The activities and services proposed aim to increase suicide bereavement support and mental health; spread knowledge and training at national, local and regional levels; coordinate the postvention activities in the country; suggest new interventions and integrate what is available in general bereavement support for the promotion of specific suicide grief support.

The ideal suicide postvention center would offer a range of services and activities complementing each other. A map with all the activities proposed is available at the appendix II, figure 2 and the table with the explanation of each topic are available at appendix II, table 4.

The proposed postvention center is divided in 7 (seven) main areas with as follows:

- 1) Bereavement support include:
 - a. Development and training for self-help groups;
 - b. Assessment sessions for psychiatric illness, psychological pain and suicidality;
 - c. 8 week bereavement groups;
 - d. Children bereavement group;
 - e. Referral for psychological and/or psychiatric treatment.

- 2) Education and Awareness include:
 - a. Research support, internships to educate new professionals and supervision of suicide bereavement cases;
 - b. Training courses for volunteers, first responders, mental health professionals, gatekeepers, school principals, significant others and professionals interested in postvention;
 - c. Media guidelines.

- 3) Partnership include:
 - a. Screening of and partnership for services and projects regarding suicide survivor issues with NGO'S, Voluntary agencies, existent services for general bereavement support and clinical services (psychotherapy);
 - b. Media.
- 4) Policies
 - a. Revision of laws;
 - b. Guidelines.
- 5) Outreach Services
 - a. Support;
 - b. Written Material;
 - c. Suicide death communication.
- 6) Association
 - a. Academic linkage;
 - b. Community linkage;
 - c. National linkage.
- 7) Web based services
 - a. Survivor website;
 - b. Guidelines;
 - c. Material for download: Educational packages for care providers;
 - d. FAQ;
 - e. Services availability;
 - f. Links;
 - g. Reading lists;
 - h. Professionals network;
 - i. Survivor network;
 - j. Online courses;
 - k. Suggestions.

After the establishment of the center and depending on the demand, affiliates can be proposed to attend specifically regions with high suicide rates.

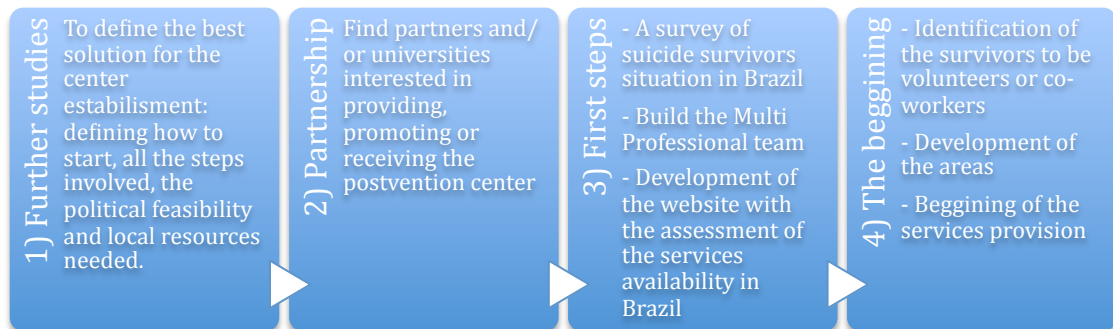
6.1.1 – How to Get There?

In order to start this project, associations need to be established. The center could be developed based in three possibilities of partnerships and fund-raising:

- 1) with public services, incorporating the postvention center activities to the suicide prevention public policies and in accordance with the ordinance 1.876 from August 14th, 2006 from the Ministry of Health that states the National Strategy for Suicide Prevention.

- 2) with private companies and associations interested in the subject.
- 3) with some already established suicide prevention center present in some universities in the country, as a sponsor center. This could promote sharing of material, local and human resources, including academic expertise in suicide prevention field.

For the solutions proposed start, some stages are needed for any one of the alternatives above. An idea of the stages can be seen below:



6.1.2 – Goals of The Center:

- Provide support for the suicide bereaved person, respecting as much as possible their unique journey, their identity and their need of service provision in a public health service;
- Offer immediate, short-term, long-term, active and passive postvention services;
- Promote postvention activities at national, regional and local levels;
- Develop actions at the different levels of mental health;
- Identify all public and private bereavement support services available in Brazil, including what type, location, price, what do they offer and how to get an appointment;
- Connect suicide survivors with each other, providing training, support for self-help groups and the establishment of a suicide survivor network;
- Develop guidelines for outreach services, contacting new bereaved families, offering support after the suicide death and during the first year of bereavement in regular intervals;
- Offer training about suicide grief for generic bereavement support services and community health workers, improving their knowledge about suicide survivors and integrating them to a national network for the provision of suicide grief support;
- Offer training and support for first responders and for professionals that have/had contact with the suicide person and with the suicide bereaved individuals;

- Increase the survivors coping skills for the bereavement to take its natural course;
- Screen psychiatric illness and suicidality in suicide survivors;
- Promote awareness campaigns about bereavement and grief reactions following suicide;
- Promote and evaluate best practices in this field constantly;
- Provide a service that is accessible for the population and respects the unique needs of suicide bereaved people;
- Contribute to the development of scientific knowledge about suicide postvention;
- Contribute for suicide prevention and mental health promotion through suicide bereavement services and postvention activities;
- Place Brazil in contact with postvention centers worldwide.

6.1.3 – Potential Barriers:

- Lack of interest from the government and society to address suicide survivors issues, especially in a country with extreme high rates of traffic accidents and homicides;
- The complexity and unwillingness from the survivor to seek support;
- The perceived versus the received support by the survivors;
- The connection from the services offered to the survivors;
- Lack of societal knowledge to help people bereaved by suicide;
- Adaptation of suicide bereavement services for a huge country with a rich, diverse and multi-cultural population;
- Provision of services to remote areas without internet access;
- Meeting the demand generated by the referrals because of the lack of public clinic services availability;
- Access to survivors that want and are ready to participate as co-workers or volunteers in the center.

6.2 – Discussion of the methodology

6.2.1 – Strengths and Limitations:

The strengths of this study are in addressing an important need of an especial population that is not receiving any attention by the country. This is the first study about suicide survivor's lack of services in Brazil and the center proposed is pioneer in the country. All the solutions proposed were based on the comparison with what is available worldwide, after adaptation to the Brazilian

situation. The suggested center does not need to have all areas functional simultaneously in the beginning; the areas can be implemented one by one as they become ready.

The limitations are that, even though there is no agreement regarding the cost effectiveness of the postvention activities and suicide bereavement interventions, this study assumes that those services are beneficial and it is a prudent and cautious approach for suicide prevention and mental health promotion to offer it.

Although this study recognizes the needs of native tribes suicide survivors and is aware of the high rates of suicide in indigenous communities, the solution proposed by this study does not include interventions specially designed for this population, as it is assumed that they deserve a particular study to access their specific needs concerning suicide postvention.

Some evaluation tools are available for postvention services, however they were not cited in this study, because this research is focused in the design of the ideal model and believes that the evaluation tools need to be addressed in further studies.

6.2.2 – Methodological Considerations

The strength of the method chosen is to base the study on the literature review of suicide survivors interventions and postvention activities available in the world, combining the research of evidence-based interventions and expert statements to produce the knowledge about what is the current approach in this field, contributing to the development of the solution presented in this research. Some studies were found proposing similar solutions for suicide survivors provision of support.

Furthermore, the method chosen could limit the results as it is based just on the literature review and the experiences and needs of Brazilian suicide survivors could not be accessed in this way, limiting the results to international and published interventions that maybe will not fully work here. A triangulation of methods, like an association of key informant in-depth interviews, focus group interviews, suicide survivors questionnaire and literature review could produce a trustworthy picture of the best practices on this field combined with the actual situation and real needs of survivors, leading to better intervention plan design.

6.2.3 – Implication of The Findings to Suicide Prevention and Mental Health Promotion:

Brazil can address the suicide survivors needs with knowledge; and could invest more in this area as suicide rates and evidently the people left behind, are increasing in the whole country. This study indicates that it is possible to develop a multi-service center to attend some of the suicide survivor demands. Policymakers and stakeholders need to be aware of the suicide-bereaved support services condition and take actions to change the current situation. As postvention is prevention, the center proposed could contribute to the mental health promotion and to the suicide prevention.

6.2.4 – Ethical Considerations Regarding the Proposed Center:

Public mental health services in Brazil are scarce, therefore this center would generate a demand that could not be absorbed by the public services available, creating hope and expectations of interventions that have the probability to not happen or be delayed. For this not to occur, a referral manager needs to be created, making sure that the survivors who are referred will receive the proposed services, ensuring the continuity of care. Partnerships or previous agreements for support services with non-profit organizations and universities need to be established.

6.2.5 – Transferability of the Results:

The result of this study can be used in other countries or areas, as it is based on key articles and international studies of suicide bereavement and postvention interventions and can be adapted to different cultures and realities.

7 – Further Studies

There is an important need for more research in the suicide postvention area. Further studies are also needed before the implementation of the postvention center proposed in this study. Some examples of the studies can be seen below:

1) Questions about the suicide survivor experience as the knowledge about the helpful and harmful interactions they experienced could help to develop a better understanding about their feelings and needs for improvement and create programs. Examples: a) How help after a suicide was presented, given, sought and experienced by people bereaved by suicide of a loved one; b) How survivors view themselves;

2) Questions about suicide survivors' needs, like: a) How, for what, where, when and by whom they would like to have had help for their grief; b) What survivors suggest for interventions direct or indirect related to the suicide grief;

3) Questions about evidence-based research and outcome measures: a) How to measure the effectiveness and efficacy of services and activities to suicide survivors; b) What can we measure and what do we have to assume? c) What is the cost-effectiveness of postvention activities and suicide bereavement services?;

4) Studies about health grief processes and coping strategies to use in development of intervention for complicated grief processes;

5) How suicide survivors in Brazil are similar or different from suicide survivors worldwide;

6) Questions about the implementation of the postvention center: a) which sponsors or partners the center can have; b) how is the best way to implement all the center proposals; c) where would be the better place to open it; d) viability, political feasibility and costs of the center; etc.

8 - Conclusion

Suicide survivors need support and services available for them to decrease the complicated grief outcomes that they usually face. A range of services can be seen worldwide for the provision of support for suicide survivors. Postvention activities are growing despite of the lack of evidence-based interventions.

The lack of agreement towards the best and effective interventions for suicide survivors cannot excuse the service provision for this population. Suicide postvention activities can reduce the negative bereavement outcomes, and automatically some of the risk factors for the suicide, thus it is fundamental that suicide postvention also becomes essential in suicide prevention strategies.

Brazil economy is growing fast, especially in the last decade and the variety of services available in the country could follow that. Although the suicide rates in Brazil are not so high in the average, they are increasing every year, especially in young adults population. The suicide rates are rising more than homicide and traffic accidents rates, nevertheless there is ANY place available in Brazil specialized in suicide survivors support services and this need to change. Suicide prevention and postvention activities deserve attention from the public health policies and the government to help to decrease the suicide growing rates.

It is possible to develop an intervention plan based on the research of current approaches in this field and keeping cultural adaptations in mind. A suicide postvention multi service center can become an ideal model of provision of the support and is a plausible solution for the lack of this type of services in the country, developing new activities and integrating the fill bereavement support services available to a specialized suicide grief support.

Provide this type of service in Brazil it is a huge step and poses the biggest challenge of this research, which is to transform the ideas presented in actions.

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Organizations Websites:

AAS - www.suicidology.org

AFSP – www.afsp.org

Befrienders International – www.befrienders.org/

Bereaved through Suicide Support Group – www.bts.org.au/

CASP – www.casp-acps.ca

CVV – www.cvv.org.br

Griefnet – www.griefnet.org

Helplines center – www.helplinecenter.org

IASP - www.iasp.info

Lifeline - www.lifeline.org.au

London Bereavement Network – www.bereavement.org.uk

LOSS – www.lossteam.com/

SOBS – www.uk-sobs.org.uk

SPA – www.suicidepreventionaust.org/

SPINZ - www.spinz.org.nz/

Survivors of Suicide – www.survivorsofsuicide.com

WHO - www.who.int

List of Contacts (from the field experts contacted):

Ana Maria Ferrara – email – June 22, 2010

Britta Alin-Åkerman – email – November, 2010

David Titelman – meeting – October 21, 2010

Diana Stark Ekman – email – September, 2010

Karl Andriessen – email - November 4, 2010

Neury José Botega – email – November 1, 2009

APPENDICES I – ACRONYMS, TERMS AND DEFINITIONS

Acronyms:

AAS – American Association of Suicidology

AFSP – American Foundation of Suicide Prevention

CASP – Canadian Association of Suicide Prevention

CVV – Centro de Valorização a Vida (Life Recovery Center)

GP’S – General Practitioners

IASP – International Association of Suicide Prevention

IPEA – Instituto de Pesquisas Economicas Aplicadas (Institute of Applied Economic Research)

LOSS – Local Outreach to Suicide Survivors Program (USA)

OPS – Organização Pan Americana da Saúde (Pan American Health Association)

SPA – Suicide Prevention Australia

SOBS - Survivors of Bereavement by Suicide (UK)

SPINZ – Suicide Prevention Information New Zealand

Terms and Definitions:

Terms used in this research:

Bereavement – the entire experience of mourning and grief after the death of a loved one.

Best Practices – “a practice that is most appropriate under the circumstances, esp. as considered acceptable or regulated in business; a technique or methodology that, through experience and research, has reliably led to a desired or optimum result” (dictionary.com)

Complicated Grief – defined as the symptoms that appear when the integration for the death does not occur. For this diagnose, the symptoms of invasive thoughts of the dead person, bitterness, extreme loneliness and anger need to be present during more than 6 months with interference in life normal function. (Flexhaug and Yazganoglu, 2008)

Evidence-based - “*conscientious, explicit and judicious use of current best evidence in making decisions ...*” (Sackett et al., 1996). Refers to programs that had been scientifically tested, meeting rigid criteria’s and that demonstrated to produce better outcomes for the participants. (Bode, 2006)

Grey Literature - refers to materials that are not easily found by usual channels, like publishers. They can include reports from governments, from scientific research groups and associations.

Grief – normal reaction to the death, includes the personal experience related to the bereavement, involves the physical, spiritual and emotional responses to the loss.

Intervention – “the act or fact or a method of interfering with the outcome or course especially of a condition or process”. (Meriam-Webster, 2011)

Mourning – the process of adaptation and the social expression of the death of a loved one, includes the acts and feelings from the one who mourns, can be influenced by the culture (public rituals, symbols, etc.).

Narrative review – “A narrative review discusses and summarises the literature on a particular topic ... usually gives a comprehensive overview of a topic, rather than addressing a specific question such as how effective a treatment is for a particular condition” (NHS, 2009)

Psycho educational Programs – programs designed for support and education of suicide survivors to cope with emotional, cognitive, behavioural and social aspects of suicide bereavement. (Lifeline, 2009a)

Service Providers – professionals (therapists, medical doctors, nurses, etc) that were involved with the person that committed suicide or are in contact with the suicide survivors.

Significant Others – people, other than family members, which had a meaningful relationship with the deceased, including partners, close friends, classmates and workmates of a person.

Suicide: the act of someone who takes his own life.

Suicide Bereavement Support – the support that is given especially for people bereaved by suicide to facilitate the grief and mourning processes.

Suicide Postvention – presented by Shneidman (1973), includes the actions and activities, like interventions, support and assistance for those affected by a completed suicide to facilitate the grief and mourning processes (AAS, 1998). For Bates et al, 2008 the aims of suicide postvention are “the relief of the suffering and related effects on the suicide loss, the prevention of the onset of adverse grief reactions and complications, the minimization of the risk of suicidal behaviour in the suicide bereaved, encouragement of resilience and coping in the suicide survivor” (pg. 16).

Suicide Survivor - Even though in the literature there is no agreed definition of what constitutes a survivor status (Flexhaug and Yazganoglu, 2008). WHO (2008) states that suicide survivors are the people that lost someone or were affected somehow by the other person’s suicide, referring to those who are left behind or had the life changed because of the loss.

APPENDICES II – TABLES

Table 3: Explanations of bereavement services

Intervention	Explanation	Example
Help-Lines	Telephone counselling, where the survivor can talk with someone about his or her grief experience anonymously. They can be especially for suicide survivors or open to all needs. Usually with no limit of time and length of the calls.	Help Line Center (USA); Befrienders International; SOBS (UK); CVV (Brazil)
Counselling	Non-clinical intervention to provide some guidance, direction or advice during difficult periods of the bereavement.	
Critical Incident Debriefing	A semi- structured conversation, in one session with the individual who has just experienced a stressful or traumatic event	
GP's	The GP'S can give information, assistance and support to the family, especially if they knew the person who died. It would be important to train the GP'S that wish to provide specialized support for the survivors. (Flexhaug and Yazganoglu, 2008)	A survey of Dutch GPs' attitudes towards help seeking and follow-up care for relatives bereaved by suicide (de Groot et al., 2009)
Clinical Therapy	Psychological or Psychiatric treatment. Can be divided in Individual, Group and Family therapy.	Solution-focused therapy for families coping with suicide (de Castro and Guterman, 2008); Grief therapy (Clements et al., 2004)
Self help Groups	The most common form of suicide survivor support. The groups can be open or closed; people can take part of them as drop-in meetings for ongoing support and follow-up or can have an specific target in closed groups, with a limit of time, participants and number of sessions. (Farberow et al., 1992a, Farberow et al., 1992b, Flexhaug and Yazganoglu, 2008). Those groups can be lead by professional,	The AFSP Support Group, The Community-Based Family Support, The Psycho Educative Intervention Program, The Survivors of Suicide (Los Angeles), The Family Support Team (New York) and

	<p>survivor/professional or just survivor people. Self-help groups can have several activities: discussion groups, invited speakers and social meetings. (Beautrais, 2004). In some places, the groups can divided the sessions especially for mothers, fathers, siblings, friends, professionals, families, because then they can find a safe environment with people that had already experienced a similar loss (Beautrais, 2004, Flexhaug and Yazganoglu, 2008, Grad et al., 2004, Clark and Goldney, 1995, Jordan and McMenemy, 2004). Mitchell at al (2007) states that those groups can be a powerful source of the empowerment of hope. It is considered a significant support factor for families dealing with suicide grief. (Grad et al., 2004)</p>	<p>the Bereaved through Suicide Support Group (Australia). (Flexhaug and Yazganoglu, 2008)</p>
Bereavement groups	<p>Usually closed and with a time limit – help the bereaved to understand the suicide and develop support. Can use both psychotherapeutic and psycho educational interventions.</p>	<p>Group intervention for children bereaved by suicide (Pfeffer et al., 2002); Family bereavement program (Sandler et al., 2003); Children’s SOS Bereavement Support Group (Mitchell et al., 2007); The Psycho Educative Intervention Program (Dyregrov, 2002); Group intervention for Widowed Survivors of Suicide (Constantino et al., 2001).</p>
Outreach Services	<p>Offered immediately after the suicide death, usually by a team approach in a familiar environment. Provide support for the immediate trauma, referral, home visit and information’s about resources available. Can be provided by volunteers (usually survivors). (Wilson and Clark, 2005).</p>	<p>LOSS (USA), the AFSP Outreach Program (USA), the SOPRoxi Project (Scocco et al., 2006). It can also be seen at Ireland, Flemish-Belgium and Queensland (Flexhaug and Yazganoglu, 2008) .</p>

Web based	<p>This type of service is growing fast despite the evidence of effectiveness. Internet can reach places and people that would not be possible to reach by regular services, can provide information and be accessed maintaining the privacy and the anonymity of the user. It can be updated very often and maybe could be a useful source for online support groups for people in very remote areas. Chat rooms, bulletin boards (specifically for suicide survivors), email support groups, fact-sheets, discussion boards, websites of interest, survivor e-network (targeting the survivors that are not in the grieving process anymore) are some of the activities that can be offered electronically. (Clark, 2001)</p>	<p>CASP; AFSP; Griefnet; Web-Based Psycho-Educational Program for Adolescent Suicide Survivors. (Hoffmann, 2006); The Support Network in Alberta (Flexhaug and Yazganoglu, 2008);</p>
Involvement Therapy or Survivor Activities	<p>Participation of the bereaved person in survivor support teams and educational/informational programs, youth educational programs, suicide prevention/survivors associations. Can include the production of a life keeper memory quilts or jewellery, getting involved in advocacy/political will, influence policies, participation in help lines or volunteer services, belong to awareness programs/activities, providing social support for new survivors. Those activities can be defined as an involvement therapy for the ones that are not in the acute phase of the grief process. (WHO, 2008, Flexhaug and Yazganoglu, 2008)</p>	<p>IASP; CASP; AAS; AFSP; Lifeline; London Bereavement Network</p>

Index 1: The rights of suicide survivors.

(Andriessen, 2004a)

The survivor has the right:

1. To mourn in his own way and within the time it takes;
2. To know the truth about the suicide, to see the body of the deceased, and to organize the funeral with respect to one's own ideas and rituals;
3. To consider suicide as the result of several interrelated causes that produced unbearable pain for the deceased: suicide is not a free choice;
4. To live, wholly, with joy and sorrow, free of stigma or judgment;
5. To respect one's own privacy as well as that of the deceased;
6. To find support from relatives, friends, colleagues, and survivors, as well as from professional helpers who have knowledge and insight in the dynamics of bereavement, potential risk factors, and in the practical consequences;
7. To be contacted by the clinician/caregiver (if any) who treated the deceased person;
8. To not be considered as a suicide candidate or as a patient;
9. To place one's experiences in the service of other survivors, caregivers, and everyone who seeks to better understand suicide and suicide bereavement;
10. To never be as before: there is a life before the suicide and a life afterwards.

Figure 2 – Suicide Postvention Center

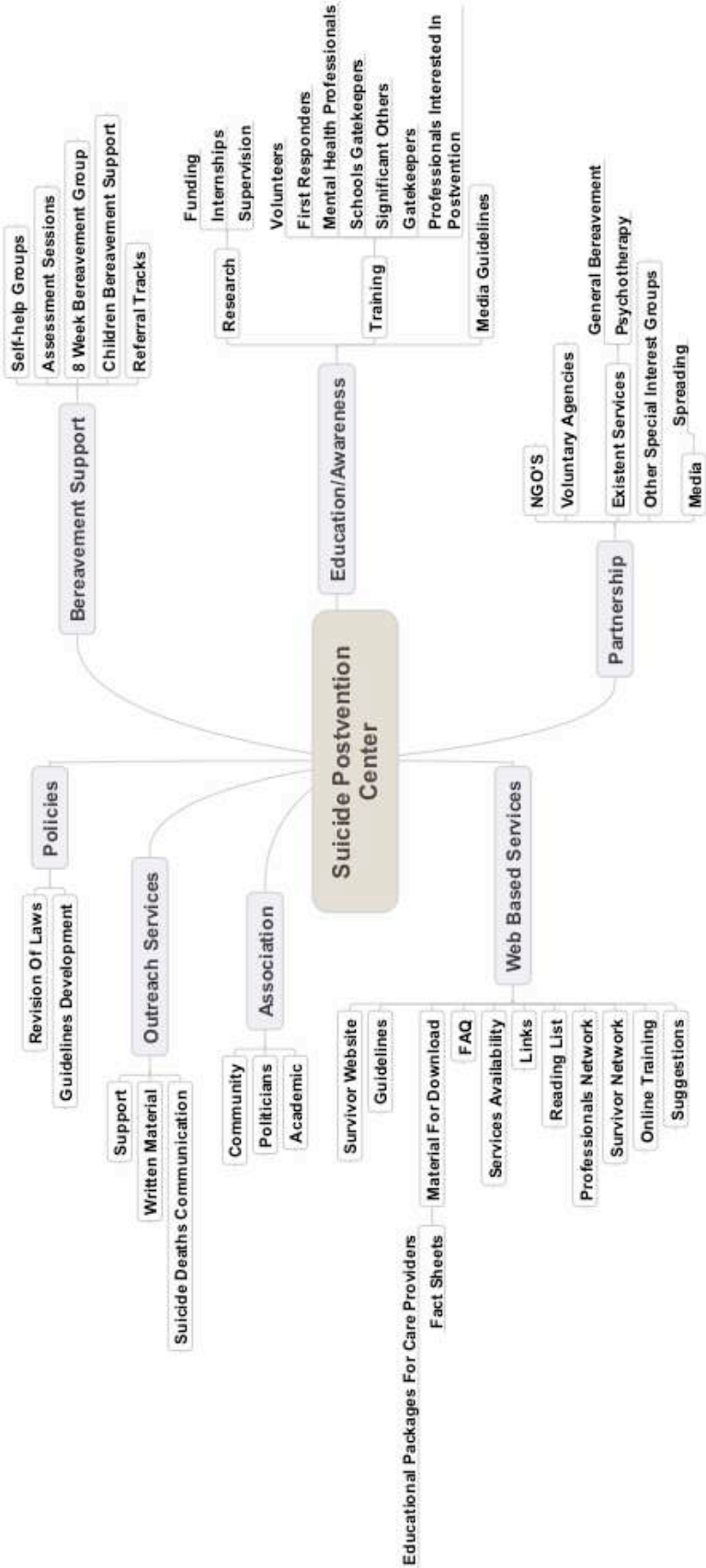


Table 4 – Suicide Postvention Center – Explanations

1 - Bereavement support	
Self-help groups	Development, support and training of self-help groups. Support for initiatives in other locations. Provision of a local and a professional participation for groups meetings at the center.
Assessment Sessions	In two sessions, for the assessment of psychiatric illness, suicidality and psychological pain. Can be connected to counselling sessions, bereavement group activities or referral needs.
8-week bereaved group	Closed group with other survivors to discuss pre-determined topics, for support, assessment, increase of coping skills and referral if needed.
Children Bereavement group	For addressing children special needs, with parent counselling about grief and bereavement. Include the specific themes of suicide grief, like the shame, stigma and guilt.
Referral tracks	Referral for private or public services in the person's living or working area for psychological or psychiatric treatment.
2 - Education / Awareness	
Research	Support of suicide postvention research, with funding for new studies, internships for students and professionals interested in the area and supervision of suicide survivors cases treated by mental health professionals.
Training	Training courses about 1) suicide bereavement, including how to attend a suicide death, with training of judgment values for first responders, clergy, policy, etc. and 2) grief reactions and helping behaviours for volunteers, mental health professionals, gatekeepers, school principals, significant others, etc.
Media guidelines	Agreement and reinforcement with the media about how to communicate suicide news for the public, encouraging responsible media coverage for this subject.
3 - Partnership	
Partnership for the provision of services and the postvention center sustainability regarding suicide survivor issues with NGO'S, voluntary agencies, universities, other especial interest groups, existing services for general bereavement support, psychotherapy and clinical services.	

Media	Utilization of media social incentives in the sectors of social responsibility to spread the center activities and promote awareness and knowledge of suicide bereavement in the society. Using the media as one of the biggest helpers to change the government attention to suicide postvention.
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4 - Policies

Revision of laws	Promote the consciousness of policymakers for acknowledgement of postvention as prevention strategies, developing postvention guidelines, strategies and policies. Example: the right of psychological intervention/treatment during the bereavement by the private health insurance and public services; the necessity of having services specialized in survivors in accordance with the National Strategy for Suicide Prevention; compulsory notification of suicide deaths, etc.
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Development of guidelines	Regarding suicide postvention and suicide bereavement services. Suggested themes: recommendations for mental health professionals, GP's, community organizations; pathways for caring, coping with the loss, establishing good practices, suicide support groups, etc.
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5 - Outreach Services

Support	Contact and support offered to suicide survivors and professionals involved immediately after the death and during the first year.
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Written material	Material available at the first point of contact services after a suicide, like morgue, police office, funeral houses. Themes related to suicide and suicide grief facts, available resources, reading list, support groups, how to help children, etc.
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Suicide deaths communication	Agreement with the morgue to inform the postvention center about suicide cases, for the provision of outreach services, offering a contact, knowledge and support for the newly bereaved.
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6 - Association

Promote connections with universities and research groups; with the community and with politicians for spread of postvention activities and services.

7 – Web-based Services

Survivor website	National website with information and services for suicide survivors.
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Guidelines	Distribution of guidelines developed by the center. Ex. For families, schools, significant others, first responders, service providers, etc.
Material for download	Educational packages and fact sheets for care providers, families, schools, first responders, mental health professionals, support group, etc.
FAQ	Frequently Asked Questions regarding suicide, suicide bereavement and suicide prevention.
Services availability	A list of public and private services available in the country regarding suicide prevention, suicide prevention research groups, suicide postvention, support groups, bereavement support services, psychotherapy and bereavement associations.
Links	List of services, institutions, associations, support groups, interested websites regarding suicide grief and bereavement etc.
Reading list	Reading list of suicide grief, general grief, suicide prevention, survivors books, etc.
Professional Network	Network for professionals to exchange experiences, questions, services. A source of contact, education and support for service providers.
Survivor Network	Promote suicide survivors network.
Online training	Online courses for professionals with themes related to suicide grief and bereavement, support groups, suicide postvention.
Suggestions	Channel for the survivors, professionals and community to suggest interventions, studies, services, etc.