

# Suicide survivor activities, an international perspective

By Karl Andriessen

*The aim of this article is to present a brief description of suicide survivor activities with an international, mostly European perspective; to report on the activities of IASP Taskforce Postvention; and to raise a few questions regarding future developments in the field of postvention.*

## Introduction

IASP Taskforce Postvention was established after the XXth IASP Congress held in 1999 in Athens. The aim of the Taskforce is to increase the awareness of issues concerning suicide survivors and postvention activities within IASP, its members and affiliations. A first objective of the Taskforce was to publish a Directory of suicide survivor services.

The European directory was published in 2002 and the information will become available as a searchable database in IASP website in due time (www.iasp.info).

Currently the Directory of services in Australia and New Zealand is in preparation. A second objective of the Taskforce is to hold (open) meetings to discuss postvention issues and to facilitate communication in this field.

## Suicide survivor services in Europe

A survey was conducted in 42 countries of the European continent, of which 31 were IASP members. The goal was to compile a directory of all the services that target suicide survivors. Aims of publication of the Directory include to provide the public with information about the available services for survivors; and to increase awareness in the general public, the (mental) health professionals, caregivers and policy makers of the necessity of support for suicide survivors, and their possible contribution in suicide prevention (Andriessen & Farberow, 2002).

The construction of the Directory began in December 2000 with the mailing of a letter and a brief questionnaire to the 31 National Representatives of IASP of the European countries and to other contacts asking for leads to the services they knew were already functioning.

Each lead was then asked to complete a questionnaire and also to provide the names and addresses of other similar services or of other leads. Questionnaires were available in English, French and Dutch/Flemish.

## Levels of activity

Information was obtained from 20 of the 31 countries, or 65%, a gratifying number for a first effort. The greatest number of services was reported in the northwestern and mid-European countries. Thus, Austria, Germany and Switzerland reported a moderate number of services, while Belgium, France, Ireland, Norway, Sweden, and U.K. reported a larger number of services working together in umbrella associations, or linked with each other and/or with community resources in national networks. In addition, in the period after the survey, the national suicide prevention plan of Germany was launched, including the suicide survivor network. Finland, Slovenia and Turkey each reported one agency, each in its capital city. Contacts in Denmark, Estonia, Lithuania and Russia reported there was no current activity but initiatives were in preparation. Representatives and contacts in Hungary, Yugoslavia and Spain reported there was no current activity.

It is worth noting that of the 10 countries reported by Farberow (1998) in his '97 survey as having no suicide survivor services (Yugoslavia, Greece, Romania, Bulgaria, Lithuania, Russia, Iceland, Portugal, Spain and Liechtenstein) only two countries, Spain and Yugoslavia, continue to report no activity in the current survey. Hungary seems to have lost whatever survivor services it had in the interim years. Contacts in Hungary reported that while the need is high there seemed to be no public or political interest in the survivors at that time.



In countries where activities were reported as 'in preparation', Estonia, Lithuania and Russia, references are made to the examples of network activities in Sweden and Norway. Representatives in Denmark explained that their suicide survivor activities are planned as part of their recently launched national suicide prevention policy.

Amongst the countries that have only few initiatives it should be pointed out that the support group in Slovenia now is in operation for 15 years.

Countries reporting a rather high level of activities but without a national network specifically dedicated to suicide survivors, such as France, the Netherlands, and to some degree the U.K., indicated that the support is provided by different initiatives that exclusively target suicide survivors, or survivors of other types of loss as well as suicide survivors.

The countries with national networks differed in their development. Sweden and Norway have a longstanding tradition

on. In the year 2000, an international alliance, the International Network for Survivors of Suicide, was established with survivor services from Norway, Sweden, Estonia, and USA, with the expectation to improve the development in northern European countries. In 2002–3 representatives from Uruguay, Russia, France and Belgium joined the network.

Ireland has a well-established suicide survivor network and is considered as an integral part of the national suicide prevention policy. In the U.K. several nationwide organisations (such as Compassionate Friends) with numerous local contacts are operational. The establishment of a national network in Belgium started in the year 2000 and this has led to a large increase of the number of services. France showed a mixed picture, with both local services and nation-wide organisations, all functioning in the national platform of suicide prevention.

Comparison of the availability of suicide survivor services and the degree of network development with the actual suicide rates in these countries indicates there is no relation between the two. Suicide survivor services are most available in northern and northwestern Europe, suggesting that socio-economic and cultural conditions are the primary determining factors for the current distribution of survivor services.

The number of agencies providing bereavement services varied widely in each country, with on the one hand some countries estimated as many as approximately 300 in the U.K. and reported 97 in Norway, while on the other hand a significant number of countries reported that the initiation of such services were 'in preparation'.

Those agencies in operation indicated they had offered service to a total of 6,314 survivors in one year. However, not all groups and networks provided an estimate of their caller load. An educated guess of the total number could be approximately 10,000 a year, obviously a distressingly small percentage of the number in need of the services.

### **Population served**

While most agencies offer services for all (adult) survivors, a few focus on specific groups such as parents, siblings, adults, partners, close friends, and/or combinations of groups such as parents and siblings. Some groups are open for bereaved persons regardless the cause of death. Services for children and for clinician-survivors were notably few or absent.

### **Type of group**

The bereavement services are offered in mostly two formats, open (membership keeps changing), closed (membership stays the same, frequently for a limited number of meetings. Some agencies also offered individual meetings as well.

In Austria, France, Germany, Norway and the U.K. primarily open groups were conducted, while closed groups were more common in The Netherlands. Both types were equally available in Belgium and Switzerland. Some of the groups and networks reported they also offer individual support, both by telephone, and by face-to-face meetings.

### **Facilitators**

Group leadership was either by peer (a survivor), mental health professional, or both.

Predominantly peer-facilitated programs were found in Austria and Germany, while predominantly professional-facilitated programs were found in Belgium, France and The Netherlands. Ireland, Norway, and Switzerland had approximately the same number of peer-led and professional-led groups.

Agencies facilitated by both peers and professionals could be found in Belgium, Ireland, Norway, Sweden, The Netherlands, and the United Kingdom.

It should be noted that many of the peers (or volunteers) are paraprofessionals, indicating some formal training or some level of experience, or both. Also, many of the peer-facilitated initiatives employ a mental health professional back-up.

### **Fees**

Sources of support for the agencies varied, coming from regular fees, donations, contributions and grants. Clerical assis-

tance and agency administration services were accepted by a few agencies in lieu of fees.

### **Newsletter**

Only a handful of the local groups publish a newsletter. National newsletters are produced in France, Germany, Switzerland, and the U.K.

### **Brochures/leaflets**

Approximately two in three of the groups and the networks provide brochures describing their activities.

### **Internet**

The national networks in Belgium, Germany, Finland, France, Ireland, Norway, Sweden, and the U.K. and some individual groups in Austria, Belgium, France, Germany, and the Netherlands have websites providing information on the available services, upcoming events, etc. In addition, in Austria, Belgium, and Switzerland, information on all self-help groups is available in national ngo-databases.

### **Concluding remark of the survey**

As a result of our survey we can say that, to enable maximum development, it seems beneficial (1) to develop a national suicide survivor network linked with community resources, (2) to link with contacts in other countries and (3) to sustain suicide survivor activities within a national prevention policy.

### **Meetings of the taskforce**

Last year during the XXIIth IASP Congress in Stockholm, 10–14 September 2003, the Taskforce held its first open meeting and welcomed 16 participants from four continents (America, Europe, Asia and Australia & New Zealand). Firstly, we looked at expectations of participants regarding the Taskforce. Major expectations were to have more contacts and to exchange information. Further, participants felt a need for more evaluation and research for psychotherapeutic work, group work and community work. Topics that were discussed included: experiences with starting a survivor group and community linking; organising a discussion forum (web page) on post-



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vention; involving stake holders in congresses; and the need for more presentations on survivor issues and increased visibility during congresses. The meeting offered a platform to exchange ideas and to meet people who are doing similar work and have similar interests. This was highly appreciated by the participants and it was decided that more open meetings should be held.

As a result, we were able to plan a new open meeting during the Xth European Symposium on Suicide and Suicidal Behaviour, (Copenhagen, 25–28 August 2004). In addition, the umbrella organization Suicide Prevention Australia took the initiative to host a meeting of IASP Taskforce Postvention as a pre-event of their annual conference ([www.suicidepreventionaust.org](http://www.suicidepreventionaust.org), Sydney, 29–31 October 2004). The aims of these current meetings of the Taskforce are to bring together everyone who is involved in, or has a profound interest in postvention work either as survivor, caregiver/clinician, support group leader, community worker, policy maker, researcher, etc.; to learn to know other people in this field and to facilitate the exchange of experiences among participants. Questions that can be raised at the meetings include: Were do survivors go for support? What support and care programmes are available? What do we know about their effectiveness? What are the relations between support groups, clinical work, community work and research? What strategies exist to increase service

provision? What are recent evolutions in different countries? Training in postvention? Issues for the professional? Why is this area so little researched? The meetings will conclude with a list of points of interest and recommendations.

### Looking ahead

Looking at the future there may be important evolutions going on. The availability of Directories and databases of services for suicide survivor support will assist survivors and caregivers to find appropriate support. Further, these Directories may facilitate exchange, national and international, of experiences between different services that were unaware of each other's existence. And publicity for these Directories may contribute in raising public awareness regarding survivor issues.

The Taskforce wants to continue to bring together people who are involved in postvention and to offer a communication platform for exchange of experiences and expertise. Indeed, with the hope that this may enrich our work and that this will contribute to the growth of the postvention field, e.g., support and care for survivors and research regarding survivor's needs and effective service delivery, which is very much needed.

Lastly, IASP policy to schedule the congresses in different continents brings this platform of suicide prevention and postvention to people who otherwise would not be reached. In many countries, support and services for survivors are not or barely existing. It is to hope that

exploring needs with survivors and caring for survivors will become a more regular practice.

(Artikkelen er oversatt av Kari Helene Hestvik.)

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