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Evidence Check

Suicide postvention and bereavement support services

An Evidence Check rapid review brokered by the Sax Institute
for the Department of Health, Tasmania—October 2024

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This report was prepared by: Karl Andriessen[1], Chandra Ramamurthy[1], Trisnasari Fraser[1], Jacinta Hawgood[2], Kairi Kolves[2], Lennart Reifels[1], Nicola Reavley[1], Karolina Krysinska[1]. [1]Centre for Mental Health and Community Wellbeing, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne; [2]Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University, Brisbane, Australia.

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Enquiries regarding this report may be directed to the:

Director
Evaluation and Evidence Services
Sax Institute
www.saxinstitute.org.au
evidence@saxinstitute.org.au

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Effectiveness of suicide postvention and bereavement support services

An Evidence Check rapid review brokered by the Sax Institute for the Department of Health, Tasmania. October 2024.

This report was prepared by: Karl Andriessen[1], Chandra Ramamurthy[1], Trisnasari Fraser[1], Jacinta Hawgood[2], Kairi Kolves[2], Lennart Reifels[1], Nicola Reavley[1], Karolina Krysinska[1]. [1]Centre for Mental Health and Community Wellbeing, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne; [2]Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University, Brisbane, Australia.

Contents

Key messages

Every life lost to suicide has a substantial impact on family, friends and the wider community. Suicide has been recognised as a major public health issue. Suicide postvention includes a range of services that provide immediate and ongoing support for those bereaved by suicide. Effective postvention is understood to contribute towards suicide prevention and therefore represents a key component of suicide prevention strategies. This Evidence Check rapid review aimed to address the following question: Which suicide postvention service models have been shown to be effective in reducing distress in family, friends and communities following a suicide?

We analysed 19 peer-reviewed papers and 14 guidelines published between 2014 and 2024. The research studies assessed the effectiveness of suicide postvention interventions, which were conducted across a range of settings including school and community-based environments. The sample populations were diverse, encompassing schoolchildren and suicide-bereaved military widows. Various measures and instruments were used to assess outcomes, such as mental health indicators, mindfulness and semi-structured interviews.

These studies helped identify several potentially effective postvention components, including the use of trained volunteers in support and therapy groups, workplace training programs and arts-based interventions. The findings suggest some components of postvention could be beneficial for individuals bereaved by suicide in Tasmania. A public health approach is advised to meet the needs of all individuals and communities, and to align postvention in Tasmania with national and international suicide prevention efforts.

Executive summary

Background

In Tasmania, there have been 841 deaths by suicide recorded over the past 10 years (1). There is a higher risk of adverse mental health and suicidal behaviour among those exposed to suicide (2-4), with between six family members and up to 135 community members estimated to be exposed to an individual suicide (5). Suicide has been recognised as a major public health issue, and the Commonwealth and state and territories government response has been ratified in the *National Mental Health and Suicide Prevention Agreement* in 2022 (6). Suicide postvention includes a range of services that provide immediate and ongoing support for those bereaved by suicide. Effective postvention is understood to contribute towards suicide prevention (7, 8) and therefore represents a key component of suicide prevention strategies.

Evidence Check question

This Evidence Check aimed to address the following question:

Which suicide postvention service models have been shown to be effective in reducing distress in family, friends and communities following a suicide?

Summary of methods

We conducted systematic searches of peer-reviewed and grey literature, including guidelines, published between 2014 and 2024. Nineteen peer-reviewed research studies (9-27) and 14 guidelines were analysed in detail (28-41) and were included in the Evidence Check. We assessed the quality of the included studies using the National Health and Medical Research Council (NHMRC) Levels of Evidence (42) and the Quality Assessment Tool for Quantitative Studies (43). The guidelines were analysed based on the criteria provided in the Appraisal of Guidelines for Research and Evaluation II (AGREE) Instrument (44).

Key findings

The 19 peer-reviewed studies from the US, Australia and Europe encompassed both group and individual interventions in various settings including schools and community situations. The Evidence Check considered a range of populations encompassing schoolchildren and priority population groups such as military survivors of suicide. The studies employed a variety of outcome measures including semi-structured interviews and mental health, resilience, mindfulness and death anxiety scales. Against the quality criteria applied, the overall study quality was weak.

We identified seven indicated interventions (15, 18, 19, 21, 25-27) and 12 selective interventions (9-14, 16, 17, 20, 22-24) but found no universal interventions. We found limited evidence as to the effectiveness of postvention interventions and service delivery, largely because of a scarcity of research. However, some Australian studies (10, 12, 14, 24) indicated the effectiveness of peer-support groups in reducing psychological distress among those bereaved by suicide and emphasised the importance of addressing the needs of the postvention workforce.

The 14 guidelines demonstrated reasonable rigour of development against the criteria applied. Ten of the guidelines described a theoretical framework based on the *continuum of suicide survivorship* (45), which may have some limitations according to recent empirical testing (46). Five guidelines described a theoretical framework based on the *public health model*, which is recommended to align with suicide prevention efforts and tailor service delivery to the varied needs of those affected by suicide (47, 48).

Within the scope of the Evidence Check, the findings suggest some components of postvention could be beneficial for individuals bereaved by suicide in Tasmania, and a public health approach is advised to meet the needs of all individuals and communities and to align postvention in Tasmania with national and international suicide prevention efforts.

Background

Introduction

Every life lost to suicide has a broader impact on family, friends and the wider community. In 2022, 3249 people died by suicide in Australia, an age-standardised rate of 12.3 per 100,000 population (1). This equates to approximately nine deaths per day (49). In Tasmania in 2022, the age-standardised rate was 14.3 per 100,000 population and 841 deaths by suicide have been recorded in the state over the past 10 years (1). There is a higher risk of adverse mental health and suicidal behaviour among those exposed to suicide (2-4). Between six family members and 135 community members can be exposed to an individual suicide (5), with 4.3% of people exposed to suicide in a year and 22% over the course of their life (50). Suicide has been recognised as a major public health issue and the Commonwealth and state and territories government response has been ratified in the *National Mental Health and Suicide Prevention Agreement* in 2022 (6).

Suicide postvention includes a range of services that provide immediate and ongoing support for those bereaved by suicide. Grief following suicide may require specific interventions because of the sudden and violent nature of the death (51, 52). Grief following suicide can be accompanied by strong feelings of rejection, shame and stigma (53), and those bereaved have reported distress caused by coronial inquests, legal proceedings and media (54). Effective postvention is understood to contribute towards suicide prevention (7, 8) and therefore represents a key component of suicide prevention strategies. Reviews of postvention services and guidelines show mixed evidence of the effectiveness and substantiation of recommendations, and underline the complex nature of postvention services taking place in a variety of settings including schools, workplaces and communities (48, 55-57).

Aim and Evidence Check question

This Evidence Check aimed to identify effective service models for postvention, bereavement and critical incident support. The findings will inform future work and serve as a foundation for mapping the current postvention, bereavement and critical incident support systems, with the aim of establishing best practices. This will inform the co-design of a service model, oversight framework and response mechanisms for postvention, bereavement and other relevant critical incidents to be piloted in Tasmania.

The Evidence Check aimed to address the following question:

Which suicide postvention service models have been shown to be effective in reducing distress in family, friends and communities following a suicide?

Scope of the Evidence Check

Definitions

In this Evidence Check "suicide postvention service models" refers to a coordinated approach to supporting individuals affected by the death from suicide of a family member, friend or person within a network (e.g. school, nursing home, workplace). A service model includes:

Evidence-based interventions (service components): The Evidence Check will thoroughly assess and synthesise the effectiveness of evidence-based interventions with respect to the outcomes of interest. These interventions are:

- Universal interventions such as online and social media interventions
- Selective interventions, including online, peer-facilitated and open support groups, as well as online services
- Selective interventions, including closed support groups, therapeutic/psychoeducational supports, counselling services and workforce training to prevent burnout and vicarious trauma in staff
- Indicated interventions, including evidence-based treatments, psychotherapy and collaborative care.

Service delivery: The Evidence Check will consider the impact of service delivery on outputs and outcomes of interest. This includes:

- In settings such as schools, universities, communities, nursing homes and workplaces
- Modes of delivery, such as face-to-face, online, SMS, phone and email
- Required staff for service delivery
- Family and community engagement.

A coordinated system-level approach to linking services:

- Referrals
- Case management
- Linkages with mainstream services
- Policy support and funding.

Outcomes of interest: The Evidence Check will provide a high-level overview of the evidence regarding the impacts of system-level coordination on service delivery and outcomes.

- Primary outcome: Reduction in distress among family, friends and networks

- Other outcomes: Reduced suicide risk; return to participation in employment, education and social activities; access to services.

Population considerations: The Evidence Check will consider the effectiveness of interventions for both general and priority populations, including those facing adversity, Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, veterans and different age groups (5-17, 18-24, 25-64, 65+).

Depth and scope

- We will prioritise evaluated models but will include detailed descriptions if evaluations are scarce
- The Evidence Check will focus on studies from Australia, the UK, the US, Canada, New Zealand and Western Europe, and will primarily use English-language sources published after 2013
- While the focus is on suicide postvention, we will also include evidence about bereavement support services provided after other unexpected, acute traumatising incidents such as accidental deaths
- Information on evaluation frameworks and clinical tools used to measure distress will also be included where available.

Methods

Peer-reviewed literature

Search strategy

This Evidence Check rapid review was conducted in line with the PRISMA guidelines (http://www.prisma-statement.org/). We developed a search strategy based on the purview of the review question and the experience of the research team in conducting rapid and systematic reviews (48, 58). We ensured the search terms included all the criteria that were outlined in the review question, to establish the depth and scope of the Evidence Check. We used different search words and discussed the databases that we would trial before deciding on the best combination of search words and databases. The search string was further checked for repeat terms, corrected for errors and refined by the University of Melbourne Library services before we began the systematic search.

The search was also revised after discussion with the agency, and the terms *peer *caregiv and treat* were incorporated. The final search string (MEDLINE), comprising a combination of MeSH and keywords, was as follows:

> ((bereav* or grief or grieve or grieving or mourn*) and (famil* or friend* or peer* or acquaintance* or caregiv* or student* or school* or survivor*) and (counseling or counselling or intervention* or postvention* or treat* or psychotherap* or support group* or self-help group* or social media or internet) and (suicide or suicides or postsuicide) and (refugee* or asylum or migrant* or immigrant* or migration or immigration or trauma* or workplace* or aboriginal* or veterans* or cald or linguistic or esl or second language or non native speak* or cultural* divers* or indigenous or ptsd or posttrauma* or deaths or poor or poverty or social exclusion or low income or underserved or resource limited)).mp.
>
> limit 1 to (english language and yr="2014–Current")

We conducted systematic searches in five databases through Ovid. The databases included MEDLINE, PsycINFO, Embase, Web of Science and EBM Reviews, which includes the Cochrane Database of Systematic Reviews, ACP Journal Club, Database of Abstracts of Reviews of Effects, Cochrane Clinical Answers, Cochrane Central Register of Controlled Trials, Cochrane Methodology Register, Health Technology Assessment and the NHS Economic Evaluation Database. The same search string was run in other databases using the same subject headings and keywords. Appendix 1 includes the search strings.

The results from the database searches were imported into the Covidence data management software (59) and duplicate records were removed. We removed three duplicate records manually. CR and JH screened the remaining records for eligibility, based on title and abstract. CR and JH independently conducted the full-text screening of the remaining studies against the inclusion and exclusion criteria. We searched the reference lists of review papers and the included studies, and

conducted a forward citation search of the selected studies to identify additional relevant studies. KKr and JH reviewed portions of the included and excluded records. Any disagreement was resolved by discussion with KA. Figure 1 illustrates the search and selection process in the form of the PRISMA flow diagram.

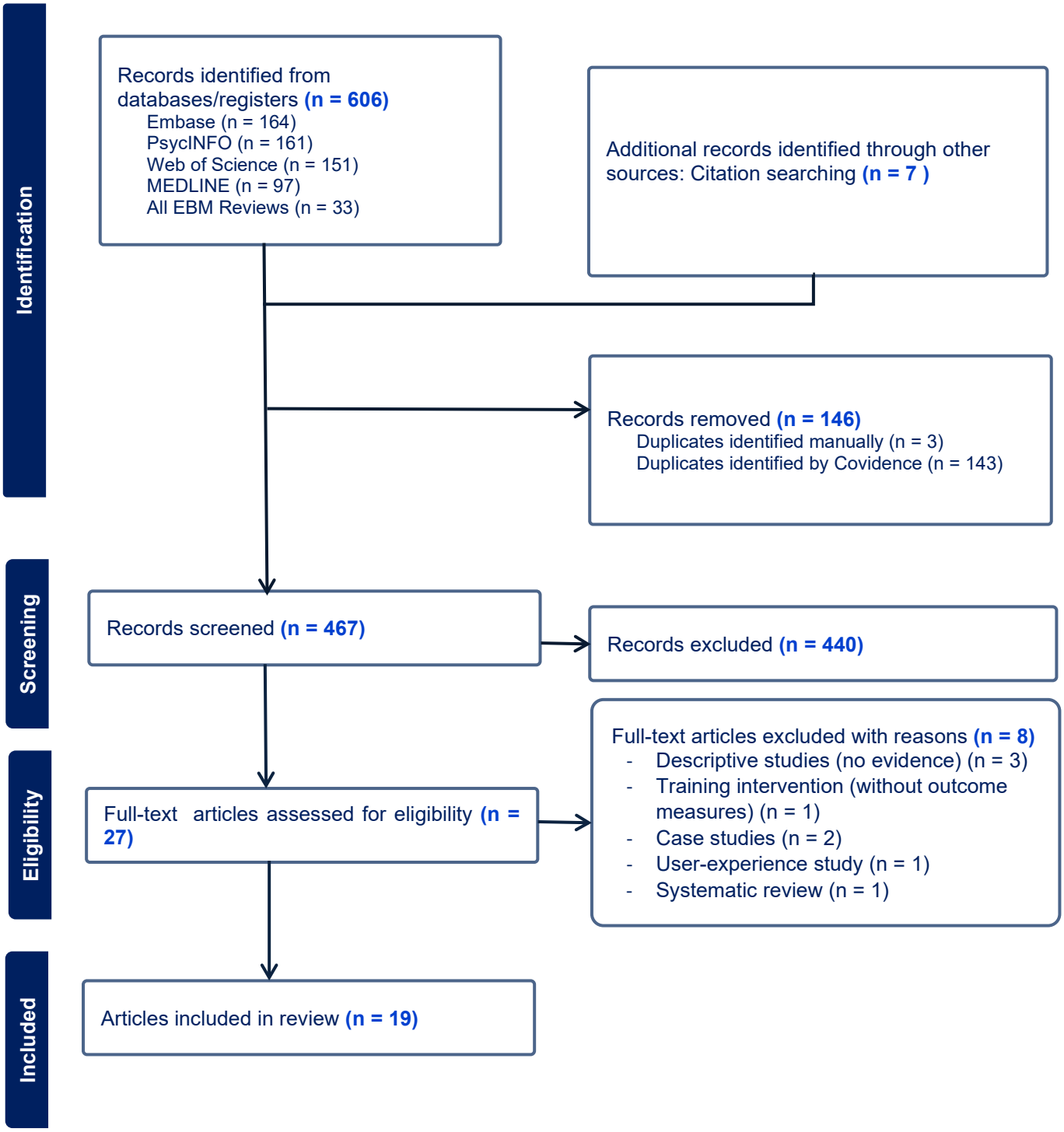
Inclusion and exclusion criteria

Original studies published in peer-reviewed journals were included if: 1) the study population consisted of people bereaved by suicide; 2) the study applied quantitative, qualitative or mixed methods; and 3) the study reported data on effectiveness of different interventions or service delivery on the study population. We excluded studies that: 1) were not about suicide bereavement; 2) did not provide original data, such as review papers; 3) did not report on suicide postvention services; and 4) if the full text was unavailable, such as conference abstracts.

Data extraction

Two researchers, CR and JH independently extracted the following data from the selected studies using a data extraction form developed for this Evidence Check: study reference comprising author, year and location (country), study design, assessments, sample size, participants' age and sex distribution, intervention setting, outcome measures, main outcomes of the study, and study limitations. KKr and JH reviewed portions of the data extraction. Any disagreements during the data extraction were resolved through discussion with KA.

Figure 1—PRISMA flow diagram: peer-reviewed literature



Evidence grading

We evaluated the quality of the included studies using two tools: 1) the National Health and Medical Research Council (NHMRC) Levels of Evidence (42), and 2) the Quality Assessment Tool for Quantitative Studies (43). The NHMRC Levels of Evidence employs a hierarchical system for

classifying evidence, which helps evaluate the certainty of a body of evidence. This widely adopted system is designed to address questions regarding the effectiveness of interventions based on randomised and observational studies. Additionally, it can be applied to assess both narrative and statistical syntheses (60). Importantly, the assessment of evidence certainty is conducted for each outcome individually.

The NHMRC Levels of Evidence are structured into six tiers according to study design, with systematic reviews of randomised controlled trials (RCTs) representing the highest level (Level I) and case series with post-test or pre- and post-test outcomes at the lowest level (Level IV). The NHMRC tool also necessitates summarising the overall evidence across five key components: the evidence base (e.g. number and quality of studies), consistency of results, clinical impact, generalisability and relevance to the Australian or local context. Researchers CR and JH independently assessed the studies using these tools and any disagreements were resolved through discussion with KA.

The Quality Assessment Tool for Quantitative Studies is a critical appraisal tool that is useful for knowledge synthesis, offering a standardised method to evaluate overall study quality across eight categories. It also aids in formulating recommendations based on study findings (61). This tool evaluates six components: selection bias, study design, confounders, blinding, data collection methods, and withdrawals and dropouts, each rated as ‘strong’, ‘moderate’ or ‘weak’. According to the tool’s guidelines, a study received a strong overall rating if none of its components were rated weak, a moderate rating if only one component was rated weak, and a weak rating if two or more components were rated weak. Additionally, the tool assesses the integrity of the intervention and analysis, such as intention-to-treat analysis. Researchers CR and JH independently assessed the quality of the studies and resolved any disagreements through discussion with KA.

Grey literature

Search strategy

We conducted a grey literature search to capture studies and guidelines for postvention service delivery. The search strategy was developed based on previous work by the research team (55, 58), indications from the literature (62-64) and consultation with the commissioning agency. The search was conducted in Google Chrome in July 2024. To meet the scope of the Evidence Check, we set the search settings to the following Google regions: Australia, UK, US, Canada and New Zealand. In each region, for each of the following search terms, we opened a new page using Guest Mode (to avoid browser history affecting results):

> ‘suicide bereavement support’, ‘suicide loss support’, ‘suicide survivor support’, ‘effective suicide bereavement support’, ‘effective suicide loss support’, ‘effective suicide survivor support’, ‘suicide bereavement service’, ‘suicide loss service’, ‘suicide survivor service’, ‘effective suicide bereavement service’, ‘effective suicide loss service’, ‘effective suicide survivor service’, ‘postvention support’, ‘postvention service’, ‘effective postvention support’, ‘effective postvention service’, ‘support after suicide’, ‘help after suicide’, ‘effective support after suicide’, ‘effective help after suicide’, ‘postvention guidelines’, ‘suicide loss guidelines’ and ‘suicide bereavement guidelines’.

We retained the results of the first two pages per search term. Secondary links to resources or publications were screened for studies or guidelines that met the inclusion criteria outlined below. This approach reproduced how most people search for health-related information via the internet, limiting their search to the first page (62-64) while aiming to identify as many grey literature studies and best-practice guidelines as possible.

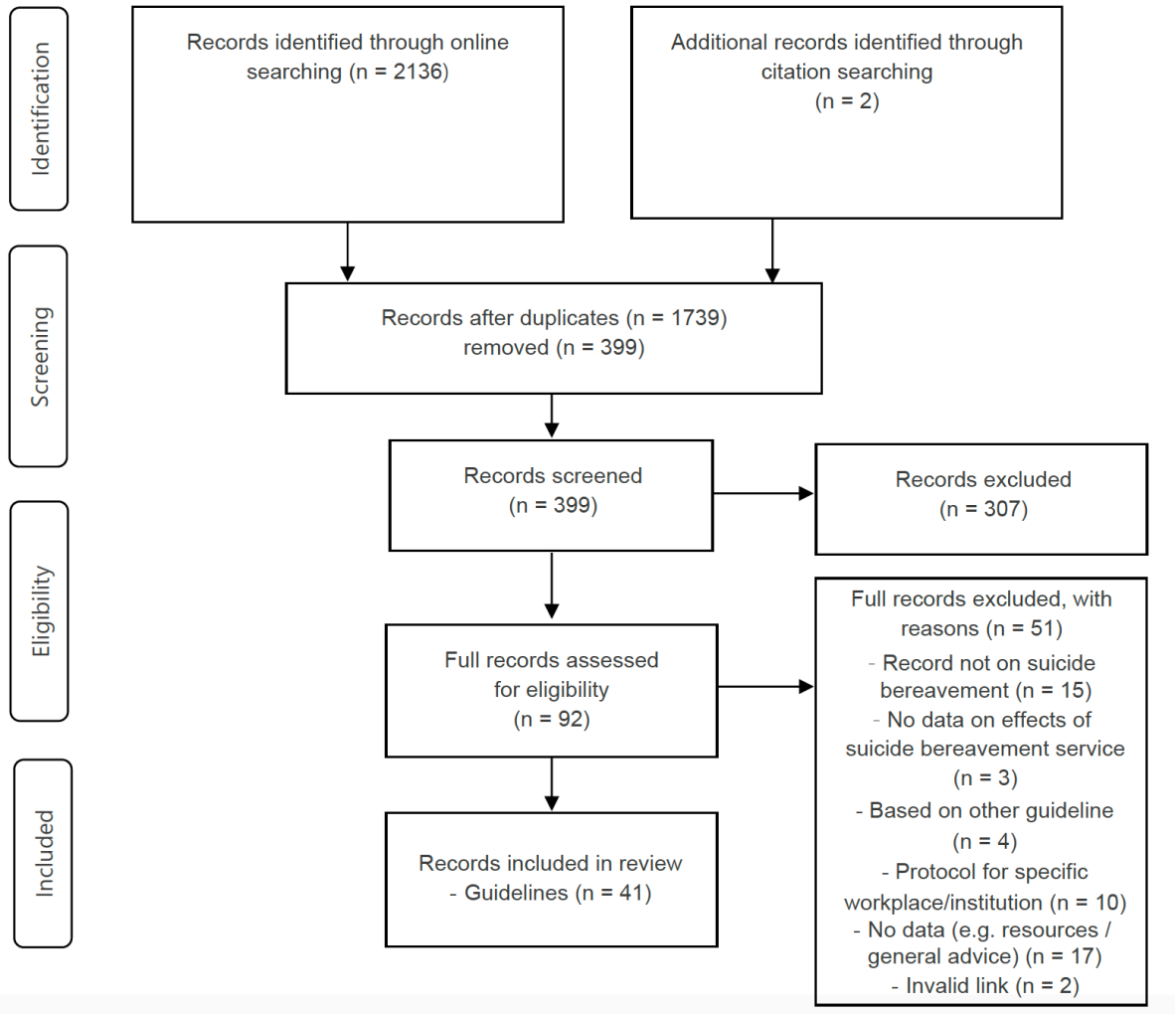
Inclusion and exclusion criteria

Based on the peer-reviewed criteria, we included grey literature studies published since 2014 if: 1) they reported on a study population consisting of people bereaved by suicide; 2) the study applied quantitative, qualitative or mixed methods; 3) they reported data regarding the effects of evidence-based interventions or service delivery on the study population. Grey literature studies were excluded if they: 1) were not about suicide bereavement; 2) did not provide original data of effects of interventions; 3) did not report on suicide postvention services (for example, web pages limited to written resources, links or referral addresses); or 4) were invalid links.

The Appraisal of Guidelines for Research & Evaluation (AGREE) II defined guidelines as *"systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances*" (44). Based on this definition, our inclusion criteria for guidelines published since 2014 were as follows: 1) self-identifed as 'guidelines'; and/or 2) comprised a structured set of statements as to how an organisation or a service can provide help to individuals bereaved by suicide. We excluded records if they: 1) comprised a collection of resources (where no resources were identified to be either a study or guideline); 2) provided general advice about how to support a person bereaved by suicide or self-care information for the bereaved; or 3) were invalid links.

To further manage the volume of records returned in the grey literature search, we also applied the following exclusion criteria: 4) postvention guidelines or protocols for an individual education institution or workplace; or 5) postvention guidelines significantly based on another guideline.

Figure 2—PRISMA flow diagram: grey literature



Duplicates (n = 1698) were identified via browser history by opening the saved Google Chrome searches within a user profile and identifying the same reports via different links (n = 41). Following initial screening of 399 records (TF), we retained 92 records for full-text screening. TF conducted full-text screening and KA, CR and KKo reviewed portions of the included and excluded records. Any disagreements (0.06% on inclusion of guidelines, 0.08% on data extraction and quality) were resolved through discussion. Figure 2 summarises the search and selection process.

Data extraction and quality appraisal

The grey literature search did not identify additional eligible empirical studies. We found 41 guidelines through the grey literature search. Data extraction and quality appraisal of guidelines was based on the criteria provided in the AGREE II Instrument (44) and previous work by the research team (55). The AGREE II Instrument was designed to inform development of guidelines and assess their quality (44). However it offers no defined cut-off to distinguish high-quality from low-quality guidelines (65). For the purposes of this Evidence Check rapid review, we focused our analysis on the guidelines that describe the theoretical model underpinning the postvention. This allowed an assessment of the

likely effectiveness of these guidelines based on an evaluation of evidence for the underlying theoretical framework.

Reflecting the criteria of the AGREE II (44) the following data were extracted for all eligible guidelines: title, author, year and country; target users and population; indications of whether objectives and methods of development were described, whether target users were involved in the development, whether the evidence base of the guidelines and the theoretical model of postvention were described, and whether key recommendations or sample material, such as templates, were included. TF conducted the data extraction and CR and KKo reviewed portions of extracted data. For brevity, data extraction is reported for the 14 guidelines that described the theoretical model underpinning the postvention (Table 5). Appendix 4 includes a full list of the 41 guidelines identified through the grey literature searches, and descriptions of the 14 guidelines analysed in detail are included in Appendix 5.

Findings

Study characteristics

The Evidence Check identified 19 peer-reviewed papers published between 2014 and 2024. Table 1 summarises the included studies (9-27). The studies are categorised according to types of interventions/ model of care and the NMHRC level of evidence.

There were two RCTs (26, 27), two non-randomised comparative studies with case control (22, 23), three mixed-methods studies (9, 14, 16), seven studies with pre-post design measures without control groups (13, 15, 17-20, 25), one prospective observational study (21), one prospective longitudinal study (11) and three retrospective cross-sectional studies (10, 12, 24).

The Evidence Check comprised six studies from the US (15, 17, 20, 21, 25, 27), six studies conducted in Australia (9, 10, 12, 14, 16, 24), four studies from Italy (18, 19, 22, 23), two from Belgium (including one also conducted in the Netherlands) (13, 26), and one from Ireland (11).

The interventions varied in their settings. Six were based in a community setting (10, 12, 15-17, 24), four were based in a clinical setting that included a hospital-based mental health clinic (21, 25-27), two were residential or group settings (18, 19), two were school settings (22, 23), three were based online and through telephone (11, 13, 14), one in a group activity in an art studio (20) and one in a funeral home (9).

Most of the studies focused on adult populations, with three studies involving older adult participants (age range from 59–95 years) (14, 21, 27), though they did not specifically target an older demographic. Two studies were school-based and included children (22, 23). Across the studies, most participants were female, ranging from about 64% – 92%, including those in the school-based studies.

The study populations were primarily composed of family members (10, 12-14, 16, 26, 27), some included other relatives and non-relatives (13, 18, 24, 26, 27), two included peers at school (22, 23), one included employees of a funeral home (9).

The interventions varied from community-based programs (10, 15-17, 24, 26) to group interventions in schools or retreats (9, 18-23), and individual interventions in clinical settings (25, 27). Five of the interventions were identified as manualised (21-23, 25, 27).

There was considerable variation in the time of bereavement reported by the participants across the studies, ranging from less than 48 hours (14) to 30 years (18).

The interventions involved individuals early in the grief process within 48 hours of bereavement (14) to 30 years (18). Duration of intervention and the timing of participant assessment varied considerably between studies, ranging from assessment shortly after the intervention (16, 18) to assessment at 12-months follow-up (13).

Studies used different measures and instruments to measure outcomes. Most studies used mental health measures along with semi-structured interviews and a combination of other outcome measures, such as mindfulness, resilience and death anxiety scales. While 10 studies measured suicidality and grief (10, 11, 13, 15, 17, 21, 24-27), nine studies did not assess grief (9, 12, 14, 16, 18-20, 22, 23) but focused on the emotional impact of working with suicide bereavement funerals and protective factors such as mitigating death anxiety and improving mindfulness.

Table 1—Summary of included studies (n = 19)

Study reference, location	Study design, assessment	Level of evidence (NHMRC grade)	Sample Intervention / control /N_ _=_ _… _ Age: M (SD) or range, sex: F/M: n/n (%/%)	Intervention, setting	Outcome measures	Main outcomes	Limitations
Indicated interventions							
Wittouck et al. (2014) (26) A CBT-based psychoeducational intervention for suicide survivors: a cluster randomized controlled study. Crisis, 35(3), 193–201. https://doi.org/10.1027/0227-5910/a000252 **(Belgium)**.	Cluster RCT: baseline, 8 months after study entrance.	II	Intervention group: N = 47, Age: M=49.3 (SD 13.8), F/M: 38/9 (81%/19%) Control group: N = 36, Age: M=47.6 (SD 12.8) F/M: 25/11 (69%/31%).	Cognitive behavioural therapy-based psychoeducational intervention facilitated by clinical psychologists, held at the participant's home, 2hr session, 4 sessions, frequency not reported. Setting: clinical group/ family.	Semi-structed interviews, self-report questionnaires—Inventory of Traumatic Grief (ITG) (Dutch version), the Beck Depression Inventory (BDI-II-NL), Becks Hopelessness Scale (BHS), Grief Cognitions Questionnaire (GCQ), The Utrecht Coping List (UCL).	No significant effect on development of complicated grief reactions, depression, suicide risk factors. Decrease in grief intensity, depression, passive coping style, social support seeking, behavioural expression of negative feelings in only the intervention group (all p<.05).	Small sample, mostly women, possible selection bias. Findings generalisable only to bereaved people at risk of complicated grief and /or seeking psychotherapy.
Zisook et al. (2018) (27) Treatment of complicated grief in survivors of suicide loss: A HEAL report. J Clin Psychiatry, 79(2), 17m11592. https://doi.org/10.4088/JCP.17m11592 **(US)**.	RCT: baseline, monthly, at week 20.	II	N = 395 suicide bereaved (SB) N = 58, accident/ homicide (A/H) N = 74, natural causes (NC) N = 263. Randomised in 4 groups: medication, placebo, CGT + medication, CGT + placebo, Age: SB:M=47.2, SD 14.1, A/H: M=51.6, SD 14.8, NC: M= 54.6, SD 14.2, F/M: SB: 48/10 (82%/17%), AH: 56/18 (76%/24%), NC: 204/59 (78%/22%).	Manual-based structured Complicated Grief Therapy (CGT), facilitated by social workers, psychiatrists, psychologists. Citalopram (antidepressant) with individual follow-up, medication for 12 weeks with 2-4 weekly visits until week 20, 16 sessions CGT over 20 weeks Setting: clinical, individual.	Structured clinical interview for DSM-IV-TR Axis 1 (SCID-1), Complicated Grief Clinical Global Impression Scale-Improvement (CG-CGI-I), Inventory of Complicated Grief (ICG), Structured clinical interview for complicated grief (SCI-CG), Grief-Related Avoidance Questionnaire (GRAQ), Columbia Suicide Severity Rating Scale-Revised (CSSRS-R), Work and Social Adjustment Scale-Revisited (WSAS),Typical Beliefs Questionnaire (TBQ).	CGT seemed acceptable in all groups, CGT effective in all bereaved groups concerning CG symptom severity, suicidal ideation, grief-related functional impairment, avoidance and maladaptive beliefs. Low acceptability of medication-only treatment, low improvement on clinician-rated CG-CGI-I in SB versus AH and NC groups (p<0.5).	Sample underpowered to examine cause of death as a moderator and other interactions such as demographic variables, high dropout rate in medication-only group, heterogeneity within cause of death subgroups, lack of no-treatment control group.
Ohye et al. (2022) (15) Intensive outpatient treatment of PTSD and complicated grief in suicide-bereaved military widows. Death Studies, 46(2): 501–507.	Pre-post study, mixed methods: pre- and post-treatment measures and satisfaction survey.	IV	N = 25, 24 completed program (one early discharge due to medical reasons). Mean age of participants was 36.63 (SD 8.65). Composition: 20 Caucasian (83.4%), two Hispanic (8.3%)	Structured phone interviews by clinical social workers, completion of validated self-report measures, women admitted to program for 2 weeks of treatment (accommodation and transport	PTSD Checklist for DSM-5, 8-item Patient Health Questionnaire (PHQ-8), Inventory of Complicated Grief (ICG), Typical Beliefs Questionnaire (TBQ), Grief-Related Avoidance Questionnaire (GRAQ), Patient-Reported	Symptomatic sample, mean scores at entry were high 43.42 (SD17.40) on the PCL-5, 40 (SD 12.95) on the ICG, and 14.57 (SD 5.92) for the PHQ-8. 87.5% were above the screening level of 10 recommended for the PHQ-8. Grief-related avoidance and maladaptive loss-related cognitions were	Small sample, not generalisable, group dynamics may influence individual outcomes. No control comparator, primary assessment of symptom severity and change was

https://doi.org/10.1080/07481187.2020.1740832 **(US)**.			and two Black (8.3%). Majority of widows (N = 22, 91.7%) reported having children.	provided). Standard clinical assessments at initial screening, pre-treatment, and post-treatment (immediately upon completion of the 2-week program). Setting: community based.	Outcomes Measurement Information System (PROMIS), Anonymous Patient Satisfaction Questionnaire.	elevated as well (GRAQ mean = 26.79, SD 14.36; TBQ mean = 56.30, SD 19.32). Grief-related avoidance (GRAQ) showed no significant change from baseline (M = 26.79, SD 14.36) to post-treatment (M = 25.21, SD 14.24, p > .05). Participants reported a high level of satisfaction with the program (N = 23, 95.8%).	limited to self-report validated measures.
Scocco et al. (2019) (18) Mindfulness-based weekend retreats for people bereaved by suicide (Panta Rhei): A pilot feasibility study. Psychol Psychother: Theory, Res, Pract. 92(1), 39–56. https://doi.org/10.1111/papt.12175 **(Italy)**.	Pre-post study: baseline 4-6 days before intervention, post: 4-6 days after.	IV	N = 61. Age: M=49.5 (SD 11.0) F/M: 49/12 (80%/20%).	A support program of mindfulness-based residential weekend retreats, including emotion and grief-oriented exercises. Setting: group, residential.	Five Facet Mindfulness Questionnaire (FFMQ), Self-Compassion Scale (SCS), Profile of Mood States (POMS).	Significant improvements in almost all dimensions of mood states (POMS) over time. No change in dimensions of SCS and FFMQ. Compared with first-time participants, multi-participation groups showed significant improvements over time on the self-kindness subscale of SCS and non-judging scale of FFMQ.	Mostly female sample, help seeking, selection bias, voluntary/self-initiated enrolment, small cohort, no control group or follow-up data, no grief-specific scale to assess grief intensity or the presence of complicated grief, not clear if observed effects related to intervention or group effects.
Scocco et al. (2022) (19) Panta Rhei: a Non-randomized Intervention Trial on the Effectiveness of Mindfulness-Self-compassion Weekend Retreats for People Bereaved by Suicide. Mindfulness 13, 1307–1319 (2022). https://doi.org/10.1007/s12671-022-01880-0 **(Italy)**.	Non-randomised trial, pre-post study: 4–6 days prior to and after the intervention.	IV	Intervention group N = 97 F/M: 76 (78.3%)/76 (78.3%) Age (yrs):48.5 (13.0), Control group N = 50 F/M: 44 (88.0%)/6 (12.0%) Age (yrs): 45.9 (11.9).	Three sessions on acquaintance, dealing with emotional challenges specific to suicide bereavement and on deepening awareness. Setting: group, residential.	Self-Compassion Scale (SCS), Five Facet Mindfulness Questionnaire (FFMQ), Profiles of Mood States (POMS) before and after the intervention.	Significant growth in participant awareness and ability to explore difficult cognitions and mental states, enhances the sense of the shared human experience because of group setting and lessens psychological distress by enhancing mindfulness abilities and specific self-compassion meditations.	Mostly female sample, help seeking, selection bias, lack of randomisation, passive control groups, differences in grief duration adding to group dynamics.
Supiano et al. (2017) (21) The transformation of the meaning of death in complicated grief group therapy for survivors of suicide: A treatment process analysis using the meaning of loss codebook. Death Studies, 41(9), 553–561. https://doi.org/10.1080/07481187.2017.1320339 **(US)**.	Prospective observational study: analysis of the process of individual participant change in three complicated grief therapy groups.	IV	N = 21, Age: M=53 (range 34-73) F/M:15/6 (71%/29%).	Complicated grief group therapy (CGGT)—a multimodal manualised group psychotherapy with 2hr-sessions over 16 weeks. Setting: clinical, group.	Meaning of Loss Codebook (MLC), Grief and Meaning Reconstruction Inventory (GMRI), Brief Grief Questionnaire (BGQ). Also weekly assessment using Clinical Global Impressions–Severity Scale (CGI-S) and Clinical Global Impressions–Improvement Scale (CGI-I).	Therapy facilitated resolution of complicated grief symptoms and integrated memory of the deceased. MLC codes captured statements of the participants, helped articulate the therapeutic process and showed that CGGT facilitated grief. Some participants continued to experience physical distress, depression, anxiety even with improved self-care.	Small and mostly women. Limited to people bereaved by suicide with complicated grief. Findings may be generalisable to people seeking intensive psychotherapy, no control group.

Williams et al. (2020) (25) Novel Application of Skills for Psychological Recovery as an Early Intervention for Violent Loss: Rationale and Case Examples. Omega: J Death Dying, 81(2), 179–196. https://doi.org/10.1177/0030222818766138 **(US)**.	Pre-post study: pre-treatment assessment battery, followed by 5 SPR sessions and measures repeated post intervention.	IV	2 case examples, both female. Age: mid-fifties and late forties.	Full-day SPR workshop in five 50-min sessions, by two clinical psychologists, assessment of patients (pre- and post-intervention) for symptoms of PTSD, depression and PGD. Setting: hospital-based mental health clinic.	National Stressful Events Survey PTSD module (a 20-item self-report measure of PTSD symptoms that correspond to the DSM-5 criteria for PTSD), Beck Depression Inventory–II, Prolonged Grief13 (PG-13) Scale, problem-solving worksheets.	Both individuals reported a positive response to SPR intervention; one showed improvement on measures of PTSD and depressive symptoms whereas for the other scores on the PTSD were mostly unchanged with some slight increase in depressive symptoms.	No controlled randomised clinical trial; cannot conclude changes were result of intervention rather than natural passage of time; follow-up data not available, no data that SPR intervention targets some symptoms such as grief more effectively than others such as trauma, or whether potential intervention effects are moderated by type of loss.
Selective interventions							
Testoni et al. (2018) (22) Psychodrama and Moviemaking in a Death Education Course to Work Through a Case of Suicide Among High School Students in Italy. Front Psychol, 9, 441. https://doi.org/10.3389/fpsyg.2018.00441 **(Italy)**.	Non-randomised pre-post study. Assessment: experimental group-baseline, DE (psychodrama techniques and artistic production of movies) and post DE measures. Control group baseline, no DE and measures.	III-2	N = 268, experimental group (DE): n = 138, age M= 17.1, SD 0.6, F/M: 75 (54%)/63 (46%). Control group (no DE): n = 130, age M=17.2, SD 0.6, F/M: 77 (59%)/ 53 (41%).	Experimental group with DE, consisting of formal work (classroom lessons on death, meditation etc.), informal work (production of pictures, short movies etc.). Control group with no DE. Setting: school.	The Testoni Death Representation Scale (TDRS), Toronto Alexithymia Scale (TAS), Personal Meaning Profile (PMP), Death Anxiety Scale (DAS).	Pre-test and post-test measures assessed ontological representations of death, death anxiety, alexithymia, and meaning in life. Experimental group showed reduced death anxiety and reduced representation of death as annihilation and alexithymia, enhancing spirituality and the meaning of life compared with the 'no DE' group.	Non-randomised, cannot generalise, lack of long-term follow-up, necessary to explore the concept of death with empirical research.
Testoni et al. (2021) (23) My Future: Psychodrama and Meditation to Improve Well-Being Through the Elaboration of Traumatic Loss Among Italian High School Students. Front Psychol, 11, 544661. https://doi.org/10.3389/fpsyg.2020.544661 **(Italy)**.	Non-randomised, pre-post study: experimental and control group, 3 days pre- and 3 days post-intervention; online questionnaires administered before and after	III-2	N = 82 experimental group: N = 45, F/M: 27/18 (M = 15.98, SD = 1.12). Control group: n = 37, F/M: 33/4 (M = 16.14, SD = 1.00).	Experimental group: Eight 2-hr meetings, themes of death and loss were dealt with through theoretical discussions, dramatisation and meditation. Control group: no activities Setting: school.	Death Attitude Profile-Revised (DAP-R), Psychological Well-being Scale (PWBS), Resilience Scale for Adolescents (READ), Self-Transcendence Scale (STS), Testoni Death Representation Scale (TDRS).	3 days pre- and 3 days post-intervention questionnaires were administered online. No significant difference between the two groups was found at the pre-test, except for PWBS-Environmental Mastery (t = 2.09, df = 80, p = 0.040, d = 0.46). Decrease in fear of death and in avoidance of death observed in the experimental group, increase in neutral acceptance of death lending to psychological wellbeing and resilience.	Small sample size, previously established (school classes) and non-randomised groups. Both groups mainly composed of females, proportion of females greater in the control group, intervention not offered to control group after study.

	death education intervention (philosophy lesson, psychodramatic techniques and meditation with Tibetan bells, total of 8 meetings).						
Gehrmann et al. (2020) (10) Evaluating the Outcomes for Bereaved People Supported by a Community-Based Suicide Bereavement Service. Crisis, 41(6), 437–444. https://doi.org/10.1027/0227-5910/a000658 **(Australia)**.	Retrospective cross-sectional study: control (non-StandBy clients) and experiment group: 3-month and 12-month StandBy client follow-up calls.	III-3	N = 545, 84% female. Intervention group: n = 121 Age (yrs): 47.8. Control group: N = 424 Age (yrs): 42.4 (12.9).	Outcomes compared between people bereaved by suicide who had accessed StandBy (intervention group) and those who did not access StandBy (control group). Suicidality (SBQ-R), grief reactions (GEQ) and social isolation (DLS) measured. Setting: community based.	Suicidal Behaviors Questionnaire-Revised (SBQ-R), Grief Experience Questionnaire (GEQ), De Jong Gierveld Loneliness Scale (DLS).	Significant group differences on four of the outcome variables, intervention group significantly lower on the SBQ-R, the grief reaction of loss of social connections, and social loneliness, but significantly higher on the grief reaction of responsibility compared with control group. No significant difference between participants with loss >12 months; risk of suicidality; outcome variables based on types of support received.	Cannot determine changes in outcomes over time, low response rate, individuals seeking support may have better coping skills, use of an online survey leading to self-selection bias.
Griffin et al. (2022) (11) Psychosocial Outcomes of Individuals Attending a Suicide Bereavement Peer Support Group: A Follow-Up Study. Int J Environ Res Public Health, 19(7), 4076. https://doi.org/10.3390/ijerph19074076 **(Dublin)**.	Prospective longitudinal study: baseline survey before attending their first group session and two further surveys at three- and six-month follow-up.	III-3	N = 75, current and new community support group members, mostly female (n = 64; 85.3%) median age 46 years (interquartile range (IQR): 16), half (N = 40; 53.3%) in a relationship or married, one quarter (19; 25. 3%) separated, divorced or widowed.	Baseline survey (T1) before attending their first group session, two further surveys at three- and six-month follow-up (T2 and T3). Setting: online.	World Health Organization-Five Wellbeing Index (WHO-5), Patient Health Questionnaire Depression Scale (PHQ-9), Work and Social Adjustment Scale (SAS-SR), Traumatic Grief Inventory-Self-Report (TGI-SR), Grief Experience Questionnaire (GEQ).	Mostly negative scores across outcome measures at baseline. Those bereaved within three years had poorer levels of wellbeing (mean diff: −11.8; 95% CI: −21.3 to −2.2; p = 0.016), stronger indications of depressive symptoms (+3.5; 0.4 to 6.6; p = 0.027), poorer social adjustment (+5.8; 1.3 to 10.4; p = 0.013) and higher levels of traumatic grief (+11.6; 4.0 to 19.2; p = 0.003). A significant improvement in wellbeing at T2 (mean difference: +11.8, 95% CI: 4.7 to 18.8) with a significant reduction in traumatic grief (−6.9, −10.7 to −3.1). All changes held at T3.	Missing data leading to four participants being excluded at T1. Limited sample size, no control group, survey respondents actively engaged with the peer support groups and may have availed themselves of support and treatment. The follow-up study involved individuals who had only attended online.
Hill et al. (2022) (12) Reach and perceived effectiveness of a community-led active outreach postvention intervention for people bereaved by suicide. Front	Retrospective cross-sectional study, mixed methods approach statistical	III-3	Semi structured qualitative online interviews: 5 bereaved individuals, 18 stakeholders from the PaRK Suicide Prevention Response Group (SRG)	Descriptive statistics to summarise characteristics of those who died by suicide as well as bereaved people receiving support from PCN. Interviews with police,	Quantitative analysis from data sources, themes: Linking individuals to the support they need, postvention as suicide prevention, maintaining	N = 164 who were offered outreach, accepted further support in the form of suicide bereavement information (98%), mental health or clinical support (49.6%), specialised postvention counselling (38.4%), financial assistance (16%),	No control group or longitudinal follow-up, no statistical support to support qualitative findings, cannot determine efficacy of model for grief

Public Health, 10, 1040323. https://doi.org/10.3389/fpubh.2022.1040323 **(Australia)**.	analysis of data collected by PCN and semi-structured qualitative interviews were conducted online.		and 5 employees of the WA police force involved in the implementation and delivery of the PCN model.	postvention stakeholders and people bereaved by a suspected suicide. Setting: community, individual, stakeholders.	connection to the community, and areas for improvement.	assistance with meals (16%), housing assistance (14%) and referral to community services (11%). Police, stakeholders and people with lived experience perceived PCN model to be to be effective.	outcomes, assessment of PCN model as a sustainable postvention approach in other communities that have fewer services or lack capacity to be done.
Visser et al. (2014) (24) Evaluation of the effectiveness of a community-based crisis intervention program for people bereaved by suicide. J Community Psychol, 42(1), 19–28. https://doi.org/10.1002/jcop.21586 **(Australia)**.	Retrospective cross-sectional study: baseline and assessment after intervention (unspecified).	III-3	Experimental group: N = 90, Age: M=45.7 (SD 15.8), F/M:73/17 (82%/18%). Control group: n = 360, Age: M=40.1 (SD 13.4) F/M: 311/49 (88%/11%).	Face-to-face outreach and telephone support provided by a professional crisis response team. The service then develops a customised plan, referring clients to a community service matching their need, which is provided to those who request it. Setting: community based.	EQ-5, the ICECAP index of capability Kessler Psychological Distress Scale (K), Suicidal Behaviors Questionnaire-Revised (SBQ-R), World Health Organization and Work Performance Questionnaire (HPQ), healthcare usage questions.	StandBy clients scored better on suicidality (p= .006), no significant difference on other scales or healthcare use.	Self-selected sample, mostly women, low rate of participant response (23%), significantly demographic difference between two groups, grief not assessed, observational design, no control of confounding variables (age of bereaved, time since death and other treatments sought by participants)
Clements et al. (2023) (9) Towards an Evidence-Based Model of Workplace Postvention. Int J Environ Res Public Health, 20(1), 142. https://doi.org/10.3390/ijerph20010142 **(Australia)**.	Instrumental case study, mixed methods: baseline questionnaires, training and post training questionnaires.	IV	N = 67 (baseline) through email, F/M: 23/13, n = 36 trainees in four face-to-face postvention, 32 (88.9%) completed the post-training questionnaire.	3hr training session, mixed groups of 8-12 staff from different roles and office locations. Eight-item baseline questionnaire prior to the training, and post-training questionnaire. Setting: funeral company.	Baseline questionnaire (experiences, comparative difficulty and emotional impact of working with suicide bereavement funerals), post questionnaire (impact of the training, confidence, awareness and willingness to share postvention information). Semi-structured interviews on the same variables measured in the questionnaires.	32/36 (88.9%) trainees completed the post-training questionnaire. 100% found the training useful, better understanding of emotional impact of working with suicide bereavement funerals, 85% were more confident about appropriate (best practice) language and 88% said it helped them better manage this impact. 43.8% reported pressure working with suicide bereavement funerals with no change as a result of training. Themes: work & role, engagement, emotionality.	Data obtained from one company in a metropolitan area, cannot be generalised.
Kramer et al. (2015) (13) The mental health of visitors of web-based support forums for bereaved by suicide. Crisis, 36(1), 38–45. https://doi.org/10.1027/0227-5910/a000281 **(Belgium and the Netherlands)**.	Pre-post study, mixed methods: self-reported measures and interviews, baseline, follow-up at 6 and 12 months, interviews with	IV	N = 270, Age: M=42.9 (SD 12.4) F/M: 238/32 (87%/13%). Interview subgroup: N = 29, Age: M=45.3 (SD 10.8) F/M: 26/3 (90%/10%).	Two government-funded web-based peer support forums for the bereaved by suicide—one in the Netherlands, founded in 2010, and one in Dutch-speaking Belgium, founded in 2006. Visitors to site can read/post messages about a specific topic. Both forums similar in layout, structure and	WHO-Five Well-being Index, Center for Epidemiological Studies Depression Scale, Inventory of Traumatic Grief, MINI-plus-MINI-International Neuropsychiatric Interview, semi-structured interviews with forum members.	Significant improvement in wellbeing and symptoms of depression (p<.001 in both groups), small-to-medium pre-post effect sizes for wellbeing (6 months: d = 0.24, 12 months: d = 0.36) and small for depressive symptoms (6 months: d = 0.18, 12 months: d = 0.28). Change in grief symptoms nearly reached significance (p = .08, 6 months: d = 0.05, 12 months: d = 0.12). No significant	Online sample, help seeking, self-selected, mostly women. Self-report measures subject to recollection bias, high dropout rate (43%). No control group. Dutch forum launched 1 month before

	selected sample after 12 months.			in most of predefined subforums. Setting: online.		changes in suicide risk at 12 months, 17.2% of participants (n = 28) compared with 20.8% (N = 32) at baseline. The reasons for visiting the forum: to find similar situations like own (N = 16, 55%), find recognition (n = 14, 48%), and find peers to share experiences with (N = 7, 24.1%).	the recruitment started and not at its full capacity.
Maple et al. (2019) (14) Providing support following exposure to suicide: A mixed method study. Health Soc Care Community, 27(4), 965–972. https://doi.org/10.1111/hsc.12713 **(Australia)**.	Mixed methods: descriptive statistical analysis of the client contact database and semi-structured interviews.	IV	Quant N = 2748 service users, Qual N = 6 StandBy female staff, 65% of female. Six female co-ordinators participated in semi-structured interviews, relatively new to the role (1–19 months, M = 13; SD = 6.65) Age range 33–59, M = 45; SD = 9.72.	Service-usage data from StandBy and semi-structured interviews Setting: phone interviews.	The impact of StandBy on service users and individuals providing the support measured through service-usage data routinely collected by StandBy, and semi-structured interviews.	Kin and non-kin access support services following exposure to suicide, workers providing postvention support are a unique workforce who are cumulatively exposed to suicide vicariously, as well as potentially being exposed in their personal lives, needs of postvention workers require further attention.	Not generalisable to other workers or workplaces where postvention is not the service focus, variability of the data, high level of missing data, urban focus, could not include all coordinators of StandBy.
Peters et al. (2015) (16) The Lifekeeper Memory Quilt: evaluation of a suicide postvention program. Death Studies, 39(6), 353–359. https://doi.org/10.1080/07481187.2014.951499 **(Australia)**.	Retrospective study, mixed methods: self-reported measures (online or hardcopy) and interviews, assessment shortly after intervention.	IV	N = 82, Age: 75% over age of 45, F/M: 75/7 (91%/9%). Interview subgroup: N = 30.	The Lifekeeper Memory Quilt project implemented in 2008 by Suicide Prevention Bereavement support services (Salvation Army), provides support for suicide loss survivors and creating public awareness of suicide. Setting: community based.	Help Is at Hand questionnaire with 16 items of the Participants' Evaluation of Quilt (PEQ-16) scale, semi-structured interviews on participants' experiences.	High participant satisfaction (M 69.6, SD 9.1), approx. 92% rated it as helpful or extremely helpful, over half (48%) reported that a year after loss was the best time to be participating in the Quilt project. Themes: healing, creating opportunity for dialogue, reclaiming the real person, and raising public awareness.	Mostly female sample, self-selected (55% response rate), participants not necessarily representative, no assessment of grief, no control group, descriptive study.
Saindon et al. (2014) (17) Restorative retelling for violent loss: an open clinical trial. Death Studies, 38(4), 251–258. https://doi.org/10.1080/07481187.2013.783654 **(US)**.	Pre-post study: pre-treatment assessment battery, followed by a weekly 1.5h RR group treatment for 10 sessions and measures repeated post-intervention.	IV	N = 51, mostly female (M=37, 72.5%). Age: M=44.84 (13.35).	Participants assessed for comorbidity before enrolling in RR, completed pre-treatment assessment battery, weekly 1.5h RR group treatment for 10 sessions followed by post-intervention assessment. Setting: community counselling centre.	Beck Depression Inventory–A, Impact of Events Scale (IES and IES-R), Inventory of Traumatic Grief (ITG).	Average score of participants on ITG items was 2.75 (SD .84, median = 2.56), mean level of intrusion symptoms on the IES was 14.84 (SD 4.69, median =14.98). Significant Symptom Severity x time Interaction Effect for depressive symptoms $F(1, 46)=15.45$, $p < .001$, partial $n2 = .25$, for avoidance symptoms, $F(1, 38) = 7.85$, $p = .008$, partial $n2 = .17$ and traumatic grief symptoms, $F(1, 35) = 4.96$, $p = .032$, partial $n2 = .12$. For each of these variables, those above the median	Significant missing data, no comparison group, therapists' adherence to treatment protocol not assessed, positive treatment results could be function of improvements because of time or regression to the mean, majority participants were white, non-Hispanic women.

						improved over time, but those below the median did not change significantly.	
Strouse et al. (2021) (20) Benefits of an open art studio to military suicide survivors. Arts Psychother, 72, Article 101722. https://doi.org/10.1016/j.aip.2020.101722 **(US)**.	Pre-post study with single group mixed methods study design: pre-post test before and after art studio.	IV	N =39, mostly female (N = 34; 87.2%), and white (N = 29; 74.4%). 62.2% attended the first time, 8.1% for the 2nd time, 5.4% the 3rd time, 5.4% the 4th time, and 16.2% for the fifth time or more. Majority of the participants (75%) attended at least two out of the three days, participating for at least half a day each day (4h), created at least two art products.	Pre-test measures before working on art, post-test after working on art, completed only once, even if participants participated in the studio for several days. Setting: Artful Grief Studio (AGS) initiated at Tragedy Assistance Program for Survivors (TAPS) in 2019.	Social meaning in life event stress (SMILES), Post traumatic growth inventory (PTGI), Follow-up program evaluation survey.	Significant increase in social validation n ($t(36) = -2.11$, $p = .021$, $p < .05$), decrease in social invalidation n ($t(36) = 2.70$, $p = .005$, $p < .05$), significant increase in relating to others ($t(36) = -2.10$, $p = .022$, $p < .05$), and new possibilities ($t(36) = -1.69$, $p = .050$, $p < .05$). Significant decrease in the PTG subscale scores about appreciating life ($t(36) = 2.21$, $p = .017$, $p < .05$). No differences in PTG cognition, scores related to personal strength, spiritual change. Themes: bereavement processing, sharing and collaboration, contributions of the art experience, relaxation effects.	Small percentage of missing data on various items (<5%), replaced with mean scores. Posttraumatic growth measure not designed for complex grief. Difficult to find measures for brief art therapy interventions and complex grief. One-third of the participants who completed follow-up survey may have felt more positively about the studio.

Evidence grading

Tables 2 and 3 provide a summary of the ratings of the reviewed studies based on the NHMRC Levels of Evidence. There were two level II studies, two level II-2 studies, four level III-3 studies and 11 level IV studies (Table 2). Table 3 rates the evidence base of the peer-reviewed literature using the NHMRC framework for evaluating evidence. Based on the rating across five components, three components were rated 'D', which is poor in evidence base, consistency and clinical impact, and two components were rated 'C', indicating a satisfactory rating in generalisability and applicability to the target population and to the Australian context, respectively.

Table 2—NHMRC Levels of Evidence for peer-reviewed literature

	Study	NMHRC Level of Evidence
Indicated interventions		
1	Wittouck *et al*. (2014)	**II**
2	Zisook *et al*. (2018)	**II**
3	Ohye *et al*. *(*2022)	**IV**
4	Scocco *et al*. (2019)	**IV**
5	Scocco *et al*. (2022)	**IV**
6	Supiano *et al*. (2017)	**IV**
7	Williams *et al*. (2020)	**IV**
Selective interventions		
1	Testoni *et al*. (2018)	**III-2**
2	Testoni *et al*. (2021)	**III-2**
3	Gehrmann *et al*. (2020)	**III-3**
4	Griffin *et al*. (2022)	**III-3**
5	Hill *et al*. (2022)	**III-3**
6	Visser *et al*. (2014)	**III-3**
7	Clements *et al*. (2023)	**IV**
8	Kramer *et al*. (2015)	**IV**
9	Maple *et al*. (2019)	**IV**
10	Peters *et al*. (2015)	**IV**

	Study	NMHRC Level of Evidence
11	Saindon *et al*. (2014)	**IV**
12	Strouse *et al*. (2021)	**IV**

Table 3—NHMRC matrix to summarise the evidence base of peer-reviewed literature

Component	Rating
Evidence base	**D** (Poor—many level IV, III and II studies with high risk of bias)
Consistency	**D** (Evidence is inconsistent)
Clinical impact	**D** (Slight or restricted)
Generalisability	**C** (Population in this review differs but can be applied to target population with few reservations)
Applicability	**C** (Probably applicable to Australian contexts with some caveats)

Table 4 provides a summary of the study quality based on the six components of the Quality Assessment Tool for Quantitative Studies (43). Overall, the studies were rated as having weak quality. Only one study (26) was rated strong in four components, while three studies (22, 23, 27) were rated strong in three components. Ten studies received strong ratings in two components (10, 12, 14, 15, 17-21, 25) and four studies were strong in one component (11, 13, 16, 24). One study (9) did not receive any strong ratings.

The weakest aspects across the studies included group differences before the intervention, control of confounders, selection bias, blinding, handling of withdrawals and dropouts, and missing data. Only two studies used randomised designs (22, 23) and none reported employing an intention-to-treat analysis. Most studies appeared to use valid and reliable measures. Although some studies evaluated the consistency of the intervention (10, 11, 15, 17-21, 27), it remains unclear whether other studies accounted for the effects of other treatments.

Table 4—Summary of study quality

Quality criteria	Clements *et al.* (2023 (9)	Gehrmann *et al.* (2020) (10)	Griffin *et al.* (2022) (11)	Hill *et al.* (2022) (12)	Kramer *et al.* (2015) (13)	Maple *et al.* (2019) (14)	Ohye *et al.* (2022) (15)	Peters *et al.* (2015) (16)	Saindon *et al.* (2014) (17)	Scocco *et al.* (2019) (18)	Scocco *et al.* (2022) (19)	Strouse *et al.* (2021) (20)	Supiano *et al.* (2017) (21)	Testoni *et al.* (2018) (22)	Testoni *et al.* (2021) (23)	Visser *et al.* (2014) (24)	Williams *et al.* (2020) (25)	Wittouck *et al.* (2014) (26)	Zisook *et al.* (2018) (27)
A. Selection Bias																			
Representativeness	Not likely	Very likely	Not likely	Very likely	Not likely	Very likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely	Not likely
Percentage agreed	80-100%	80-100%	Can't tell	80-100%	Can't tell	80-100%	80-100%	<60%	80-100%	80-100%	80-100%	80-100%	Can't tell	80-100%	80-100%	<60%	80-100%	80-100%	Can't tell
Rating	**Weak**	**Strong**	**Weak**	**Strong**	**Weak**	**Strong**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**
B. Study design																			
Study design type	Other	Other	Other	Other	Cohort	Other	Cohort	Other	Cohort	Cohort	Cohort	Cohort	Other	Other	Other	Other	Cohort	RCT	RCT
Described as randomised?	No	No	No	No	No	No	No	No	No	No	No	No	NA	No	No	No	No	Yes	Yes
Method of randomisation described	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Yes	Yes
Method appropriate	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Yes	Yes
Rating	**Weak**	**Weak**	**Weak**	**Weak**	**Moderate**	**Weak**	**Moderate**	**Weak**	**Moderate**	**Moderate**	**Moderate**	**Moderate**	**Weak**	**Weak**	**Weak**	**Weak**	**Moderate**	**Strong**	**Strong**

C. Confounders																			
Pre-intervention differences?	NA	NA	Yes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Yes	Yes	Yes	NA	Yes	Yes
Percentage confounders controlled for	NA	NA	<60% (few/none	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	80-100%	80-100%	<60% (few/none)	NA	80-100%	<60% (few/none)
Rating	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Strong**	**Strong**	**Weak**	**Weak**	**Strong**	**Weak**
D. Blinding																			
Outcome assessors were blinded	No	No	No	No	No	No	No	No	No	No	No	No	Can't tell	No	No	No	No	No	Yes
Participants were blinded	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Yes
Rating	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Strong**
E. Data collection methods																			
Valid measures?	Can't tell	Can't tell	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Reliable measures?	Can't tell	Can't tell	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rating	**Weak**	**Weak**	**Strong**	**Weak**	**Strong**	**Weak**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**

F. Withdrawals and dropouts																			
Numbers and reasons reported per group	Yes	No	NA	No	No	No	Yes	NA	No	No	No	Yes	No	No	No	NA	No	Yes	No
Percentage completed study?	<60%	80-100%	NA	80-100%	<60%	80-100%	80-100%	NA	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	NA	80-100%	80-100%	<60%
Rating	**Weak**	**Strong**	**Weak**	**Strong**	**Weak**	**Strong**	**Strong**	**Weak**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Strong**	**Weak**	**Strong**	**Strong**	**Weak**
Total A–F	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**	**Weak**
Number of 'strong' ratings	0/6	2/6	1/6	2/6	1/6	2/6	2/6	1/6	2/6	2/6	2/6	2/6	2/6	3/6	3/6	1/6	2/6	4/6	3/6
G. Intervention integrity																			
Percentage participants receiving intervention?	60-79%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	80-100%	60-79%
Intervention consistency measured?	Can't tell	Yes	Yes	Can't tell	Can't tell	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Yes
Confounding unintended intervention?	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell

H. Analyses																			
Unit of allocation	Individual	Individual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individual	Individual	Individual
Unit of analysis	Individual	Individual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individ-ual	Individual	Individual	Individual
Appropriate statistical methods?	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Analysis by intention-to-treat status	No	No	No	No	No	No	No	No	No	No	No	No	No	Can't tell	Can't tell	No	No	No	No	Can't tell

Guidelines characteristics

We analysed 14 guidelines published from 2015–2023 (Table 5). Four were published in the US (33, 34, 36, 40), four in Australia (32, 35, 37, 39), three in the UK (30, 38, 41), two in Canada (28, 31) and one in Ireland (29). Four guidelines were developed for schools/youth settings (31, 33, 35, 37); six were for workplaces, including general guidelines (29, 39) and guidelines for specific workplaces such as the UK National Health Services (30) and roles such as military (34), police (38) and clinicians (36); and four were developed for a range of services and communities (28, 32, 40, 41).

All guidelines described their objectives and evidence base, which comprised mainly literature, and expert and lived-experience advisory groups. Eight guidelines described their developmental methods (28, 30-32, 34, 36, 38, 40). Target users were involved in the development of 10 guidelines (28-32, 34, 38, 40, 41). Two guidelines provided key recommendations (35, 41). Six guidelines (28-30, 33, 35, 37) provided sample material such as communication/notification/email templates, scripts and meeting agendas.

Prominent among the theoretical frameworks underpinning the guidelines were the *continuum of suicide survivorship* (32, 34, 39-41) and *public health models* (28, 29, 32, 40, 41). An assessment of the likely effectiveness of these guidelines based on an evaluation of the evidence or theory underpinning the approach is included in the analysis of evidence.

Table 5—Summary of guidelines (n = 14)

Title, author, country, year	Target users	Target pop.	Objectives described	Devel. methods described	Target users inc. in devel.	Evidence base described	Theory of postvention described	Key recom-menda-tions included	Sample material included
Being Prepared to Act in the Event of a Suicide: Postvention program Seguin M, Roy F, Boilar T, Secrétariat à la jeunesse du Québec Canada, 2020 (28).	Institutions and organisations that offer postvention services.	Quebec community.	Yes	Yes	Yes	Yes (literature, Delphi consensus study, community and stakeholder focus groups).	Yes—public health model.	No	Yes
Grief in the workplace, responding to suicide: A guide for employers McGuiness B, Skehan O, Irish Hospice Foundation and National Office for Suicide Prevention Ireland, 2021 (29).	Employers and union representatives.	Employees affected by suicide.	Yes	No	Yes	Yes (literature).	Yes—public health model.	No	Yes
NHS employee suicide: a postvention toolkit to help manage the impact and provide support Samaritans and NHS Confederation	NHS organisation leaders (esp. HR	NHS employees affected by suicide.	Yes	No	Yes	Yes (literature).	Yes—circles of impact	No	Yes

Title, author, country, year	Target users	Target pop.	Objectives described	Devel. methods described	Target users inc. in devel.	Evidence base described	Theory of postvention described	Key recom-menda-tions included	Sample material included
UK, 2023 (30).	and OHS and wellbeing).								
Postvention across settings and sectors: a resource for community-based service providers Ontario Youth Suicide Prevention Life Promotion Collaborative Canada, 2022 (31).	Community and education based providers.	Youth and their families bereaved by suicide.	Yes	Yes	Yes	Yes (literature and lived experience).	Yes—circles of vulnerability.	No	No
Postvention Australia guidelines: A resource for organisations and individuals providing services to people bereaved by suicide Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017 (32).	Organisations and individuals providing services.	People bereaved by suicide.	Yes	Yes	Yes	Yes (literature, lived experience focus groups and expert review).	Yes—public health model & continuum of suicide survivorship.	No	No
Postvention standards manual: a guide for a school's response in the aftermath of a sudden death (5th edition) McCommons P, Rosen P, Services for Teens At Risk (STAR Center)	Educators, social workers, psychologists, counsellors and other professionals	Those affected by any tragic death (including by suicide) in	Yes	No	No	Yes (literature).	Yes—SAFER-R, PREPaRE & Be CALM.	No	Yes

Title, author, country, year	Target users	Target pop.	Objectives described	Devel. methods described	Target users inc. in devel.	Evidence base described	Theory of postvention described	Key recom-menda-tions included	Sample material included
US, 2020 (33).	who work with youth.	school settings.							
Postvention Toolkit for a Military Suicide Loss US Department of Defense, Defense Suicide Prevention Office US, 2019 (34).	Individuals in various relevant military roles.	Those affected by suicide in the military.	Yes	Yes	Yes	Yes (literature, lived experience and expert review).	Yes—continuum of suicide survivorship.	No	No
Responding to the suicide of a student: a guide to assist secondary schools headspace and The Department of Education and Training (Vic) Australia, 2021 (35).	Secondary school staff and leaders.	Those affected by suicide/ suspected suicide of a secondary school student.	Yes	No	Unknown	Yes (literature).	Yes—circles of vulnerability and continuum of mental health.	Yes	Yes
The impact of suicide on professional caregivers: a guide for managers and supervisors New York State Office of Mental Health's Suicide Prevention Center and New York State Office of Addiction Services and Supports	Managers and supervisors of clinical providers and staff.	Clinical providers and staff in the event of a client suicide.	Yes	Yes	Unknown	Yes (literature).	Yes—social ecological model.	No	No

Title, author, country, year	Target users	Target pop.	Objectives described	Devel. methods described	Target users inc. in devel.	Evidence base described	Theory of postvention described	Key recom-menda-tions included	Sample material included
US, 2022 (36).									
Suicide Postvention Resources: Complete Toolkit Be You and Beyond Blue Australia, 2023 (37).	Secondary school educators.	Those affected by suicide by a secondary school student.	Yes	No	Unknown	Yes (literature and best practice).	Yes—circles of vulnerability.	No	Yes
Suicide postvention toolkit National Police Wellbeing Service UK, 2022 (38).	Senior leadership in police forces.	Police staff after the loss of a colleague to suicide.	Yes	Yes	Yes	Yes (literature).	Yes—circles of impact.	No	Yes
Workplace toolkit: Workplace response to suicide Standby: Support after Suicide Australia, 2022 (39).	Employers, managers and others in a leadership role.	Those affected by suicide in the workplace.	Yes	No	Yes	Yes (literature and program evaluation).	Yes—continuum of suicide survivorship.	No	Yes
Responding to grief, trauma, and distress after a suicide: U.S. national guidelines	All professionals and peers wishing to help those impacted by suicide loss.	People bereaved by suicide.	Yes	Yes	Yes	Yes (literature, taskforce, expert group	Yes—public health model and continuum of	No	No

Title, author, country, year	Target users	Target pop.	Objectives described	Devel. methods described	Target users inc. in devel.	Evidence base described	Theory of postvention described	Key recom-menda-tions included	Sample material included
Survivors of Suicide Loss Task Force, National Action Alliance for Suicide Prevention US, 2015 (40).						review, ref to NSSP).	suicide survivorship.		
Support after a suicide: A guide to providing local services: A practice resource Public Health England, and National Suicide Prevention Alliance UK, 2016 (41).	Commissioners, local health and wellbeing boards, others.	People bereaved by suicide.	Yes	No	Yes	Yes (literature, advisory group, ref to national suicide prevention strategy).	Yes—public health model and continuum of suicide survivorship.	Yes	No

Based on the criteria of the Appraisal of Guidelines for Research and Evaluation II (AGREE Next steps Consortium, 2017) (44)

*Guideline titles include hyperlinks to source documents

Analysis of evidence

We present the studies according to types of interventions/ model of care and the NMHRC level of evidence. We outline the main characteristics of each of the peer-reviewed studies (n = 19), followed by a summary of the evidence for peer-reviewed studies and substantiation for the guidelines (n = 14).

Peer-reviewed studies (N = 19)

The peer-reviewed studies are categorised into two types of interventions. Indicated interventions consist of evidence-based treatments, psychotherapy and collaborative care. Selective interventions involve closed support groups, therapeutic/psychoeducational support, counselling services and workforce training aimed at preventing burnout and vicarious trauma among staff. None of the studies included any universal interventions.

Indicated Interventions:

Two randomised controlled trials (RCTs), one from Belgium and another from the US, were in included in the Evidence Check. **Wittouck et al. (2014)** (26) evaluated the effects of a cognitive behavioural therapy (CBT)-based psychoeducational intervention on depression, complicated grief and suicide risk factors among suicide loss survivors. This study compared participants (n = 47) in a CBT intervention, which included psychoeducation about suicide, bereavement and coping with loss, with a no-treatment control group (n = 36). The intervention resulted in a significant reduction in the intensity of depressive and grief symptoms as well as in the passive coping styles and behavioural expression of negative feelings in the intervention group. The study did not report any significant effect on development of complicated grief reactions. There was also a significant decline in seeking social support after the CBT intervention.

Zisook et al. (2018) (27) conducted a study to assess the effectiveness and acceptability of citalopram antidepressant medication and complicated grief therapy (CGT), a therapy designed to address grief complications and support those grieving a suicide loss. Among those receiving only medication, the suicide-bereaved had significantly lower completion rates (36%) compared with those bereaved by accident or homicide (54%) and natural causes (68%). However, completion rates for antidepressant medication were notably higher when CGT was also provided. CGT completion rates were similar across all groups (suicide 74%, accident/homicide 64%, natural causes 77%). Although participants bereaved by suicide showed significant reductions in complicated grief scores after CGT, the improvements were smaller than those seen in other bereaved groups. However, they experienced similar progress in other areas, such as suicidal ideation, grief severity and grief-related impairment.

Additionally, four studies reported on different psychotherapeutic interventions. **Ohye et al. (2022)** (15) reported on the Home Base Intensive Outpatient Program for Survivors (IOPS), a two-week treatment for suicide-bereaved widows of veterans with complicated grief (CG) and post-traumatic stress disorder (PTSD). The study used pre- and post-treatment measures and satisfaction surveys. Of 25 participants, 24 completed the program. The mean scores at entry were high across three measures. Additionally grief-related avoidance and maladaptive loss-

related cognitions were elevated. The study found significant reductions in self-reported symptoms of PTSD, depression, complicated grief and maladaptive loss-related cognitions over the two-week period from pre-treatment to post-treatment. Although grief-related avoidance did not change significantly, improvements were noted post treatment in perceived ability to engage in social roles and satisfaction with social participation, consistent with large effect sizes.

In a mixed-methods pilot study in Italy, **Scocco et al. (2019)** (18) evaluated the feasibility and psychological outcomes of Panta Rhei, a mindfulness-based weekend retreat for people bereaved by suicide. The program included mindfulness meditation, grief-oriented meditation, soothing practices such as poetry, music, mindful yoga and emotion-focused practices. Participants (n = 61) reported significant reductions in tension/anxiety, depression, anger, fatigue and confusion. The study did not assess participants' levels of grief. Significant improvements were seen in almost all dimensions of mood states (POMS) over time. There were no notable changes in mindfulness or self-compassion scores, except for an increase in 'describing' mindfulness scores and a decrease in 'over-identification' self-compassion scores. Compared with first-time participants, multi-participation groups showed significant improvements over time on the self-kindness subscale of the Self-Compassion Scale (SCS) and the non-judging scale of the Five Facet Mindfulness Questionnaire (FFMQ).

Scocco et al. (2022) (19) conducted a pre-post study to assess the effectiveness of Panta Rhei, a 16-hour intensive mindfulness-based self-compassion intervention for those bereaved by suicide. This non-randomised trial included 97 participants from 11 Panta Rhei retreats and a control group of 50 bereaved individuals. Effectiveness was evaluated 4–6 days before and after the retreat. Results showed Panta Rhei significantly improved mood, mindfulness and self-compassion. The intervention enhanced awareness, facilitated exploration of difficult thoughts and emotions, promoted a sense of shared human experience and reduced psychological distress through self-compassion meditations.

In their prospective observational study, **Supiano et al. (2017*)*** (21) examined the impact of complicated grief group therapy (CGGT) on individuals bereaved by suicide. CGGT, which combines psychoeducation, motivational interviewing and cognitive-behavioural elements, helped participants (n = 21) reframe their loss within the context of mental illness, shift away from self-blame and focus on positive memories. Though most participants transitioned from feelings of shame and guilt to greater acceptance and self-worth, not all experienced a reduction in symptoms such as intrusive dreams, physical distress or anxiety.

Based in a hospital mental health clinic, **Williams et al. (2020)** (25) conducted a pre-post assessment study to evaluate the use of Skills for Psychological Recovery (SPR) as an early intervention for survivors of violent loss. The SPR program aims to reduce distress by teaching problem-solving and coping skills, and promoting engagement in enjoyable activities, helpful thinking and social support. The study involved two cases: a suicide survivor and a homicide survivor. Participants attended five 50-minute SPR sessions led by two clinical psychologists. Post-intervention assessments of PTSD, depression and prolonged grief disorder showed a positive response overall. The suicide survivor improved in PTSD and depressive symptoms while the homicide survivor had mostly unchanged PTSD scores and a slight increase in depressive symptoms.

Selective interventions:

Two Italian school-based non-randomised comparative studies explored death education (DE) activities, including discussions on the philosophical and religious aspects of death and life's meaning, visits to a hospice, psychodrama and a short film production. The goal was to help adolescents better express their emotions, gain control over their thoughts about death, and reduce death anxiety following traumatic deaths in their school cohort. **Testoni et al. (2018)** (22) conducted a non-randomised pre-post study to explore the psychological effects of a death education (DE) intervention related to a suicide case in an Italian high school. The study involved 268 students (57% girls) from 10th and 11th grades across three schools in southern Italy. Of these, 138 students participated in the DE course (DE group), while 130 did not (control group). Pre- and post-test assessments measured death anxiety, ontological views of death, alexithymia and meaning in life. The DE group showed significant reductions in death anxiety, the view of death as annihilation and alexithymia, along with increased spirituality and meaning in life compared with the control group. These findings suggest death education interventions, which include religious discussion, psychodrama and filmmaking, can effectively help manage trauma and grief in schools.

In another non-randomised action research study, **Testoni et al. (2021)** (23) examined the impact of a project aimed at restoring wellbeing among adolescents who experienced traumatic loss from a classmate's car accident death and a friend's suicide. The study evaluated the effectiveness of art therapy and psychodrama in helping participants cope with loss, fostering a spiritual connection and encouraging critical, non-stereotypical thoughts about death. A total of 82 students participated (45 in the experimental group, 37 in the control group) in eight sessions, each lasting two hours, focused on death and loss through discussions, dramatisation and meditation. Online questionnaires were administered three days before and after the intervention. While no significant differences were found between the groups at the pre-test except for environmental mastery, the experimental group showed a decrease in fear and avoidance of death and an increase in neutral acceptance of death, contributing to improved psychological wellbeing and resilience.

In another retrospective cross-sectional study, **Gehrman et al. (2020)** (10) assessed the effectiveness of the StandBy program in reducing suicidality, grief reactions after suicide bereavement and social isolation among individuals bereaved by suicide. The study compared those who accessed StandBy (intervention group, n = 121) with those who did not (control group, n = 424). This retrospective cross-sectional study employed an online survey to measure suicidal behaviours and grief experiences during the three-month and 12-month follow-up calls. The findings revealed significant differences between the two groups on four outcome variables. The intervention group showed significantly lower scores on suicidal behaviour, experienced less grief related to loss of social connections and reported lower social loneliness, but had significantly higher scores on the grief reaction of responsibility compared with the control group. No significant differences were observed among participants who had been bereaved for more than 12 months, in terms of suicidality risk or in the outcome variables based on the types of support received.

In a prospective longitudinal study, **Griffin et al. (2022)** (11) assessed the outcomes for individuals attending two peer-support groups in Ireland run by HUGG, a charity providing community-based peer support for adults bereaved by suicide (66). Using an online survey, 75

participants completed baseline surveys before their first group session, with 52 (69.3%) being new members. Follow-up surveys were conducted at three and six months. Baseline scores showed mostly negative outcomes, with those bereaved within three years reporting lower wellbeing, higher depressive symptoms, poorer social adjustment and greater traumatic grief. Significant improvements were observed at three months, including increased wellbeing and reduced traumatic grief, with these improvements maintained at six months.

Two of the retrospective cross-sectional studies focused on StandBy, Australia's largest national suicide postvention program, which supports people and communities bereaved or impacted by suicide. StandBy is unique in its responsiveness to the social, geographic and cultural aspects of suicide in each region. As a community-based program, it provides coordinated support with indications of being economically effective in delivering postvention services (67). **Hill et al. (2022)** (12) used a retrospective cross-sectional mixed methods approach to evaluate the reach of the Primary Care Navigator (PCN) model, developed by the WA Primary Health Alliance and WA Police, in response to a suicide cluster in southwest metropolitan Perth (PaRK region). The PaRK suicide prevention response group has implemented a peer-support program for individuals bereaved by suicide known as the Roses in the Ocean Peer CARE Companion program (68). The study aimed to describe the support provided to those bereaved by suspected suicide and assess the perceived effectiveness of the model from the WA Police's perspective. Descriptive statistics summarised the characteristics of both those who died by suicide and the bereaved individuals who received PCN support, offering insights into their needs. Interviews with five bereaved individuals, 18 stakeholders from the PaRK Suicide Prevention Response Group (SRG), and five WA Police employees involved in the PCN model highlighted themes such as linking individuals to necessary support, postvention as suicide prevention, maintaining community connection, and areas for improvement.

Visser et al. (2014) (24) evaluated the effectiveness of the StandBy Response Service, which offers face-to-face outreach, telephone support and referrals for individuals bereaved by suicide. The study compared 90 clients of the service with 360 individuals who had not used it. The results indicated clients had significantly lower levels of suicidality. While the study did not assess grief levels in the participants, it noted non-significant trends towards reduced psychological distress, lower use of medical and healthcare services, higher quality of life and increased work productivity among the clients.

Clements et al. (2023) (9) conducted a case study on suicide postvention in workplaces, focusing on a large metropolitan funeral company. Using a mixed-methods approach, the study examined staff experiences with suicide bereavement funerals and their responses to specialised postvention training designed to enhance awareness, skills and confidence in supporting clients bereaved by suicide and managing the emotional impact of this work. Thirty-six staff attended the three-hour training, with 32 (88.9%) completing a post-training questionnaire. All participants found the training valuable and gained a better understanding of the emotional toll of working with suicide bereavement funerals. Additionally, 85% felt more confident using appropriate language, and 88% reported improved management of the emotional impact. However, 43.8% still felt pressure from working with suicide bereavement funerals, with no change after the training. Semi-structured interviews with 11 staff revealed themes related to work roles, engagement and emotionality.

Among the pre-post studies, **Kramer et al. (2015)** (13) studied the effects of online support forums on people bereaved by suicide (n = 270) in Belgium and the Netherlands. They found small-to-medium improvements in wellbeing and depressive symptoms over 6–12 months, but no significant changes in grief or suicide risk. Despite these gains, 12 months later some participants still struggled with depression (61%), low wellbeing (57%), complicated grief (27%) and high suicide risk (6.5%). Semi-structured interviews (n = 29) revealed participants sought connection with others in similar situations, recognition and peer support. While most appreciated the support, some criticised the forums for triggering depressive feelings, lack of structure, slow response times and insufficient positive messages.

A mixed-method study by **Maple et al.** (14) was designed to use routinely collected service usage data (n = 2748) from each StandBy site regarding each individual contact made to the service, followed by semi-structured interviews (n = 6) with StandBy co-ordinators. The study provided perspectives relating to postvention support services provision to understand the population who were being provided with the postvention support, as well as the experience of the StandBy workers providing the service. The study faced limitations because of its urban focus, data variability and a significant amount of missing data. Additionally, not all StandBy coordinators were included. The findings indicated that both relatives and non-relatives seek support services after exposure to suicide. The workforce providing postvention support is distinct, as they experience cumulative vicarious exposure to suicide including in their personal lives. Findings suggest the needs of postvention workers require further attention.

Peters et al. (2015*)* (16) conducted a mixed-methods study to evaluate the Lifekeeper Memory Quilt Project by the Suicide Prevention-Bereavement Support Services of the Salvation Army. This project provided a space for people bereaved by suicide to memorialise their loved ones while also raising awareness of suicide's impact and supporting prevention efforts. Bereaved family members contributed photos and 25-word narratives about their deceased loved ones to create the quilt. The study's quantitative results (n = 82) showed high satisfaction, with 90% of respondents finding the project helpful or extremely helpful. Qualitative data (n = 30) revealed four key themes: healing, facilitating dialogue, reclaiming the memory of the person and raising public awareness.

In a records review open trial of 51 survivors of violent loss at a community counselling clinic, **Saindon et al. (2014*)*** (17) evaluated the effectiveness of Restorative Retelling (RR), a structured 10-session intervention for adult survivors of violent deaths, in reducing trauma, depression and prolonged grief symptoms. Participants underwent pre-treatment assessments, followed by weekly 1.5-hour RR group treatment for 10 sessions, with measures repeated after the intervention. The study found RR led to reductions in depression symptoms, avoidance and prolonged grief reactions. Additionally, RR appears to improve symptoms for those survivors who reported higher levels of distress at baseline.

Strouse et al. (2021) (20) conducted a study to evaluate the Artful Grief Studio (AGS) at the 2019 Tragedy Assistance Program for Survivors (TAPS) National Suicide Survivors Conference. The study included 39 participants. Participation varied, with 62.2% attending for the first time and others attending multiple times. Most participants (75%) attended for at least two out of the three days, participating for at least half a day each day, and created at least two art pieces. Pre- and post-test measures were administered before and after working on the art (to be completed only once), revealing significant increases in social validation, relating to

others, and new possibilities, along with a decrease in social invalidation and posttraumatic growth subscale scores about appreciating life. However, there was a significant decrease in appreciating life, with no changes in posttraumatic growth cognition, scores related to personal strength or spiritual change. Qualitative analyses of follow-up survey responses yielded themes of bereavement processing, sharing and collaboration, contributions of the art experience, and the relaxing effects of the art experience.

Summary of research studies

The reviewed studies generally provide limited evidence for the effectiveness of interventions. While many report positive outcomes, these findings are often restricted by significant design, methodological and generalisability limitations, making the overall reliability and applicability of the interventions uncertain.

The interventions were conducted in diverse settings: community based (10, 12, 15-17, 24), clinical settings including hospital-based mental health clinics (21, 25-27), residential/group settings (18, 19), schools (22, 23), online/telephone (11, 13, 14), art studios (20) and a funeral home (9).

Two arts-based interventions, the Lifekeeper Memory Quilt and an open art studio (16, 20), showed the value of creative approaches in coping with suicide bereavement and enhancing social support. School-based studies (22, 23) focused on death education, using philosophical/religious discussions, psychodrama and film production to improve the wellbeing of adolescents who experienced traumatic loss. Six studies (15, 17-19, 21, 25) on psychotherapeutic interventions reported improvements in depression scores, with more modest effects on grief scores.

Research indicates peer-support groups are crucial in reducing emotional burdens and supporting postvention service providers. Australian studies (10, 12, 14, 24) highlighted the effectiveness of these groups in reducing psychological distress among those bereaved by suicide and emphasised the importance of addressing the needs of the postvention workforce.

In conclusion, while some components show emerging evidence, the Evidence Check offers limited support for identifying effective models of postvention service delivery.

Guidelines (N = 14)

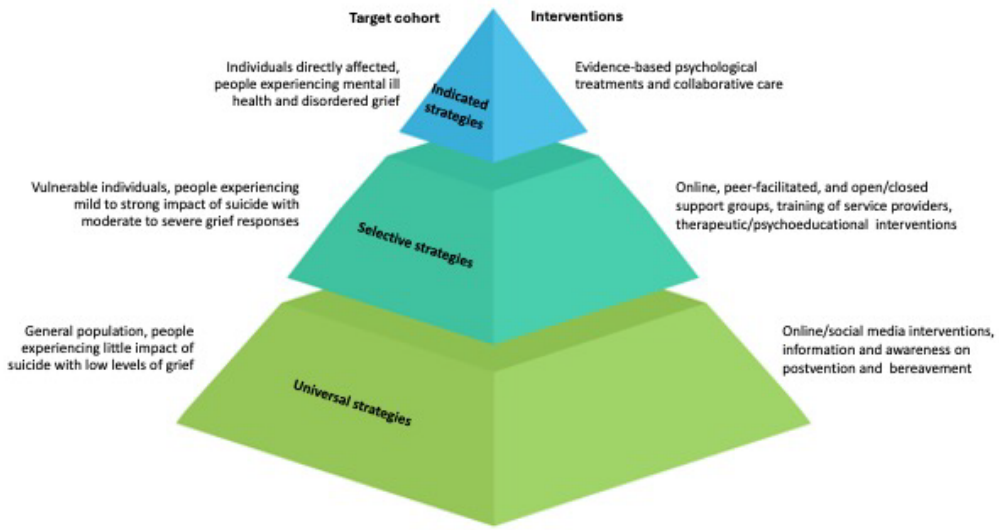
Considered against the criteria detailed in the AGREE II Instrument (44), the guidelines demonstrated reasonable rigour of development. The evidence base was described in all 14 guidelines, comprising a combination of literature and expert advisory groups; and eight guidelines included description of developmental methods. An evaluation of the likely effectiveness based on an evaluation of evidence for the underlying theoretical framework follows. A description of each guideline is provided in Appendix 5.

Overview and evaluation of theoretical frameworks

Ten guidelines referred to models that considered different levels of impact on those exposed to suicide, to guide varying levels of monitoring and support needs, and to inform communications strategies for different affected groups (30-32, 34, 35, 37-41, 69). Although the guidelines use different terminology, including *circles of vulnerability* and *circles of impact*, all derive from the theoretical *continuum of suicide survivorship* proposed by Cerel and colleagues (45). Based on this model, Hawton and colleagues outlined a *circles of vulnerability* model and matrix to help to identify and monitor for suicide clusters and contagion (70). They drew on the *continuum of suicide survivorship* model, proposing the range of people affected by suicide from the long-term suicide bereaved in the centre to those exposed to suicide at the outermost level; and the idea that those psychologically close to the deceased will be most affected. Evidence suggests the *continuum of suicide survivorship* model may overlook the emotional distress caused by suicide for people who are not psychologically close to the deceased, such as first responders (46).

Five guidelines (28, 29, 32, 40, 41) described a theoretical framework based on the *public health model*, comprising universal, selective and indicated strategies (71). Of the five guidelines, Séguin and colleagues (28) provide a high-level framework for the timing of interventions, while acknowledging *"No one can determine, ahead of time, when such interventions will have to take place"* (p. 3). The public health model is outlined in Figure 3, over page, illustrating how universal strategies are for all, selective strategies are for some and indicated strategies are for a few. Universal strategies are for people experiencing little impact of suicide with low levels of grief and may include information and awareness on postvention, grief and bereavement by suicide, and direction to resources. Selective strategies are for people experiencing a mild-to-strong impact of suicide with moderate-to-severe grief responses and may include training of service providers, therapeutic/psychoeducational interventions, peer support and self-help. Indicated strategies are for people experiencing mental ill health and disordered grief and include evidence-based psychological treatments and collaborative care. The *public health model* best aligns postvention with suicide prevention programs and tailors service delivery to the varied needs of suicide bereaved and affected (47, 48, 72).

Figure 3—Public health model outlining target cohorts and interventions at each level of universal, selective and indicated strategies (based on the literature and Figure 2, p.14 Séguin et al. (28))



There were a number of theoretical frameworks identified in school-based guidelines (33, 35). *Postvention standards manual: a guide for a school's response in the aftermath of a sudden death* (33) is underpinned by three crisis interventions models: *SAFER-R*, a form of psychological first aid (PFA) that includes stages of stablisation, acknowledgement, facilitation of understanding, encouraging effective coping and recovery or referral (73, 74); the *PREPaRE Model*, which sets out hierarchical and sequential activities for members of school crisis response teams, including prevent and prepare, reaffirm, evaluate psychological trauma risk, provide interventions, respond to mental health needs and examine the effectiveness of crisis preparedness (75); and *Be CALM*—a school crisis approach that guides school leadership to get the facts before acting, call for help, communicate and collaborate, anticipate and adjust plans accordingly, listen to your audience and learn what they need and manage the crisis, maintain the responders and modify the plan after evaluation (76). *SAFER-R* has shown effectiveness as a peer-support program (77) and it is argued it reduces the burden on mental health systems while including referrals to higher levels of care where indicated (78). Evidence points to the *PREPaRE Model* increasing knowledge and improving attitudes toward crisis prevention and intervention (79), and *Be CALM* is underpinned by literature and expert review (76).

Responding to the suicide of a student: a guide to assist secondary schools (35), produced by headspace and the Department of Education and Training (Victoria), refers to the *mental health continuum*, a tool developed by Be You to assist educators in assessing the need for mental health support for children and young people (80). The tool outlines behaviours to look out for, a checklist to guide decision making about whether to seek further support, and a list of evidence-based actions from a *public health model*, including 'good for all', 'necessary for some' and 'essential for a few'. The integration of the *public health model* provides a good basis for the

mental health continuum tool, which may increase the capacity of school staff, who have reported feeling ill-equipped to respond to suicide (81).

In general, the guidelines offer comprehensive plans, many dividing the response into immediate, short-term and long-term actions that consider appropriate communication, identification of varying needs for support or training, coordination with other services, stabilising, memorialisation, transitioning into suicide prevention and further evaluation of crisis prevention, preparedness and response. This is in line with arguments for further development of system-wide/whole-school approaches that move beyond crisis response (55, 57, 79, 82, 83).

Specific population groups are mentioned in 13 of the guidelines, with varying degrees of information regarding tailoring postvention responses to these groups, including: culturally and linguistically diverse communities (29-33, 35-37, 39-41), Aboriginal and Torres Strait Islander peoples (32, 35, 37, 39), and LGBTIQ+ people (30, 32, 33, 35, 37, 39, 40). Apart from two Australian school/youth guidelines which include sections on Aboriginal and Torres Strait Islander people (35, 37), the majority of guidelines recommend awareness of the different needs of these groups, pointing to the necessity for tailored guidelines for these priority populations. The use of the Appraisal of Guidelines for Research and Evaluation II (AGREE) definition of guidelines as *"systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances"* (44) may in fact exclude some culturally and linguistically diverse and Aboriginal and Torres Strait Islander populations frameworks, underlining the need for a separate review of the literature for these population groups.

Applicability to Tasmania

This Evidence Check rapid systematic review evaluated the effectiveness of postvention interventions and service delivery, drawing from peer-reviewed literature (9-27) and guidelines (28-41) published from 2014 to the present. The search included both Australian and international research and guidelines. Despite the limited evidence of effectiveness, primarily because of a lack of high-quality studies, the Evidence Check identified potentially effective components of postvention. Within the scope of the Evidence Check, the findings suggest some components of postvention such as psychoeducation, social support, peer-based support and the exchange of personal experiences of postvention could be beneficial for individuals bereaved by suicide in Tasmania. A public health approach is advised to meet the needs of all individuals and communities, and to align postvention in Tasmania with national and international suicide prevention efforts.

Discussion

This Evidence Check focused on suicide postvention and bereavement support services and aimed to address this primary question: “Which suicide postvention service models have been shown to be effective in reducing distress in family, friends and communities following a suicide?”

We examined 19 studies (9-27) and 14 guidelines (28-41) published between 2014 and 2024, drawn from peer-reviewed and grey literature. The studies encompassed a diverse array of populations, settings, interventions and measurement methods. The included studies and guidelines assessed the effectiveness and acceptability of postvention services and models. A recent systematic review (56) identified 36 studies, with 22 focusing on specific postvention services and 14 on postvention models. The StandBy service in Australia was most frequently evaluated, with four studies examining it, including one on cost-effectiveness. The Local Outreach to Suicide Survivors (LOSS) service in the US was examined in two studies, suggesting its effectiveness in connecting survivors with resources and building a supportive community. Another systematic review of effectiveness of controlled studies of interventions for people bereaved by suicide (48) identified 11 studies published between 1984 and 2018. The review found some evidence that an eight-week support group program led by a mental health professional and a trained volunteer was effective in improving grief outcomes, highlighting the importance of psychosocial approaches.

A number of studies focused on specific bereaved populations, such as widows. A study (84) comparing professionally-led group psychotherapy with a social group program for widows bereaved by suicide found grief symptoms were reduced in the therapy group. However, these effects did not show significant differences in a larger follow-up study. Our Evidence Check identified one such study (15) that focused on an intensive outpatient program for suicide-bereaved widows of veterans with complicated grief (CG) and post-traumatic stress disorder (PTSD). The current review also identified six psychotherapeutic interventions (15, 17-19, 21, 25) that seemed to alleviate grief and depression.

Similar to the two school-based interventions (22, 23) highlighted in this Evidence Check, another study (85) demonstrated that a school-based crisis intervention seemed to reduce post-traumatic stress symptoms, anxiety, depression and complicated grief among students in a trauma group. Pfeffer et al. (2002) (86) showed a bereavement group intervention focusing on grief reactions to suicide, along with strengthening coping skills and supporting parents, can alleviate distress in children bereaved by the suicide of a parent or sibling. These findings underscore the importance of addressing the vulnerabilities of children and young adults who are bereaved by suicide.

Some components that may have potentially contributed to positive outcomes in the interventions reviewed in this Evidence Check were linked to the different levels of grief or distress experienced by the bereaved. These components align with public health models (47,

48, 72) of postvention service delivery and include psychoeducation, informal social support, peer support, mutual recognition and the sharing of experiences (9, 13, 14, 16). Additionally, studies of the StandBy and Primary Care Navigator (PCN) models highlight the crucial role of bereavement support groups in providing essential postvention services, emphasising their importance in helping individuals navigate the grieving process and offering vital emotional support.

A limitation of this Evidence Check was the lack of comparability of results. Only six of the 19 peer-reviewed studies included a control group (10, 19, 22-24, 26). Overall, the studies were of low quality because of significant design, methodological and generalisability issues, raising concerns about the reliability and applicability of the interventions. While most studies showed improvements in depression scores (13, 17-19, 21, 25), the impact on grief scores were generally more limited (10, 11, 15). This variation in outcomes underscores the limitations within the studies, which may have influenced the effectiveness of the interventions in addressing grief.

Guidelines that are underpinned by a *public health model* (28, 29, 32, 40, 41) are best placed to tailor service delivery to the varied needs of those affected by suicide and align with suicide prevention efforts (47, 48, 72). The *continuum of suicide survivorship* and related frameworks that consider varying levels of the impact of suicide provide a good framework to guide varying levels of communication, monitoring and support needs (32, 34, 39-41); however, there are limitations to the model according to recent empirical testing (46).

In summary, postvention is a vital aspect of suicide prevention efforts, both in Australia and globally (8). However, there is a noticeable lack of high-quality research focusing on postvention in specific population groups that fall within this study's scope, such as culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander peoples and individuals facing significant adversity. Additionally, there is a gap in studies that explore the impact of postvention support on children and adolescents, and the long-term effects of suicide bereavement support. This scarcity of targeted research underscores the need for more comprehensive studies to better understand and support these underserved and vulnerable populations.

Conclusion

This Evidence Check rapid systematic review found promising, although limited, evidence as to the effectiveness of postvention interventions and service delivery, largely because of a scarcity of research, particularly high-quality studies focusing on specific population groups defined by the study's scope, such as culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander peoples, and those experiencing adversity. Systematic searches of peer-reviewed and grey literature uncovered 19 peer-reviewed studies and 14 guidelines. The peer-reviewed studies encompassed both group and individual interventions, varying in settings—including schools, community settings and priority population groups such as military survivors of suicide—and in the measures employed in the studies.

While the Evidence Check identified significant gaps in knowledge, it also pointed out several potentially effective components of postvention, such as involving trained peers and volunteers in support and therapy groups, workplace training programs and even arts-based interventions. Implementing a public health framework for postvention service delivery could enable customised support for bereaved individuals based on the impact of suicide on their lives and community. This approach could include providing information and raising awareness for all those bereaved by suicide, offering peer-group support and providing specialised psychotherapy for those dealing with intense grief and mental health challenges. Additionally, such a framework could help align postvention efforts with suicide prevention and mental health programs.

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*References of studies and guidelines included in the Evidence Check (9-41)

Appendices

Appendix 1—Search strings for the peer-review databases

((bereav* or grief or grieve or grieving or mourn*) and (famil* or friend* or peer* or acquaintance* or caregiv* or student* or school* or survivor*) and (counseling or counselling or intervention* or postvention* or treat* or psychotherap* or support group* or self-help group* or social media or internet) and (suicide or suicides or postsuicide) and (refugee* or asylum or migrant* or immigrant* or migration or immigration or trauma* or workplace* or aboriginal* or veterans* or cald or linguistic or esl or second language or non native speak* or cultural* divers* or indigenous or ptsd or posttrauma* or deaths or poor or poverty or social exclusion or low income or underserved or resource limited)).mp.

limit 1 to (english language and yr="2014 -Current")

Appendix 2—NHMRC Levels of Evidence

Level of evidence	Study design
I	A systematic review of Level II studies.
II	A randomised controlled trial.
III-1	A pseudo-randomised controlled trial (i.e. alternate allocation or some other method).
III-2	A comparative study with concurrent controls (i.e. non-randomised experimental trials, cohort studies, case-control studies, interrupted time series studies with a control group).
III-3	A comparative study without concurrent controls (i.e. historical control study, two or more single-arm studies, interrupted time series studies without a parallel control group).
IV	Case series with either post-test or pre-test/post-test outcomes.

Appendix 3—NHMRC matrix to summarise the evidence base

Component	A Excellent	B Good	C Satisfactory	D Poor
Evidence base	Several level I or II studies with low risk of bias.	One or two level II studies with low risk of bias or a systematic review or multiple level III studies with low risk of bias.	Level III studies with low risk of bias, or level I or II studies with moderate risk of bias.	Level IV studies, or level I to III studies with high risk of bias.
Consistency	All studies consistent.	Most studies consistent and inconsistency may be explained.	Some inconsistency reflecting genuine uncertainty about clinical questions.	Evidence is inconsistent.
Clinical impact	Very large.	Substantial.	Moderate.	Slight or restricted.
Generalisability	Population/s studied in the body of evidence are the same as the target population in question.	Population/s studied in the body of evidence are similar to the target population in question.	Population/s studied in the body of evidence differ from the target population in question, but it is clinically sensible to apply this evidence to the target population.	Population/s studied in the body of evidence differ from the target population and it is hard to judge whether it is sensible to generalise to the target population.
Applicability	Directly applicable to the Australian context.	Applicable to the Australian context with few caveats.	Probably applicable to the Australian context with some caveats.	Not applicable to the Australian context.

[A] Level of evidence determined from the NHMRC evidence hierarchy as in Table 1 (above).

[B] If there is only one study, rank this component as 'not applicable'. National Health and Medical Research Council (2009) NHMRC levels of evidence and grades for recommendations for guideline developers. Canberra: National Health and Medical Research Council.

Appendix 4—Guidelines overview (n = 41)

Title	Author, country, year
After a Campus Suicide: A Postvention Guide for Student-Led Responses	Active Minds, US, 2017
After a suicide: A Toolkit for schools, 2nd Ed.	American Foundation for Suicide Prevention, Suicide, Prevention Resource Center, Education Development Center, US, 2018
After a suicide: a guide for veterinary workplaces	American Foundation for Suicide Prevention, American Veterinary Medical Association, National Association of Veterinary Technicians in America, US, 2020
After rural suicide: A guide for coordinated community postvention response	California Mental Health Services Authority, US, 2016
A suicide prevention toolkit: After a student suicide	Centre for Suicide Prevention, a branch of the Canadian Mental Health Association, Canada, 2019
Being Prepared to Act in the Event of a Suicide: Postvention program	Seguin M, Roy F, Boilar T, Secrétariat à la jeunesse du Québec, Canada, 2020
Crisis management in the event of a suicide: a postvention toolkit for employers	Forster Communications for The Prince's Responsible Business Network and Business in the Community, UK, 2017
Funerals in Aotearoa after a death by suicide	Mental Health Foundation of New Zealand, New Zealand, 2022
Grief in the workplace, responding to suicide: A guide for employers	Irish Hospice Foundation and National Office for Suicide Prevention, Ireland, 2021
Guidelines for schools responding to a death by suicide	National Center for School Crisis and Bereavement, USC Suzanne Dworak-Peck School of Social Work, US, 2017
Guidelines for suicide postvention in fire service (Standard Operating Procedure)	New York City Fire Department, US, 2016

Title	Author, country, year
How to prepare for and respond to a suspected suicide in schools, colleges and other youth settings in the UK: Postvention	Samaritans, UK, 2020
How to respond to a student suicide: Suicide Safer guidance on postvention	Papyrus & Universities UK, UK, 2022
NHS employee suicide: a postvention toolkit to help manage the impact and provide support	Samaritans and NHS Confederation, UK, 2023
Postvention across settings and sectors: a resource for community-based service providers	Ontario Youth Suicide Prevention Life Promotion Collaborative, Canada, 2022
Postvention: A Guide for response to suicide on college campuses	Higher Education Mental Health Alliance, US, 2014
Postvention Australia guidelines: A resource for organisations and individuals providing services to people bereaved by suicide	Australian Institute for Suicide Research and Prevention, Australia, 2017
Postvention guidance: Supporting NHS staff after the death by suicide of a colleague	Universities of Surrey, Keele and Birmingham, UK, 2023
Postvention standards manual: a guide for a school's response in the aftermath of a sudden death (5th edition)	Services for teens at risk (STAR Center), US, 2020
Postvention Toolkit	Suicide Prevention Ottawa, Canada, 2019
Postvention Toolkit for a Military Suicide Loss	US Department of Defense, Defense Suicide Prevention Office, US, 2019
Responding to suicide in secondary schools: A Delphi Study	headspace School Support, Australia, 2015
Responding to suicide: a toolkit for Australian Universities	headspace and Universities Australia, Australia, 2020

Title	Author, country, year
Responding to the suicide of a student: a guide to assist secondary schools	headspace and the Department of Education and Training (Vic), Australia, 2021
The impact of suicide on professional caregivers: a guide for managers and supervisors	New York State Office of Mental Health's Suicide Prevention Center and New York State Office of Addiction Services and Supports, USA, 2022
Suicide bereavement support groups: guide	Canadian Association for Suicide Prevention (CASP) and Centre for Suicide Prevention (CSP), Canada, 2023
Suicide postvention guidance for veterinary workplaces	Dr Rosie Allister, Vetlife Helpline Manager, UK, 2022
Suicide Postvention Guide for Schools in Washington State	Washington Office of Superintendent of Public Instruction and Forefront Suicide Prevention, US, 2021
Suicide Postvention Resources: Complete Toolkit	Be You and Beyond Blue, Australia, 2023
Suicide postvention toolkit	National Police Wellbeing Service, UK, 2022
Suicide Postvention: Unit Commander's Handbook	Army Resilience Directorate, US, 2021
Suicide Related Behavior Response and Postvention Guide	US Navy HR, US, 2024
Support after a suicide: Developing and delivering local bereavement support services	National Suicide Prevention Alliance & Support After Suicide, UK, 2021
Support After Suicide Toolkit: Postvention Response for Site Owners and Leadership	StandBy: Support after Suicide & Lifeline, Australia, 2021
Supporting Pacific Communities Bereaved by Suicide	Hibiscus Research, New Zealand, 2018
Supporting Survivors of Suicide Loss: A Guide for Funeral Directors, 2nd ed.	Education Development Center & Samaritans, US, 2020

Title	Author, country, year
Understood: Supporting people bereaved by suicide who are neurodivergent	Roper M, UK, 2024
Workplace Considerations After a Suicide or Other Unexpected Death: A Handbook	United Counseling Service, US, 2023
Workplace toolkit: Workplace response to suicide	StandBy: Support after Suicide, Australia, 2022
Responding to grief, trauma, and distress after a suicide: U.S. national guidelines	Survivors of Suicide Loss Task Force, National Action Alliance for Suicide Prevention, US, 2015
Support after a suicide: A guide to providing local services: A practice resource	Public Health England and National Suicide Prevention Alliance, UK, 2016

*Guideline titles include hyperlinks to source documents

Appendix 5—Guidelines description (n = 14)

Schools/youth settings

Postvention across settings and sectors: a resource for community-based service providers was developed to guide community and education providers' response in the event of youth suicide (31). It outlines a community/multi-sectoral approach to postvention including the following stages: preparation (including developing a postvention plan); short term—24-48 hours after suicide (including on-scene supports and referral pathways, appropriate communication with community and media, bereavement support, collaboration between first responders and mental health organisations); medium term—days and weeks after suicide (including appropriate communication, dealing with the media, social media, support, normalising stress response); long term—months and first year after suicide (normal and complicated grief, ongoing support, role of primary care and community mental health providers, culture or faith-based groups and schools, trauma-informed care, anniversaries). The guidelines refer to the *circles of vulnerability* model (70), using a nested model of suicide survivorship derived from the *continuum of survivorship* model (45).

Postvention standards manual: a guide for a school's response in the aftermath of a sudden death was written for educators, social workers, psychologists, counsellors and other professionals working with youth after a tragic death of a student (33). The document includes guidelines on postvention planning and personnel, appropriate communications to students, school community and media, supporting the postvention team, evaluating the postvention, memorials, trauma, loss and grief responses, and transitioning from postvention to prevention. Communication templates and sample agendas are also included. The guidelines are underpinned by three crisis interventions models: *SAFER-R*; the *PREPaRE Model*; and *Be CALM.*

Headspace and Department of Education and Training (Victoria) produced *Responding to the suicide of a student: a guide to assist secondary schools* (35). The guidelines include background on suicide and terminology (including appropriate language, identifying young people at risk), mental health and wellbeing following exposure to suicide, identifying the incident and immediate response (including liaising with bereaved family, community services and neighbouring schools, managing media and social media, postvention responses for Indigenous, culturally diverse, LGBTIQ+ and refugee backgrounds), short-term response—one week to three months (including ongoing support, restoring regular school routine, spontaneous memorials, grief responses), long-term response—three to 12 months (including permanent memorials, anniversaries, information and education sessions). Example scripts, email templates and additional resources are provided. The authors refer to the *circles of vulnerability* model (70) and the *mental health continuum*, a tool developed by Be You (80).

Be You and Beyond Blue developed *Suicide Postvention Resources: Complete Toolkit* to guide response to a death by suicide of a student in secondary school (37). The document is divided into immediate (including establishing an emergency response team, communicating with mental health professionals, informing staff and the wider community, suicide contagion and identifying risk), short-term (including returning to school routine, identifying, monitoring and supporting young people at risk, supporting staff wellbeing, memorials, critical incident review) and longer-term responses (ongoing support and monitoring, anniversaries, ongoing postvention). The guide also includes sample scripts and templates and links to online resources. The *circles of vulnerability* model (70) using geographical, psychological and social proximity is recommended to assess risk of suicide.

Workplaces

The Irish Hospice Foundation and National Office for Suicide Prevention developed *Grief in the workplace, responding to suicide: A guide for employers* (29). It is divided into three sections, including supporting employees bereaved by suicide in their personal lives, how to respond when an employee, contractor or member of the public dies by suicide on- or off-site, and suggestions for developing a bereavement policy to deal with suicide in the workplace. The sections include guidelines for providing support, appropriate communication, managing return to work, culturally diverse approaches to death, self-care, incident response and honouring the memory of the deceased. The document also includes case studies of employees bereaved by suicide, a sample bereavement policy, online resources, checklists and a sample internal notification of the death of an employee. The authors follow a public health model, using the *Pyramid of Bereavement Care* to describe the needs of four different levels of bereavement, and the knowledge/skills required of support services for each level of those affected by suicide (47).

NHS employee suicide: a postvention toolkit to help manage the impact and provide support was developed by the Samaritans and the NHS Confederation, for National Health Service (NHS) organisation leaders in the event of a death by suicide of an employee or student on placement (30). The document includes guidelines on relevant workplace training for suicide awareness and mental health first aid, appropriate communication, forming a postvention group and developing a postvention approach, culturally diverse approaches, bereavement and practical support, responses to grief, initial response, managing suicide risk, cooperating with an inquest, returning to work, reinforcing and building trust in leadership, preparing for anniversaries, events and milestones, and reviewing the postvention response. Additional online resources and communications templates are provided. A *circles of impact* tool is recommended to think about the probable level of impact of different people in the workplace and to guide communication strategies for each of the following groups: circle 1—close colleagues, line manager; circle 2—former colleagues, students, patients, other affected teams and social groups.

Postvention Toolkit for a Military Suicide Loss was written for people supporting others in the event of a death by suicide in the military (34). The guide includes a background to suicide and its impacts; postvention (including stabilising, grieving and growing phases); a timeline of postvention roles; and self-care strategies. Following these sections the guide includes further detail for the following roles: unit commanders and leaders, chaplains, casualty assistance officers, first responders, military investigators, non-clinical providers, suicide prevention program managers and long-term casualty support coordinators. Checklists and links to further resources are included. The authors refer to the *continuum of survivorship* model (45) using the nested model identifying the range of people affected by suicide from the long-term suicide bereaved in the centre, to those exposed to suicide at the outermost level.

The New York State Office of Mental Health's Suicide Prevention Center and New York State Office of Addiction Services and Supports developed *The impact of suicide on professional caregivers: a guide for managers and supervisors* to guide response to death of a client in a clinical setting and to support clinical providers and staff (36). Included are guidelines for first response, debriefing and supporting staff, including consideration of unresolved grief, compassion fatigue, vicarious trauma and burnout, self-care for clinicians, supporting other clients, appropriate communication in group client settings, suicide screening for other clients, memorial services, considerations for children and youth, grief screening tools and interventions for other clients, contact with family members and legal and

ethical considerations. Additional online resources are provided. The authors refer to a *social ecological model* to prioritise who needs to be notified or supported, with individuals; peers, family, clans; community, tribes, village; and society illustrated in a nested model. It is similar to the *continuum of survivorship* model (45) and is attributed to *The Connect Suicide Prevention Program*, which outlines individual, family and community risk factors for suicide and other self-destructive behaviours (87).

The National Police Wellbeing Service Suicide postvention toolkit was developed in consultation with the Samaritans to guide police leadership response to the death of police staff (38). It includes guidance for managing stigma about suicide, forming a postvention group and approach, steps to take immediately following suicide, and in the next 48 hours and the following weeks and months, including communication, providing support and managing risk. In the longer term the guide addresses reinforcing trust in leadership, return to normal operations, and reviewing the postvention plan and response. The content is similar to the NHS postvention toolkit, also developed in collaboration with the Samaritans, including the use of the *circles of impact* tool to determine the probable level of impact for different groups in the workplace.

Workplace toolkit: Workplace response to suicide, produced by StandBy: Support after Suicide, was developed for employers, managers and others in leadership roles and was designed to be used with support from a StandBy coordinator (39). It includes information about StandBy, the impact of suicide in Australia, postvention, trauma and grief, the range of people impacted by suicide (based on the *continuum of survivorship* model (45)) and guidance for postvention planning, coordination with EAP and immediate and acute response, as well as 1–2 weeks following, two weeks to six months following and longer-term follow-ups.

Services/communities

Being Prepared to Act in the Event of a Suicide is the Quebec Government's Postvention Guidelines, updated in 2020 (28). The program uses a *public health model* framework (47) and specifies 10 measures to implement over four sequential phases including: preparation (measures: organisation of the community), at the time of the event (measures: urgency and protection; communication and information; detection and indicated interventions), after the event (measures: analysis, clinical management, and postvention coordination; communication and information; memorials; support for interveners; detection and indicated interventions; detection and selective interventions) and medium- and long-term follow-up (measures: ongoing after the event measures and detection and universal interventions; review of the postvention).

Postvention Australia's guidelines are a resource for organisations and bereavement services (32). General guidance is offered to a broad range of people in contact with the bereaved individuals, including social workers, healthcare professionals, funeral directors and volunteers. The guidelines include provision of culturally sensitive and appropriate services, development and implementation of postvention practices, research and evaluation, and awareness and promotion of suicide postvention services, such as enhancing the resilience of individuals, families and communities to respond to suicide, and raising awareness. The guidelines are based on a postvention service provision model comprising a) those bereaved by suicide, b) an organisational framework, c) service provision, and d) impact on workers. The guidelines draw on a *public health model framework* (71) and *continuum of survivorship* model (45).

The Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention developed the *Responding to Grief, Trauma, and Distress After a Suicide: US National Guidelines* for all groups and individuals involved in a postvention response (40). The guidelines draw on a *public health model framework* (71) and *continuum of survivorship* model (45) to inform response by first responders, (mental) health professionals and services, faith organisations, funeral services, (suicide) bereavement support organisations, schools and colleges, and the military. In addition to information about suicide exposure and bereavement the guidelines outline four strategic directions including: a) healthy and empowered individuals, families and communities, b) clinical and community preventive services, c) treatment and support services, and d) surveillance, research and evaluation.

Public Health England and National Suicide Prevention Alliance developed *Support after a suicide: A guide to providing local services: A practice resource* (41). It provides information about who is affected by suicide, best practice in delivering bereavement support and guidance about evaluating outcomes. It is complemented by two other resources, *Support after a suicide: Developing and delivering local bereavement support services* and *Support after a suicide: Evaluating local bereavement support services*. Additional resources and a sample form are also included. The guidelines draw on a *public health model framework* (71) and *continuum of survivorship* model (45).