National Institute for Health and Care Excellence

Guideline version (Draft)

Preventing suicide in community and custodial settings: Postvention

[Evidence review for interventions to support people bereaved by suicides]

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Evidence reviews

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Draft for Consultation

These evidence reviews were developed by Public Health Internal Guideline Development team]

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Interventions to support people who are bereaved or affected by suicide (postvention)

Introduction

In 2014 there were 6,122 people aged 10 and over who died by suicide in the UK and the suicide rate was 10.8 deaths per 100,000 of the population.. It is estimated that between 6 and 60 people are affected by each suicide. Bereavement through suicide can result in suicide ideation and poor social functioning. People who have been bereaved by suicide report that the experience affected their ability to cope with everyday activities such as work, relationships and self-care.

The most recent economic analysis estimates that each suicide costs the economy in England around £1.67 million, although the full costs may be difficult to quantify. It is estimated that around 60 per cent of the cost of each suicide is attributed to the impact on the lives of those bereaved by suicide (HM Government 2017).

The aim of this review is to examine interventions that can be delivered in community and custodial settings to provide support for people bereaved by suicide and to encourage them to seek help. This may include:

- providing information about grief and bereavement by suicide (leaflets, verbal info, social media)
- giving information about bereavement support services (sign-posting)
- community or peer support.

Review question

Are approaches that provide people affected by suicide with information about grief and bereavement and bereavement support services (postvention) effective and cost effective at encouraging those people to seek help?

What impact do the following have on the effectiveness, cost effectiveness of different interventions: deliverer, setting, timing?

PICO table

The review focused on identifying studies that fulfilled the conditions specified in PICO table (Table 1). For full details of the review protocol, see Appendix A:

Table 1: PICO inclusion criteria for the review question of interventions to support people who are bereaved by suicides.

Population	People who are bereaved by suicide For example: • families, friends, colleagues and peers Populations may include people in workplaces, schools/colleges and prisons
Interventions	Local interventions to support those bereaved or affected by suicide (postvention). Postvention in scope is limited to: • those interventions providing information about grief and bereavement by suicide (leaflets, verbal info, social media)

	• those interventions giving information about bereavement support services (sign-posting) • those interventions providing community or peer support. Therapeutic interventions would not be included unless interventions were provided in the community settings such as participants' homes.
Comparator	Comparators that will be considered are • Other intervention • Status quo/do nothing/control • Time (before and after)
Outcomes	The outcomes that will be considered when assessing the impact on health are: • Suicide rates among target/participant communities • Suicide attempts • Changes in mental health state • Reporting of suicide ideation. The outcomes that will be considered when assessing help-seeking behaviour: • Service uptake (such as mental health services, helplines) The outcomes that will be considered when assessing attitude and behaviour: • Changes in knowledge, attitude, acceptance, intentions, beliefs and behaviour of people who are bereaved by suicide.

Public Health evidence

In total, 19,228 references were identified through the systematic searches, which included therapeutic interventions provided in the community setting (i.e. participants' homes). References were screened on their titles and abstracts and 34 references that were potentially relevant to this question were requested. Of these, 15 studies were included: 7 were quantitative studies; 7 were qualitative studies and one economic study (see Appendix E: for the evidence tables) and 19 studies were excluded. For the list of excluded studies with reasons for exclusion, see Appendix D:.

Findings

Summary of quantitative studies included in the evidence review

7 quantitative studies provided evidence on the effectiveness of bereavement intervention. Table 2 presents a summary of included quantitative studies.

Table 2: summary of included quantitative studies for postvention review

Study [country]	Design	Population	Intervention	Comparator	Outcome
Constantino et al 2001 [USA]	Experimental	Widowed survivors of suicide	Group intervention	Before vs after participating group intervention	• Depression
De Groot et al 2010/2007[Netherlands]	RCT	First degree relatives and spouses bereaved by suicide	Family-based cognitive behaviour therapy	Usual care	• Depression • Traumatic grief • Suicidal ideation

Kovac and Range 2000 [USA]	Experimental	University undergraduates bereaved by suicide in past 2 years	Writing projects: writing about traumatic events that have not been disclosed to other individuals	Writing projects: writing about innocuous events such as objectively describing what they have done since waking up	• Stress (the impact of event scale) • Traumatic grief • Non-routine health centre visits
Pfeffer et al 2002 [USA]	Experimental	Children bereaved by suicide of a parent or sibling	Bereavement group intervention	no bereavement group intervention	• Anxiety • Depression • Post-traumatic stress
Poijula et al 2001 [Finland]	Quasi-experimental	School students bereaved by peer suicide	Psychological debriefing	Before vs after intervention	• Number of suicides
Visser et al 2014 [Australia]	Observational (cross-sectional)	People bereaved by suicide	StandBy response service, provides face-to-face outreach and telephone support offered by a professional crisis response team and referral to other community services matched to need	Control (not received the service)	• Psychological distress • Suicidality (suicidal behaviours questionnaire) • Quality of life (general and health related quality of life) • Use of health care
Wittouck et al 2014 [Belgium]	RCT	Suicide survivors who lost a loved one through suicide	Family-based cognitive behaviour therapy psycho-educational intervention	Usual care	• Depression • Traumatic grief

Summary of qualitative studies included in the evidence review

7 qualitative studies were included in this review. The quality of the studies was assessed with 5 of the studies rated [+] and 2 studies rated [-]. 2 of the studies were conducted in the UK, 1 in Ireland, 2 in Australia and 2 in the US. All studies included small sample sizes and therefore may not represent the views of the broader community.

Table 3 presents a summary of included qualitative studies. Themes reported by authors of these studies were listed and the impact of bereavement intervention was identified through secondary analysis in themed evidence statements.

54 **Table 3: Included qualitative studies for postvention review**

Study [country]	Design (method)	Population	Intervention	Aim of the study	Themes reported in the study
Aguirre and Terry 2014 [USA]	Qualitative (interviews)	Suicide survivors, the LOSS team member, counsellor (n=11)	Local Outreach to Suicide Survivors (LOSS), where volunteers team member (usually survivors of suicide themselves) meet with new survivors	Evaluation of LOSS on the grief process of suicide survivors	**Timing of support services** • Decreased time in connecting with resources • Significant importance of the LOSS team on-scene activities for survivors: making connection. • The importance of follow-up visits and the importance of meeting both on-scene and later with the survivor
Foggin et al 2016 [UK]	Qualitative (semi-structured interview)	GPs who had dealt with people bereaved by suicide (n=13)	Usual care delivered by GP	To identify the experiences of GPs who dealt with parents bereaved by suicide and any difficulties encountered	**Timing of support services** • To be proactive and to instigate contact with bereaved parents **Resources** • Preparedness to meet bereaved parents **Others** • The importance of managing mental health problems in primary care • Impact on GPs themselves
Hawton et al 2012 [UK]	Mixed (questionnaire; focus group; Interviews)	People used the resource including health professionals, charity workers and service users (n=9 telephone interviews)	Help is at Hand	Evaluation of a resource for people bereaved by suicide	**Timing of support services** • Availability of the intervention: the resource was not reaching all of the people who needed it, and participants noted that Help is at Hand would have been more useful at the early stages of their bereavement. **Others** • Feedback on the intervention was mostly positive.
McKinnon and Chonody	Qualitative (in-depth interviews)	People bereaved by suicide (n=14)	Local social service organisations including peer	Perceptions and experiences of formal supports including peer	**Healing effect** • On-going support (experience of support group): not helpful, unproductive.

Study [country]	Design (method)	Population	Intervention	Aim of the study	Themes reported in the study
2014 [Australia]			support group meetings	support group and professional support	**Personal impact/growth** • Normalisation (immediate one-on-one support) **Resources** • Supports in the immediate aftermath did not assist participants in the immediate context of the suicide (experience with first responders); • A professional presence is needed to help direct the support group • Difficulties to get help (i.e. local doctors) from professionals **Others** • Barriers to on-going support (physical and mental health);
Peters et al 2015 [Australia]	Qualitative (questionnaire; interviews)	People bereaved by suicide (n=30 interviews)	The Lifekeeper Memory Quilt initiative	Evaluate satisfaction with the Quilt project (a memorial project) for those bereaved by suicide	**Healing effect** • Healing: facilitated grief journey; fostered personal resilience • Creating opportunity for dialogue (opening a conversation; feeling connected with others bereaved by suicide; sharing common understanding) **Personal impact/growth** • Reclaiming the real person: the opportunity to remember them in a more revered way. **Others** • Raising public awareness: instead of just numbers these are people, and to contributed to suicide prevention.

Study [country]	Design (method)	Population	Intervention	Aim of the study	Themes reported in the study
Supiano 2012 [USA]	Qualitative (interviews)	People bereaved by suicide, by at least one year (n=9)	Grief support group	Perceptions and experiences of bereavement group support	**Healing effect** • Ways of coping: grieving persons were able to gain support from others having a similar loss, to reduce isolation, the challenge assumption about grief and loss, to provide an opportunity providing support to others by sharing experience; **Personal impact/growth** • Personal growth: a recollections of the early response to the suicide
Trimble et al 2012 [Ireland]	Qualitative (questionnaire)	People bereaved by suicide, by at least one year (n=10)	Professional support and community service including support groups, counselling, psychotherapy, group therapy, general practitioners, psychiatrists, family support services, and pharmacological treatment	Perceptions and experiences of social support and support groups including support groups, counselling, psychotherapy, group therapy, GPs, psychiatrists, and family support services.	**Healing effect** • Emotional expression and sharing (bereavement experience); **Personal impact/growth** • Minimising stigma (the importance of feeling understood and of the depth and complexity of the feeling); **Timing of support services** • Initial support from the people in the local community as being most helpful following the loss; • Graduate detachment involved a lack of openness about the deceased person and the cause of death as time went on.

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Economic evidence

Included studies

Comans et al (2013) provided economic evidence on a community-based crisis intervention programme for people bereaved by suicide.

Summary of studies included in the economic evidence review

Comans et al (2013) is an evaluation study which examined the economic efficiency of the StandBy response service supporting people bereaved by suicide. Full details are found in the evidence tables (see Appendix E:).

Evidence statements

Quantitative evidence

Evidence statement 6.1-suicide

Evidence from an experimental study found a reduction in suicide amongst students by 1.0%, from 1.1% to 0.1% following 2-hours of psychological debriefing sessions (relative risk=0.14, [95%CI 0.01 to 2.75]), absolute difference=10 fewer per 1000, [95%CI 11 fewer to 19 more]). This reduction was not significant. The committee's confidence in the evidence was low.

Evidence statement 6.2-suicidal behaviours

Evidence from a RCT study found a non-significant difference in suicidal ideation among people bereaved by suicide who received family-based cognitive behaviour therapy compared with those who received usual care, 13 months after suicide[a] (relative risk=1.06, [95%CI 0.48 to 2.33], absolute difference=10 more per 10000). The committee's confidence in the evidence was low.

Evidence from an observational study found a significant difference in the number of people considered to be at high risk for suicidality (suicidal behavioural questionnaire scored over 7) between people bereaved by suicide who had contacted a suicide bereavement support service (StandBy response service) and those who had not (relative risk=0.75, [95%CI 0.59 to 0.94], absolute difference=160 fewer per 1000, [95%CI 38 fewer to 262 fewer]). The committee's confidence in the evidence was very low.

Evidence statement 6.3-service uptake

Evidence from an experimental study found a non-significant reduction in non-routine health centre visits between people bereaved by suicide who participated in a writing project (encouraged to write about traumatic events) and those who wrote about innocuous events at 6-weeks follow-up[b] (mean difference=1.21 fewer visits, [95%CI 2.72 fewer to 0.30 more]). The committee's confidence in the evidence was very low.

Evidence from an observational study found a non-significant reduction in the number of visits to emergency care services by people bereaved by suicide who had contacted suicide bereavement support service (StandBy response service) and those who had not (mean

[a] De Groot et al (2007), at baseline, 24% (16/68) in the intervention group and 20% (11/55) in the control group reported suicidal ideation. The difference between 2 groups was not statistically significant.

[b] Kovac and Range (2000), at baseline, the mean number of non-routine health centre visits was 0.33 in the intervention group and 0.38 in comparison group. The difference between 2 groups was not statistically significant.

difference=0.06 fewer, [95%CI 0.18 lower to 0.06 more]). The committee's confidence in the evidence was very low.

Evidence statement 6.4-depression

Evidence from 2 RCT studies found a non-significant difference in depression scores between those bereaved by suicide who received family-based cognitive behaviour therapy and those in the control group up to 13 months after suicide[c] (measured by either the Centre for Epidemiological Studies - Depression scale, mean difference=0.90 higher, [95%CI 3.42 lower to 5.22 higher]; or by Beck depression inventory, mean difference=3.60 fewer, [95%CI 8.69 lower to 1.49 higher]). The committee's confidence in the evidence was low.

Evidence from an experimental study found a significant difference in the level of depression between children bereaved by suicide who received bereavement group intervention and those who did not[d] (Children's Depression Inventory mean difference=9.8 lower, [95%CI 16.01 lower to 3.59 lower]). The committee's confidence in the evidence was very low.

Evidence from an experimental study found widows bereaved by suicide who received group intervention had lower depression scores (Beck Depression Inventory), from 18.66 pre-intervention to 7.7 post-intervention (1 years follow-up). The mean change was statistically significant (mean difference=10.96 lower, [95%CI 14.50 lower to 7.42 lower]). The committee's confidence in the evidence was very low.

Evidence statement 6.5-traumatic grief

Evidence from 2 RCT studies found a non-significant difference in the level of traumatic grief between people bereaved by suicide who received family-based cognitive behaviour therapy and those in control group up to 13 months after suicide[e] (measured by The Traumatic Grief Evaluation of Response to Loss, mean difference=3.40 higher, [95%CI 4.99 lower to 11.79 higher]; measured by The Inventory of Traumatic Grief, mean difference=1.90 lower, [95%CI 13.11 lower to 9.31 higher]).The committee's confidence in the evidence was low.

Evidence from an experimental study found a non-significant difference in the level of traumatic grief between people bereaved by suicide who participated writing project to write about traumatic events and those who wrote about innocuous events at 6-weeks follow-up[f] (mean difference=15.85 lower, [95%CI 34.86 lower to 3.16 higher]). The committee's confidence in the evidence was very low.

Evidence statement 6.6-anxiety

Evidence from an experimental study found a significant difference in anxiety symptoms between children bereaved by suicide who received bereavement group intervention and those who did not receive the intervention[g] (mean difference=16.90 lower, [95%CI 25.90 lower to 7.90 lower]). The committee's confidence in the evidence was very low.

[c] De Groot et al (2007), at baseline, mean depression score was 20.6 in the intervention group and 24.4 in the control group. The difference between 2 groups was not statistically significant. Wittouck et al (2014), at baseline, mean depression score was 18.6 in the intervention group and 21.8 in the control group. The difference between 2 groups was not statistically significant.

[d] Pfeffer et al (2002), at the baseline, mean depression score was 46.8 in the intervention group and 51.7 in the control group. The difference between 2 groups was not statistically significant.

[e] De Groot et al (2007), at baseline, mean traumatic grief score was 78.8 in the intervention group and 74.6 in the control group. The difference between 2 groups was not statistically significant; Wittouck et al 2014, at baseline, mean traumatic grief score was 78.1 in the intervention group and 75.8 in the control group. The difference between 2 groups was not statistically significant.

[f] Kovac and Range 2000, at baseline, mean of grief experience question was 109.86 in the intervention group and 122.57 in the comparison group. The difference between 2 groups was not statistically significant.

[g] Pfeffer et al (2002), at the baseline, mean anxiety score was 49.5 in the intervention group and 51.0 in the control group. The difference between 2 groups was not statistically significant.

Evidence statement 6.7-stress

Evidence from 2 experimental studies found a non-significant difference in the level of stress between children or adults bereaved by suicide who received bereavement intervention and those who did not receive the intervention[h] (children who bereaved by suicide, mean difference=1.80 higher, [95%CI 5.67 lower to 9.27 higher]; adults who bereaved by suicide, mean difference=1.06 lower, [95%CI 13.71 lower to 11.59 higher]). The committee's confidence in the evidence was very low.

Evidence statement 6.8-psychological distress

Evidence from an observational study found a non-significant difference in the level of psychological distress between people bereaved by suicide who had contacted suicide bereavement support service (StandBy response service) and those who had not (mean difference=0.79 lower, [95%CI 2.34 lower to 0.76 higher]). The committee's confidence in the evidence was very low.

Evidence statement 6.9-quality of life

General quality of life

Evidence from an observational study found a non-significant difference in general quality of life between people bereaved by suicide who had contacted suicide bereavement support service (StandBy response service) and those who had not (mean difference=0.02 higher, [95%CI 0.02 lower to 0.08 higher]) The committee's confidence in the evidence was very low.

Health related quality of life

Evidence from an observational study found a non-significant difference in health-related quality of life between people bereaved by suicide who had contacted suicide bereavement support service (StandBy response service) and those who had not (mean difference=0.02 higher, [95%CI 0.02 lower to 0.06 higher]). The committee's confidence in the evidence was very low.

Qualitative evidence

Evidence statement 6.10-healing effect

There is evidence from 4 qualitative studies (Supiano 2012 [+]; Trimble et al 2012[-]; McKinnon and Chonody 2014 [+]; Peters et al 2015[+]) which explored the experience of people bereaved by suicide but not in the context of UK services. 3 studies identified coherent evidence that support groups helped grieving people with their bereavement. This included facilitating their grief journey, fostering their personal resilience for grief, enabling them to express their feelings and to feel accepted, telling their stories and sharing their experience with other people. But not all people liked the groups, as some participants in one study stated that they did not want to share their or hear other people's stories (McKinnon and Chonody 2014). The committee's confidence in the evidence was moderate.

Evidence statement 6.11-personal impact/growth

There is evidence from 4 qualitative studies (Supiano 2012 [+]; Trimble et al 2012[-]; McKinnon and Chonody 2014 [+]; Peters et al 2015[+]) which reported personal impact and/or growth of people who received postvention interventions. These studies were not carried out in the UK. All 4 studies identified coherent evidence that bereavement support

[h] Pfeffer et al (2002), at the baseline, mean posttraumatic stress score was 25.3 in the intervention group and 28.9 in the control group. The difference between 2 groups was not statistically significant; Kovac and Range 2000, at baseline, mean score of the impact of event scales was 27.6 in the intervention group and 31.93 in the comparison group. The difference between 2 groups was not statistically significant.

groups helped people bereaved by suicide improve their personal awareness of the impact of suicide on survivors (Supiano 2012, Trimble et al 2012) and enabled them to combat stigma surrounding suicide (Trimble et al 2012; Peters et al 2015). The group also provided a sense of normalisation through a shared experience (Supiano 2012; McKinnon and Chonody 2014). The committee's confidence in the evidence was moderate.

Evidence statement 6.12-timing of support services

There is evidence from 4 qualitative studies which considered that immediate support for people bereaved by suicide were useful (Trimble et al 2012[-]; Hawton et al 2012[-]; Aguirre and Terry 2014 [+]; Foggin et al 2016 [+]). GPs acknowledged their responsibility to be proactive and to instigate contact with bereaved patients (Foggin et al 2016).Suicide survivors noted that the community outreach (LOSS) team enabled them to connect to resources quickly (Aguirre and Terry 2014) but the service/resource was not reaching all of the people at the early stages of their bereavement (Hawton et al 2012). In addition to initial support, follow-up support was also considered necessary for bereaved people as they could think more clearly at a later date (Aguirre and Terry 2014). People who had received initial support described a feeling of isolation and a disconnection ('gradual detachment') as time went on (Trimble et al 2012). The committee's confidence in the evidence was moderate.

Evidence statement 6.13-resources

There is evidence from 2 qualitative studies which identified a lack of resources for bereavement support (McKinnor and Chonody 2014; Foggin et al 2016). GPs felt they could offer little to bereaved patients, often relying on third-sector services, and GPs themselves described a lack of personal preparedness to help bereaved patients (Foggin et al 2016). People bereaved by suicide felt peer support groups could assist with their grief but these groups needed professional input to keep up-to-date with new coping strategies, and they felt identifying support from someone who was experienced in grief and loss was a challenge (McKinnon and Chonody 2014). The committee's confidence in the evidence was moderate.

Economic evidence

Evidence statement 6.14-cost effectiveness of postvention

There is evidence from 1 economic study explored the cost-effectiveness of postvention service (standby response service) and found the service for bereaved people was cost-saving when productive cost from suicide were taken into account (incremental costs=AUS$ 803 lower). The committee's confidence in the evidence was very low.

Expert testimony

Evidence statement 6.15 - Support for people bereaved by suicides

The expert witness illustrated how people were affected by suicide, and noted that huge discrepancy in existing literature on the numbers of people who could be affected after each suicide. In the UK, there is no specialist service to support people affected by suicide; in addition, many healthcare professionals such as GPs felt anxious and uncertain how to respond to people bereaved by suicides. Although a lack of national specialist suicide bereavement service within the NHS, some services are developed locally to support people who need help. For example, the Western Health and Social Care NHS Trust, in Londonderry developed the first postvention (care of those bereaved by suicide) service in 2008, and several other NHS trusts are also in the process of replicating a similar service in England. To inform the development of bereavement services, a large-scale survey study is underway to explore and perceived needs of those bereaved and affected by suicide.

Recommendations

Supporting people bereaved or affected by a suspected suicide

1.8.1 Identify those who may be affected by a suspected suicide or may benefit from bereavement support by using rapid intelligence gathering (see recommendations 1.4.2 and 1.4.3) and data from other sources, such as coroners. Those affected may include relatives, friends, classmates, close contacts including cell or prison mates and peer support workers in custodial settings, as well as first responders and other professionals who provided support.

1.8.2 Provide sensitive, practical and evidence-based early support, such as Public Health England's Help is at hand guide, which provides support for people bereaved by suicide and also signposts to other services.

1.8.3 Consider peer support provided by trained people who have been bereaved or affected by a suicide or suspected suicide.

1.8.4 Consider providing ongoing support for people bereaved or affected by a suicide or suspected suicide if they need this.

Research recommendations

1. How effective and cost effective are interventions to support people who are bereaved or affected by a suicide?

Criterion	Explanation
Population	People in the community who have been bereaved or affected by a suicide
Intervention	Specialist bereavement services (group and/or individual)
Comparator	Usual care or no intervention
Outcomes	Primary outcomes to include unresolved grief, isolation and mental health (for example, self-rated depression), Secondary outcomes to include service use and costs
Study design	Study designs could include cluster RCTs of a specialist bereavement service or other types of evaluation with the purpose of ascertaining the effectiveness of a specialist bereavement services at help with feelings of grief and loss. It will also be important to gain public and staff feedback as part of any study so a mixed methods approach to include qualitative elements may also be appropriate

Timeframe	Studies would require sufficient follow up time to capture changes in primary outcomes (ideally 6 months)

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236 **2. What factors can affect uptake and access to bereavement services among people**
237 **who are bereaved or affected by a suicide?**

Criterion	Explanation
Population	People in the community who have been bereaved or affected by a suicide
Intervention	Specialist bereavement service (group and/or individual)
Comparator	Comparative effectiveness of other interventions such as usual care (that is the same or alternative interventions delivered elsewhere)
Outcomes	Uptake and access to bereavement support services Secondary outcomes to include modifying factors or determinants of behavior for example mental wellbeing, quality of life, awareness, knowledge, attitudes, intentions)
Study design	Study designs could include effectiveness studies or other types of evaluation with the purpose of ascertaining the effectiveness of uptake and access to specialist bereavement services. It will also be important to gain public and staff feedback as part of any study so a mixed methods approach to include qualitative elements may also be appropriate
Timeframe	No specific timeframe

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239 **3. What are the needs for bereavement services in relation to different population**
240 **groups who are bereaved or affected by a suicide?**

Criterion	Explanation
Population	People in the community who have been bereaved or affected by a suicide
Intervention	Not applicable
Comparator	Not applicable
Outcomes	Thematic analysis of specific needs of people who are bereaved or affected by a suicide or suspected suicide
Study design	Study designs could include qualitative or a mixed methods approach to include qualitative elements
Timeframe	No specific timeframe

241

242 **4. What are the training needs for staff in custodial and detention settings when**
243 **supporting people bereaved or affected by suicide?**

Criterion	Explanation
Population	People within custodial or detention settings who work with those who have been bereaved or affected by suicide
Intervention	Postvention training (training for people to support those bereaved or affected by suicide)

Comparator	Usual care or no intervention
Outcomes	Primary outcomes to include suicide-related outcomes (Suicides, attempted suicides and suicidal ideation) Secondary outcomes, to include mental health (for example, self-rated depression), service use and costs
Study design	Study designs could include cluster RCTs or other types of evaluation with the purpose of ascertaining the effectiveness and cost-effectiveness of non-clinical interventions at reducing suicide rates (primary outcome). It will also be important to gain public and staff feedback as part of any study so a mixed methods approach to include qualitative elements may also be appropriate
Timeframe	No specific timeframe

5. What is the experience of people who have survived from their suicide attempts? What causes them to make suicide attempts? What is their experience of services following their suicide attempts? What is the impact on their families?

Criterion	Explanation
Population	People in the community who are at risk of suicide, People in the community who have been bereaved or affected by a suicide
Intervention	Not applicable
Comparator	Not applicable
Outcomes	Thematic analysis of specific needs of people who are bereaved or affected by a suicide or suspected suicide
Study design	Study designs could include qualitative or a mixed methods approach to include qualitative elements
Timeframe	No specific timeframe

Rationale and impact

Why the committee made the recommendations

Supporting people bereaved or affected by a suicide

The committee agreed that people affected by a suspected suicide may, as a result, be at risk of harming themselves. These include family members and friends of people who have died, as well as first responders. The committee heard that bereavement support can reduce this risk, especially when tailored to the person's needs. People who had bereavement support were also likely to experience lower levels of depression and anxiety. Some of these benefits were based on personal accounts because the evidence was limited. But the committee agreed that, overall, support for people affected by suicide appeared to have a beneficial effect.

They also made 5 recommendations for research to evaluate the effectiveness of:

- non-clinical interventions
- supporting people bereaved or affected by a suicide.

Impact of the recommendations on practice

The committee recognised that providing support for people affected by suicide may be cost -effective from a societal perspective, when the costs of productivity loss are taken into account. However, because of the lack of evidence this supposition should be treated with caution.

Improved communication and information sharing between statutory agencies and community organisations may have resource implications such as the costs of staff time, communication, interventions, and meetings associated with multi-agency teams.

Providing training for journalists may have cost implications. But better reporting generally has beneficial outcomes.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The committee discussed the relative importance of the outcomes and agreed that suicide rates among people bereaved by suicide was the most important outcome for this review. Rates of suicide attempts and/or suicidal ideation for the target population were regarded as important as another measure of suicidality. Any reduction in suicide, suicide attempt or suicidal ideation would make an important difference in practice and were critical for decision-making.

Service uptake was considered relevant to help-seeking of the target population for the review. Depression, grief, and distress were considered to be the preferred outcomes of interest when considering the status of mental health.

Other outcomes specified in the review protocol, such as changes in knowledge, attitude, behaviour, and belief were not reported in the included studies.

The quality of the evidence

The committee noted that the evidence base in this topic area is hampered by the difficulty of recruiting people bereaved by suicide into studies (De Groot et al 2007/2010 study reported that around 40% of eligible participants declined to take part) The committee agreed that those who agreed to participate in these studies were largely self-selected and most of them were already in contact with services, Both of these considerations negatively impact on the generalisability of the evidence to the population of interest.

Overall, the certainty of evidence for outcomes of the interest reported in quantitative studies was defined as 'low' or 'very low'. The committee noted that none of the studies reported on the impact of postvention on suicide rates, and just 1 RCT examined suicidal ideation as an outcome.

Results of changes in mental health state were reported in 2 RCTs and 3 non-RCTs. The included studies suffered from the presence of risk of bias such as selection bias and differences in baseline characteristics between study participants in the intervention and control groups.

Overall, the quality of the qualitative studies for themes reported in qualitative studies was defined as 'moderate'. The committee had minor concerns regarding study methodology including poor sampling strategies, poor reporting of the method and data analysis. Two of the studies and the expert testimony were based on a UK context as were directly applicable to UK services.

Benefits and harms

Despite the lack of effectiveness evidence from the UK, the committee agreed that overall postvention support appeared to have a beneficial effect on people bereaved by suicide, showing that people who contacted and received support were less likely to be at high risk for suicidality (Visser et al 2014), had lower depression scores (Pfeffer et al 2002, Constantino et al 2001) and anxiety (Pfeffer et al 2002). This evidence was supported by the experiences of the committee.

The qualitative studies reported that the postvention support helped people bereaved by suicide improve their awareness of the impact of suicide and to combat the stigma around suicide. Therefore, the committee considered postvention would be helpful and should be recommended to support people bereaved by suicide and help them seek help.

There were, however, some differences in demographic profile (i.e. age, sex) and relationships to the deceased (i.e. parents, siblings, peers) in the populations of the different studies. The committee noted that, although there was an overall benefit effect of postvention, it was not possible to conclude that postvention support was equivalent in its effectiveness amongst the different population groups. The committee felt that future research would be valuable to help understand the needs of different population groups and to establish the true effect of postvention on these population groups.

None of the included studies provided evidence on potential harms of postvention support. The expert witness noted that talking about death by suicide could have a negative impact on people, specifically during the initial period after the death. In addition, a topic expert noted that in their experience, some people felt upset when they received information regarding postvention support as they did not want to accept that their loved one had died by suicide. The topic experts also reported that this reaction imposed an additional challenge for first responders such as the police and emergency services, as they have to control the scene to ensure an investigation is carried out. They also must convey that the death may be a 'suspected suicide' to deceased families. With this in mind, the committee suggested that the impact of a suspected suicide on first responders should also be taken into consideration when drafting the recommendations.

The committee reflected on their experience and notified one challenge to engage and provide postvention to people who lost their loved was that people were often in denial, and refused to accept the idea of 'suicide' until after the coroner's confirmation. The committee also agreed that services need to maximise the opportunity to offer postvention support at the initial point of contacts with the service. Furthermore, the committee agreed that local data gathering should be used to identify those not in contact with support services for follow-up and they may be in need of support at a later date.

Cost effectiveness and resource use

The committee reviewed evidence from one study which evaluated cost-effectiveness of community-based crisis intervention (StandBy response service). It reported that postvention could be cost-effective from a societal perspective, when costs of productivity loss were taken into account. However, the committee suggested cautions should be taken when interpreting the results, as follows. Firstly this was a non-UK study so may not be directly applicable; secondly the study adapted the economic model from Bonanno's model of grieving events, and it was unclear whether such a model would be generalisable to grief after a suicide; and thirdly the study did not provide detailed data information on outcomes regarding the effectiveness of the intervention.

Other factors the committee took into account

None

Appendices

Appendix A: Review protocols

Component of protocol	Description
Review question	Are approaches that provide people affected by suicide with information about grief and bereavement and bereavement support services (postvention) effective and cost effective at encouraging those people to seek help? • What impact do the following have on the effectiveness, cost effectiveness of different interventions: deliverer, setting, timing?
Context and objectives	To determine whether information and sign-posting are effective and cost effective at increasing help seeking behaviour.
Participants/population	People who are bereaved by suicide For example: • families, friends, colleagues and peers Populations may include people in workplaces, schools/colleges and prisons.
Intervention(s)	Local interventions to support those bereaved or affected by suicide (postvention). Postvention interventions are in scope however this is limited to: • providing information about grief and bereavement by suicide (leaflets, verbal info, social media) • giving information about bereavement support services (sign-posting) • Community or peer support. The guideline would not be looking at one-to-one support or therapy (individual approaches). It will be necessary to separate interventions that 'sign-post' from associated therapeutic interventions. Exclusions: mass media campaigns on national level
Comparator(s)/control	Comparators that will be considered are: • Other intervention • Status quo/ control • Time (before and after) or area (i.e. matched city a vs b) comparisons
Outcome(s)	The outcomes that will be considered when assessing the impact on health are: • Suicide rates among target/participant communities

Component of protocol	Description
	• Suicide attempts • Changes in mental health state • Reporting of suicide ideation. The outcomes that will be considered when assessing help-seeking behaviour: • Service uptake (such as mental health services, helplines) The outcomes that will be considered when assessing attitude and behaviour: • Changes in knowledge, attitude, acceptance, intentions, beliefs and behaviour of people who are bereaved by suicide.
Types of studies to be included	Comparative studies including: • Randomised or non-randomised controlled trials • Before and after studies • Cohort studies Qualitative studies (which are directly related to effectiveness studies) • Interviews • Focus groups Economic studies: • Economic evaluations • Cost-utility (cost per QALY) • Cost benefit (i.e. Net benefit) • Cost-effectiveness (Cost per unit of effect) • Cost minimization • Cost-consequence Systematic reviews will only be included if they have a high level of external validity to our research questions. They will also be used as a source for primary evidence. Only full economic analyses will be included – papers reporting costs only will be excluded

358 For the full protocol see the attached version on the guideline consultation page

Appendix B: Literature search strategies

See separate document attached on the guideline consultation page.

Appendix C: References

Aguirre Regina T. P, and Terry Laura Frank (2014) The LOSS Team: An important postvention component of suicide prevention: Results of a program evaluation. Routledge international handbook of clinical suicide research. , 279-288

Comans Tracy, Visser Victoria, and Scuffham Paul (2013) Cost effectiveness of a community-based crisis intervention program for people bereaved by suicide. Crisis 34(6), 390-7

Constantino Rose E, Sekula Kathleen L, and Rubenstein Elaine N (2001) Group Intervention for Widowed Survivors of Suicide. Suicide and Life-Threatening Behavior 31(4), 428-441

de Groot , Marieke , Neeleman Jan, van der Meer , Klaas , and Burger Huibert (2010) The effectiveness of family-based cognitive-behavior grief therapy to prevent complicated grief in relatives of suicide victims: the mediating role of suicide ideation. Suicide & life-threatening behavior 40(5), 425-37

De Groot, Neeleman J, vad der Meer 2010 The effectiveness of family-based cognitive-behaviour grief therapy to prevent complicated grief in relatives of suicide victims: the mediating role of suicide ideation. Suicide and Life-threatening Behaviour 40(5): 425

Foggin Emily, McDonnell Sharon, Cordingley Lis, Kapur Navneet, Shaw Jenny, and Chew-Graham Carolyn A (2016) GPs' experiences of dealing with parents bereaved by suicide: a qualitative study. British Journal of General Practice 66(651), E737-E746

Hawton Keith, Sutton Lesley, Simkin Sue, Walker Dawn-Marie, Stacey Gemma, Waters Keith, and Rees Sian (2012) Evaluation of a resource for people bereaved by suicide. Crisis 33(5), 254-64

H M Government (2017) Preventing suicide in England: Third progress report on the cross-government outcome strategy to save live.

Kovac S H, and Range L M (2000) Writing projects: Lessening undergraduates' unique suicidal bereavement. Suicide and Life-Threatening Behaviour 30(1), 50-60

McKinnon Janette M, and Jill Chonody (2014) Exploring the formal supports used by people bereaved through suicide: a qualitative study. Social Work in Mental Health 12(3), 231-248

Peters Kath, Staines Alan, Cunningham Colleen, and Ramjan Lucie (2015) The Lifekeeper Memory Quilt: evaluation of a suicide postvention program. Death studies 39(6), 353-9

Pfeffer Cynthia R, Jiang Hong, Kakuma Tatsuyuki, Hwang Judy, and Metsch Michele (2002) Group intervention for children bereaved by the suicide of a relative. Journal of the American Academy of Child and Adolescent Psychiatry 41(5), 505-13

Poijula S, Wahlberg K E, and Dyregrov A (2001) Adolescent suicide and suicide contagion in three secondary schools. International journal of emergency mental health 3(3), 163-8

Supiano Katherine P (2012) Sense-Making in Suicide Survivorship: A Qualitative Study of the Effect of Grief Support Group Participation. Journal of Loss & Trauma 17(6), 489-507

Trimble Timothy, Hannigan Barbara, and Gaffney Megan (2012) Suicide postvention; Coping, support and transformation. The Irish Journal of Psychology 33(2-3), 115-121

Visser Victoria S, Comans Tracy A, and Scuffham Paul A (2014) Evaluation of the effectiveness of a community-based crisis intervention program for people bereaved by suicide. Journal of Community Psychology 42(1), 19-28

Wittouck Ciska, Van Autreve, Sara, Portzky Gwendolyn, van Heeringen, and Kees (2014) A CBT-based psychoeducational intervention for suicide survivors: a cluster randomized controlled study. Crisis 35(3), 193-201

Appendix D: Excluded studies

No.	Study	Reason for exclusion
1.	Cerel (2008) Suicide survivors seeking mental health services: a preliminary examination of the role of an active postvention model. Suicide & life-threatening behaviour. 38 (1): 30-34.	Setting of the Intervention unknown
2.	Crenshaw (2015) Attitudes of African American clergy regarding the postvention needs of African American suicide survivors. Pastoral Psychology 64(2): 169-183.	Qualitative study which is not related to effectiveness of an intervention that has been included
3.	de Groot (2013) Course of bereavement over 8-10 years in first degree relatives and spouses of people who committed suicide: longitudinal community based cohort study British Medical Journal 347: 1756-1833.	Outcomes of interest not included
4.	Dyregrov (2011) What do we know about needs for help after suicide in different parts of the world? A phenomenological perspective. Crisis 32(6): 310-8.	Systematic review, included studies checked against review protocol
5.	Forde (2006) Postvention: A community-based family support initiative and model of responding to tragic events, including suicide. Child Care in Practice 12(1): 1357.	Study is concerned with the design of a postvention and no outcomes reported)
6.	J Levitt Aaron (2011) Suicide awareness and prevention workshop for social workers and paraprofessionals. Journal of Social Work Education 47(3): 607-13.	Intervention is not consider to be a postvention
7.	Jordan (2011) Group work with suicide survivors. Grief after suicide: Understanding the consequences and caring for the survivors. 282-300	Not a systematic review
8.	Linde K et al (2017) Grief interventions for people bereaved by suicide: a systematic review. Plos One 12(6): e0179496.	Systematic review, included studies checked against review protocol
9.	McDaid (2008) Interventions for people bereaved through suicide: systematic review. The British journal of psychiatry: the journal of mental science 193(6): 438-43.	Systematic review, included studies checked against review protocol
10.	Milner (2015) Workplace suicide prevention: a systematic review of published and unpublished activities. Health promotion international 30(1): 29-37	Intervention is not postvention
11.	Ono (2013) Effectiveness of a multimodal community intervention program to prevent suicide and suicide attempts: A quasi-experimental study. PloS one 8	Intervention is not postvention
12.	Oulanova (2014) From suicide survivor to peer counsellor: breaking the silence of suicide bereavement. Omega: Journal of Death and Dying 69(2): 151-168.	Qualitative study which is not related to effectiveness of an intervention
13.	Robinson (2013) A systematic review of school-based interventions aimed at preventing, treating, and responding to suicide-related behaviour in young people. Crisis: The Journal of Crisis Intervention and Suicide Prevention 34(3): 164-182.	Interventions is not postvention

No.	Study	Reason for exclusion
14.	Sandler Irwin, Tein Jenn-Yun, Wolchik Sharlene, and Ayers Tim S (2016) The Effects of the Family Bereavement Program to Reduce Suicide Ideation and/or Attempts of Parentally Bereaved Children Six and Fifteen Years Later. Suicide & life-threatening behaviour 46 Suppl 1, S32-8	Study population (only 13% of participants bereaved due to suicide)
15.	Skehan (2013) Suicide bereavement and the media: A qualitative study. Advances in Mental Health. 11(3): 223-237.	Qualitative study which is not related to effectiveness of an intervention
16.	Spencer-Thomas Sally, and Stohlmann-Rainey Jess (2017) Workplaces and the aftermath of suicide. Postvention in action: The international handbook of suicide bereavement support. , 174-185	Outcome of interest not included
17.	Szumilas Magdalena, and Kutcher Stan (2011) Post-suicide intervention programs: a systematic review. Canadian journal of public health 102(1), 18-29	Systematic review, included studies checked against review protocol
18.	Wilson (2010) Consumer participation: ensuring suicide postvention research counts for end users. International journal of nursing practice 16(1): 7-13.	Outcome of interest not included
19.	York (2013) A systematic review process to evaluate suicide prevention programs: A sample case of community-based programs. Journal of Community Psychology 41(1): 35-51.	Systematic review, included studies checked against review protocol

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1 Appendix E: Evidence tables

E21 Public health evidence

E.1.3.1 Quantitative studies

E.1.4.1 Constantino et al 2001

Constantino R E, Sekula L K, Rubinstein E N Group intervention for widowed survivors of suicide. Suicide and life-threatening behaviour 2001; 31 (4): 428-41.			
Study details	**Research Parameters**	**Population / Intervention**	**Results**
Author/year Constantino et al 2001 **Quality score** **+** **Study type** Experimental **Aim of the study** To evaluate the effects of group interventions (the Bereavement Group Postvention (BGP) and the Social Group Postvention (SGP)) on the bereavement outcomes in widowed survivors of suicide. The goals were to determine if the group interventions would significantly decrease levels of	**Number of participants** 60 adult widowed survivors of their spouse's suicide **Participants characteristics** The population included 60 adult widowed survivors of their spouse's suicide Forty-seven participants attended all eight postvention group sessions. Thirteen participants attended less than four postvention group sessions and, although they remained in their assigned groups, they were excluded from study analyses. Of the 47 participants included in the analyses, the majority (*n* = 37) were female. The length of widowhood ranged from 1 to 27 months. 40% had been widowed less than 6 months. 43% of the participants were Caucasian. Over one third (n=17) had a high school education,	**Intervention / Comparison** Group intervention **Intervention:** Bereavement group postvention (BGP) emphasises the curative factors of group psychotherapy, curative factors derived from the practice setting, underscore the complexity of therapeutic change and its occurrence through the interactions of human experiences. Social group postvention (SGP) promotes the principles of socialisation, recreation and leisure. It provides for personal insights, role clarification, recreation, and leisure which promote change. **Comparison:**	**Primary outcomes** *Beck Depression Inventory (BDI)* The BDI is a 21-item multiple-choice scale measuring both the presence of and severity of depression. The summed score for the BDI, ranging from 0 to 66. *Brief Symptom Inventory (BSI)* A total BSI score reflects psychological symptom patterns of stress in individuals. 53-items self-report questionnaire. *Grief Experience Inventory (GEI)* The GEI is a 135-item self-administered questionnaire with a true-false response format designed to assess experience, feelings, symptoms and behaviours frequently associated with the process of grief. *Social Adjustment Scale (SAS)* The SAS measures adjustment by assessing performance of work at home, work outside the home, work as a student, spare

<table>
<tr>
<td>depression, psychological distress, and grief, as well as significantly increase the level of social adjustment among widowed survivors of suicide

Location and setting

Pittsburgh, USA

Length of study

12 months follow-up

Source of funding

This study was funded by grant #RO1NR02108-01A2, NIH, NINR, Bethesda, MD.</td>
<td>while the remaining 2/3 had education ranging from some college to a doctoral degree.

The majority of participants receiving support from a friend or relative. The most frequent suicide methods used by the spouses were gunshot and carbon monoxide poisoning.

Inclusion criteria

Volunteer subjects (adult widowed survivors of their spouse's suicide.

Volunteer must have survived the suicide of a spouse, be 18 years of age or older, and be able to speak and understand English.

Exclusion criteria

not reported</td>
<td>Pre-intervention vs 12 month after intervention</td>
<td>time, family, parental role, family unit and financial independence, as well as a total SAS score.

<table>
<tr><td></td><td>Pre

(n=47)</td><td>1-year
(n=47)</td><td>Effect (95%CI)</td></tr>
<tr><td>BDI</td><td>18.66
(11.24)</td><td>7.7
(5.18)</td><td>-10.96

(-14.50, -7.42)</td></tr>
<tr><td>BSI</td><td>0.99
(0.69)</td><td>0.55
(0.46)</td><td>-0.44

(-0.68, -0.20)</td></tr>
<tr><td>SAS</td><td>2.16
(0.54)</td><td>1.60
(0.44)</td><td>-0.56

(-0.76,-0.36)</td></tr>
</table>
(effect was estimated change in outcome measures from baseline to the end of follow-up)

Author's conclusion

Participants experienced a significant reduction in overall depression, psychological distress, and grief, as well as an increase in social adjustment.</td>
</tr>
<tr>
<td colspan="4">Limitations identified by author
Training bereavement group leaders in that specific bereavement training may not be as important as the fact that any type of group support, even social may be equally beneficial. Entering a group where they have the interest and support of the leader and the other members may provide a level of caring and understanding that provides healing factors.

Limitations identified by review team
An overall effect of 2 group interventions, and the effect of individual intervention cannot be concluded.</td>
</tr>
</table>

E.1.1.2 De Groot et al 2007/2010

De Groot et al 2007 Cognitive behaviour therapy to prevent complicated grief among relatives and spouses bereaved by suicide: cluster randomised controlled trial. BMJ

De Groot, Neeleman J, vad der Meer 2010 The effectiveness of family-based cognitive-behaviour grief therapy to prevent complicated grief in relatives of suicide victims: the mediating role of suicide ideation. Suicide and Life-threatening Behaviour 40(5): 425.

Study details

Author/year

De Groot et al 2007/2010

Quality score

+

Study type

RCT

Aim of the study

To examine the effectiveness of a family based grief counselling programme to prevent complicated grief among first degree relatives and spouses of someone who had committed suicide; to explore the effectiveness of family based cognitive behavioural therapy to relief grief among high risk individuals indicated by the presence of suicide ideation briefly following a loss of a family member of suicide.

Location and setting

General practices in the Netherlands

Length of study

13 months after the suicide

Source of funding

Research Parameters

Number of participants

122 first degree relatives and spouses of 70 people who died from suicide;

95 participants (from 51 families) with no suicide ideation (NSI)

27 participants (rom 19 families) with suicide ideation (SI)

Participants characteristics

	Intervention (n=68)	Control (n=54)
Mean age (SD)	43 (13.7)	43 (13.5)
Mean age of dead person	44 (17.1)	46 (15.2)
Relationship to dead person		
Spouse	21 (31%)	15 (28%)
Parent	21 (31%)	8 (15%)
Child	11 (16%)	16 (29%)
Sibling	12 (18%)	9 (17%)
In laws/other	3(4%)	6 (11)
Median duration of relationship (range)	29 (3-50)	28 (1-58)

Population / Intervention

Intervention / Comparison

Families were randomly allocated to attend a grief counselling programme or to receive care as usual.

Intervention:

A grief counselling programme

Grief therapy is based on cognitive-behavioural concept of complicated grief.

Each family was counselled by one nurse. With an interval of two to three weeks, four sessions of two hours were planned at the families' homes at three to six months after the suicide.

The counselling programme aimed to offer relatives a reference frame for their grief reactions, engage emotional processing, enhance effective interaction, and improve problem solving.

Participants used a manual with information on suicide and bereavement after suicide, homework, a bibliography, and addresses for additional help. Issues were discussed in four sessions of two hours each; urgent problems were handled first.

Comparison:

Care as usual; Participants with or without suicidal ideation.

Results

Primary outcomes

Primary outcome was self-reported complicated grief, measured with the inventory of traumatic grief.

This inventory yields scores ranging from 29 to 145 and measures experiences of complicated grief in a scale format. Higher scores indicate a higher risk of complicated grief.

Secondary outcomes were depressive symptoms during the past week, assessed with the Centre for Epidemiologic Studies depression scale (CESD), ranging from 0 to 60, and suicidal ideation in the previous month assessed by four questions, with scores ranging from 4 to 20

	Intervention (N=68)	Control (N=54)	Effect (95%CI)
2.5months after suicide (baseline)			
Mean traumatic grief score (SD)	78.8 (21.2)	74.6 (20.9)	4.20 (-3.31, 11.71)
Mean depression score	20.6 (12.3)	24.4 (12.5)	-3.80 (-8.23, 0.63)
No (%) with suicidal ideation	16 (24)	11 (20)	1.16 (0.59, 2.28)
No (%) with perceptions	22 (32)	13 (24)	1.34

Netherlands Organisation for Health Research and Development

Marital status of participants		
Single	5 (7%)	6 (11%)
Divorced	3(4%)	7 (13%)
Widowed	23 (34%)	14 (26%)
Level of education		
High	24 (36%)	23 (43%)
Middle	22 (33%)	18 (34%)
Low	37 (54%)	26 (48%)
In paid employment	37 (54%)	26 (48%)
Felt need for help	48 (73%)	38 (71%)

Participants by those with suicide ideation and those without suicide ideation

	NSI (n=95, 51 families)	SI (n=27, 19 families)
Mean age (SD)	43 (14.1)	42 (12.0)
Male participants	30 (33.6%)	10 (37.0%)
Kinship relation to the victim		
spouse	27 (28.4%)	9 (33.3%)

of being to blame			(0.75, 2.41)
10.5months after suicide (13 months after suicide)			
Mean traumatic grief score (SD)	69.9 (23.1)	66.5 (23.8)	3.40 (-4.99, 11.79)
Mean depression score	14.2 (11.4)	13.3 (12.6)	0.90 (-3.43, 5.22)
No (%) with suicidal ideation	12 (18)	9 (17)	1.06 (0.48, 2.33)
No (%) with perceptions of being to blame	10 (15)	12 (22)	0.66 (0.31, 1.41)

Suicide ideation over the previous 4 weeks was assessed with Paykel's suicidality items.

Perceptions of guilt and self-blame were assessed.

	NSI		SI	
2.5months after suicide (baseline)	Intervention (N=52)	Control (N=43)	Intervention (n=16)	Control (n=11)
Mean complicated	73.4	69.2 (18.5)	96.4	95.7

Parent	19 (21.0%)	10 (37.0%)
Child	25 (26.3%)	2 (7.3%)
Sibling	17 (17.8%)	4 (14.8%)
In-law/other	7 (7.4%)	2 (7.4%)
Ever clinically depression	19 (20.2)	12 (46.2)
Ever clinically anxious	15 (16.0%)	10 (38.5%)
Ever attempted suicide	2 (2.1%)	5 (18.5%)
Family history of suicide	7/51 (13.7%)	5/19 (26.2%)
Neuroticism (0-12)	5.2 (3.2)	9.1 (3.0)
Mastery (7-35)	14.9 (4.8)	19.3 (5.3)
Self-esteem (10-40)	16.2 (4.9)	21.6 (6.8)

Inclusion criteria

We included first degree relatives (aged >15 years) and spouses of people who had committed suicide between 1 September 1999 and 1 January 2002 in the northern part of the Netherlands.

Exclusion criteria

grief score (SD)	(19.1)		(18.5)	(16.5)
Mean depression score	17.1 (11.2)	22.0 (11.7)	32.1 (8.0)	33.9 (11.2)
No (%) with suicidal ideation	0	0	16 (100%)	11 (100%)
No (%) with perceptions of being to blame	15 (28.8%)	6 (14.0%)	7 (43.8%)	7 (63.6%)
10.5months after suicide (13 months after suicide)	N=52	N=43	N=16	N=11
Mean complicated grief score (SD)	65.7 (22.2)	60.0 (19.1)	84.0 (21.1)	91.9 (24.5)
Mean depression score	11.2 (10.5)	10.0 (9.2)	23.8 (8.8)	26.2 (16.1)
No (%) with suicidal ideation	5 (10%)	2 (5%)	7 (44%)	7 (64%)
No (%) with perceptions of being to blame	7 (13.5%)	8 (18.6%)	3 (18.8%)	4 (36.4%)

Estimated effect at baseline 2.5 months and follow-up months following the suicide

	Baseline 2.5 months	13-months follow-up

	Relatives' lack of fluency in Dutch or imprisonment, or both. If relatives were mentally ill, their eligibility to be approached was left to the discretion of the general practitioner of the dead person **Method of analysis** Subjects with suicidality scores higher than 8 were indicated as suicide ideators. The effect of grief therapy was separately examined in suicide ideators and non-ideators. Effect analyses ere on an intention-to-treat basis; that is, irrespective of the final content of the therapy and number of sessions attended. The effect of grief therapy on outcomes was examined using regression analyses.		<table><tr><td>NSI</td><td></td><td></td></tr><tr><td>Grief</td><td>4.20 (-3.38, 11.78)</td><td>5.7 (-2.61, 14.01)</td></tr><tr><td>Depression</td><td>-4.90 (-9.54, -0.26)</td><td>1.20 (-2.76, 5.16)</td></tr><tr><td>SI</td><td></td><td></td></tr><tr><td>Grief</td><td>0.70 (-12.61, 14.01)</td><td>-7.90 (-25.69, 9.89)</td></tr><tr><td>Depression</td><td>-1.80 (-9.49, 5.89)</td><td>-2.40 (-12.85,8.05)</td></tr><tr><td>Suicide ideation</td><td></td><td></td></tr><tr><td>NSI</td><td></td><td>2.07 (0.42, 10.13)</td></tr><tr><td>SI</td><td></td><td>0.69 (0.34, 1.40)</td></tr></table> **Author's conclusion** A family based cognitive behaviour grief counselling programme offered to first degree relatives and spouses of people who had committed suicide had no beneficial effect on complicated grief reactions, suicidal ideation, and depression 13 months after the event. We did, however, see a trend towards reduced perceptions of being to blame for the suicide in the intervention group than in the group allocated to care as usual. This study shows grief therapy likely reduces the risk of maladaptive grief reactions among suicide ideators. Therefore, suicide ideators may benefit from grief therapy following a loss through suicide.
Limitations identified by author Selection bias, the considerable number of families that refused to take part; People who did not complete the study showed lower levels of complaints than those who did **Limitations identified by review team** Masking of participants and personnel was not reported in the study Outcomes were self-reported			

E.1.1.3 Kovac and Range 2000

Kovac S H, and Range L M (2000) Writing projects: Lessening undergraduates' unique suicidal bereavement. Suicide and Life-Threatening Behaviour 30(1), 50-60

Study details

Author/year

Kovac and Range 2000

Quality score

[+]

Study type

Experimental (uncontrolled)

Aim of the study

To compare whether writing about bereavement would produce negative emotions immediately after 4 days of writing, compared to writing about trivial topics.

To compare writing exercise results on grief and healthcare visits at 6 weeks.

Location and setting

Missisippi USA; University of Southern Mississipi, (lab study)

Length of study

Research Parameters

Number of participants

42 eligible participants (of 53 contacted).

40 (95%) participants completed post testing (19 profound/ 21 trivial).

30 (75%) participants completed follow-up measures at 6 weeks

N=15 Intervention group

N=15 Control group

Participant characteristics

Undergraduates from University of Southern Mississippi.

33 women 9 men, average age 24; 88% white, 10% African American; 76% single, 19% married,5% divorced.

Intervention	control
I: n=20	C: n=22
Mean age 23 years (s.d.=7)	Mean age 25 years (s.d.=8)
25% male, 90% White	14% male, 91% White
Baseline measures	
IES mean score	

Population / Intervention

Intervention / Comparison

Intervention group: Profound writing project:

At meetings bi-weekly over 2 weeks participants given instructions for 15 minutes continuous writing 'about the events and emotions surrounding the death of your loved one'. Emphasis on events/emotions not previously shared with others. An exploration of deepest emotions and thoughts.

Control group: Trivial writing project:

At meetings bi-weekly over 2 weeks. Participants given instructions for 15 minutes continuous writing about different trivial events: description of bedroom, what they had done since waking, what they have eaten, what they plan to do once writing completed.

All participants were offered counselling, and extra academic credits for participating.

Results

Outcomes

Non-routine health centre visits

Impact of Event Scale (IES) - subjective measure of stress related to specific life events used it assess impact of bereavement.

Grief Experience Questionnaire (GEQ) - 55 items to assess specific aspects about suicidal bereavement

Grief Recover Questions (GRQ) – 8 questions about participants' perception of their grief.

Sought counselling/therapy since study ended. Data for this outcome were not reported.

The direction of effect for all outcomes at 6 weeks follow-up favoured the intervention. However, no significant differences were found between groups.

Outcome	Intervention mean (SD) N=15	Control mean (SD) N=15	Mean Difference (CI)
Non-routine health centre visits	0.33 (0.72)	1.54 (2.88)	-1.21 (-2.71, 0.30)
Grief Experience Questionnaire	90.3 (25.6)	106 (27.5)	-15.85 (-34.86, 3.16)
Grief recovery questions	29 (14.9)	38 (14.7)	-9.0 (-19.61, 1.61)

<table>
<tr>
<td>pre-post test (at 2 weeks).

6 week mailed follow-up.

8 weeks total

Source of funding

Master's thesis partially funded by Mississippi Psychological Association Student Research Grant.</td>
<td>
<table>
<tr><td>I: 27.60 (s.d.=17.67),</td><td>C: 31.93 (s.d.=15.60)</td></tr>
<tr><td>GRQ mean score

I: 36.20 (s.d.=14.87)</td><td>

C: 45.73 (s.d.=12.05)</td></tr>
</table>
Both groups were similar in demographic measures at baseline. The control group had higher scores on Grief and Impact of Event scales.

Inclusion criteria
- Lost a loved one to suicide in previous 2 years.
- Close to the deceased.
- Upset by the death.

Exclusion criteria
- Not reported.
</td>
<td></td>
<td>
<table>
<tr><td>Impact of Event Scale</td><td>19.9 (19.7)</td><td>20.9 (15.5)</td><td>-1.06 (-13.71, 11.59)</td></tr>
</table>
Author's conclusion

The experimental and control groups were not significantly different in general grief or health visits. Writing about grief associated with the suicide of a loved one appeared to reduce suicidal grief associated with this event.
</td>
</tr>
<tr>
<td colspan="4">Limitations identified by author
It was assumed that suicidal death was the ,most traumatic event in participant lives, though there may have been another
.Lack of generalisability given 80% women, and all participants were students – other groups may have responded differently to grief or writing event. No attempt to specifically recruit participants from clinical populations may have resulted in selection bias of a more resilient population.
Limitations identified by review team
Selective outcome reporting - Sought counselling/therapy since study ended, not reported. Poor reporting and analysis of between group differences in outcome data make it difficult to assess the effectiveness of either writing approach, without further analyses by NICE analysts. 15% loss to follow up and no ITT analysis. Ethical approval not reported.</td>
</tr>
</table>

E.1.1.4 Pfeffer et al 2002

Pfeffer Cynthia R, Jiang Hong, Kakuma Tatsuyuki, Hwang Judy, and Metsch Michele (2002) Group intervention for children bereaved by the suicide of a relative. Journal of the American Academy of Child and Adolescent Psychiatry 41(5), 505-13			
Study details	**Research Parameters**	**Population / Intervention**	**Results**

Author/year

Pfeffer et al 2002

Quality score

[+]

Study type

Experimental

Aim of the study

To evaluate efficacy of a manual-based bereavement group intervention for children who suffered suicide of a parent or sibling.

Location and setting

USA

Length of study

12-weeks

Source of funding

This study was supported by Nanette L. Laitman and the William and Mildred Lasdon Foundation, a fund established in The New York Community Trust by DeWitt-Wallace, the William T. Grant Foundation, the Klingenstein Third Generation Foundation, and the Rodd D. Brickell Foundation.

Number of participants

75 children

Participants characteristics

The 39 children (mean age = 9.6 ±2.9 years) assigned to the intervention were significantly younger at study entry than the 36 non-intervention children (mean age = 11.4 ±3.5 years) ($t73 = 2.4$, $p \leq .02$). There were no significant differences between the 39 or 36 children for other demographic variables or methods of relatives' suicide, which included gunshot (37%), hanging (27%), overdose (12%), jumping (10%), and other (14%). No children witnessed the suicide.

	Intervention (n=39)	No intervention (n=36)
Mean age (SD)	9.6 (2.9)	11.4 (3.5)
No. of Male (%)	16 (41)	12 (33.3)
No of white (%)	28 (90.9)	24 (66.6)
Time from death to initial assessment , day (SD)	306 (376)	515 (1008)
Baseline measure		
Anxiety	49.5 (9.6)	28.51 (10.1)
Depression	46.8 (8.9)	51.7 (13.1)

Intervention / Comparison

After eligibility was established, families were assigned in alternating order to or not to receive the intervention. If there was more than 1 month's wait to recruit a family, the next eligible family was assigned to intervention to avoid delay in beginning intervention. In this case, once at least two families were available for intervention, it began and the next family was assigned to not receive the intervention. Those who received the intervention did not receive other interventions. Those who did not receive the intervention could receive other interventions but participated in the research assessments. Such families received bimonthly brief telephone calls to maintain contact.

Intervention:

Bereavement group intervention

The bereavement group intervention (BGI) was offered in ten 1.5- hour group sessions weekly to bereaved children from two to five families and separately but simultaneously to parents.

Each group, led by a trained master's-level psychologist, was composed of two to five children of similar developmental levels and grouped by age, i.e., 6 through 9 years, 10 through 12 years, and 13 through 15 years.

Siblings were assigned to the same group unless problems discussing concerns in the presence of siblings or developmental differences were present. Such siblings were included in different groups.

Primary outcomes

The Children's Depression Inventory (CDI) a questionnaire completed by children, assessed severity of depressive symptoms. *T* scores ≥60 indicated clinically significant depressive symptoms.

The Childhood Posttraumatic Stress Reaction Index (CPTSRI), administered in semi-structured interviews to children, identified severity of posttraumatic stress. Scores ≥25 indicated clinically significant symptoms.

The Revised Children's Manifest Anxiety Scale (RCMAS), a questionnaire completed by children, assessed severity of anxiety symptoms. *T* scores ≥63 indicated clinically significant anxiety symptoms.

The Social Adjustment Inventory for Children and Adolescents (SAICA) was administered in semi-structured inter- views to children and separately to parents, who reported on children's current social adjustment. Consensus ratings of children's social adjustment were obtained by using parents' and children's reports. Scores ≥2 indicated clinically significant maladjustment.

Outcome measures are 12-weeks follow-up

	Intervention	No intervention	Effect (95%CI)
Anxiety	39.6 (10.6)	56.5 (10.2)	-16.90 (-25.90, -7.90)
Depression	44.1 (8.7)	53.9 (7.8)	-9.80 (-16.01, -3.59)
Posttraumatic stress	19.6 (11.4)	17.8 (9.1)	1.80 (-5.67, 9.27)

Posttraumatic stress	25.3 (12.2)	28.9 (13.6)
Social adjustment	1.5 (0.2)	1.7 (0.3)
Parent depression	14.7 (8.3)	15.4 (12.0)

Non-intervention children had poorer initial social adjustment (mean T1 SAICA = 1.7 ± 0.3) than children assigned to the intervention (mean T1 SAICA = 1.5 ± 0.2) ($t68 = 2.9$, $p \leq .005$).

Children older than 13 years had higher initial anxiety ($t34 = 5.0$, $p \leq .0001$), depression ($t37 = 3.2$, $p \leq .0003$), and posttraumatic stress than younger children ($t37 = 2.1$, $p \leq .04$).

Significantly higher dropout rates occurred among non-intervention children (27, 75%) than for children assigned to the intervention (7, 18%)

Inclusion criteria

Children, aged 6 through 15 years, whose parent or sibling died from suicide from January 1996–November 1999.

Exclusion criteria

Children were exclude if they did not speak English, had clinically estimated mental retardation, did not know the cause of death was suicide, or did not have a participating parent/caretaker. Children with current psychiatric disorders were excluded because this study evaluated efficacy of the intervention to decrease bereavement-related symptoms rather than those related to psychiatric disorders

Psychoeducational components focused on discussing children's concepts of death and its permanence, identifying feelings of grief, defining what is suicide, discussing why people commit suicide, discussing prevention of children's suicidal urges, and enhancing children's skills in problem-solving.

Supportive components facilitated children's expressions of grief and their identification with positive attributes of the deceased but avoidance of suicidal urges and hopelessness. Children were empowered to feel more optimistic, manage traumatic thoughts and stigmatizing concerns about the suicide, and develop new supportive interpersonal relationships.

Psychoeducational and supportive components for parents helped them to understand childhood bereavement, foster children's expressions of grief, discuss the suicide, identify children's morbid reactions, and promote children's emotional and social functioning. Support was provided for parents to ventilate their grief.

Comparison:

Intervention vs no intervention

Social adjustment	1.6 (0.2)	1.8 (0.4)	-0.20 (-0.47, 0.07)
Parent depression	11.1 (10.5)	9.7 (4.5)	1.40 (-3.53, 6.33)

Author's conclusion

A bereavement group intervention focusing on reactions to death and suicide and strengthening coping skills can lessen dis- tress of children bereaved after parental or sibling suicide.

Limitations identified by author This method of assignment may have created some biases, such as differences for age and time from death to study entry among children assigned to receive or not receive the intervention. There was a significantly greater dropout among non-intervention families (75%) than those who received the intervention (18%). Non-intervention families felt too overwhelmed to participate when not offered intervention. The eligible, assigned, and completer children were representative of suicide-bereaved children in that their deceased relatives were predominantly white males with firearm deaths. **Limitations identified by review team** Short study follow-up (12 weeks)

E.1.1.5 Poijula S et al 2001

Poijula S, Wahlberg K E, and Dyregrov A (2001) Adolescent suicide and suicide contagion in three secondary schools. International journal of emergency mental health 3(3), 163-8

Study details	Research Parameters	Population / Intervention	Results
Author/year Poijula 2001 **Quality score** - **Study type** Quasi-experimental **Aim of the study** To investigate crisis intervention in three secondary schools after 6 suicides **Location and setting** 3 secondary schools in Oulu, Northern Finland **Length of study** 1995-1999 **Source of funding** Not reported	**Inclusion criteria** Students of the 3 schools in question and homeroom classmates of the suicide victims **Exclusion criteria** Unknown **No of suicides** The first suicide happened by a 17 year old ex-student from school A in 1995, this was the first suicide within this domain. After this, during 1995-1996, five secondary school students across three schools (3 from school A) in the Oulu are of Northern Finland area died by suicide. All schools were located in rural areas. Geographically however they were not neighbouring communities. 6 total suicides within this Oulu area between 1995-1996 across these schools	**Participant numbers:** 89 student who were homeroom classmates of the victims (46 boys and 43 girls): School A: n=31 participants (of 270 school population). School B: n= 32 participants (of 346 school population). School C: n= 26 participants (of 585 school population). Ages: 13- 17 years **Participant characteristics** Secondary school students who were homeroom classmates of those who died by suicide. Schools all located in small rural communities. Participants were aged 13-17 and had equal gender distribution. School / Female (n) A / 16 B / 17 C / 10	**Primary outcomes** *Contagion of the suicides:* At School A, 2 suicides of the 15 year old male subjects occurred 4 months after the initial suicide. Assuming a rate of 21.6 per 100,000 suicides per year (the national rate among 15-19 year olds reported by Statistics Finland 1998), one would expect to see a 0.0311968 suicides in this secondary school of 148 male students in one year and 0.00324 in the group of 15 boys in homeroom classrooms. The observed rate was 63.6 times the expected rate in the whole school and 617.3 in the two homeroom classes. In school B, the 2 suicides of 14 year olds occurred within one month of each other. Assuming a rate of 1.9 per 100,000 per year (the national rate among 10-14 year olds reported by the Statistics Finland 1998), one would expect to see a 0.003249 suicides in this school of 171 males per year and 0.0028 of the homeroom class males. The observed rate was 307.8 times that expected for the whole school for males and 3508.9 for homeroom class males. For females (rate of 1.8 per 100,000) in a school this size the expected number is 0.00315 and for homeroom classes of 17 girls 0.00306. The observed rat was 317.5 times higher than Using the Poison distribution the number of suicides that occurred in all secondary schools in one year were markedly increased by chance

	Characteristics of deceased: 5/6 subjects were friends or acquaintances Ages: 13-17 years old Gender: 5 male, 1 female None of the students were known to psychiatrically disturbed or any different from other students 3 suicides were from the same school (school A) 2 from school B 1 from school C Methods: 1 self-immolation, 5 firearms **Method of analysis** The incidence of new suicides in the three school was followed for a four year period 1995-1999. Poison distribution was calculated for determining if the number of increased suicides was due to chance – SPSS software.	**Intervention** In School A there was no contingency plan. After the third suicide however a crisis intervention was put in place consisting of a first talk through (FTT) and a psychological debriefing (PD) given by a trained mental health professional. FFT was held the first day after the suicide and PD, lasting 2 hours was held the following day. School B had a contingency plan in place – classroom meetings (an adaption of PD lasting 1 hour) conducted by a teacher in all but one grades. The meetings were conducted one week after the first suicide. After the second suicide an adequate crisis intervention (FTT and PD) was conducted by a trained MH professional one and four days after. School C had no contingency plan but after the case of suicide an adequate crisis intervention (psychological debriefing by a MH professional) was organised and implemented 2 days after the suicide.	(p<0.001). Contagion did not appear in the first 10 days but 1 (2 suicides), 1 ½, 2 and 4 months after the first suicide. *Interventions and contagion* In three cases, the intervention of FTT and PD was adequate. In schools and classes where a first talk-through and psychological debriefing were conducted by a mental health professional as the intervention, no new suicides appeared during the four year follow up period (August 1995-August 1999). In school B teachers conducted a classroom meeting in all but on grade class. In that school, a second suicide was committed 2 months later by a student whose class had not had the meeting. **Author's conclusions** Preliminary findings suggest that early suicide crisis intervention and use of first talk throughs and psychological debriefing do not cause suicide contagion, but lack of intervention may do so.
Limitations identified by author Small number of cases not optimal for statistical analysis, lacking sufficient statistical power Natural research design may be considered problematic Conclusions should be considered as tentative **Limitations identified by review team** The three schools were in the same area of Oulu, however it was mentioned in the text that they were not from neighbouring communities so questionable if they were classed as 'suicide clusters' together. To fit our protocol we may only consider School A where there were 3 suicides that took place over a short period of time No details of the distance between each school location			

E.1.1.6 Visser et al 2014

Visser Victoria S, Comans Tracy A, and Scuffham Paul A (2014) EVALUATION OF THE EFFECTIVENESS OF A COMMUNITY-BASED CRISIS INTERVENTION PROGRAM FOR PEOPLE BEREAVED BY SUICIDE. Journal of Community Psychology 42(1), 19-28

Study details

Author/year

Visser et al 2014

Quality score

[+]

Study type

Retrospective cross-sectional

Aim of the study

To evaluate the effectiveness of a suicide bereavement support service in reducing adverse health and social outcomes for people bereaved by suicide.

Location and setting

Australia

Length of study

People who used StandBy service between June 2009 and March 2011.

Source of funding

This project was funded by the Australian Government Department of Health and Ageing under the National Suicide Prevention Program.

Research Parameters

Number of participants

96

Participants characteristics

Participants were recruited from current and previous StandBy clients between the period June 2009 and March 2011. A control group was drawn from people who responded to advertisements in national newspapers and social media sites.

Cases (those who had received the postvention service) were matched with controls (those who had not received the service) using the time since bereavement and the relationship to the deceased to ensure comparability of groups

	Intervention (n=90)	Control (n=360)
Mean age (SD)	45.7 (15.8)	40.1 (13.4)
No. of female (%)	73 (82)	311 (88)
No of white (%)	28 (90.9)	24 (66.6)
No. of degree	13 (15)	55 (16)

Population / Intervention

Intervention / Comparison

Intervention:

The StandBy Response Service (StandBy used hereafter) is a suicide bereavement support service, which, at the time of this evaluation, operated in nine locations across Australia.

The service provides clients with face-to-face outreach and telephone support provided by a professional crisis response team. A site coordinator then develops a customized case management plan, referring clients to other existing community services matched to their needs.

StandBy responds only to people who request the service. The service is available to clients at any time after the loss and clients are able to access the service as often as necessary.

Interventions provided by StandBy are based on contemporary crisis intervention theory and strategies. The specific services provided to each client by the StandBy service and other local organisations can vary considerably, depending on their individual needs, as well as the availability of different services within the community.

Comparison:

Results

Primary outcomes

The evaluation questionnaire measured quality of life using two instruments. EQ-5D is a standardized instrument for measuring generic health-related quality of life. The ICECAP index of capability is a measure of general quality of life and covers five additional attributes not measured by the EQ-5D.

Psychological distress was measured using the Kessler Psychological Distress Scale version K6.

Suicidality was measured using the Suicidal Behaviours Questionnaire-Revised

Work performance was measured using the World Health Organization Health and Work Performance Questionnaire

Health care usage was measured by asking participants to enter the number of times they had visited various medical and health practitioners over the past four weeks (not including contact with StandBy).

	Intervention	Control	Effect (95%CI)
Psychological distress	8.99 (6.62)	9.78 (6.37)	-0.79 (-2.34, 0.76)
Suicidality	7.52 (4.49)	8.88 (4.11)	-1.36 (-2.38, -0.34)
Quality of life			

	graduate (%)			
	No. of married or cohabitating (%)	36 (41)	143(41)	
	No. in full time employment (%)	17(19)	80(23)	
	Time since bereavement, 0-12 month (%)	52 (60)	132 (37)	

Inclusion criteria

People who had experienced suicide bereavement and were over 18 years of age

Exclusion criteria

Not reported

Cases who had received the postvention service vs those who had not received the service

EQ-5D	0.711 (0.24)	0.69 (0.24	0.02 (-0.04, 0.08)
ICECAP	0.76 (0.17)	0.74 (0.20)	0.02 (-0.02, 0.06)
Health care usage (visits to health care professionals in the previous 4 weeks)			
No. of visit GPs	0.97 (1.7)	0.96 (1.9)	0.01 (-0.39, 0.41)
No. of visits to specialists	0.25 (0.7)	0.39 (1.6)	-0.14 (-0.36, 0.08)
No. of visits to emergency care	0.21 (0.5)	0.27 (0.6)	-0.06 (-0.18, 0.06)
No. of visits to mental health care specialists	0.81 (1.3)	0.92 (2.2)	-0.11 (-0.46, 0.24)
No. of visits to other health care professionals	0.27 (0.7)	0.24 (0.4)	0.03 (-0.12, 0.18)

Author's conclusion

The results of this study suggest that the service significantly reduces clients' risk of high levels of suicidality. These findings support previous research findings that postvention support can be an effective method for preventing further suicidality.

Limitations identified by author
The observational design of this study means that bias may be present and the direction of this bias is difficult to assess. An experimental study design using randomized control groups is difficult with this group, because of their elevated risk factors for adverse health outcomes and suicidality.

Respondents were self-selected and there may have been systematic differences between those who chose to be included and those who did not. This means that the results may not be transferable to all people bereaved by suicide. There were some significant demographic differences between the intervention and control groups and these differences may have influenced the results. The low response rate by StandBy clients (23%) may also have influenced the results. Although the results of this study show a significant reduction in self- reported suicidal thoughts and behaviours by StandBy clients, it is extremely difficult to unequivocally prove that the intervention reduces actual suicide numbers or rates for people bereaved by suicide. **Limitations identified by review team** Self-reported data for outcome measures.

E.1.1.7 Wittouch et al 2014

Wittouck Ciska, Van Autreve, Sara, Portzky Gwendolyn, van Heeringen , and Kees (2014) A CBT-based psychoeducational intervention for suicide survivors: a cluster randomized controlled study. Crisis 35(3), 193-201

Study details	Research Parameters	Population / Intervention	Results
Author/year Wittouch et al 2014 **Quality score** **[+]** **Study type** RCT **Aim of the study** The primary aim of the study was to test the hypothesis that a CBT-based psychoeducational program provides added benefit to care as usual in reducing maladaptive grief reactions including self-blame, depressive symptoms, and suicidal ideation and hopelessness. The secondary aim was to test the hypothesis that the psychoeducational program provides added benefit by reducing	**Number of participants** 83 randomised, 70 included in the analysis **Participants characteristics** No significant differences were found between the intervention group and the control group with respect to gender of participant and deceased, age of participant and deceased, current employment, relationship to deceased (parent/partner vs. other), and time since loss. The two study groups differed, however, regarding living situation and the highest achieved level of education. Significantly fewer participants in the intervention group lived alone at the time of the study in comparison with control group participants. In addition, significantly more participants in the intervention group received high school or less than high school education and significantly fewer participants in the intervention group went to college or university than control group participants.	**Intervention / Comparison** **Intervention:** **The CBT-Based Psychoeducational Intervention for Adult Suicide Survivors** The intervention, which took place during four 2-hr home visits by a clinical psychologist, comprised psychoeducation regarding suicide, aspects of bereavement, specific aspects of bereavement by suicide, and coping with bereavement. Psychoeducation concerning suicide contained an illustration of the suicidal process and an explanation of a comprehensive explanatory model of suicidal behaviour. The cognitive-behavioural conceptualization of complicated grief was used as a rationale for the development of the intervention	**Primary outcomes** Assessments took place using semi-structured interviews during two home visits by a clinical psychologist, at baseline (home visit 1 [H1], at study entrance) and at 8 months' follow-up (home visit 2 [H2], 8 months after study entrance). Participants in the intervention group received four additional home visits, by a second clinical psychologist, during which the CBT-based psychoeducational intervention took place. Primary outcome measures included maladaptive grief reactions, depressive symptoms, suicidal ideation, and hopelessness. The Dutch version of the Inventory of Traumatic Grief as used to measure maladaptive grief symptoms. The ITG assesses 29 maladaptive grief symptoms, the presence of which has to be described in terms of *never*, *seldom, sometimes, often, or always,* resulting in a total score ranging from 29 to 145. This inventory measures experiences of complicated grief in a scale form, with higher scores indicating a higher risk of complicated grief. The Beck Depression Inventory is a 21- item scale that examines the presence and severity of depressive symptoms including suicidal ideation.

negative cognitions and maladaptive coping behaviour including avoidance behaviours.

Location and setting

Belgium

Length of study

8-month follow-up

Source of funding

This study was supported by a grant from Go for Happiness.

	Intervention (n=47)	Control (n=36)
Mean age (SD)	48.6 (13.3)	49.3 (13.8)
No. of female (%)	63 (75.9)	38 (80.9)
No of living alone (%)	13 (15.7)	4 (8.5)
No. of college or university graduate (%)	43 (51.8)	17 (36.2)
No. of currently at work (%)	46 (55.4)	25 (53.2)
Age decreased	41.5 (16.1)	41.5 (16.9)
Time since loss, months	11 (6.1)	9.8 (5.7)

Inclusion criteria

The loss of a loved one through suicide between 3 months and 2 years before study participation was the main inclusion criterion for the study.

There were no limitations regarding kinship or relationship to the deceased, so that both family members and friends could take part in the study.

The 83 participants corresponded to 65 suicide cases. Multiple survivors of one suicide were allocated to the same study arm in order to avoid confounding of the results.

Comparison:

Invention vs care as usual

The Beck Hopelessness Scale measures an individual's attitudes toward the future. The 20 items can be answered with *yes* or *no*. A total score of 9 or more indicates high hopelessness and is associated with a significantly increased risk of suicide.

	Intervention	Control	Effect (95%CI)
Baseline			
Traumatic grief	78.1 (23.3)	75.8 (27.6)	2.30 (-8.91, 13.51)
Depression	18.6 (10.7)	21.8 (13.7)	-3.20 (-8.62, 2.22)
Hopelessness	8.9 (5.0)	10.2 (6.6)	-1.30 (-3.89, 1.29)
8-month follow-up			
Traumatic grief	72.1 (22.7)	74.0 (24.6)	-1.90 (-13.11, 9.31)
Depression	15.4 (10.8)	19.0 (10.8)	-3.60 (-8.69, 1.49)
Hopelessness	8.2 (5.6)	9.4 (6.6)	-1.20 (-4.11, 1.71)

Author's conclusion

The results from the current study suggest that CBT-based psychoeducational interventions can serve as supportive counselling for suicide survivors, who, for instance, may gain

	Participants had to be 18 years or older and Dutch speaking. **Exclusion criteria** Not reported		more insight into their mourning process and develop a better understanding of their emotional reactions.
Limitations identified by author Only a small group of suicide survivors participated in the study, possibly introducing selection and participation biases. Certain features of the study participants may have had an effect on the representativeness of the sample and thus on the extent to which the findings are applicable to suicide survivors in general. For instance, survivors who cope adequately with their grief may be more willing to participate in bereavement studies, while the most suffering survivors may not be reached. The two home visits in the control group may have biased the results. Differences in outcome measures between the two study groups at follow-up could have been significant if there would not have been any face-to-face contact with control group participants. **Limitations identified by review team** Self-reported data for outcome measures and relatively short study follow-up			

E.1.2 Qualitative studies

E.1.2.1 Aguirre and Terry 2014

Aguirre Regina T. P, and Terry Laura Frank (2014) The LOSS Team: An important postvention component of suicide prevention: Results of a program evaluation. Routledge international handbook of clinical suicide research. , 279-288				
Study details	**Research Parameters**	**Inclusion/ Exclusion criteria**	**Population**	**Results**
Author and year Aguirre and Frank 2014 **Quality score** **+** **Study type** Qualitative **Aim of the study** To evaluate the impact of the first year of the LOSS team's	**Data collection** Phenomenological interviews with suicide survivors, the LOSS team members and counsellor. Topics were to explore the role of the LOSS team in the grief process. **Method of analysis** Interviews recorded with consent.	**Inclusion criteria** Survivors receiving a LOSS team outreach; survivors who linked to service in Tarrant County prior to the LOSS team's establishment; LOSS team members, and a counsellor from one of 2 police departments that refer to the LOSS team. **Exclusion criteria** Not reported	**Participant numbers** 8 suicide survivors, 2 LOSS team members and 1 counsellor from a referring police department **Participant characteristics** Not reported in the study **Intervention** The TC LOSS team was born out of concern in the mental health community related to linking survivors to resource.	**The main themes identified were: decreased time in connecting with resources, impact of the LOSS team member being survivors themselves, importance of multiple visits with the LOSS team, impact of the LOSS teams' on-scene activities for the survivors, and the role of the LOSS team to the referring police department** *Decreased time in connecting with resources* Survivors all agreed that the LOSS team's ability to connect survivors to resources quickly is an important and impactful service. One survivors without a LOSS team contact noted: "Basically as far as the resources itself. You know, knowing the facts and the experiences would have helped me seeking counselling a lot faster

experience in Tarrant County. **Location and setting** Tarrant county, USA **Source of funding** Not reported	Data were analysed using constant comparison approach.		The LOSS team is a team of volunteers who are survivors of suicide and/or mental health professionals. Through referrals from local police departments and others in the community, the team provides supportive service on – scene when the decreased is found or in the week after (delayed contact) to people who have lost a loved one to suicide. The team is devoted solely to the new survivors: answering questions, offering comfort, and explaining available community services.	than I did. As far as you know, you had a loss, you don't know what you're going to be doing next or anything of that nature too." *Impact of the LOSS team members being survivors themselves* One of the strengths of the LOSS team is that many members are survivors themselves. The importance of this characteristic emerged during the interviews, and this speaks to a "connection" that is formed between the team member and the new survivor when the survivor learns of the shared tragedy. "One of my co-workers, um, he doesn't work here anymore, but his wife also died of suicide and so, he knew about SOS and was able tom you know…my boss, soon after my wife passed away, he arranged a meeting with him and me. So I met him at a coffee shop and we talked for an hour or two. Yeah, we talked about our experience and things." *Importance of multiple visits with the LOSS team* This themes has 2 sub-themes: the importance of follow-up visits and the importance of meeting both on-scene and later with the survivor. As a part of LOSS team procedures, there are several follow-up visits with survivors-in-persons via phone depending on the survivor's preference. The importance of this element was clear through the interviews with survivors. "Yeah, nothing is going to help. The only thing that is really important is to make sure that they're not alone for the first three weeks. Make sure no one is alone." Related to on-scene and later follow-up, to date, whether the LOSS team goes on-scene is at the discretion of the referring police departments, and this, the majority of contacts have been delayed rather than on-scene for the Team's safety. The team has wondered if delayed is 2just as good" since there has been success in reducing the time between the death and accessing service. The survivors indicated that both on-scenes and delayed follow-up visits were necessary. *Importance of the LOSS team's on scene activities for the survivors* Related to the importance of both an on-scene and follow-up presences is the significance of certain on-scene activates of the LOSS team. These activities were specifically the LOSS team's role in making connections for

				survivors and in helping they consider whether or not to see the body of their loved one. "It would be helpful to make sure that, if a LOSS team member was there, to make sure there were connections made between you and your family or friend to make sure you are not alone for the first few weeks." *The role of the LOSS team to the referring police department* The interview with a referring counsellor indicated that the LOSS team fills an important role to provide services to survivors when the police department has not been able to due to protocols in the death investigation process and to provide long-term follow-up for survivors beyond the scope of the police department's crisis intervention role. **Author's conclusion** The study was learnt that the LOSS team served an important role in helping survivors connect to life-saving resources that engender belongingness.
Limitations identified by author Not reported **Limitations identified by review team** 11 participants including 8 survivors. The study poorly reported sampling, method and data analysis.				

E.1.2.2 Foggin et al 2016

Foggin Emily, McDonnell Sharon, Cordingley Lis, Kapur Navneet, Shaw Jenny, and Chew-Graham Carolyn A (2016) GPs' experiences of dealing with parents bereaved by suicide: a qualitative study. British Journal of General Practice 66(651), E737-E746				
Study details	**Research Parameters**	**Inclusion/ Exclusion criteria**	**Population**	**Results**
Author and year Foggin et al 2016 **Quality score** **+** **Study type** Qualitative	**Data collection** Semi-structured interviews with GPs were conducted by one of authors between2012-2014. Topic guide included questions that prompted the perceptions of dealing with parents	**Inclusion criteria** Cause of death determined by coroner as suicide, open, or narrative **Exclusion criteria** Not reported	**Participant numbers** 29 parents interviewed initially (results not reported by this study). 24 parents gave consent for contact with GP. 13 GPs. **Participant characteristics**	**The main themes identified were: mental health as integral to general practise; facing the bereaved parent; helping the bereaved parent; and GPs helping themselves.** *Mental health as integral to general practise* GPs described the importance of managing mental health problems in primary care as 'part and parcel' of the job. In contrast GPs described suicide as uncommon and reflected on their lack of exposure to and unpreparedness to face it:

Aim of the study To explore GPs experiences of dealing with parents bereaved by suicide and any difficulties encountered. **Location and setting** Parents identified and recruited from the North of England and Wales – then asked if their GPs could be contacted to be interviewed. The interview setting is not specified. **Source of funding** National Institute for Health Research (NIHR)	bereaved by suicide; descriptions of their responses; what they found difficult; what they might have done differently; and what they felt they should be included in training for healthcare professionals. Interviews with GPs ranged from 13 to 80 minutes. **Method of analysis** Interviews recorded with consent. Data were analysed using constant comparison techniques. Thematic analysis of interviews conducted – transcripts were read, qualitatively coded, reviewed and labelled. Three of the authors used 'focused' coding, utilising prominent themes and as the basis for more fine-grain analyses. Throughout discussion and consensus broad codes were gradually refined and reviewed by the broader research team.		Parents' deceased offspring age: 16-40 years GPs age: 36-60 Urban practise: 10; Semi-rural practise: 3 Years of practise: 8-32 11 GPs recruited through an interviewed bereaved parent-several had also been personally affected by suicide 2 GPs recruited separately who had been affected by suicide both professionally and personally **Intervention** Conducted as part of a larger study which focused on the perceived experiences of parents whose adult offspring died by suicide – results helped inform the design and development of evidence-based training to provide GPs with knowledge, skills and a framework in which to guide them on how to respond and care for parents bereaved by suicide – the: Postvention: Assisting Those Bereaved by Suicide (the PABBS training intervention)..	"…it doesn't happen every week, it doesn't happen every month, you know, it's quite an infrequent event in practise or a doctors life' Although most GPs were comfortable talking about mental health problems, they were less comfortable talking about suicide, commonly using terms such as 'topped themselves' 'this sort of incidence' or 'died suddenly', one GP avoided the word suicide completely. *Facing the bereaved parent* The need to be prepared to meet a parent bereaved by suicide was emphasised by all GPs, and included the need to be informed in advance, prepare emotionally, and identify resources and/or support to offer the patients. GPs commented on the poor communication around deaths and many were not informed of the suicide prior to a consultation with the bereaved patient. "The embarrassment of not knowing when someone's died if you're dealing with a patient is…acute, you really don't want that. So you need to know who has died" Several GPs suggested that it was their responsibility to be proactive in these situations and to instigate contact with the bereaved parent: "If there are things that we can be doing proactively to help people in that situation then I think that's what we should be doing" Other GPs believed that the parent would contact them or the practise if they needed help, particularly if they were not well known to them. Those who did not know their parents well described feeling worried. Concerned about intruding on private grief, they questioned how they could help someone they did not know. "In the immediate aftermath, a stranger coming in and talking to you, what good is that going to do?" *Helping the bereaved parent* A few GPs recognised that they could offer advice about the practicalities following suicide, including: helping parent deal with coroners; talking about death certificates; stopping hospital correspondence; fit note certifications; and medication for parents. However most GPs described feelings that they could offer little to bereaved parents. "I haven't really given…I mean, we…were recommended Cruse for bereavement, but that's general bereavement"

				They reported not being aware of the services to support parents, either because of changing availability or that they just did not know what would help these parents. Many of the GPs also suggested that they do not have the resources to provide bereavement support themselves "People have to try and work things through and then go in to a full bereavement counselling situation if they're not making any progress really, but GPs don't have enough time" Many GPs recognised the need to refer patients for some sort of support but suggested that long waiting times are inappropriate for patients who had been bereaved and where intervention needs to be fast and responsive "Typically if we refer to, uhm, traditional mental health services, then they're not responsive enough…for this sort of problem" Most GPs reported on relying on third sector organisations, if available in the area. They identified them as more responsive compared with statutory services and sometimes the only option to suggest to patients "Voluntary organisations… have a big part to play, because the NHS can't afford to do everything it wants to do." Very few GPs were able to name third sector organisations that specifically supported those bereaved by suicide. **Author's conclusion** GPs need to feel confident and competent to support parents bereaved by suicide. Although this may be facilitated through training initiatives, and accessible services to refer parents to, GPs also require formal support and supervision, particularly around significant events such as suicide. Results from this qualitative study have informed the development of evidence based suicide bereavement training for health professionals.
Limitations identified by author Potential participant bias; GPs most likely to agree to participate had a prior interest in suicide and mental health. Possible that GPs who felt uncomfortable about their experience with the bereaved patient may have been more likely not to participate Most GPs interviewed were experienced, being in practices of an average of 22 years- may not be reflective of those in practices for shorter durations **Limitations identified by review team** Participate bias (self-sampling) – some GPs who agreed to participate did have a prior interest in suicide as they had suffered personal bereavement – reflected in results				

E.1.2.3 Hawton et al 2012

Hawton Keith, Sutton Lesley, Simkin Sue, Walker Dawn-Marie, Stacey Gemma, Waters Keith, and Rees Sian (2012) Evaluation of a resource for people bereaved by suicide. Crisis 33(5), 254-64

Study details	Research Parameters	Inclusion/ Exclusion criteria	Population	Results
Author and year Hawton et al 2012 **Quality score** - **Study type** Qualitative **Aim of the study** To evaluate the UK Department of Health's 'Help is at Hand' – a resource for people bereaved by suicide **Location and setting** Questionnaire: Coroners officers in four coroner's jurisdictions in England gave copies of Help is at Hand to those bereaved – information letter, consent form and envelope for returning the questionnaire were included. Recruitment varied over jurisdictions – face-to	**Data collection** The resource was evaluated in three ways: (1) By assessing the access to both the online and hard copies of the resource through tracking statistics, (2) investigating user's views of the resource available from official sources via questionnaires and (3) user's views of the resource through a focus group and telephone interviews *User's views of the resource through questionnaires:* Questionnaires were completed by participants 3 months after being given the resource by the coroner's officers in four jurisdictions in England *Users views of the resource through a focus group and interviews:*	**Inclusion criteria** No clear outline of inclusion criteria **Exclusion criteria** Not reported	**Participant numbers** 35 questionnaires were completed Focus group completed by 6 charity workers Interviews carried out with 5 professionals and 4 service users (those bereaved) **Participant characteristics** *Questionnaires* – Male: 8, female: 27 49% 45-64 years old, 0% <19 years old, 23 bereaved by suicide, 7 by other sudden traumatic deaths, Relationship to deceased: 11 spouse, 10 child, 5 parent Time of loss for those bereaved: 77% in previous 6 months *Focus group and/or interviews-* Professional group: Male: 2, female: 3 (health service workers) Charity worker group: Male: 3, female 3 (bereavement charity workers) Service user group: Male: 1, female 3 (personal bereavement) The 1 hour focus group was only held with the Charity worker group. Feedback from the other groups was	**Access to the resource:** Interest peaked when the new edition of Help is at Hand was published in September 2008: (1,405 downloads and 2,412 sessions) – The number of downloads stabilised to a level similar to that before the launch. Data on location of visitors to the website for a 14 month period showed that of 52220 visits 90% were from UK sites. Other visits were from mainly English speaking countries – USA 19%, Australia 16%, New Zealand (11%) Republic of Ireland (10%) and Canada (5%). The majority of orders for hard copies came from clinical services, substantial numbers were also ordered by primary care and other community services. Within central government agencies the bulk of orders came from the police (n=2,648) and coroners (n=1,218). Some orders came from educational establishments, especially universities (n=335), colleges (n=328) and schools (n=299). The next largest number of orders came from voluntary organisations, including bereavement support groups (n=1,699) and mental health charities (n=2,813). **Evaluation of users views of the resource through questionnaires:** *Rating of the resource* Overall (n=35) – 1 person (3%) claimed the resource was no help, 2 (6%) stated it was slightly helpful, 12 (34%) stated it was helpful and 20 (57%) claimed it was extremely helpful. **Focus group and interview results:** *General* All participants agreed that the material was well written and appropriate, however some aspects were not considered sensitive to the state of mind of people using it (the tear out questionnaire and the pictures)

face meetings, by telephone or by post Focus group/Interviews: All participants were recruited via a modified snowball technique from Derbyshire, UK. Specific locations/settings for focus group/interviews not clear **Source of funding** The study was supported by a grant from the Department of Health. Researchers were also supported by NIHR.	One (1 hour) focus group with charity workers who used Help is at Hand. A series of one-to-one telephone interviews with professionals and service users (those bereaved) who had used Help is at Hand **Method of analysis** Quantitative questionnaires were statistically analysed using SPSS Qualitative data from the focus group and telephone interviews were pooled before analysis and then themes were derived from close scrutiny of the transcripts with simple grounded theory.		gained through one-to-one telephone interviews. **Intervention** Help is at Hand, a hardcopy and online booklet produced as part of England's suicide-prevention strategy. *Help is at Hand* was developed as a resource for people bereaved by suicide as a component of the National Suicide Prevention Strategy for England *Help is at Hand* was launched by the UK Department of Health in September 2006 and updated in September 2008 (accompanied by a second launch). *Help is at Hand* includes the following sections: a) *Practical matters* – arranging the funeral, the inquest, and media reporting; b) *Experiencing bereavement* – emotions that may be experienced and how to cope with them; c) *Bereaved people with particular needs* – e.g., parents, children and young people, lesbian, gay, and bisexual people; d) *How friends and colleagues can help* – advice for friends, employers, work colleagues, teachers, as well as prison, police, health, and social care personnel; e) *Sources of support* – useful organizations, websites, books, and other material.	*Sections* The information given in help is at hand was regarded as extremely helpful both for practical issues and aiding the understanding of emotional responses: "I thought it was an amazingly useful resource, it had lots of practical advice but done in a very sensitive way." – PG1 "…the section that does talk about the feelings that you're going to have, and the loss and the questions you're going to have, is well written. It's written in a way that is easily understandable, it's like someone is talking to you." – PG4 *Availability and Distribution* This was regarded as the main problem by all groups. Professionals and charity workers were concerned that it wasn't reaching all of the people who needed it. Service users said they had received it too late, and that the content regarding practical issues would have been more useful at the early stages of their bereavement. "I found [Help is at hand] a year in to my bereavement… I wish I'd have found it sooner because you do search initially the first few hours, days, you search for answers. And a lot of the [answers] to the practical stuff, you sort of have to stumble across…things like the inquest and the coroners reports…why things take so long, why certain things happen, why they have to happen that way, I think it would have explained that a lot better." (SUG4) It was also suggested that the resource should be used in training people who offer support or information or those bereaved by suicide. It is already used for training in charity worker groups but participants felt it may also benefit those who the bereaved person first has contact with such as paramedics, police, emergency department staff: …the police are often the first ones on the scene, and when they're doing their interviews and that, it might be useful if they could say, 'well, there is actually something that explains it, the process.'"

				Author's conclusion Evaluation of resources for people bereaved by suicide is difficult by worthwhile. Help is at hand was largely week received. The main problem was with regard to individuals gaining access to it, especially at a time when they most needed it. Promotion of resources such as help is at hand need to be prioritised.
Limitations identified by author Findings of the evaluative study are limited by the low number of questionnaire respondents and the small sample of participants of the focus group and interview study- all of whom came from the same geographical area. **Limitations identified by review team** No clear definition of inclusion/exclusion criteria –study was not solely looking at those who were bereaved by suicide who used the resource, as some of the respondents to the questionnaire/ had not been directly bereaved by suicide and were utilising it for professional or other personal reasons. Focus group and interview participants were also a mix of professionals and those bereaved. The resource was developed by members of the evaluation team. Note: this is a national resource which is beyond the scope of the current guideline. However, local distribution and provision/development of local support resources may be informed by this research.				

E.1.2.4 McKinnon and Chonody 2014

Mc Kinnon Janette M, and Jill Chonody (2014) Exploring the formal supports used by people bereaved through suicide: a qualitative study. Social Work in Mental Health 12(3), 231-248

Study details	Research Parameters	Inclusion/ Exclusion criteria	Population	Results
Author name and year McKinnon and Chonody 2014 **Quality score** **+** **Study type** Qualitative (interpretive phenomenology) **Aim of the study**	**Data collection** Recruitment was conducted via peer support groups and advertising via suicide/postvention agencies. Study utilised a phenomenological method to gain an in depth knowledge of the formal supports employed after experiencing the death of a loved one. In-depth interviews lasted around 90 minutes. Data was	**Inclusion criteria** Bereaved by suicide. Lived in either rural or metropolitan areas (with a research aim to include a representative sample by location). Other essential criteria unknown. **Exclusion criteria** Not reported	**Participant numbers** 14 **Participant characteristics** Male: 2, Female: 12 Age: 26-75 *(mean age 49)* At the time of suicide age range: 18-74 Rural: 6, Metropolitan: 8 Relationships of the deceased: 5 brothers, 5 sons, 1 grandfather, 1 husband, 1 father, 1 sister, 1 wife. Bereavement periods: 12 months- 24 years. (mean 5.93 years). **Intervention** The study doesn't focus on a specific intervention, but explores the	**Immediate aftermath** *Nine participants indicated that they had a number of negative experiences with first responders who did not assist them in the immediate context of the suicide*. Specifically, they found that many of these personnel lacked compassion and respect for what they were feeling. They also felt unheard and judged and were not allowed enough time to say goodbye to their loved one: "…they said 'don't hurry, nothing to do here.' I shall always remember that, as the top of his voice…I thought good God. It was really bad…none of them spoke to him [husband]. I mean they didn't speak to me, but I was still in coping mode, [but] he had completely collapsed. I would have thought they would have done a bit more." *Of those how had direct contact with the police after the suicide (n=9) the majority reported support that was kind, compassionate, caring and empathetic:* "…the police were fantastic. They were incredible, very understanding and very supportive, and no pressure…"

To explore formal supports utilised by those bereaved by suicide which aid the grieving process and reduce negative outcomes **Location and setting** Fourteen participants were purposefully sampled. The setting of the interview was not clear. **Source of funding** Not reported	transcribed and then emailed to each participant for further clarity. **Method of analysis** Thematic analysis - common words, phrases and concepts were identified from transcripts which generated codes. Themes were identified by analysing specific similarities and differences.		helpfulness of postvention social supports and support groups. Key objectives: Identify what supports participants used through their bereavement journey Identify which supports were helpful Identify participants unmet support needs Identify how the used supports affected their bereavement journey.	Written materials received during initial police encounters as a means of providing information to assist with the grieving process were viewed as out dated and irrelevant to their needs. One participant was connected to an early support service which she found to be appropriate and useful. **Ongoing support** *Nine participants emphasised how their physical and mental health hindered their ability to search for ongoing support services on their own, i.e they needed the help to be freely available and easily accessible:* "…I think you don't have the energy when you're needing the help the most, you don't have the energy to seek it out…" *This issue was further emphasised in those from rural areas who could not find formal supports in their local area and were expected to travel long distances to gain access to support*. "I don't want to, I'm stressed enough as it is, I don't want to have to drive to the city." **Peer support groups** *Eight participants were adamant that attending a peer support group would not help them better cope with their grief. They indicated that they did not want to listen to others retelling their stories and would find it difficult to share their own:* One who did not attend a peer support group said "…I don't know if I can sit and listen to other peoples' tragic stories; I'll just be heartbroken." *Five participants felt that overall their experiences in a peer support group were unproductive and four never returned. They felt that the groups did not introduce them to new ways of healing* "…I needed to do more than just talk around in circles…I needed to know that there were strategies that you could use; there were ways of healing." Some participants felt that the groups needed a professional presence to give direction to the group "…It would be wonderful with these groups if there was a trained professional there who could, to be the one to sort of direct…they have a professional insight into what could be helpful if need be."

				11 participants identified some aspects of the peer support groups to be helpful. Such as companionship, mutual understanding, comfort, hope and a sense of belonging: "The most helpful thing above all was just being with people who understood…there's just something so comforting about knowing that someone else has the similar burden." **Other professionals** *Three participants were able to locate and connect with local counsellors that gave them helpful strategies, but local doctors were also an important support in their network. Nine participants found their local doctors to be very supportive:* "…Our GP has counselled us. I personally found his chat much more realistic, and helpful than other counselling." *One participant had opposing ideas:* "…She wasn't even very…very compassionate actually…was quite a clinical approach." **Author's conclusion** Our findings indicate that formal supports were inconsistent with some participants receiving support that helped ease their grief, while others experienced inadequate assistance, which contributed to their grief. Empathy, compassion, and non-judgemental communication in the immediate after- math of a suicide create an atmosphere for those bereaved to feel supported. Ongoing supports that normalize the experience and offer healing strategies can facilitate the grief journey.
Limitations identified by author Only represents those who sought help from one support service that they were currently using, or from which they had once received support. Variances in the sociodemographic characteristics of participants may have led to different narratives. **Limitations identified by review team** No definition of inclusion of exclusion criteria – no clear identification of study setting or location The length of time since bereavement varied considerably, from 1 to 24 years				

E.1.2.5 Peters et al 2015

Peters Kath, Staines Alan, Cunningham Colleen, and Ramjan Lucie (2015) The Lifekeeper Memory Quilt: evaluation of a suicide postvention program. Death studies 39(6), 353-9				
Study details	**Research Parameters**	**Inclusion/ Exclusion criteria**	**Population**	**Results**

Author name and year Peters et al 2015 **Quality score** - **Study type** Qualitative **Aim of the study** To evaluate satisfaction with the Quilt project – a national Lifekeeper Memory Quilt initiative launched by the Salvation Army, Hope for Life Suicide prevention and Bereavement Support **Location and setting** Interviews were conducted over the telephone averaging 30 minutes in duration. Specific locations/settings for interviews not clear Memory Quilt project implemented by the Salvation Army in Australia in 2008	**Data collection** A survey (developed by drawing on the Help Is at Hand Questionnaire) was conducted by 82 bereaved subjects. The survey included 16 items measured on a 5 point scale. Items included whether the Quilt assisted with their bereavement journey, dialogue with their family about the loss, remembering loved ones, and promoting public awareness. Participants were asked to include contact details if they wished to participate in an interview Semi-structured open – ended interviews averaging 30 minute durations. Main interview question centred on participants experiences of participating in the Quilt project. Further prompt questions were used to explore their reasons for participating in the Quilt project, what they found helpful/difficult about the project, whether the project had impacted on their grief journey, whether the project assisted in communication with	**Inclusion criteria** No clear outline of inclusion criteria **Exclusion criteria** Not reported	**Participant numbers** Survey: 82 Interviews: 30 **Participant characteristics** *Survey* Women; 75, 75% aged over 45 years 66% lost a child to suicide, 13% a sibling, 12% a spouse/partner, 5% a parent Age of deceased: 13-76 (M=32.24, SD=14.45) *Interviews* Bereavement period – 8 months- 15 years (M=5.96, SD=3.74) **Intervention** The Lifekeeper Memory Quilt project invited families bereaved by suicide to submit via email or post a photographic tribute and a 25-word narrative about their loved one who had died by suicide. A Salvation Army volunteer created the memorial quilts for individuals. In addition, Hope for Life developed five state-based quilts that are available for community suicide prevention and postvention awareness events. The Lifekeeper Memory Quilt has 2 objectives: To provide a sensitive and fitting memorial to enable to enable bereaved families to celebrate the lives of their loved ones	**Survey:** About 80% participated in the project over a year after their loss while the remaining respondents enrolled in the project between 1-12 months after. Over half reported that a year post bereavement was the best time to be participating in the quilt project Overall, approximately 92% of participants who completed the survey rated the Quilt project to be helpful or extremely useful **Interviews:** Analysis of the qualitative data revealed the following four themes: healing, creative opportunity for dialogue, reclaiming the real person, and raising public awareness. These themes illuminated how the Quilt assisted in their bereavement and provided insight in to why they engaged in the Quilt project. *Healing* Participants conveyed that the Quilt facilitated their grief journey (“I think it’s given me my power back. Power to move on, power to be able to get on with my life”). They also appreciated the support they received (“I found the Quilt project as healing and very supportive”) Another said that the Quilt fostered personal resilience in providing a positive outcome for their grief: ‘I feel better about myself that I actually did something. I’m a big believer in that, actions do speak louder than words, and I couldn’t do much and I felt really, really helpless at the time.” *Creating opportunity for dialogue* Participants conveyed that they had substantial difficulty in talking about their loved one and this reluctance limited them in seeking and receiving appropriate support in their bereavement. By its very design , the Quilt project provided a space free from stigma, judgment, and negative social reactions that encouraged people to discuss their loss from suicide “[The Quilt] has been helpful because I’ve talked to people, I’ve shown them the picture of the Quilt to those that knew my [loved one]. I think it’s made people around me more aware about what’s going on” “It gave a chance to talk to the kids a little bit even though they’re not very talkative and open about it. To have more of a positive thing that they can contribute to”

Source of funding The Salvation Army	members of the community, and how they would like to see the Quilt used. **Method of analysis** Data was audio recorded, transcribed verbatim and thematically analysed by two of the authors independently		To raise awareness of the impact of suicide with the hope that this prevents further suicide	The Quilt made participants feel connected with others bereaved by suicide. They felt a sense of community with other participants of the Quilt project and described a sense of mutual understanding with others who had lost loved ones to suicide "There was a connection, there was somehow a link. I felt safe in doing that process" "Unless you've also been bereaved by suicide, you don't really get it. There's always empathy but even other people bereaved by other sudden deaths, they don't quite get it" "I know that I'm not the only one out there now, there's lots of people out there that are dealing with the same thing. I feel for everybody involved, I really do" Raising public awareness *Why they participated in the project:* Participants hoped that their contribution to the Quilt would create public and private dialogue to promote suicide prevention "So this is an opportunity to be able to try and inform the public and the need to talk about suicide and for people who may be vulnerable and maybe hopefully then prevent somebody from taking their own life". "Knowing that it was helping- that somehow it was a contribution for other people as well as getting things out there in the open. It's not shameful or anything like that. Its just – they're just at the end of their tether basically and people have to understand that" All participants hoped that the Quilt could be used in public forums to educate communities and promote discussions around suicide "I think it's a very positive thing and I hope that it will be used as a teaching tool…Seeing those people happy, smiling faces of the people, on that Quilt, they were cut down before they even reached their potential. They were stripped of a life and their families bear that scar forever" **Author's conclusion** Results indicated that the Quilt was helpful in assisting participants in their bereavement. The Quilt project gave participants an opportunity to reflect on the life of their loved one and provided a space for them to grieve without fear of negative social reactions.
Limitations identified by author Sample predominantly made up of women – findings may not be applicable in informing bereavement support for men				

Subjects not representative of all people bereaved by suicide- over 75% over the age of 45 years People who participate in Quilt projects are not representative of all suicide survivors; those that did not respond may have a different perspective on the project **Limitations identified by review team** No clear definition of inclusion/exclusion criteria No detailed description of specific participant characteristics for those who participated in the interviews (although we know they were recruited from the survey sample)

E.1.2.6 Supiano K P 2012

Supiano Katherine P (2012) Sense-Making in Suicide Survivorship: A Qualitative Study of the Effect of Grief Support Group Participation. Journal of Loss & Trauma 17(6), 489-507

Study details	Research Parameters	Inclusion/ Exclusion criteria	Population	Results
Author name and year Supiano 2012 **Quality score** **+** **Study type** Qualitative **Aim of the study** To explore the impact of participation in suicide loss grief support groups on changes in self-reported symptoms of grief distress **Location and setting** USA.	**Data collection** Study was conducted as a phenomenological inquiry of suicide survivorship. Open ended semi-structured, in depth dialogues of 90-180minutes. Interview sessions were audio recorded and professionally transcribed. **Method of analysis** Systematic steps of grounded theory guided the analysis After transcription of the tapes, mind-mapping techniques identified concepts. Common themes were then identified and results presented according to these themes.	**Inclusion criteria** Suicide survivors. Participants were at least 1 year post loss and had completed the group at least 6 months prior to enrolment. At least one symptom of complicated grief at group onset (yearning, difficulty accepting reality, distressing thoughts, alienation from social relations) **Exclusion criteria** not reported	**Participant numbers** 9 **Participant characteristics** Male: 4, Female: 5 8 survived death of an adult child, 1 survived spousal death. **Intervention** Suicide loss grief support groups. Support groups were clinician facilitated 8 week closed groups for community residents offered in a University setting.	**Healing in the grief support group** The grief support groups enabled those grieving to gain support from others having similar loss, to reduce isolation, to challenge assumption about grief and loss and to allow the support through the sharing of experiences. *One facilitator encouraged journaling as a healing tool:* "To write, to vent, it helped. But to hear what [group members] said [about what she'd written] helped most" *The experiences of other group members helped in recognising individual growth*: "It has been the longest time [since the suicide] for me. And when I saw the [members] were going through, and remembered I had [felt that], I thought, I must be making progress" *Deeper understanding of the nature of suicide in the context of mutual support:* "And when [facilitator] said 'look around the room and feel tangible pain here/. If you can imagine…your loved ones as feeling hundreds of times worse than this, then maybe we can begin to understand more about their experiences as they contemplated ending their lives'. Well, I bega**n** to open myself to other explanations"

Nine participants from a suicide support group were purposefully sampled. **Source of funding** Not reported				**Author's conclusion** Suicide is a catastrophic event that inherently has the power to devastate many lives. Those closest to the suicide completer may be more at risk for the worst grief outcomes. The capacity of suicide survivors to grieve deeply, fully, and with resolution is mediated by their ability to make sense of the death in a way that actualizes personal and spiritual growth and achieves a personal identity of self-acceptance. This meaning-making is facilitated by supportive interpersonal relationships, among which grief support groups may be extremely valuable.
Limitations identified by author The size and composition of the study sample limits the transferability of findings. Only one example of loss of a spouse to suicide. Represents only those who sought help from a suicide support group. **Limitations identified by review team** No clear definition of exclusion criteria. There is limited information about the recruitment process and participant demographics. There is limited information about the grief support group and the role of the facilitator. Note: The aims of the study were broader than gathering views on the intervention, therefore not all the study data were relevant to the scope of the current review.				

E.1.2.7 Trimble et al 2012

Trimble Timothy, Hannigan Barbara, and Gaffney Megan (2012) Suicide posttension; Coping, support and transformation. The Irish Journal of Psychology 33(2-3), 115-121				
Study details	**Research Parameters**	**Inclusion/ Exclusion criteria**	**Population**	**Results**
Author name and year Trimble et al 2012 **Quality score** - **Study type** Qualitative	**Data collection** Semi-structured qualitative questionnaire – questions guided subjects to report on experiences accessing social, community and professional support networks.	**Inclusion criteria** The loss of partner or close family member by suicide a minimum of one year previously, which occurred in the Republic of Ireland. **Exclusion criteria**	**Participant numbers** 10 **Participant characteristics** Male: 5, Female: 5 Participants age ranged from 18 – 60 + with a mean age of 38.	**Thematic domains from the analysis:** <u>Experiences in the community</u> *Initial support* – many participants mentioned receiving practical, emotional and financial support from family, neighbours, friends, teachers, clergy *Gradual detachment* – lack of openness about deceased person and cause of death as time went on, distancing and isolation

Aim of the study To explore the postvention experiences of those bereaved by the suicide of a close family member **Location and setting** Semi-structured qualitative Q administered to subjects in Dublin, Ireland. **Source of funding** Not reported	Questionnaire was piloted before-hand and revised. **Method of analysis** Descriptive and thematic analysis- Data collected are assigned in to domains which represent a conceptual framework, the meaning units were delineated, categories were generated through comparisons and main findings were narrated.	Not reported	Length of time since bereavement ranged from 1 – 24 years. **Intervention** The study doesn't focus on a specific intervention, but explores the helpfulness of postvention social supports and support groups. Participants had accessed a range of professional and community support services including support groups, counselling, psychotherapy, group therapy, GPs/MDs, psychiatrists, family support services, and pharmacological treatment.	"Immediately I got good support from the community as I lived in a small town…but soon after the death people drifted away and didn't know what to say to me anymore" "The community showed great care in the beginning and then detached themselves as they did not want to mention (relatives) name" <u>Support groups</u> Most participants described experiences in support groups, as opposed to other professional services. Participants described being able to express feelings and feel accepted, to share their own stories and to hear the stories of others '. . . met people who I could speak all personal feelings to and they did not think I was going mad'(Jane). The sharing element seemed very important for participants, and helped individuals to contextualise and normalise their feelings. '. . . listening to other people's experiences helped me understand my own feelings better' (Sarah). <u>Experiences with professional support services</u> Themes arising from analysis: Lack of understanding – feeling uncomfortable, not understood, professional services did not know how to help. Need for better access to services – more availability, promotion, expansion, low cost, more specialised services Some suggested proactive support networks such as: "One professional assigned to liaise with the bereaved family to offer support". *Minimising stigma* – increasing awareness, providing information, breaking silence, particularly with older generations and schools. *Knowledge of the traumatic impact* – desire for professionals to know and recognise pain, strong feelings, expression and acceptance difficult to cope with. Subjectivity – uniqueness of context, individual, grief, coping and needs *Do not think the professional will understand unless the professional has personal experience* *Access and Cost*

				Not ready to face issue **Author's conclusion** The study finds that trauma focused interventions may benefit survivors who also report the desire for greater access to networks and the further development of proactive networks of support. It is clear from the foregoing that postvention supports, using protocols developed from key research, can go some way in reducing the impact of suicide.
Limitations identified by author The sample size limits the transferability of findings. Represents only those who sought help from bereavement support services. Experience of those bereaved by suicide who received no intervention or support from local mental health services is needed **Limitations identified by review team** No clear definition of exclusion criteria, only a small amount of qualitative data reported. Limited information about the data collection process and the role and nature of the questionnaire. The length of time since bereavement varied considerably, from 1 to 24 years. It was not clear from the analysis how different participants' experiences varied.				

E12 Economic evidence tables

E.2.1 Comans et al 2013

Bibliographic details	Intervention and Comparison	Data sources	Time horizon & Method	Results	Authors' discussion
Full citation Comans T et al 2013 **Ref Id** **Economic study type** Cost effectiveness	**Study dates** Published 2013 **Intervention** StandBy response Service, provides face-to-face	**Source of effectiveness data** Quality of life was measured using the EQ-5D, a standardised instrument covering 5 domains, which measures generic health-related quality of life. **Source of cost data**	**Time horizon and discount rate** A 1-year analysis was used for the base case. This was extrapolated to 5 years in a sensitivity analysis. People would move between health	**Cost per patient per alternative** • Total cost of the StandBy group to be AUS $13,255 and of the control group to be AUS $14,058. Costs saved: • A cost saving from delivering the StandBy Response Service to bereaved people of AUS$803.	**Limitations** 1. The cohort was self-selected in both arms, and there may be systematic differences between study participants and all those affected by suicide bereavement. 2. Differences between the StandBy group and

Bibliographic details	Intervention and Comparison	Data sources	Time horizon & Method	Results	Authors' discussion
Country(ies) where the study was done Australia **Perspective & Cost Year** Social perspective. **Source of funding** Not reported	outreach and telephone supported offered by a professional crisis response team and referral to other community services matched to need. **Comparison(s)** Usual care	Health and work performance were measured using World Health Organisation Health and Work Performance Questionnaire. The HPQ is a self-report instrument designed to estimate the workplace costs of health problems in terms of reduced job performance, absence due to illness, and work-related accidents-injuries, and has been used previously in Australia to measure the effects of mental health on absenteeism and presenteeism. **Intervention costs** The costs of the intervention were estimated April 2010 to March 2011 using a top-down approach from budget information provided by the sites that StandBy operates in. Annual operating costs include both costs associated with providing interventions and those associated with community	states once a year. Extrapolations of costs and outcomes beyond 1 year were discounted at 5% annually. A half-cycle correction was applied to costs and outcomes. **Method of eliciting health valuations (if applicable)** NA **Modelling approach** Markov model.	**Effectiveness per patient per alternative** QALYs gained • StandBy service: 0.79. • Usual care: 0.77. **Incremental cost-effectiveness** <u>Mean ICER</u> • Intervention dominates comparison, no ICER is presented **Uncertainty** One-way and sensitivity analyses carried out. If the upper range of intervention costs are used instead of the average costs with the cost of the StandBy response set to the upper limit of AUS$3,283, the ICER is no longer cost saving. However the programme shows an ICER of under AUS$7,000 per QALY, which is considerably less than the generally accepted thresholds for cost-effectiveness for government subsidy in Australia. The major driver of change in the model is presenteeism owing to the large confidence intervals and uncertainty associated with this variable. Therefore, a further analysis was conducted where presenteeism was excluded from the analysis. This analysis demonstrated that the ICER, while no longer cost saving, remains acceptable at AUS$15,938 per QALY. Probabilistic sensitivity analyses	the control group. The control group were more likely to have been friends with the decreased compared to the StandBy group. Control group also had on average a longer period of bereavement. **Conclusion(s)** The standby Response service has significant and positive benefits for both people bereaved by suicide and the communities in which it is established.

Bibliographic details	Intervention and Comparison	Data sources	Time horizon & Method	Results	Authors' discussion
		development, engagement, and training. **Health-care costs** Participants were asked to enter the times they had seen various health professionals including GPs, specialists, allied health and psychological and psychiatry service over the past 4 weeks. The January 2011 Medicare Benefits Schedule was used to estimate the cost of these consultations to construct total health care costs. **Other data sources e.g. transition probabilities** Initial state probabilities were 0 for complicated grief and death. The resilient state proportion was set at the proportion of people who had been recently bereaved (<1 month) and had scored less than 5 on the K6 and the grief state was 1-resilient. Transition probabilities were estimated using the		In order to assess the likelihood or probability of the model being cost-saving, a second-order probabilistic sensitivity analysis was conducted. The analysis samples random values from the distributions around each of the variables, this more accurately representing what may happen to a cohort of people experiencing suicide bereavement in real life. It shows 81% of all points are cost-effective, indicating a high probability that the SandBy response service intervention is cost-effective.	

Bibliographic details	Intervention and Comparison	Data sources	Time horizon & Method	Results	Authors' discussion
		Bonnano grief model in which after each year, approximately one third of people remain in a grief state. 20% of people move to a complicated grief state, and the remainder move to a resilient state.			

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1 Appendix F:GRADE tables

F21 Suicide

Quality assessment							Number of event/participants		Effect		Committee confidence
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Before	After	Relative risk ratio (RR) (95% CI)	Absolute/mean differences	
Number of suicide events following intervention (debriefing after 2 days of a suicide case)											
1 (Poijula et al 2001)	Quasi-experimental	Serious[1]	Not applicable	No serious[2]	Serious[3]	none	3/270 (1.1%)	0/270	0.14 (0.01, 2.75)	10 more per 1000	LOW

1. Characteristics of participants and their exposure to the intervention were not reported in the study.
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of RR around point estimate crosses line of no effect which the committee agreed should be the minimal important difference

F32 Suicidal ideation and suicidality

Quality assessment							Number of event/participants/mean score		Effect		Committee confidence
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	intervention	Control	Relative risk ratio (RR) (95% CI)	Absolute/mean differences	
Suicide ideation											
1 (De Groot et al 2007)	RCT	Serious[1]	Not applicable (NA)	No serious[2]	Serious[3]	none	12/68 (17.6%)	9/54 (16.7%)	1.06	10 more per 1000	LOW

									(0.48, 2.33)	(87 fewer to 222 more)	
1 (De Groot et al 2010)	RCT	Serious[1]	NA	No serious[2]	Serious[3]	Subjects with suicidality scores lower than 8 were indicated as non- suicide ideators.	5/52 (10%)	2/43 (5%)	2.07 (0.42, 10.13)	50 more per 1000	LOW
1 (De Groot et al 2010)	RCT	Serious[1]	NA	No serious[2]	Serious[3]	Subjects with suicidality scores higher than 8 were indicated as non- suicide ideators.	7/16 (44%)	7/11 (64%)	0.69 (0.34, 1.40)	200 fewer per 1000	LOW
Suicidality (high risk for suicidality, suicidal behaviour questionnaire score >7)											
1 (Visser et al 2014)	Observational	Serious[4]	NA	No serious[2]	No serious[5]	Retrospective study	43/90 (48.0%)	226/353 (64.0%)	0.75 (0.59, 0.94)	160 fewer per 1000	VERY LOW

1. Selection of participants (92 out of 236 refused to participate)
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of RR around point estimate crosses line of no effect which the committee agreed should be the minimal important difference
4. Selection bias (systematic difference between those who chose to be included and those who did not)
5. 95% CI of RR around point estimate not crosses line of no effect which the committee agreed should be the minimal important difference

F13 Service uptake

Quality assessment	Mean score (at the end of follow-up)	Effect	Committee confidence

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	intervention	Control	Relative risk ratio (RR) (95% CI)	Absolute/mean differences (95%CI)	
Writing projects (non-routine health centre visits)											
1 (Kovac and Range 2000)	Experimental	Serious[1]	NA	No serious[2]	Serious[3]	80% of participants were women	0.33 (0.62)	1.54 (2.88)	-	-1.21 (-2.72, 0.30)	VERY LOW
StandBy service (emergency care)											
1 (Visser et al 2014)	Observational	Serious[4]	NA	No serious[2]	Serious[3]	Retrospective study	0.21 (0.5)	0.27 (0.6)	-	-0.06 (-0.18, 0.06)	VERY LOW

1. Selection bias (only those dealt relative well with their loss agreed to participate)
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of MD around point estimate crosses line of no effect which the committee agreed should be the minimal important difference
4. Selection bias (systematic difference between those who chose to be included and those who did not)

F14 Depression

Quality assessment							Mean score (at the end of follow-up)		Effect		Committee confidence
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	intervention	Control	Relative risk ratio (RR) (95% CI)	Absolute/mean differences (95%CI)	
CBT-centre for epidemiological studies depression scale (CESD)											
1 (De Groot et al 2007)	RCT	Serious[1]	NA	No serious[2]	Serious[3]	none	14.2 (11.4)	13.3 (12.6)	-	0.90 (-3.42, 5.22)	LOW
1 (De Groot et al 2010)	RCT	Serious[1]	NA	No serious[2]	Serious[3]	Subjects with suicidality	11.2 (10.5)	10.0 (9.2)	-	1.20 (-2.76,5.16)	LOW

						scores lower than 8 were indicated as non- suicide ideators.					
1 (De Groot et al 2010)	RCT	Serious[1]	NA	No serious[2]	Serious[3]	Subjects with suicidality scores higher than 8 were indicated as non- suicide ideators.	23.8 (8.8)	26.2 (16.1)	-	-2.40 (-12.85, 8.05)	LOW
CBT-Beck depression inventory											
1 (Wittouck et al 2014)	RCT	Serious[4]	NA	No serious[2]	Serious[3]	none	15.4 (10.8)	19.0 (10.8)	-	-3.60 (-8.69, 1.49)	LOW
Bereavement group intervention (children depression inventory)											
1 (Pfeffer et al 2002)	Experimental	Serious[5]	NA	No serious[2]	No serious[6]	A small number of participants (n=9) retained in no intervention group	44.1 (8.7)	53.9 (7.8)	-	-9.8 (-16.01, -3.59)	VERY LOW

1. Selection of participants (92 out of 236 refused to participate)
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of MD around point estimate cross line of no effect which the committee agreed should be the minimal important difference
4. No true control (as control groups received 2 home visits at baseline and 8 months later)
5. Allocation bias and differences in dropout between 2 groups
6. 95% CI of MD around point estimate not cross line of no effect which the committee agreed should be the minimal important difference

1

Quality assessment	Mean scores	Effect	Committee confidence

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Before	After	Relative risk ratio (RR) (95% CI)	Absolute/mean differences (95%CI)	
Group intervention-Beck depression											
1 (Constanino 2001)	Experimental	Serious[1]	Not applicable	No serious[2]	No serious[3]	2 group interventions	18.66 (11.24)	7.70 (5.18)	-	-10.96 (-14.50, -7.42)	VERY LOW

1. The self-selection of the participants; reporting bias (self-reported)
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of MD around point estimate not cross line of no effect which the committee agreed should be the minimal important difference

F15 Traumatic grief

Quality assessment							Mean score (at the end of follow-up)		Effect		Committee confidence
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**intervention**	**Control**	**Relative risk ratio (RR) (95% CI)**	**Absolute/mean differences (95%CI)**	
CBT-Traumatic grief score (The Traumatic Grief Evaluation of Response to Loss)											
1 (De Groot et al 2007)	RCT	Serious[1]	NA	No serious[2]	Serious[3]	none	69.9 (23.1)	66.5 (23.8)	-	3.40 (-4.99, 11.79)	LOW
1 (De Groot et al 2010)	RCT	Serious[1]	NA	No serious[2]	Serious[3]	Subjects with suicidality scores lower than 8 were indicated as non- suicide ideators.	65.7 (22.2)	60.0 (19.0)	-	5.7 (-2.61, 14.01)	LOW

1 (De Groot et al 2010)	RCT	Serious[1]	NA	No serious[2]	Serious[3]	Subjects with suicidality scores higher than 8 were indicated as non- suicide ideators.	84.0 (21.1)	91.9 (24.5)	-	-7.90 (-25.69,9.89)	LOW
CBT-The Inventory of traumatic grief (ITG)											
1 (Wittouck et al 2014)	RCT	Serious[4]	NA	No serious[2]	Serious[3]	none	72.1 (22.7)	74.0 (24.6)	-	-1.90 (-13.11, 9.31)	LOW
Writing projects (Grief Experience Questionnarie)											
1 (Kovac and Range 2000)	Experimental	Serious[5]	NA	No serious[2]	Serious[3]	80% of participants were women	90.29 (25.56)	106.14 (27.54)	-	-15.85 (-34.86, 3.16)	VERY LOW

1. Selection of participants (92 out of 236 refused to participate)
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of MD around point estimate cross line of no effect which the committee agreed should be the minimal important difference
4. No true control (as control groups received 2 home visits at baseline and 8 months later)
5. Selection bias (only those dealt relative well with their loss agreed to participate)

F16 Anxiety

Quality assessment							Mean score (at the end of follow-up)		Effect		Committee confidence
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**intervention**	**Control**	**Relative risk ratio (RR) (95% CI)**	**Absolute/mean differences (95%CI)**	
Bereavement group intervention (children manifest anxiety scale)											
1 (Pfeffer et al 2002)	Experimental	Serious[1]	NA	No serious[2]	No serious[3]	A small number of participants	39.6 (10.6)	56.5 (10.2)	-	-16.90	VERY LOW

						(n=9) retained in no intervention group				(-25.90, -7.90)	

1. Allocation bias and differences in dropout between 2 groups
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of MD around point estimate not cross line of no effect which the committee agreed should be the minimal important difference

F17 Stress

Quality assessment							Mean score (at the end of follow-up)		Effect		Committee confidence
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**intervention**	**Control**	**Relative risk ratio (RR) (95% CI)**	**Absolute/mean differences (95%CI)**	
Writing projects-impact of event scale											
1 (Kovac and Range 2000)	Experimental	Serious[1]	NA	No serious[2]	Serious[3]	80% of participants were women	19.87 (19.66)	20.93 (15.45)	-	-1.06 (-13.71, 11.59)	VERY LOW
Bereavement group intervention-posttraumatic stress											
1 (Pfeffer et al 2002)	Experimental	Serious[4]	NA	No serious[2]	Serious[3]	A small number of participants (n=9) retained in no intervention group	19.6 (11.4)	17.8 (9.1)	-	1.80 (-5.67, 9.27)	VERY LOW

1. Selection bias (only those who dealt relatively well with their loss agreed to participate
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of MD around point estimate cross line of no effect which the committee agreed should be the minimal important difference
4. Allocation bias and differences in dropout between 2 groups
5. 95% CI of MD around point estimate not cross line of no effect which the committee agreed should be the minimal important difference

F18 Psychological distress

Quality assessment							Mean score (at the end of follow-up)		Effect		Committee confidence
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	intervention	Control	Relative risk ratio (RR) (95% CI)	Absolute/mean differences (95%CI)	
StandBy service (Kessler psychological distress scale version K6)											
1 (Visser et al 2014)	Observational	Serious[1]	NA	No serious[2]	Serious[3]	Retrospective study	8.99 (6.62)	9.78 (6.37)	-	-0.79 (-2.34, 0.76)	VERY LOW

1. Selection bias (systematic difference between those who chose to be included and those who did not)
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of RR or MD around point estimate crosses line of no effect which the committee agreed should be the minimal important difference

F29 Quality of life

Quality assessment							Mean score (at the end of follow-up)		Effect		Committee confidence
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	intervention	Control	Relative risk ratio (RR) (95% CI)	Absolute/mean differences (95%CI)	
StandBy service (health related quality of life, EQ-5D)											
1 (Visser et al 2014)	Observational	Serious[4]	NA	No serious[2]	Serious[3]	Retrospective study	0.71 (0.24)	0.69 (0.24)	-	0.02 (-0.04, 0.08)	VERY LOW
StandBy service (general quality of life, ICECAP)											
1 (Visser et al 2014)	Observational	Serious[4]	NA	No serious[2]	Serious[3]	Retrospective study	0.76 (0.17)	0.74 (0.20)	-	0.02 (-0.02, 0.06)	VERY LOW

1. Selection bias (systematic difference between those who chose to be included and those who did not)
2. Interventions, population and outcomes are in line with review protocol
3. 95% CI of RR or MD around point estimate crosses line of no effect which the committee agreed should be the minimal important difference

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Appendix G: CERQual table

Review finding	Contributing studies	Overall confidence in the evidence	Explanation of confidence in the evidence assessment
Healing effect			
Participants described bereavement support groups helped them with their bereavement. Although the groups were often positively received, not everyone liked the groups (Supiano 2012, Trimble et al 2012; Peters et al 2015). Some participants from one study identified that they did not want to share their or hear other people's stories (McKinnon and Chonody 2014).	Supiano 2012, Trimble et al 2012, McKinnon and Chonody 2014; Peters et al 2015	Moderate confidence	This review finding is rated as moderate, because there are moderate concerns regarding relevance of data[1], minor concerns regarding with coherence[2] and methodological limitations due to sampling[3], and poor reporting of methods[4]. There were no serious problems with adequate data from 4 studies.
Personal impact/growth			
Studies identified evidence that bereavement support groups helped people bereaved by suicide improve their personal awareness of the impact of suicide on survivors (Supiano 2012, Trimble et al 2012) and enabled them to combat stigma surrounding suicide (Trimble et al 2012; Peters et al 2015). The group also provided a sense of normalisation through a shared experience (Supiano 2012; McKinnon and Chonody 2014).	Supiano 2012, Trimble et al 2012, McKinnon and Chonody 2014; Peters et al 2015	Moderate confidence	This review finding is rated as moderate, because there are moderate concerns regarding relevance of data[1], minor concerns regarding with methodological limitations due to sampling[3], and poor reporting of methods[4]. There were no serious problems with coherence and adequate data from 4 studies.
Timing of support services			
GPs acknowledged their responsibility to be proactive and to instigate contact with bereaved patients (Foggin et al 2016). Suicide survivors noted that the community outreach (LOSS) team enabled them to connect to	Trimble et al 2012; Hawton et al 2012; Aguirre and Frank 2014;Foggin et al 2016	Moderate confidence	This review finding is rated as moderate, because there are minor concerns regarding with adequacy of data[5] and methodological limitations due to sampling[6] and poor reported of method, analysis[7]. Very minor

Review finding	Contributing studies	Overall confidence in the evidence	Explanation of confidence in the evidence assessment
resources quickly in these situations (Aguirre and Terry 2014) but the service/resource was not reaching all of the people at the early stages of their bereavement (Hawton et al 2012). In addition to initial support, follow-up support was also considered necessary for bereaved people as they could think more clearly sometime after the suicide (Aguirre and Terry 2014). Experience of people who had received initial support described a feeling of isolation and a disconnection ('gradual detachment') as time went on (Trimble et al 2012).			concerns regarding coherence and relevance (2 UK studies).
Resources			
GPs felt they could offer little to bereaved patients, often relying on third-sector services, and GPs themselves described a lack of personal preparedness to help bereaved patients (Foggin et al 2016). People bereaved by suicide felt peer support groups could assist with their grief but these groups needed professional input to keep up-to-date with new coping strategies, and they felt identifying support from someone who was experienced in grief and loss was a challenge (McKinnon and Chonody 2014).	McKinnon and Chonody 2014; Foggin et al 2016	Moderate confidence	This review finding is rated as moderate, because there are minor concerns regarding with methodological limitations due to sampling[3,6], and there are also minor concerns regarding adequate of data[8], coherence and relevance (1 UK study).

1. All studies were not UK studies.
2. 1 study provided a different conclusion to the other 3 studies
3. Supiano et al 2012 only had 9 participants who were drawn from clinician-facilitated groups for community residents; McKinnor et al 2014 interviewed participants who were self-selected from one support service.

Review finding	Contributing studies	Overall confidence in the evidence	Explanation of confidence in the evidence assessment
4. Trimble et al 2012, Peters et al 2015 5. All studies based on interview data from small number of participants. 6. Foggin et al 2016 recruited and interviews GPs who had a prior interest in suicide and mental health. Evaluation of Help is at hand was based on 35 completed questionnaire, 1 focus group and 9 telephone interviews. 7. Trimble et al 2012, Augirre and Terry 2014 8. Two studies contributed to the finding.			

Appendix G: Expert testimony

Section A:	
Name:	Sharon McDonnell
Role:	Academic
Institution/Organisation **University of Manchester and Suicide Bereavement UK** **Contact information:**	UK suicide bereavement 6-8 Taper street, Ramsbotton, Lancashire, BL0 9EX
Guideline title:	Preventing suicide in community and custodial settings
Guideline Committee:	PHAC A
Subject of expert testimony:	[Suicide bereavement]
Evidence gaps or uncertainties:	Bereavement support services (postvention)

Section B:
Summary testimony:
Suicide Bereavement in Primary Care Five thousand, six hundred and eighty eight suicides were registered in the UK in 2016 (ONS, 2017), many thousands more are bereaved or affected by suicide. Those bereaved are a vulnerable, isolated, stigmatised, often unsupported high-risk population who are significantly at risk of dying by suicide themselves (DH, 2017, Pitman et al 2014). There is a huge discrepancy, within the literature on the numbers affected by each suicide. Until recently, it was estimated between 6-60 people (Berman, 2011). However, as our knowledge in this newly developing field advances, so does our understanding of the number of people affected by such deaths. The most recent study states that a 135

people are affected by each suicide (Cerel, Brown, Maple, Bush, vane Venne, Moore and Flaherty, (In progress).

Researchers argue that managing risk and identifying needs of those bereaved by suicide in the community, should not just be restricted to the immediate family (Maple, Cerel et al.,2017) as there are many individuals, profoundly affected by suicide, who fall outside the realm of immediate family or those recognised as traditional grievers (Cerel, McIntosh et al., 2014).

Cerel, McIntosh et al., (2014) 'Continuum of Survivorship' model demonstrates this point and highlights who might be impacted by a suicide. The model shows how those bereaved or affected by such deaths, can be placed under one of the following four categories, across the continuum: i) suicide bereaved, long term (e.g. family members, close friends, clinicians etc; ii) suicide bereaved, short term (e.g. family members, close work colleagues etc); iii) suicide affected (e.g. friends, those who find the deceased, first responders neighbours etc) and iv) suicide exposed (e.g. fans of celebrities, schools, workplaces, friends etc). Cerel, McIntosh et al., (2014) referred to the 'Continuum of Survivorship' as 'suicide exposure.'

Considering the number of people bereaved by suicide and the health risks associated with this type of loss. It is highly likely that the majority of GPs will come into contact with patients bereaved by suicide.

However, our current understanding of how to care for those bereaved or affected by suicide is far behind our understanding of other 'at risk groups and our knowledge about how, when and with whom to intervene after a suicide is extremely limited in the UK. This is despite evidence stating that those bereaved by suicide are significantly at risk of dying by suicide (DH, 2017, Pitman, Osborn et al 2014) and health professionals are often anxious and uncertain how to respond to them.

Primary Care is no exception, many GPs report feeling anxious and uncertain how to respond to patients bereaved by suicide, due to lack of training and the fact there is no national NHS specialist support for people bereaved by suicide (Foggin, McDonnell et al, 2016; McDonnell, 2006). GPs struggle to refer the bereaved to NHS services, feel unsupported by secondary care even though the difficulties their patients face are often within the remit of psychiatric services (Foggin, McDonnell et al., 2016; McDonnell, 2006;

Pitman, et al 2014). Consequently, GPs are often left with no option but to refer them to third sector organisations. However, they do not have access to an up-to-date database of the relevant services provided locally and nationally. Identifying, streamlining and coordinating good-quality services is vital (Foggin, McDonnell et al., 2016) as well as providing GPs with an up-to-date directory of services available to those bereaved by suicide. The Support After Suicide Partnership (SASP) have developed a website, which signposts those bereaved by suicide to key resources. It also has a facility, whereby the bereaved can enter their postcode to identify local support (http://supportaftersuicide.org.uk/).

Families described how their difficulties accessing NHS support, intensified their sense of helplessness and hopelessness, which are recognised as key risk factors associated with suicide (McDonnell, et al 2015). Evidence suggests, those bereaved by suicide who have a negative experience with health professionals, around the time of the death or when seeking support for themselves or their family, result in some disengaging from NHS services at a time of high risk and intense need (McDonnell, 2006). It is therefore essential that clinicians are proactive and try to ensure families remain engaged with NHS services when a 'significant other' dies by suicide (McDonnell, 2006).

The Suicide Prevention Strategy states that GPs must be aware of the vulnerability of family members bereaved by suicide and that the provision of effective and timely information and support is essential (DH, 2017). However, if this is to be achieved, it is vital that we increase GPs knowledge, confidence, skills and provide a framework and service-response plan for immediate and ongoing support for those bereaved by suicide in the form of evidence-based training (McDonnell et al., 2017; PHE, 2016). The provision of co-ordinated evidence-based postvention services provided by the NHS and the third sector are required, alongside GPs made aware of local and national resources that are available in order to signpost bereaved families (Foggin, McDonnell et al 2016).

It is important to acknowledge the important contribution the third sector make caring for this vulnerable high-risk group. In fact, evidence suggests these organisations are often the only service available to the majority of those bereaved by suicide in the UK (Foggin, McDonnell, et al 2016). Yet, these organisations do not receive government funding and are constantly under threat of closure due to the lack of funds. CCG's should consider

ways in which primary care and the voluntary sector working in suicide bereavement could collaborate to support this vulnerable population.

Public Health England (PHE), have developed a key resource for those bereaved by suicide entitled *Help is at Hand: Support After Someone May Have Died by Suicide* (PHE, 2015). This document has been well received by families bereaved by suicide. According to PHE 46,002 copies have been despatched since it was launched in September 2015. The current cost per handbook is £0.67p, excluding distribution costs (personal correspondence PHE, 26th September 2017). Arguably, every family bereaved by suicide, should be made aware of this resource during the early stages of their bereavement.

Currently there is no national specialist suicide bereavement service within the NHS. However, there is evidence of good practice in this field. For example, within some NHS Trusts, for example, The Western Health and Social Care NHS Trust, in Londonderry developed the first postvention (care of those bereaved by suicide) service in 2008, which was based on the Local Outreach to Suicide Survivors (LOSS) model, developed in the USA. Several other NHS Trusts are in the process of replicating a similar service in England and are guided by several key resources published by Public Health England (PHE 2016, NSPA 2016).

The University of Manchester and Support After Suicide Partnership (SASP) which consists of over 30 organisations which aim to improve the care those bereaved by suicide receive, are collaborating to conduct a national suicide bereavement survey. This study is unique as it explores the experiences and perceived needs of those bereaved or affected by suicide.

The overall aims of the study are:

- To understand more about the impact a death by suicide may have on the lives of those who are bereaved or affected by the death;
- To establish the support people bereaved or affected by suicide received, how the support was helpful, and where such support is lacking; and
- To examine evidence of the need for suicide bereavement support services.

It is a 12 month study (Sept 2017- Aug 2018). Anyone aged 18+ who consider to be either bereaved or affected by suicide are able to participate. Within, five weeks of it being launched 1569 participants have completed the survey. This is an unprecedented

response in this field and is generating both national and international interest. It is encouraging to note, GPs and prison staff, affected by suicide, are participating in this research. This demonstrates its relevance to the development of NICE guidelines which aim to prevent suicide in community and custodial settings.

The findings from the above-mentioned study, will also inform policy, research and practice in this newly developing field in the UK, especially England's Suicide Prevention strategy, which aims to 'provide better information and support to those bereaved by suicide' (DH, 2017).

To summarise, the provision of better support (ie. practical, emotional and training) to increase GPs confidence caring for this vulnerable high risk population cannot be under-estimated.

Recommendations:

- Those bereaved by suicide should be automatically given the 'Help is at Hand' resource published by PHE, during the early stages of their loss (cost £0.67p) (PHE, 2015);
- Parents of young children should be automatically given 'Beyond the Rough Rock: Supporting Children Bereaved by Suicide' as this provides practical advice for families, when they are immediately informed of the death etc. (cost: £5.99) (Winston's Wish, 2011);
- Parents of young children/young adults should receive immediate guidance on what to tell their bereaved children;
- GPs should have access to a comprehensive and up-to-date list of local and national support for those bereaved or affected by suicide;
- GPs should attend evidence-based suicide bereavement training, to help increase their confidence dealing with this vulnerable population;
- NHS Commissioners should provide specialist suicide bereavement support via the NHS or third sector; and
- GPs need better support (i.e. practical and emotional) to enable them to care more effectively for those bereaved by suicide.

References to other work or publications to support your testimony' (if applicable):

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