
SUICIDE BEREAVEMENT SUPPORT: A LITERATURE REVIEW

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1 INTRODUCTION

The primary aims of this report are to provide a review of literature relating to suicide bereavement support with an emphasis on evidence-based interventions and to identify examples of current suicide bereavement support practice in Ireland and internationally.

Therefore this report has five main sections, addressing the following aims:

1. To introduce and provide an understanding of suicide bereavement
2. To identify supports offered to and utilised by individuals bereaved by suicide
3. To summarise evidence for interventions tailored for those bereaved by suicide
4. To present case studies illustrating community responses to suicide internationally
5. To describe policy and case studies of suicide bereavement services in Ireland

1.1 METHODOLOGY

In order to find relevant academic literature on the topic of suicide bereavement, a search of online databases was conducted on 7th August 2018.

MEDLINE, PsycINFO, CINAHL and EBSCO were searched for articles published between 1st January 1998 and 7th August 2018. A total of 10 individual search strings were applied to retrieve relevant papers. The search strings included combinations of the following truncated terms: (suicid*); (bereave* OR grie* OR loss); (expos* OR surviv* OR postvention* OR interven* OR support)

In total, 158 records were identified through these searches. When duplicates were removed (n=91); 67 titles and abstracts were screened by EM. A further 19 articles were removed as being not relevant, with 54 articles identified for the review. Additional articles were added as discovered during the development of this literature review.

In addition, reports, policy documents and reviews relating to suicide bereavement identified by the working group were included in this review.

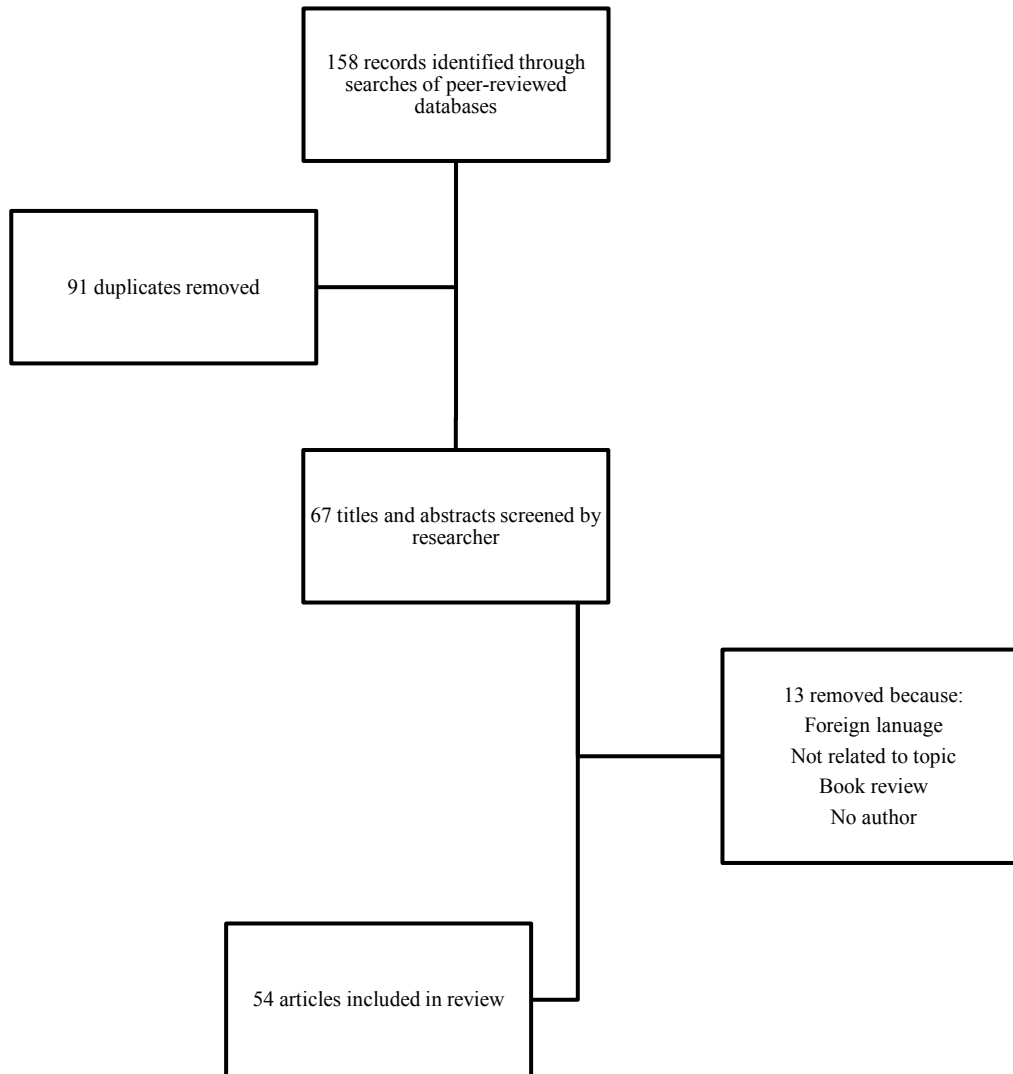


Figure 1. PRISMA flow diagram summarising search used to identify published literature

The metaphor of a stone thrown into a lake reflects the wide-reaching impact of suicide (Andriessen and Krysinska, 2012). Suicide is a leading cause of death in Ireland, especially among men. In 2017, there were 392 suicides in Ireland, 312 males and 80 females (provisional figures, CSO, 2018). This means that each year in Ireland, thousands of suicide-bereaved people will require support for their grief. The World Health Organisation (WHO) estimates that 10 people are deeply affected by each suicide death, while efforts at empirical estimates suggest a figure of 60 affected individuals (Berman, 2011) and, more recently, 135 (Cerel *et al.*, 2018). The lifetime prevalence of losing a close friend or relative to suicide is estimated at 22%, with 4% past-year prevalence (Andriessen *et al.*, 2017b). Some of those bereaved by suicide develop long lasting psycho-social sequelae of the loss, including increased risk of suicidality (Maple *et al.*, 2017, Pitman *et al.*, 2014). The challenge for effective support of those bereaved by suicide is ensuring that every bereaved person can receive the help and support they need. Provision of timely and adequate services for the bereaved requires a good understanding of the bereavement process and the needs of the bereaved as a group as well as acknowledging their individual differences. Suicide bereavement support has been identified as an important strategy for suicide prevention by the World Health Organisation (WHO, 2012). *Connecting for Life*, Ireland's National Strategy to Reduce Suicide 2015-2020, has identified those bereaved by suicide as a priority vulnerable group for whom to target approaches to improve mental health (Goal 3, page 29) (Dept. of Health, 2015).

The term "suicide survivor" is sometimes used to describe the bereaved who had a personal and close relationship with the deceased (e.g., a friend or a family member). While the word survivor tends to be used in The United States of America, in other parts of the world, "bereaved by suicide" is a more widely used term. The latter is adopted in this literature review. While a large number of people may be exposed to suicide, including those who did not know the deceased personally, this review focuses primarily on those with close personal relationships with the deceased. Efforts to support families and communities after suicide are sometimes termed "postvention".

In recent decades, public and research interest in support for families and communities after suicide has increased (Andriessen and Krysinska, 2012). The aim of these activities with or for suicide bereaved individuals is to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviour (Andriessen *et al.*, 2017a). These strategies aim to tackle the needs of the bereaved, and can

be directed from two complementary perspectives: the clinical perspective and the public health perspective of policy development and general population strategies.

Support initiatives organised by suicide bereaved people themselves, mental health professionals and concerned communities are available. For bereaved people who are struggling with their grief and loss, specialised psychotherapy and other mental health interventions have been designed, help from general practitioners is available, as well as self-help and support groups, including online communities (Cerel *et al.*, 2009a).

2.1 SUICIDE BEREAVED

Those bereaved by suicide, family members as well as other bereaved individuals, may experience a lasting impact on their emotional, physical and mental health (Maple *et al.*, 2017, Pitman *et al.*, 2014, Spillane *et al.*, 2017). Suicide bereavement shares many of the reactions typically present in bereavement after all types of death, such as sorrow and yearning to be reunited with the deceased, as well as reactions characteristic of bereavement after unexpected deaths including shock and a sense of unreality about the death. Elements of bereavement after violent deaths, for example the trauma of finding the body of a loved one and shattered illusion of personal invulnerability are also common. A research study in which parents bereaved by suicide, homicide or accidents were assessed over several years after bereavement found that the pervasiveness and persistence of negative outcomes were similar in the three groups (Murphy *et al.*, 2010). Despite these shared reactions, those bereaved by suicide experience features which seem unique to suicide bereavement, such as anger at the deceased for “choosing” death over life and the feeling of abandonment. Their reactions differ as a consequence of previous history of suicidality of the deceased and the expectation of death. Those on long-term “suicide watch” might experience the feeling of relief (often subjectively perceived as unacceptable and coupled with guilt), while those for whom the death came unexpectedly might react with a shock, accompanied by numbness and disbelief (Andriessen and Krysinska, 2012). Suicide bereaved, compared with other groups, experience more frequent feelings of rejection, responsibility and more total grief reactions (Bailey *et al.*, 1999). Among those bereaved by suicide, seeing the body at the scene of the death has been found to be a significant predictor of high levels of distress, and support from family and friends the strongest protective factor (Callahan, 2000).

Official procedures necessitated by a possible suicide and media attention may also influence the experiences of bereaved people (Hawton and Simkin, 2003). In Ireland, potentially distressing aspects of

the coroner's inquest include the delay before the inquest, the courtroom atmosphere of many inquests, hearing details of the nature of the death and post-mortem examination, and a sense that the only goal is to reach an official verdict. Factually inaccurate or insensitive media reporting can also cause problems for bereaved people. A recent Irish study explored how people bereaved by suicide in Ireland experience the inquest process (Spillane *et al.*, 2019). Interviews with bereaved family members raised both negative and positive aspects of the coronial process. While family members responded to the process in different ways, the process was found to be traumatic when conducted poorly. In particular this was the case when family members were not adequately informed of its purpose and nature of the coronial process. For most participants, intense anxiety was felt before and during the inquest. Some positive elements of the process were also cited, where some gained clarity about the nature of their family member's death along with a sense of closure. Participants acknowledged the compassionate approach of the coroner, pathologist and the liaison police officer as being important. Those who experienced a private inquest found that this was appropriate and that it made the process easier. The study authors highlight the importance of standardising coronial procedures in Ireland and in other countries with a similar process.

People bereaved by suicide commonly experience complicated grief, depressive symptoms, hopelessness and dissatisfaction with life. A subgroup of may be at risk of severe psychological distress (Bellini *et al.*, 2018). Recent Irish research exploring psychosomatic disorders after suicide bereavement reported that initial feelings of guilt, blame, shame and anger often manifested in enduring physical, psychological and psychosomatic difficulties (Spillane *et al.*, 2018).

A Danish national register-based cohort study of adults bereaved by a partner's suicide reported that, compared with those bereaved by other modes of death, suicide bereaved people were at increased risk of mental disorders and an increased risk of suicide and all-cause mortality. Suicide-bereaved adults were 80% more likely to drop out of a job or course, and were also more likely to take extended periods of sick leave, to be unemployed, and to claim disability pensions (Erlangsen *et al.*, 2017).

A systematic review of physical and psychosomatic health outcomes in people bereaved by suicide found that, in comparison with those bereaved by other causes of death, suicide-bereaved family members were more likely to experience pain, physical illness and poorer general health. Suicide-bereaved family members were also at increased risk of cardiovascular disease, diabetes, hypertension and chronic obstructive pulmonary disease (Spillane *et al.*, 2017).

In a UK study, adults bereaved by suicide had a higher probability of attempting suicide than those bereaved by sudden natural causes, but not than those bereaved by sudden unnatural causes, while there was no difference in probability of suicidal ideation. The significant association between bereavement by suicide and suicide attempt became non-significant when adding perceived stigma (Pitman *et al.*, 2016b). People bereaved by suicide have also been reported to be more likely to drop out of employment or education (Pitman *et al.*, 2016b), while one in 10 people from a UK sample of suicide-bereaved adults subsequently attempted suicide (Pitman *et al.*, 2016b),

The issue of stigma may partly explain the elevated risk of mental ill health and suicidal behaviour among the suicide bereaved. A qualitative study of the stigma experienced by those bereaved through sudden deaths identified two key themes: specific negative attitudes of others, and social awkwardness. Both themes were common to interviewees bereaved by suicide, sudden unnatural death, and sudden natural death. All interviewees reported the experience of stigmatising social awkwardness, but this may have been experienced more acutely by those bereaved by suicide due to self-stigma. This study provides evidence of a persistent death taboo in relation to sudden deaths. There is potential for anti-stigma interventions to reduce the isolation and social awkwardness perceived by people bereaved suddenly, particularly after suicide loss (Pitman *et al.*, 2018).

After a child's suicide death, parents' risk of suicide is particularly marked in the first month (Qin and Mortensen, 2003). These early weeks are a period during which people bereaved by suicide report being particularly poorly supported, reinforcing their sense of shame and self-stigma (Pitman *et al.*, 2017b). Early intervention during this vulnerable period is important given the potential for deteriorating mental illness to contribute to suicide risk in bereaved family members or friends.

2.2 WHAT SUPPORT DO PEOPLE BEREAVED BY SUICIDE RECEIVE?

A recent Irish study of suicide bereavement found that bereaved family members reported requiring a range of supports (Spillane *et al.*, 2018). However, these needs were often not fully addressed by the formal and informal support networks. This disparity in the needs and availability of support impacted on the participant's grieving process. Primarily, both formal and informal support were required to address intense psychological, psychosomatic and physical symptoms brought about by feelings of anger, guilt and blame (Spillane *et al.*, 2018). The authors report that informal support, in the form of practical and emotional support from family and friends, was as important as formal support to some participants. Informal support can include emotional support, help with funeral arrangements, financial

support, preparing food and helping with practical jobs in the home. Participants in this study also highlighted the importance of accessing counselling and of the need for suicide bereavement support groups where speaking with others with similar experiences was seen as very valuable. However, availability of such support groups was an issue for this Irish group of people bereaved by suicide (Spillane *et al.*, 2018).

Similarly, a study from the UK identified a number of gaps in service provision as well as priorities for the development and evaluation of supports (Pitman *et al.*, 2016a). Gaps in service provision included geographic variability in support provided, greater diversity in peer support options, the need for immediate outreach support, and better ways to identify local supports. The group identified General Practitioners (GPs) as a group well placed to signpost those bereaved by suicide to local supports, but that training in how to respond to a person bereaved by suicide was needed. A diagram of expressed needs versus current support available was developed from this study (Figure 2).

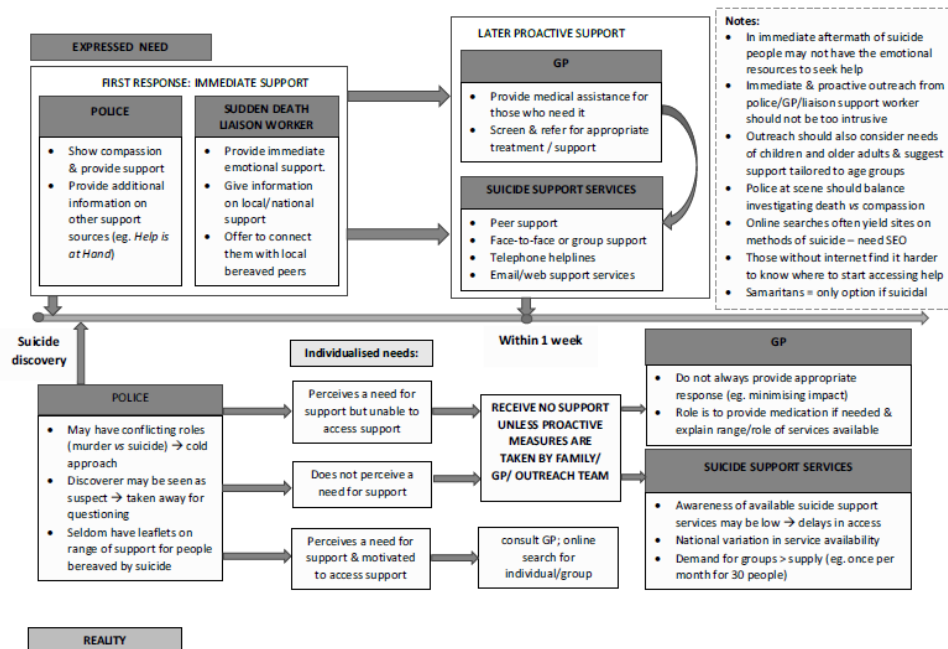


Figure 2. Schematic diagram of expressed need versus support available for individuals bereaved by suicide in the UK [from (Pitman *et al.*, 2016a), p. 112].

Another UK study comparing the supports received by young adults bereaved by suicide and other causes of death found that those bereaved by suicide were significantly less likely to have received informal support than those bereaved by other causes but did not differ on receipt of formal support (Pitman *et al.*, 2017b).

In an Australian study of support needs following suicide bereavement, 94% of suicide bereaved participants indicated a need for help to manage their grief, but only 44% reported receiving help. Only 40% of those who received professional support felt satisfied with it. When asked when they believed support was needed, 27% indicated they required support from the time of the bereavement for least 12 months and a further 19% for at least two years (Wilson and Marshall, 2010).

Researchers in the UK examined the frequency of contact between the mental health team and the bereaved family after the suicide of a person who had been in contact with psychiatric services prior to their death (Pitman et al., 2017a). Despite National Health Service (NHS) recommendations that providers of psychiatric services should contact relatives after all cases of patient suicide, no contact had been made with relatives after 3,790 suicides (33%). Of the 7,782 suicides (67%) following which relatives were contacted, 61% (n=4,755) of contacts were made face-to-face; 28% (n=2,177) by telephone call; and 11% (n=843) by letter. A violent method of suicide was associated with greater likelihood of contact with relatives, while a forensic history, unemployment, and primary diagnosis of alcohol or drug dependence or misuse by the deceased person were associated with less likelihood of contact with relatives. Given the associations between suicide bereavement and risk of suicide attempt, as well as the possibility of relatives' shared risk factors for suicide, the authors suggest the need for more proactive outreach after patient suicide.

2.2.1 FACE-TO-FACE SUPPORT GROUPS

Support groups are commonly sought by those bereaved by suicide and become an understanding community that can help ease the pain of their grief. Peer-helping seems to offer especially compelling appeal to the suicide bereaved, as compared to seeking professional assistance. Family members may be angry with practitioners for failing to successfully treat their lost loved one, and are often sceptical about the helping potential of mental health professionals. Therefore, in many cases people bereaved by suicide may put more confidence in those who have been similarly bereaved, often feeling that only they can understand their particular needs and difficulties (Feigelman and Feigelman, 2008).

These support groups vary greatly in their leadership, membership format, timing/ length, and access (Cerel *et al.*, 2009a). A US study found that most support groups are led by a suicide bereaved person, groups typically have less than ten members per session and meet on a monthly basis. Sharing continues to be a universal experience in groups, which tend to be open-ended (Cerel *et al.*, 2009b). No longer marginalised, bereaved persons are able to offer each other important mutual aid, helping each other to

deal with the necessary life adjustments following a suicide loss. As they discover their similarities, they are drawn together to form a natural therapeutic environment. Between the successful models of coping behaviour that members offer to each other, their mutually reassuring and supportive responses, they are able to move beyond the isolating sadness of loss and once again envision possibilities for hopeful and meaningful future actions (Feigelman and Feigelman, 2008).

One Irish study by Begley and Quayle (2007) examined the lived experiences of adults bereaved by suicide. The majority of the participants in this study had attended general bereavement support networks. However, they believed that they only understood their reactions to the suicide death when they met with others who were also bereaved by suicide. They believed that suicide support should be exclusive to those who had the lived experience of suicide, as those without this experience could not fully appreciate its overwhelming impact. They also felt that the sharing of stories in the suicide bereavement group helped them make sense of their loved one's death and they felt understood (Begley and Quayle, 2007).

2.2.2 INTERNET-BASED SUPPORT

Compared to face-to-face support groups, internet-based groups offer the benefit of availability 24-hours-a-day, with opportunities to invest more time into this type of support group experience (Feigelman *et al.*, 2008). Feigelman and colleagues reported that bereaved individuals using internet support groups reported greater suicide stigmatisation from their families and social environment. Unable to find ready comfort and support from their personal communities, bereaved people, and especially those with high levels of depression, sought and obtained valuable help from online support groups (Feigelman *et al.*, 2008).

Schotanus-Dijkstra and colleagues analysed 1,250 messages from members of two Dutch language forums for the bereaved by suicide (Schotanus-Dijkstra *et al.*, 2014). They found that sharing personal experiences featured most prominently in the messages, often with emotional expressions of grief. Other frequently used communications were expressions of recognition, support and empathy and providing advice. The authors concluded that online forums appear to have relevant additional value as a platform for talking about grief and finding support (Schotanus-Dijkstra *et al.*, 2014).

2.3 EVIDENCE FOR SUICIDE BEREAVEMENT SUPPORT INTERVENTIONS

A recent systematic review of studies of grief interventions for people bereaved by suicide identified only seven relevant intervention studies, two of which fall outside of the publication timeframe of this review (1998-2008), highlighting the dearth of trial-based research examining suicide bereavement support interventions (Linde *et al.*, 2017). Of the five included studies published since 1998, two examined interventions based on cognitive-behavioural approaches, two examined suicide bereavement support groups, and one evaluated the effects of writing therapy. As the majority of the interventions were effective in reducing grief intensity, the authors concluded that there is some evidence for the benefit of these interventions (Linde *et al.*, 2017). The reviewed studies are described below.

In a Dutch randomised controlled trial (RCT), De Groot *et al.* examined the effectiveness of a family-based grief counselling programme to prevent complicated grief among first degree relatives and spouses bereaved by suicide (de Groot *et al.*, 2007). Participants received a cognitive behaviour counselling programme of four sessions with a trained psychiatric nurse counsellor between three and six months after the suicide. Control participants received usual care. With an interval of two to three weeks, four sessions of two hours were delivered at the families' homes. The timeframe of three to six months after the suicide was chosen to intervene before negative beliefs became fixed. The programme addressed problems of the complete family system and aimed to offer relatives a reference frame for their grief reactions, to help them engage in 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.

The intervention was not associated with a reduction in complicated grief. However, after adjustment for baseline group differences, the intervention reduced the risk of perceptions of being to blame and maladaptive grief reactions (de Groot *et al.*, 2007).

A high-quality Belgian study examined the effects of a cognitive behavioural therapy (CBT)-based psychoeducational intervention on depression, complicated grief, and suicide risk factors (Wittouck *et al.*, 2014). Participants were 83 adults bereaved by suicide between three months and two years previously, who were randomised to the intervention or the control condition in a cluster randomised controlled trial. Intervention group participants received four 2-hour home visits by a clinical psychologist, during which the CBT-based psychoeducational intervention took place, with control group participants receiving care as usual. The intervention comprised psycho-education regarding suicide,

aspects of bereavement, specific aspects of bereavement by suicide, and coping with bereavement. Psycho-education concerning suicide contained an explanation of explanatory models of suicidal behaviour. In addition, the content, course, and cultural context of grief and coping with bereavement were discussed with participants. The cognitive-behavioural conceptualisation of complicated grief (Boelen *et al.*, 2003) was used as a rationale for the development of the intervention. Primary outcome measures included maladaptive grief reactions, depression, suicidal ideation, and hopelessness, with grief-related cognitions and coping styles also examined. There was no significant effect of the intervention on the outcome measures. However, the intensity of symptoms of grief, depressive symptoms, and passive coping styles decreased significantly in the intervention group but not in the control group, leading the study's authors to conclude that their findings may serve as supportive of counselling as a suicide bereavement support intervention.

Bereavement groups were found to be effective in lowering the intensity of uncomplicated grief in two studies (Barlow *et al.*, 2010, Constantino *et al.*, 2001). In a small study by Barlow and colleagues a peer support intervention introduced in Alberta, Canada was evaluated (Barlow *et al.*, 2010). The programme was designed to use the experiences and strengths of trained volunteers who had been bereaved by suicide themselves, referred to as peer supporters, in providing interim support for individuals bereaved by suicide. Peer supporter-client dyads were matched according to gender, type of loss, age, and relationship to the deceased and were contracted to meet regularly, face-to-face for four months. In addition, counsellors held monthly debriefing and educational sessions. Both peer supporters and bereaved clients experienced short-term positive outcomes from the programme, reporting that the programme was helpful. There were some improvements in terms of aspects of grief reactions among participants measured before and after participation. The authors note that this study challenges the assumption that suicide bereaved people require the services of highly skilled professionals and supports an intervention protocol that consists of peer supporters and professionals working collaboratively to offer cost-effective, client-centred services (Barlow *et al.*, 2010).

The study by Constantino *et al.* evaluated the effects of two group interventions in those bereaved by the suicide of a spouse (Constantino *et al.*, 2001). The aims were to determine if group-based supportive nurse-led interventions would significantly decrease levels of depression, psychological distress, and grief, as well as significantly increase the level of social adjustment. Participants were sixty suicide bereaved adults randomised to either a Bereavement Group Postvention (BGP) or a Social Group Postvention (SGP) for 1.5 hour weekly sessions over an eight-week period. The sessions were delivered

by a trained leader with a higher qualification in mental health nursing. The aim of both programmes was to promote wellbeing by mediating grief reactions through therapeutic group activities and interactions. The focus of the BGP arm was the principles of group psychotherapy, while the SGP arm had a focus on socialisation and recreation. Statistically significant changes were found on all measures when the SGP and the BGP were combined for analyses on post-treatment assessments at three to five days after completion of the group intervention, and six months and 12 months after the intervention. Participants experienced a significant reduction in overall depression, psychological distress, and grief, as well as an increase in social adjustment. However, there was no control condition for comparison.

The final study included in the review by Linde et al assessed whether writing projects lessened undergraduates' grief following a loved one's suicide (Kovac and Range, 2000). Participants were 40 students who were bereaved by suicide in the past two years. They wrote on four occasions over two weeks about profound topics (e.g., events and emotions surrounding the death) or trivial topics (e.g., description of the previous meal). Participants completed pre- and post-test measures of grief and self-reported health visits. Those in the profound writing topic condition reported less grief associated with suicide at follow-up than those in the trivial condition. However, this benefit did not extend to general grief or physical health (Kovac and Range, 2000).

While the studies presented above include some positive findings in terms of bereavement groups, CBT-based interventions and writing interventions, review authors suggest that results should be considered exploratory due to limitations of the included studies, including selection bias, the lack of blinding, lack of randomisation and small sample sizes (Linde *et al.*, 2017).

Although not specific to suicide bereavement, A US study by Murphy et al reported that mothers bereaved by the violent death (including one quarter of the sample bereaved by suicide) who participated in a general group bereavement intervention had significantly better scores in the short term on measures of overall mental distress and post-traumatic stress disorder (PTSD) than control participants. However, benefits were not sustained at longer term follow up (Murphy *et al.*, 1998). Participating fathers had significantly lower overall mental distress scores than control sustained at the six-month follow-up; however, no programme effect on fathers' PTSD scores or grief responses was evident.

2.4 PHYSICAL AND EMOTIONAL WELLBEING FOR THOSE BEREAVED BY SUICIDE

There is a dearth of research examining interventions with a focus on physical activity, diet and overall wellbeing for those bereaved by suicide. However some studies have found evidence for a number of protective factors for those bereaved, including sudden bereavements. Religious participation was found to be associated with increased self-esteem among those suddenly bereaved, with social support increasing self-esteem and reducing depressive symptoms (Sherkat and Reed, 1992). Interventions such as writing therapy may be helpful in contributing to self-care, but evidence is limited (O'Connor *et al.*, 2003). A study of bereavement programs for parents following violent deaths of their children reported that several health-protective behaviours (including diet, not smoking, low alcohol consumption, weekly exercise and leisure) were significantly associated with fewer stress-related illnesses, reduced absenteeism from work and higher work productivity (Murphy, 2000).

A recent Italian pilot study (Scocco *et al.*, 2018) investigated the impact of a brief mindful-self-compassion retreat on mood states, mindfulness qualities and self-compassion in individuals bereaved by suicide. A total of 61 participants were included, 80% of whom were female, with a mean age of 50 years. A significant improvement in mood states was found following the retreat, as well as a decrease in over-identification. However as the study involved a self-selected group and did not include follow up data or a control group, the results should be interpreted with caution. Nevertheless, mindfulness could be beneficial for those bereaved by suicide at an appropriate time (at least three months following a bereavement).

A study of a mindfulness-based intervention (the ATTEND model) reported preliminary findings on mental health outcomes for traumatically bereaved individuals. The intervention was delivered via one-to-one counselling, and a decline in trauma, anxiety and depressive symptoms were reported (Thieleman *et al.*, 2014).

The effect of suicide bereavement on children and adolescents varies widely between individuals, with important factors including the characteristics of the death, the quality and closeness of the relationship with the deceased and the social support available to the bereaved young person. Here we present some key research findings on bereavement in childhood and adolescence.

The few studies that have directly compared those bereaved by suicide with those bereaved by other causes have often failed to reveal unique or especially negative outcomes for the suicide-bereaved group (Hung and Rabin, 2009). A review of parental suicide (Ratnarajah and Schofield, 2007) found that studies showed a marked increase in psychiatric symptoms and social maladjustment for children bereaved by suicide. In a community-based sample of parentally bereaved children and adolescents aged 5–17, which included death by suicide as well as other causes, Cerel and colleagues examined psychopathology and family functioning both before and after the death for approximately two years (Cerel *et al.*, 2000). Results indicated that suicide-bereaved children were more likely to have behavioural and anxiety symptoms in the first two years after the death compared with those bereaved by other causes. They were also more likely to experience anger and shame after the death than those bereaved by other causes. Levels of depression, suicidality, and psychosocial functioning, however, yielded minimal group differences.

Pfeffer *et al.* compared children aged 5–12 bereaved by parental suicide with those bereaved by parental death from cancer (Pfeffer *et al.*, 2000). Although the suicide-bereaved children reported significantly more depressive symptoms (including negative mood, interpersonal problems, ineffectiveness, and anhedonia) than the cancer-bereaved group, the majority fell within the normative range for depression. Bereavement through suicide therefore shares many features with other bereavement, while presenting the potential for complicated grief and psychopathology among some young people. As a link between younger age at experiencing complicated grief including bereavement through suicide and greater psychological risk has been identified, it is important to target young people experiencing complicated grief with non-pathologising, child-centred interventions (Melhem *et al.*, 2007).

Few research studies have examined suicide bereavement in adolescence, with many studies including both children and adolescents, despite developmental differences. Adolescents who are bereaved by suicide are at increased risk of new psychiatric problems, mostly depression and anxiety, shortly after the death and irrespective of the kinship relationship with the deceased (Andriessen *et al.*, 2016). In

addition, suicide-bereaved adolescents are at increased risk of suicidal behaviour, especially after parental suicide, independent of family history of psychopathology (Mittendorfer-Rutz *et al.*, 2008). Social support is associated with positive grief outcomes, yet bereaved adolescents report experiencing a lack of understanding within their social environment, and relationships became more troubled or avoidant, which hindered their help-seeking (Andriessen *et al.*, 2018).

A number of factors influencing adjustment to parental suicide have been identified, including the characteristics of the child, family relationships, socio-environmental factors and the process of meaning-making (Ratnarajah and Schofield, 2007). The child's age and developmental stage can significantly determine their adjustment to parental loss and suicide. Generally it is thought that a realistic comprehension of the finality of death is not achieved until the age of 8 to 11 years, and this is influenced by how the child is told of the parent's death (Cain, 2002). Such factors can influence the meaning that the child constructs about the suicide but also about their sense of self. Andriessen notes that, among adolescents, the impact of the suicide might be mediated by three types of features. Pre-loss features related to personal and family history, type of relationship, and especially emotional closeness of relationship; the type of death; and finally post-loss issues such as quality of remaining relationships. (Andriessen *et al.*, 2015). Developing resilience in children and adolescents bereaved by suicide has been emphasised, with a view to decreasing risk factors while encouraging factors which are protective. Such an approach may require a whole systems approach of support for the bereaved family (Ratnarajah and Schofield, 2007).

3.1 EVIDENCE FOR INTERVENTIONS FOR CHILDREN AND ADOLESCENTS BEREAVED BY SUICIDE

Hung and Rabin have noted that, due to the broadly similar experiences and needs of young people bereaved by suicide and other causes, there is some empirical evidence for the efficacy of general childhood bereavement groups. While support specific to suicide bereavement may be beneficial for children and adolescents, Hung and Rabin conclude that current support group interventions for suicide bereaved children are limited and lack strong empirical support (Hung and Rabin, 2009).

One recent review focused on the literature concerning support groups specifically targeting children and adolescent suicide bereaved (Journot-Reverbel *et al.*, 2017). This review yielded two studies which met inclusion criteria, only one of which was a controlled trial. A randomised study from the United States evaluated the efficacy of a bereavement group intervention focusing on reactions to death and suicide and strengthening coping skills for children and adolescents aged 6-15 who suffered the suicide

of a parent or sibling (Pfeffer *et al.*, 2002). Pfeffer and colleagues examined 39 suicide-bereaved children who received 10 psychotherapeutic group sessions each lasting 1.5 hours, delivered by a psychologist. The manual-based intervention aimed to improve coping with bereavement and results were compared to another 36 suicide-bereaved children who received no intervention. The outcome measures examined included post-traumatic stress reactions, levels of anxiety and depression and social adjustment. Changes in anxiety and depressive symptoms were significantly greater among children who received the intervention than in those who did not, suggesting that such group interventions can be effective in lessening the distress of bereaved children and may prevent future morbidities. However, substantial methodological problems have been identified in this review (Journot-Reverbel *et al.*, 2017).

In the second included study included in the Journot-Reverbel *et al.* review, participants were suicide-bereaved children aged 6-12 who participated in a 12-session group therapy programme. Some pre-post changes were reported on several measures including reduction of anxiety and depressive symptoms. However, interpretations of results were limited by the small sample size and lack of control group (Daigle and Labelle, 2012).

The review authors concluded that they failed to find strong support for delivering support groups for children and adolescents who have lost a close relative to suicide and, without evidence of efficacy of any approach, no particular treatment approach should be favoured over another (Journot-Reverbel *et al.*, 2017).

A unique small-scale Irish study by Veale (2014) examined the effectiveness of group therapy for children aged 8-12 years who had been bereaved by suicide. The Children's Bereavement Group met weekly for 1.5 hours over 12 weeks. Group-work was facilitated by a Child & Adolescent Psychotherapist and family workers. The group-work model used was informed by recommendations arising from the Barnardos project "Talking with children bereaved by suicide". Methodologies included art, physical activities, worksheets, reflective activities, and mindfulness practice. Sessions were structured to progressively explore the bereavement experience, moving to memories of the loved ones and finally a focus on the future. Each session began with lighting a candle. In the first session, children were told this was to help them to think about the person they had lost. Various activities were used to involve children in the group-work activity including art activities, physical activities, worksheets, reflective activities, and mindfulness practice. Participants were four boys and one girl aged 8-12 years referred to a community-based bereavement support service in Dublin, Ireland following the death of a family member by suicide. All had previously attended individual counselling. All were at least one year post-

bereavement. At follow up six months post-intervention, symptomatology had decreased substantially and in the longer term, children's qualitative reports highlighted that participation in group work enhanced connectedness, emotional expression, family communication processes, memory and sense-making, and processes associated with active coping. It facilitated remembering, allowed the narrative of the suicide to unfold, gave children a space to ask questions about suicide and engage in sense-making. Group work appears able to address isolation, social stigma and communication challenges with suicide-bereaved children and highlights the contribution of peer support (Veale, 2014).

From a public health perspective, tertiary suicide prevention (typically postvention) services are a vital part of suicide prevention (World Health Organisation, 2012). While this typically involves strategies that target individuals bereaved by suicide, the overall aim is to aid the grieving process and reduce the risk of suicide contagion in the community (Szumilas and Kutcher, 2011). A systematic review of suicide postvention (n=16), including school-based, family-focused and community programs, did not find any protective effects for suicide deaths or self-harm. Regarding community-based programmes, to date no known formal analysis has been conducted. Despite this, there are some common themes emerging from the literature on community-based approaches, including the need for a co-ordinated and consistent approach to suicide postvention.

4.1 CASE STUDY: ENGLAND

Public Health England have published guidance for local communities in providing support after a suicide as well as developing local services (England, 2016). In particular, a multi-agency approach is advocated, including primary care, mental health services, bereavement services, voluntary sector organisations and community sectors. The need for information sharing across organisational and professional boundaries is emphasised. A pathway of care and support is outlined consisting of: first contact, referral to support service, face to face meeting, additional support, feedback and evaluation. Two activities in England which have been implemented to improve bereavement support are the Help is at Hand booklet (<https://supportaftersuicide.org.uk/support-guides/help-is-at-hand/>) and an evidence-based training programme to guide health professionals in responding to parents bereaved by suicide (<https://suicidebereavementuk.com/sbuk-training>).

4.2 CASE STUDY: AUSTRALIA

The StandBy Response Service is an Australian suicide bereavement support service, providing face-to-face outreach and telephone support offered by a professional crisis response team and referral to other community services matched to need (www.standbysupport.com.au). The service also supports emergency and community service providers and the broader community, aiming to build community capacity in suicide postvention and prevention. Tailored case management plans are developed to refer individuals to existing community services based on their needs. StandBy is a self-referral service. An evaluation of the service involving 96 clients reported a reduction in levels of suicidality. There was also

some evidence for an improvement in quality of life, psychological distress, health care usage and work performance (although non-significant) (Visser *et al.*, 2014). This service was found to be a cost-effective strategy and may even be cost-saving if all costs to society from suicide are taken into account (Comans *et al.*, 2013).

4.3 CASE STUDY: UNITED STATES

A US study (Hacker *et al.*, 2008) detailed a community response to a number of youth suicides and overdoses in a town over a five-year period. This was an ecological study using multiple data sources (death certificates, youth risk surveys, 911 call data and hospital discharge data) to measure the impact of the community response on suicidal behaviour. The response included a community-based trauma response team, improved media relationships, focus groups for those bereaved by suicide and prevention trainings for community stakeholders. No formal analysis was conducted, but post-intervention data showed that the activities had a favourable impact on containing the contagion. It was concluded that the interplay of multiple strategies in multiple settings amplified the effect of the interventions.

4.4 CASE STUDY: ACTIVE POSTVENTION MODEL

Traditional passive models of postvention following suicide typically involve those bereaved by suicide finding out about available resources. On the other hand, an active postvention model involves supplementing existing services from traditional first responders, involving training personnel to respond to scenes of suicide (Aguirre and Slater, 2010). While no formal evaluation of such a model has been conducted, an analysis of seven years' data from a US town (Cerel and Campbell, 2008) found that those bereaved by suicide who received an active model of postvention presented sooner for treatment than those who received passive postvention (48 vs. 97 days). They were also more likely to attend support group meetings. Such an active model can allow for outreach to begin sooner, and to provide support services and referrals directly, and have been recommended to be part of postvention programmes (Aguirre and Slater, 2010).

4.5 POSTVENTION IN SCHOOLS

Research around adolescent bereavement recommends that crisis intervention is organised in schools following a sudden death. This can involve a range of activities. A recent Delphi study (Cox *et al.*, 2016) used expert consensus to develop suicide postvention guidelines for secondary schools. A total of 548

endorsed actions were incorporated into 20 common themes. Although grief hierarchy and exposure are used in prioritising to whom help is offered, it is recommended that everyone exposed to a suicide requires some level of care (Mauk and Weber, 1991, Poijula *et al.*, 2001).

A Finnish study reported the response to five student suicides in a school year across three schools (Poijula *et al.*, 2001). First talk-through and psychological debriefing were conducted by a mental health professional which seemed to reduce suicide contagion. In one school where an incomplete crisis intervention was conducted, a new suicide occurred. The authors conclude that early intervention fosters an open discussion and may prevent fantasising and death glorification. It may also prevent imitative behaviour.

5 PROFESSIONALS AND VOLUNTEERS SUPPORTING THOSE BEREAVED BY SUICIDE

5.1 PROFESSIONALS' NEEDS AND EXPERIENCES

Those bereaved by suicide require support from a range of formal and informal sources, beginning at the time of the bereavement and for a significant period of time thereafter. A qualitative study of interviews with persons bereaved by suicide explored their experiences of responses following the suicide (Peters *et al.*, 2016). A primary theme emerging was that of understanding of the complexity of suicide bereavement by emergency responders, health professionals and community services, in order to ensure provision of appropriate responses and effective support. In particular, communications and experiences occurring directly after the suicide can impact on the distress of those bereaved. Previous research has suggested that inappropriate responses from services in the period following a suicide may be a determinant of complicated grief (Knieper, 1999). This study identified mental health nurses as being well positioned to provide training and education to emergency responders and other service providers. The importance of being offered support was also highlighted, with research suggesting that those bereaved by suicide are more likely to engage in interventions if they are actively presented with them (Cerel and Campbell, 2008).

There has been very little research examining the experiences of professionals who may be the first contact point for the bereaved at the time of a suicide death. Professionals who the bereaved meet are often emergency medical personnel, police officers and GPs. However, there are no guidelines that address pre-hospital support to those bereaved.

A Swedish study used focus groups to examine the experiences of professionals in this situation (Nilsson *et al.*, 2017). When supporting those bereaved by suicide, participants reported experiencing feelings of inadequacy and powerlessness when facing the emotional storm of suicide bereavement, and feeling that they had not been trained to deal with the situation. Another theme which emerged was the attempt to shield both themselves and the bereaved emotionally from the reality of the suicide, as well as to shield themselves and the bereaved from unpleasant visual impressions. Professionals felt that although they didn't have a formal duty to support the bereaved, being accessible for the bereaved and responsive to their needs was emphasised as very important to them individually. Nilsson and colleagues highlight the importance of providing continuity of support for the bereaved by developing a

care pathway that begins at this first contact at the time of the death and then continues through contact with established health-care providers.

The GP or family doctor is ideally placed to provide ongoing support to the suicide bereaved family. In a qualitative study of interviews with British GPs, Foggin *et al* reported that although the majority of GPs felt a responsibility to contact parents bereaved by the suicide of a child, they also disclosed low confidence in dealing with suicide and an unpreparedness to face parents bereaved by suicide (Foggin *et al.*, 2016). Some GPs described guilt surrounding the suicide, and a reluctance to initiate contact with the bereaved parents. GPs talked of their duty to care for the bereaved patients, but admitted difficulties in knowing what to do, particularly in the perceived absence of other services.

A Dutch study by de Groot *et al* investigated GPs' management of help requests from relatives bereaved by suicide and examined determinants of GPs willingness to refer for evidence-based follow-up care. Of the requests for help received from bereaved family members, two thirds were handled by the GP and over half were ultimately referred, principally for mental health care. Prior suicide exposure on the part of the doctor and female gender were associated with the doctor's perception that follow-up care following a loss through suicide is useful (de Groot *et al.*, 2009).

Approximately one-quarter of those who die by suicide have engaged with mental health services in the twelve months prior to death (Appleby *et al.*, 1999). Therefore community mental health teams (CMHTS) have an important role in facilitating suicide bereavement support (Corry *et al.*, 2016). However the impact of a death can also have a detrimental impact on members of these teams. Support and guidelines for mental health services in terms of the impact of a suicide are warranted (Canning and Gournay, 2014) and in Ireland, there are limited protocols to guide community mental health teams (McGuire and Muthy, 2019).

5.2 TRAINING OF PROFESSIONALS

The first of its kind internationally, an evidence-based suicide bereavement support training programme entitled Postvention: Assisting those Bereaved By Suicide (PABBS) is now available in the UK through Suicide Bereavement UK (<https://suicidebereavementuk.com/sbuk-training>). The programme was originally designed for health professionals, in particular GPs and mental health professionals, but was subsequently found to be relevant to a much wider audience. The training helps participants to recognise that supporting those bereaved by suicide is a key component of suicide prevention; to enable

participants to increase their knowledge, confidence, skills and provide a framework and service-response plan for immediate and ongoing support for parents bereaved by suicide. It aims to encourage health professionals to consider and recognise their own emotional or self-care needs and develop a strategy or support structure that will be available to them if a patient dies by suicide. The training is evidence-based and theory-driven and has been informed by a three year study which identified the vulnerability and perceived needs of parents bereaved by suicide and health professionals who were responsible for their care. Training is delivered in the format of an interactive one day workshop.

6 SUICIDE BEREAVEMENT POLICY IN IRELAND

This section will describe the policy and guidance concerning bereavement supports and services in Ireland. In addition, previous evaluation of suicide bereavement services in Ireland will be summarised. Finally, Irish research emerging concerning persons bereaved by suicide will be outlined.

6.1 IRISH POLICY AND GUIDANCE

6.1.1 NATIONAL QUALITY STANDARDS

In 2012, national quality standards for the provision of suicide bereavement services were published (Console *et al.*, 2012). This document was to be used by services or organisations to examine, improve and validate the services they provide in relation to bereavement following suicide, for those working in bereavement support and services. Thus, the document serves as a self-assessment tool for services. Four different levels of services are identified: 1) Information; 2) Support; 3) Counselling; 4) Psychotherapy. The standards are divided into sections, according to these service levels.

Table 1. Irish quality standards for bereavement support services [adapted from (Console et al., 2012)]

Level 1: Information services	
1.1	The service/ organisation subscribes to the Guiding Principles as detailed in this document
1.2	All information provided is accurate, timely and legitimate
1.3	The mediums used follow other best practice standards
1.4	The organisation works collaboratively with others
1.5	The organisation/ service safely refers those outside its remit to other agencies
Level 2: Support services	
2.1	The service/ organisation subscribes to the Guiding Principles as detailed in this document
2.2	All information provided is accurate, timely and legitimate
2.3	The mediums used follow other best practice standards
2.4	The organisation works collaboratively with others
2.5	The organisation/ service safely refers those outside its remit to other agencies
2.6	Education & awareness programmes are appropriate
2.7	Service policies and procedures are in place
2.8	Organisational policies and procedures are in place
2.9	Appropriate recruitment and selections procedures are in place
2.10	Staff and support personnel are appropriately supported
2.11	Appropriate training & development procedures are in place
2.12	Services are measured
Level 3: Counselling services	
3.1	The service/ organisation subscribes to the Guiding Principles as detailed in this document
3.2	The mediums used follow other best practice standards
3.3	The organisation works collaboratively with others
3.4	The organisation/ service safely refers those outside its remit to other agencies

3.5	Service policies and procedures are in place
3.6	Organisational policies and procedures are in place
3.7	Appropriate recruitment and selections procedures are in place
3.8	Staff and support personnel are appropriately supported
3.9	Appropriate training & development procedures are in place
3.10	Services are measured
Level 4: Psychotherapy services	
4.1	The service/ organisation subscribes to the Guiding Principles as detailed in this document
4.2	The organisation works collaboratively with others
4.3	The organisation/ service safely refers those outside its remit to other agencies
4.4	Service policies and procedures are in place
4.5	Organisational policies and procedures are in place
4.6	Appropriate recruitment and selections procedures are in place
4.7	Staff and support personnel are appropriately supported
4.8	Appropriate training & development procedures are in place
4.9	Services are measured

6.1.2 IRISH CHILDHOOD BEREAVEMENT NETWORK (ICBN) STANDARDS

In 2017, the Irish Childhood Bereavement Network (ICBN) published standards for supporting bereaved children and young people (ICBN, 2017). While the standards do not specifically mention children who are bereaved by suicide, the standards are relevant in circumstances where the death was sudden or unexpected. In such circumstances, extra support should be provided.

- | | |
|-------------------|---|
| Standard 1 | Child & Young Person: <i>Children's experience of bereavement will be recognised, acknowledged and supported in accordance with their needs over time.</i> |
| Standard 2 | Family: <i>The family is generally the main source of care for the bereaved child and will require access to reassurance, information, guidance and support to provide this care.</i> |
| Standard 3 | Local Community: <i>All bereaved children should have access to bereavement information, guidance and support services in their local community as required.</i> |
| Standard 4 | Service Providers: <i>All service providers will ensure that governance, procedures and protocols are in place to ensure ethical, safe and appropriate bereavement service delivery to the children in their care.</i> |
| Standard 5 | National: <i>National policy and local infrastructure includes appropriate responses to, and integrates the needs of, bereaved children.</i> |

Figure 3. Irish Childhood Bereavement Network (ICBN) standards for supporting bereaved children and young people (ICBN, 2017)

These guidelines note that any information, assistance or service provided to children and adolescents should take account of their age and developmental stage and also take cognisance of the circumstances of their bereavement and family functioning. The optimal timing for intervention cannot be standardised. Rather, the decision to intervene should be based on the child's individual needs and the extent of their resilience in managing the loss. Any interventions should have the appropriate consent of parents/guardians.

6.1.3 REVIEW OF BEREAVEMENT SUPPORT SERVICES (PETRUS CONSULTING, 2008)

In 2006/2007, the Health Service Executive's National Office for Suicide Prevention commissioned a review of evidence for bereavement support services, conducted by Petrus Consulting (2008). Key recommendations related mainly to organisations and services providing information (level 1) and support (level 2) services. The report recommended that there is no evidence for one therapy or intervention, and so a range of supports should be available. In addition, all organisations and individuals offering support in this area need at least a minimum standard of training. A national accredited qualification in bereavement support should be developed in conjunction with existing training providers. The report recommended that suicide bereavement supports should be integrated with general bereavement support services, rather than the requirement of a standalone suicide bereavement support response.

6.2 IRISH SERVICE MODELS: CASE STUDY

The Mayo Suicide Liaison Service (MSLS) was established in 2012 as a designated suicide bereavement service (Gordon *et al.*, 2015). The aim of this service is to: “provide emotional and practical support to the bereaved and to help them to access ongoing support and therapeutic services as required”. It can be accessed through first responders, those in contact with the bereaved (e.g. GPs, schools) and self-referral. The service is delivered by a liaison worker. An evaluation of the service for the period 2012-2015 recorded a total of 255 individuals (related to 77 cases), with the majority of referrals made within six months of bereavement (65%). A total of 71 cases received face-to-face support contact, with five availing of telephone support without the need for further support. A total of 115 referrals were made to other services, including counselling, suicide bereavement support groups, community groups, peer mentoring, GP and mental health services. The group comprised of 214 adults and 41 children aged under 18 years. There was a fairly even gender split, with 53% of the group female. The bereaved included nuclear (immediate family, including parents, siblings and children) families, extended families, close friends and colleagues.

A qualitative analysis of views and experiences of using the service identified four key themes:

1. Suicide Bereavement is Different
2. Support Needs are Unique and Diverse
3. Responding Flexibly and Seamlessly
4. Benefits are Tangible

6.3 RESPONSE TO UNTIMELY DEATHS AMONG THOSE IN CARE OF MENTAL HEALTH SERVICE

A 2016 report published by the National Suicide Research Foundation reported on the findings from a study of untimely sudden deaths and people who took their lives while in the care of the Donegal Mental Health Service (Corry *et al.*, 2016). The report found that there was a lack of uniformity in official procedures following a sudden death, with variation in communication with family members and signposting to specialised bereavement support services. The report recommended that the service response to family members following the death of a service user be improved. In particular, the following actions were suggested (page 11):

1. In addition to the formal contact with family members currently made by staff following a tragic death, establish a formal acknowledgment of the tragic event by letter from the mental health services, including practical information and signposts to available support services in their area;
2. Ensure an appropriately timed telephone call from Donegal Mental Health Service to ascertain the needs of family members as they come to terms with their loss;
3. Ensure collaboration with the local Suicide bereavement Liaison Officer in order to streamline provision of information and support.

For the close relatives and friends of the approximately 400 people who die by suicide in Ireland each year, receiving appropriate, timely and ongoing support is of huge importance. In this report we have reviewed the literature on suicide bereavement, particularly focusing on research examining the impact of suicide on those bereaved and studies investigating the effectiveness of bereavement support interventions. We have also presented case studies of bereavement support services in Ireland and internationally and highlighted examples of good practice and evidence-based guidelines.

The impact of suicide on bereaved individuals, families and communities has been well researched, with clear evidence that those bereaved by suicide may experience lasting impacts on their emotional, physical and mental health. Factors contributing to poor outcomes for those bereaved by suicide include circumstances of the death (for example, seeing the body at the scene of death), supports received (both formal and family support), the inquest process and perceived stigma. Studies show that a range of supports is needed for individuals bereaved by suicide, from both formal and informal sources. Practical and emotional support from family and friends was often highlighted as being as important as formal supports.

However, studies which have involved speaking to people bereaved by suicide have shown that often their needs are not adequately addressed. In particular, information and supports are difficult to identify and access, despite these being needed in the days and weeks following a suicide. The need for and importance of immediate outreach and ways to better identify what supports are available locally emerged as an important theme. Other gaps in current service provision included geographical variation in services available and the availability and diversity of peer support options. Medical professionals such as first responders and general practitioners were identified as potential gatekeepers in suicide postvention activities, although the importance of suicide-bereavement training for professionals was also emphasised.

Overall, there are few high-quality studies examining the effectiveness of suicide bereavement support interventions. We have described a small number of studies examining a range of interventions, family-based grief counselling, cognitive behavioural therapy (CBT)-based psychoeducational interventions, group-based supportive nurse-led interventions; one-to-one peer-support interventions, writing therapy and mindfulness-based therapy. Overall, the evidence for clinical interventions for individuals bereaved by suicide is limited. Despite the dearth of research, person-based studies have found evidence for

reductions in the intensity of grief experienced by bereaved individuals. Although there is a lack of evidence for the impact of suicide bereavement support groups on outcomes for individuals, the peer-to-peer nature of support in such groups can be therapeutic and can create an environment based on common experiences. Some research has also shown evidence for protective factors following suicide bereavement, including religious participation and activities promoting self-care. In recent years, mindfulness-based interventions for those bereaved by suicide have been examined, but further research is needed.

It is clear that children and adolescents who are bereaved by suicide require tailored support. Research has shown that bereavement by suicide in young people shares many features with other forms of bereavement, yet the potential for complicated grief and psychopathology for some is present. Due to the broadly similar experiences and needs of young people bereaved by suicide and other causes, there is some empirical evidence for the efficacy of general childhood bereavement groups. While support specific to suicide bereavement may be beneficial for children and adolescents, current support group interventions for suicide bereaved children are limited and lack strong empirical support. Furthermore no one approach should be favoured over another. Although there is no clear best practice in terms of interventions for young people, developing resilience has been emphasised with a view to decreasing risk factors. Young people experiencing complicated grief should receive non-pathologising, child-centred interventions. Such approaches may require a whole systems approach for bereaved families.

At a community level, few formal studies have shown positive impacts on reducing suicidal behaviour in the community following a suicide or a number of suicides. However, a review of international examples of community-based approaches generated some common themes. These case studies identify the need for a co-ordinated and consistent approach to suicide postvention. Such responses should involve multiple agencies, with information sharing across organisations and professions emphasised. The importance of standardised and detailed information sources (e.g. booklets) was also emphasised, as was the need for professionals to actively provide this information to bereaved individuals and families following the death. The importance of timely, standardised support for all was highlighted, via an appropriate pathway of care and support. An active postvention model was seen as being particularly effective over traditional passive models, and was shown to increase help-seeking activities among those bereaved by suicide. Training of professionals was also seen as an integral part of community responses to suicide.

7.1 RECOMMENDATIONS FOR FUTURE RESEARCH

This review has highlighted the lack of research on suicide bereavement, in particular the effectiveness of bereavement support interventions. With just five studies on interventions for adults bereaved by suicide included in this review, there is a need for high-quality, trial-based research examining suicide bereavement supports. For young people in particular, the evidence around the appropriateness of supports and interventions is limited, as is our understanding of how suicide bereavement differs for young children and adolescents. In recent years, there has been some qualitative research exploring individuals' experiences of suicide bereavement. This type of research is imperative in developing appropriate community responses, and research which involves bereaved persons in the design should be prioritised.

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