School of Psychology
Ysgol Seicoleg

A Systematic Review of the Mental Health Impact of Losing a Friend or Sibling to Suicide and an Empirical Study Developing Co-Produced Postvention Guidelines for Bereaved Friends and Siblings

Thesis submitted in partial fulfilment of the requirement for the degree of:

Doctorate of Clinical Psychology (DClinPsy)

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

Sarah Rook

Supervised by: Dr Helen Penny and Dr Cerith Waters

05/12/22

Acknowledgements

I am grateful to all the people who gave up their time to participate in this study. I would particularly like to acknowledge the experts by experience who took part. These individuals spoke eloquently and openly about their experiences despite the distressing nature of the topic. Each of them made the selfless choice to do this in the hope that their participation might help others in the future. I am so grateful to have had the privilege to hear a little about the loved ones that you have lost. The admiration and love you continue to feel for each of them, was clear.

My supervisors, Dr Helen Penny and Dr Cerith Waters deserve enormous thanks. You have both been a great source of knowledge, guidance, and compassion throughout this process. I am grateful for the assistance of Jonathan Jones (Subject Librarian), without whom my systematic review would not exist. My placement supervisor, Dr Kerry-Ann Holder also deserves thanks for providing reassurance, containment, and kindness. My cohort have been a huge source of support throughout the past three years. I feel lucky to have trained with such a compassionate group of individuals.

Thank you to my Mum, who has always emphasised the importance of pursuing a career that you love. She also showed me first-hand that although completing a doctorate with a young child is challenging, it is not impossible. I am grateful too, to my Dad for his continued love and support. Thank you also to my Granny, who has always been my number-one cheerleader! My Mother-in-Law (Ann) has been a massive source of both emotional and practical support- thank you so much.

Dan, I am so grateful for you and all that you have done to make this possible. Thank you for your unfaltering love, belief, and confidence in me. This achievement is as much

yours as it is mine. Finally, I am thankful for Penny, for providing musical interludes, dance breaks, cuddles, and generally being the best thing in my life.

Table of Contents

Preface

Sadly, it is relatively common for young people to experience the death of a peer or sibling by suicide. Bereavement by suicide can have serious and enduring negative impacts on the mental health of young people. Most worryingly, studies have suggested that some young people exposed to suicide may be more likely to engage in suicidal behaviour themselves. Other adverse mental health outcomes following exposure to suicide documented in the literature include depression and anxiety and post-traumatic stress disorder (PTSD).

The systematic review section of this thesis investigated the impact of exposure to a peer or sibling's suicide on the mental health and suicidal behaviours of young people. The literature search identified 20 relevant studies. Seventeen of these studies related to peers/ friends, whereas only three focused on siblings. The methodological quality and outcomes of these papers were closely examined and synthesised. The results suggested that young people who lose a peer to suicide experience depression and anxiety, suicidal behaviour, and PTSD. They may also be at increased risk of suicide attempts; however, this is less clear. Only PTSD appeared to persist over time. Importantly, the review only included five studies that looked at the long-term impacts of exposure to suicide on peers, therefore these results should be interpreted cautiously.

Of the three studies that reported on the impact of suicide bereavement on siblings, results indicated that they experienced anxiety and depression following the loss, however this result was no longer evident 3 years later. Findings regarding PTSD were mixed. There was no evidence that exposure to sibling suicide increased risk of suicidal behaviour and attempt or substance misuse. Only one study looked at the long-term impact on siblings. Results suggested that there was no increased risk of mental health problems in exposed

siblings the long-term. However, the small number of studies included in this review as well as their methodological limitations, mean that no firm conclusions can be drawn.

More research is needed to gain a clearer understanding on the impact of suicide bereavement on young people, particularly siblings. Such research will provide important information regarding how best to provide postvention for this population. The term postvention is defined as "those activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behavior" (Andriessen et al., 2009, p. 43).

The results of this review illustrated the importance of postvention for this population, particularly in the short-term. Future studies should investigate what risk factors may be associated with more negative outcomes. Post-traumatic growth refers to the concept of experiencing a positive psychological change following exposure to a traumatic situation Future research into protective factors that facilitate post-traumatic growth following suicide bereavement should also be explored.

The empirical portion of this thesis involved working in partnership with The Mindstep Foundation and The Jacob Abraham Foundation to develop postvention guidelines for young people who experience the suicide of a sibling or peer. Postvention in this instance refers to providing support to young people following bereavement by suicide. This entailed interviewing young people bereaved by suicide (friends and siblings) and their parents for their opinions about what kind of support they felt would be helpful. The views of professionals in the field of young people's mental health and suicide postvention were also included through use of an online questionnaire. A thematic analysis (Braun and Clarke, 2006; 2019) was conducted on the qualitative data gained from the interviews and questionnaires. The analysis generated themes and sub-themes that were used to create

statements about what kind of postvention support might be helpful for young people. All of the participants were asked to complete the second questionnaire by rating how much they agreed with each statement. Of 80 statements, 77 achieved consensus (80% agreement). The statements that participants agreed were important will be used to co-produce guidelines regarding how to best support siblings and peers of young people who die by suicide. These guidelines could be used by professionals (e.g., teachers, mental health workers), caregivers and even young people themselves.

The Mental Health Impact of Losing a Friend or Sibling to Suicide: A Systematic Review

Sarah Rook

Doctoral Programme in Clinical Psychology, Cardiff University, Cardiff, UK

Correspondence address: 11th Floor, Tower Building, 70 Park Place, Cardiff, CF10 3AT
Email: Rooks@cardiff.ac.uk

**Manuscript prepared in line with author guidelines for Death Studies (Appendix B). For the purpose of thesis submission tables and figures have been embedded in the main text, however these will be placed in supplementary information for journal submission. Death Studies does not stipulate a word-limit, therefore the 8000-word limit set for the thesis has been adhered to.*

Word count: 7899

The Mental Health Impact of Losing a Friend or Sibling to Suicide: A Systematic Review

Exposure to the suicide of a friend or sibling is a relatively common occurrence for young people. Studies have suggested that the loss of a friend or sibling to suicide may be associated with mental health disorders and suicidal behaviour, however the evidence base lacks cohesion. This systematic review investigated the short and longer-term mental health sequalae for young people exposed to the suicide of a friend or sibling. A systematic search of the literature was conducted in line with PRISMA guidelines, the protocol was pre-registered on PROSPERO, and a narrative synthesis was conducted. Twenty studies met the inclusion criteria, 19 of which were rated of moderate or high quality. Analysis indicated that following exposure to the suicide of a friend or sibling, young people are at risk of depression, anxiety, PTSD, suicidal behaviour and suicide attempt. These findings have implications for postvention for this population. Future longitudinal research, particularly into sibling suicide bereavement is needed to confirm these findings and assess their generalisability to non-western populations.

Keywords: *suicide, sibling, friend, adolescent, bereavement*

Introduction

The World Health Organisation (WHO) estimates that up to 700,000 people die by suicide each year. Patalay and Fitzsimons (2020) reported that around 7% of young people in the UK have attempted suicide by age 17. A recent report commissioned by the Healthcare Quality Improvement Partnership (HQIP) found that 11% of young people under age 20 who died by suicide had been bereaved by suicide themselves (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2017).

It is thought that approximately 135 peers, friends, and family members are impacted for each person that dies by suicide (Cerel et al., 2019). Andriesson and colleagues (2017) explain that although suicide appears to be comparable to other types of death, certain features of grief such as feelings of shame and guilt or experience of stigma, may be unique

to suicide. These characteristics may mean that exposure to suicide bereavement leaves young people particularly vulnerable to negative psychological consequences.

Previous reviews in this area have illustrated the deleterious psychological impact of suicide bereavement on adults (Pitman et al., 2014). Pitman and colleagues' (2014) results suggested that exposure to suicide increased risk of suicidal behaviour, psychiatric admissions, and depression in certain populations. In terms of young people, Andriessen et al. (2016) conducted a systematic review into the pre and post loss features of adolescent suicide bereavement. Andriessen et al. (2016) concluded that both pre and post loss features (e.g., family history of mental health issues, quality of remaining relationships) impacted individuals' reactions to suicide loss. However, their broader focus, which included the wider family unit, limited the analysis and conclusions that could be made about young people specifically exposed to a friend or sibling's suicide. Several recent studies have also been published concerning the impact of suicide on young people (e.g., Liu et al., 2020; Kline et al., 2021). Taken together, this information demonstrates the need for a contemporary and in-depth systematic review of the psychological impacts of losing a friend or sibling to suicide.

There is robust evidence that siblings experience a range of negative psychological impacts following the death of a brother or sister (Balk, 2014). However, little research has focused specifically on the impact of sibling suicide on young people. Research has shown that both peers and siblings are likely to experience disenfranchised grief (Robson and Walter, 2012). This is defined as "grief experienced by those who incur a loss that is not, or cannot be, openly acknowledged, publicly mourned or socially supported" (Doka, 1999, p.37). This suggests that peers and siblings may be uniquely impacted by exposure to suicide, which may in turn have implications for subsequent provision of support.

Research into suicide exposure has largely focussed on the concept of suicide clusters, whereby a group of people affiliated with one another and/ or from the same area, die by suicide within a short period of time (Cheng, Silenzio and Caine, 2015). Evidence of increased suicidal behaviour in people exposed to suicide has been found in several methodologically robust studies (e.g., Pitman et al, 2014). A recent systematic review has also shown that suicide clusters tend to involve young people and that they most often occur within the general population and within peer groups (Niedzwiedz et al., 2014).

Psychological theories such as contagion, imitation, suggestion, and social learning theory have been proposed to explain the mechanisms by which suicide clusters occur (Niedzwiedz et al., 2014). Haw et al. (2013) identified risk factors including (but not limited to): male gender, contact with another cluster victim, past mental health history, family mental health history, drug and/or alcohol abuse, and experiences of negative life events (e.g., physical/ psychological abuse). Despite these findings, the causes and risk factors for suicide clusters are poorly understood, largely due to the ethical and methodological challenges involved with conducting research in this area (Pitman et al., 2014).

In addition to the possible increased risk of suicidal behaviour and attempt, exposure to suicide is also associated with other psychological impacts. For example, Andriessen et al. (2016) reported that young people exposed to suicide may be more likely to develop mental health conditions such as depression, anxiety and post-traumatic stress disorder (PTSD). National suicide prevention guidelines have been developed in England and Wales (e.g., Talk to me 2). These suggest that postvention support should be offered to people bereaved by suicide. Postvention is defined as a co-ordinated response following a suicide that aims to "… facilitate the healing of individuals from the grief and distress of suicide loss, to mitigate other negative effects of exposure to suicide, to prevent suicide among people who are at

high risk…" (Survivors of Suicide Loss Task Force, 2015, p. 5). Pitman et al. (2014) point out that suicide postvention policies generally provide insufficient description of the impact of suicide and unclear guidance regarding postvention for the bereaved. This suggests that there is a need for a clearer understanding around these issues.

There is a lack of clarity surrounding the mental health impact on young people of losing a friend or sibling to suicide, and the evidence base lacks cohesion. This systematic review aimed to address this gap in the evidence by systematically synthesising studies that have examined the impact of losing a peer or sibling to suicide on young people's mental health and suicidal behaviours and attempts. This will provide information that can be used by policymakers and researchers to guide the design and implementation of effective postvention support for this particularly vulnerable population.

Method

Search Strategy

This review followed PRISMA guidelines and was registered on PROSPERO prior to commencing the search [255688]. The electronic databases searched included APA Psycinfo, Scopus, and Web of Science. Searches were conducted between November 2021 and January 2022. The following main keywords were used: sibling, brother, sister, friend, peer, young person, child, adolescent, suicide. The truncation symbol (*) was used to increase search sensitivity. A specialist subject librarian was consulted with during the generation of the search terms (Table 1).

Table 1

Database Search Strings

Scopus	(TITLE-ABS-KEY ((suicide)) AND TITLE-ABS-KEY ((peer*) OR (sibling*) OR (friend) OR (friends) OR (brother*) OR (sister*)) AND TITLE-ABS-KEY ((adolescen*) OR (“young person”) OR ("young people") OR (child*) OR (teen*) OR (“young adult*”)))
Web of Science	Suicide (All Fields) and peer* OR sibling* OR friend OR friends OR brother* OR sister* (All Fields) and adolescen* OR “young adult*” (All Fields)

Selection of studies

Figure 1 represents a summary of the stages of study selection in accordance with PRISMA guidelines (Moher et al., 2009). Inclusion and exclusion criteria are shown in Table 2. Database searching retrieved 5731 abstracts prior to the removal of duplicates. Five additional papers were retrieved through hand searching the references of relevant reviews and studies identified during the search. Only the results of quantitative studies were reviewed. If a study used mixed methods, only the quantitative findings were included. In order to ensure the review remained focused, only mental health outcomes that were assessed via standardised measures were reported. However, studies that included dichotomous or non-standardised measures of suicidal behaviour were included, due to the lack of standardised measures in this area and the serious nature of this outcome. For the purposes of this study, mental health outcomes refer specifically to mental health conditions classifiable by the DSM-IV. Suicidal behaviour refers to issues including thoughts, ideation and plans. Outcomes relating to suicide were classified as suicidal behaviour unless the reviewed study specifically assessed suicide attempt, in which case they were recorded separately.

Table 2

Inclusion and Exclusion Criteria for Reviewed Studies

Inclusion criteria	• Studies that utilised quantitative methods • Studies that included standardised measures of mental health conditions • Participants included children or young people (0–25 years) • Participants had experienced the death of a peer or sibling by suicide • The study reported mental health outcomes and/ or suicidal behaviour • Studies that included deaths other than suicide or family members other than siblings were only included if they reported extractable results for siblings and/or suicides. Only the relevant results were included in the review • Studies that included exposure to both suicide attempts and deaths were only included if they reported extractable results for exposure to death. Only the relevant results were included in the review
Exclusion criteria	• Studies that failed to meet inclusion criteria above • Studies that included participants who were >25 years old (if records concerned a wider age range but had extractable data for the 0–25 age group, these were included) • Studies that did not report on mental health and/ or suicidal behaviour following a friend or sibling's suicide • Studies that were not a primary research article (e.g., reviews, conference abstracts, grey literature) • Single case designs • Qualitative studies • Studies that did not include standardised measures of mental health conditions (unless they reported on suicidal behaviour and/ or attempt) • Studies not published in English • Studies published prior to 1990

Titles and abstracts from the search (*n*= 3473) were screened by the primary investigator (SR) with 10% cross-checked by an independent researcher. Any disagreements were discussed until agreement was achieved. The primary investigator screened all full-text articles and extracted data from studies that met the inclusion criteria using a pre-determined extraction template. Pilot testing of the data extraction template and inclusion/exclusion criteria were conducted to assess its efficacy. Details of extracted data are shown in Table 3.

Figure 1.

PRISMA Flowchart of Included Studies

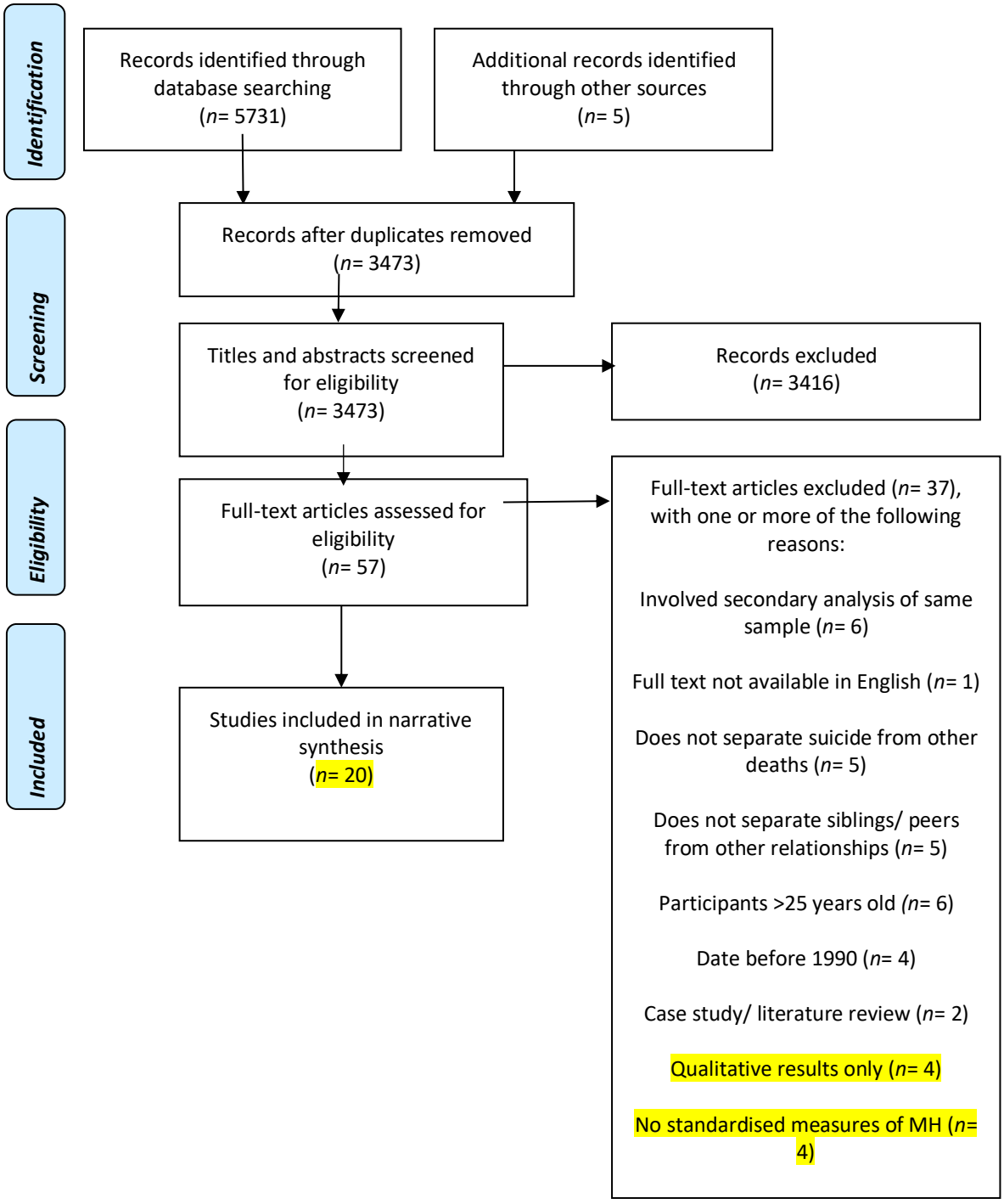


Table 3

Data Extraction Details

Extracted Data
• Title • Authors • Year • Location • Sample size • Study design • Measures • Exposure characteristics (time since loss, type of loss, context of loss, demographics) • Control characteristics (context, demographics) • Data analysis methods • Main findings regarding mental health conditions and suicidal behaviour and attempt

Quality Appraisal

Quality appraisal of the records was conducted by the author (SR) using the Mixed Methods Appraisal Tool (MMAT; Pluye et al., 2011). This tool has been developed and content validated (Souto et al., 2015). The MMAT allows quantitative, qualitative, and mixed method studies to be quality assessed concomitantly. The MMAT includes two screening questions that facilitate the identification of empirical studies and confirm whether the study is appropriate for assessment with the tool. There are two parts to the MMAT: checklist and explanation of criteria. A 'yes', 'no', 'can't tell' rating is applied to each question in the MMAT. A percentage score based on the number of 'yes', 'no' and 'can't tell' responses was calculated for each study. Studies were then categorised as low (score between 0% to 33%), moderate (score between 34% and 66%), or high quality (score between 67% and 100%).

A random sample of 25% of the included studies (n= 5) were rated by an independent second researcher. Results were discussed between raters and refinements were made to three records. Cohen's Kappa coefficient was calculated for each item of the MMAT assessed by

the two raters (Cohen, 1960). Inter rater reliability ranged from moderate (κ= 0.55) to almost perfect agreement (κ= 1.00).

Data Synthesis

Narrative synthesis was undertaken due to the methodological heterogeneity between studies under the framework of the 'ERSC Guidance on Conducting Narrative Synthesis' (Popay et al., 2006). Although this guidance was primarily developed for reviews that focus on the effects or implementation of interventions, the authors of the guidance state that it is equally applicable to other categories of review questions (Popay et al., 2006).

In order to allow a degree of comparison across studies, effect sizes have been calculated and are shown in Table 7 and Table 8. Where it was not possible to calculate an effect size (e.g., insufficient statistical data) an outcome of 'unobtainable' was recorded. Small, medium, and large effect sizes were regarded as Cohen's d = 0.2, 0.5, and 0.8; Cohen's F^2 = 0.02, 0.15, and 0.35; Pearson's r= 0.1, 0.3, and 0.5 odds ratios (OR)= 1.68, 3.47, and 6.71 (Cohen, 1988; Steiger, 2004; Dunst and Hamby, 2012; Chen et al., 2010).

Results

Tables 5 and 6 provide a summary of the key characteristics of the studies included in this review as well as their main findings. The search strategy detailed above yielded 20 studies, published between 1993 and 2021. Most studies focused on the impact of peer suicides (n= 17; 85%). Only three of the 20 studies (15%) that met the inclusion criteria reported on sibling suicides.

Participant Characteristics

Most of the studies were undertaken in the USA (*n*= 12; 57.1%). The remainder were conducted in: Australia (*n*= 2; 9.5%), Canada (*n*= 1; 4.8%), New-Zealand (*n*= 1; 4.8%), Hong-Kong (*n*= 1; 4.8%), China (*n*= 1; 4.8%), Norway (*n*= 1; 4.8%); Finland (*n*= 1; 4.8%). Overall, 48,581 participants were included across the reviewed studies. The demographic details of participants were not always reported, particularly regarding ethnicity. Most studies included majority white samples. Overall, white participants made up between 100% to 30% of participants. Studies varied in their gender distribution with female participants making up between 45% and 80% of the reported study samples. Ages of participants ranged between studies from 11 to 24 years old. The interval between the suicide of a peer/ sibling and data collection was not reported in all of the included studies, but ranged from approximately 2 months to 8 years in the studies that reported this data.

Study Designs and Methods

Fourteen studies used a cross-sectional design. Of these, three (21.4%) were cohort studies based on nationally representative samples, four (28.6%) used a survey design and seven (50%) used a case-control design. One core research group was responsible for six (30%) of the studies (both cross-sectional and longitudinal). However, these studies either used separate samples or involved analysis of different measures or time-points and were therefore all included in this review.

Six (30%) studies reported longitudinal data. Three (50%) were case-control designs, all conducted by the same research group. Two (33.3%) of these studies used data derived from the same sample, however the data were collected at different time points, so both studies were included in the review. Three (50%) were longitudinal cohort study analyses.

The reported aims of each of the included studies is shown in Table 4. The studies used a combination of parent and self (young person) report interviews and/or questionnaires to assess outcomes. Table 5 and 6 includes a summary of the main measures used by each study to assess mental health outcomes.

Table 4

Reported Aims of Studies

Study	*Aims*
Bartik et al. (2013)	Investigated the psychological impact of peer suicide on depression and stress in comparison to scale norms.
Brent et al. (1993a)	Investigated new-onset psychiatric problems of young people exposed to suicide of a peer on a school-bus. Also looked at suicidality of exposed peers.
Brent et al. (1993b)	Compared new-onset psychopathology including suicide attempt and behaviour, of young people exposed to a suicide of a peer to unexposed controls.
Brent et al. (1993c)	Compared new-onset psychopathology including suicide attempt and behaviour, of young people exposed to a suicide of a sibling to unexposed controls.
Brent et al. (1994)	Examined the risk of depression and suicidal behaviour and attempt following exposure to peer's suicide.
Brent et al. (1996a)	Looked at long-term impact on psychopathology and suicide attempt in young people after exposure to peer's suicide.
Brent et al. (1996b)	Investigated long-term impact on psychopathology and suicide attempt in young people after exposure to sibling's suicide.

Cerel, Roberts and Nilsen (2005)	Looked at whether exposure to peer suicide death or attempt increased risk of psychopathology including suicide attempt and behaviour.
Chan et al. (2018)	Investigated association between exposure to suicide death or attempt of a peer and subsequent risk of suicide attempt in young people. Also looked at whether quality of relationship impacted risk.
Dregrov and Dyregrov (2005)	Assessed post-traumatic reactions in young people bereaved by sibling suicide.
Feigelman and Gorman (2008)	Examined short and long-term impact of peer suicide on depression and suicidal behaviour in young people
Gould et al. (2018)	Researched whether exposure to a schoolmate's death by suicide led to increased risk of suicidal behaviour and depression in young people. Also looked at whether factors such as exposure to previous negative life events moderated risk.
Hazel and Lewin (1993)	Compared whether young people exposed to a peer's suicide death and/ or attempt suffered a higher incidence of psychopathology in comparison to unexposed. Looked at whether exposed had higher incidence of suicidal behaviour.
Ho et al. (2000)	Looked at the prevalence of psychological disorders and suicidal behaviours and attempts among young people exposed to suicidal behaviour of a peer. Looked at whether type of exposure (e.g., death vs attempt) and quality of relationship moderated risk of suicidal behaviour and psychopathology.
Kline et al. (2021)	Investigated the long-term relationship between young people's exposure to peer suicide and subsequent suicide risk.
Liu et al. (2021)	Examined whether exposure to friend's suicide death or attempt increased subsequent risk of suicidal behaviour or attempt.
Pirelli and Jeglic (2009)	Assessed whether exposure to death (including peer suicide) is associated with history of suicide attempt and current suicidal ideation in young people.
Poijula et al. (2001)	Looked at risk of young people developing PTSD following exposure to a peer's suicide.
Swanson and Colman (2013)	Examined the long-term relationship between exposure to peer suicide and subsequent suicidal behaviour and attempt in young people.
Watkins and Gutierrez (2003)	Investigated whether there is a relationship between exposure to a friend or acquaintance's suicide death and YP's psychopathology and suicidal behaviour.

Table 5

Characteristics and Main Findings of Cross-Sectional Studies

Authors, year, country	***Study details (design, time since death)***	***Exposed group (description, demographics)***	***Measures***	***Control group (description, demographics)***	***Main findings***
Bartik et al. (2013b) Australia	Cross-sectional Comparison to norms. Range 1-8 years	Young people who had experienced the suicide of a friend *n*= 10 80% female; No information re ethnicity; 24 years (*SD*- 3.43)	Self-report only BDI STAI	Scale norms	Exposed participants had higher levels of depression (*t*= 2.70, *p*= 0.03) compared to norms. Findings for anxiety not significant.
Brent et al. (1993a) USA	Matched case-control 2 months	Peers on a school bus with a student who died by suicide *n*= 28 46% female; 96% white; 15.8 years (*SD*- 1.1).	Child and parent report K-SADS- P&E PTSDRI	Controls drawn from similar but separate community that had not experienced any adolescent suicides in past 2 years *n*= 28 46% female, 100% white; 16.1 years (*SD*- 2.0)	Exposed group had significantly higher new-onset rates of anxiety (fisher's exact test, *p*= 0.03). Findings for depression, PTSD and suicide attempt not significant.

Authors, year, country	*Study details (design, time since death)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Brent et al, (1993b) ***USA***	Matched case-control 7 months (mean)	Friends and acquaintances identified by the families of 26 adolescent suicide victims *n*= 146 45.9% female; 97.2% white; 18.4 yrs. (*SD*- 2.0)	Child and parent report K-SADS-P&E PTSDRI SCS	Controls were drawn from a similar but separate community that had not experienced any adolescent suicides in past 2 years *n*= 146 45.9% female; 100% white; 15.5 years (*SD*- 1.7)	Incidence of new-onset depression (x^2= 25.0, $p\leq$ 0.0001), anxiety (x^2 = 5.40, p= 0.02) and PTSD (binomial test, p= 0.004) significantly increased in exposed group. No significant increase in incidence of new-onset suicide attempts, but significant increase in incidence of suicidal behaviour (x^2= 3.77, $p\leq$ 0.05).
Brent et al. (1993c) ***USA***	Matched case-control 7.8 months (mean)	Siblings of suicide victims *n*= 25 52% female; 100% white; Age: 17.4 years (*SD*- 2.8)	Child and parent report K-SADS-P&E PTSDRI SCS	Controls drawn from similar but separate community that had not experienced any adolescent suicides in past 2 years *n*= 25 52% female; 100% white; Age: 15.5 years (*SD*- 2.3)	No significant difference in rates of suicide attempt or PTSD in exposed participants. Increased incidence of new-onset depression in siblings. (x^2= 4.50, p= 0.04). Non-significant trend of increased risk of anxiety.

Authors, year, country	*Study details (design, time since death)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Cerel, Roberts and Nilsen (2005) USA	Retrospective secondary analysis of cohort study data Past 12 months	Nationally representative sample of adolescents exposed to peer suicide attempts and deaths *n*= 167 56.9% female; 71.9% white, 9.0% black, 19.1% other; Age 11-18	Self-report only CES-D (modified)	Unexposed members of cohort study *n*= 4797 No demographic information	Young people exposed to death by suicide were more likely to experience suicidal ideation (OR= 5.4*); suicide attempts (OR= 9.4*); and depression (OR= 2.9*) in comparison to non-exposed.
Chan et al. (2018) New-Zealand	Retrospective secondary analysis of cohort study data Time not reported	Nationally representative sample of adolescents exposed to peer suicide attempts and deaths. Taken from cohort study. Included deaths from family **School mate** (*n*= 1542) **Friend** (*n*= 885) Whole sample- 53.4% female; 47.2% white, 20% Maori, 14.2% pacific, 18.6% other; age range 13-17 years	Self-report only **Non-standardised:** Suicide attempt	Members of cohort not exposed to peer suicide (but may have been exposed to family suicide) *n*= 6958 (demographics not separated)	Exposure to friend's suicide death within past year (OR= 2.81*) or more than a year ago (OR= 1.59*) was associated with increased risk of suicide attempt. Exposure to schoolmate's suicide did not significantly increase risk of suicide attempt.

Authors, year, country	*Study details (design, time since death)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Dyregrov and Dyregrov (2005) Norway	Mixed methods 1.5 years (mean)	Siblings who lost a sibling to suicide while still living at home *n*= 11 45.5% female; No information re ethnicity; 17.7 years	Self-report only IES-15	Parents and older (>21 years) siblings *n*= 187 Siblings- 66.1% female; 28.4 years Parents- 60.2% female; 51.0 years	Younger siblings had higher incidence of PTSD in comparison to parents and older siblings.[+]

Authors, year, country	*Study details (design, time since death)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Gould et al. (2018) USA	Non- matched case-control 6 months (mean)	Students in 6 high schools that had experienced the suicide of a peer *n*= 2865 42% female; 87% white, 4.1% Hispanic, 3.1% Asian, 2.3% black; 15.5 years	Self-report only BDI CLES **Non-standardised:** Suicidal ideation and behaviour	Controls were drawn from 6 high schools with similar demographics but that community that had not experienced a suicide in past 4 years *n*= 2419 42% female; 77% white, 5.5% black, 7.4% Hispanic, 3.8% Asian; 15.5 years	Exposed participants in general showed no significant difference in suicidal behaviour or depression in comparison to non-exposed. Sub-group of exposed participants who had experienced recent stressful life events, did have increased risk of suicidal behaviour (OR= 1.005*) and depression (OR= 1.005*). Friends who were not close had increased risk of depression (OR= 2.30, *p*= 0.0002) and suicidal behaviour (OR= 1.85, *p*= 0.006). Close friends were found to be most at risk of depression (OR= 4.40, *p*< 0.0001).

Authors, year, country	*Study details (design, time since death)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Hazell and Lewin (1993) Australia	Matched case-control 8 months	Students from 2 high schools that had experienced student suicides *n*= 68 55.9% female; 14.72 years; no information on ethnicity	Self-report only YSR **Non-standardised:** Suicidal ideation and behaviour	Students from same 2 high schools that were not friends with either a suicide completer or attempter *n*= 554 53.8% female; no information on ethnicity; 14.72 years	No significant differences in rates of suicidal behaviour or depression between exposed and controls.
Ho et al. (2000) Hong-Kong	Non-matched case-control 16.7 months (mean)	Peers of suicide completers and attempters in 10 high schools *n*= 329 53.4% female; No data on ethnicity; 16.6 years (*SD*- 1.18)	Child and parent report YSR CBCL CLES Self-report drug use **Non-standardised:** Suicidal behaviour	Non-exposed controls were drawn from the same 10 schools as peers of suicide completers and attempters *n*= 1017 45.9% female; No data on ethnicity; Age: 15.1 years (*SD*- 1.66)	Peers of suicide completers had significantly higher incidence of depression (internalising problems; x^2= 14.2, p< 0.0001). Also, higher rates of suicide attempts (x^2= 38.9, p< 0.0001) and suicidal behaviour (x^2= 39.0, p< 0.0001) in comparison to non-exposed controls.

Authors, year, country	*Study details (design, time since death)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Liu et al. (2020) China	Retrospective secondary analysis of cohort study Time not reported	Students from 5 middle schools and 3 high schools who said they had been exposed to a peer's suicide. Included exposures other than peer suicides *n*= 497 Whole sample- 49.1% female; 14.97 years (*SD*- 1.46); no information re ethnicity	Self-report only CES-D **Non-standardised:** Suicide exposure and own suicidal behaviours	Unexposed students in cohort *n*= 11048 (Demographics not separated)	Risk of suicidal thoughts (OR= 1.57, *p*= 0.0001) and plans (OR= 1.57, *p*< 0.05) higher in those exposed to friend's suicide death in comparison to controls. No significant difference in suicide attempts.
Pirelli and Jeglic (2009) USA	Cross-sectional Time not reported	Undergraduate students. Included exposures other than peer suicides Whole sample (*N*= 396) 74.7% female; No information on ethnicity; 20.2 years (*SD*- 3.97)	Self-report only BSS **Non-standardised:** Experiences and exposure to various types of death	N/A	Exposure to a friend's suicide death was associated with increased risk of history of suicide attempt (OR= 1.76, *p*< 0.05) Exposure to friend's suicide was not significantly associated with increased risk of current suicidal ideation.**

Authors, year, country	*Study details (design, time since death)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Poijula et al. (2001) Finland	Cross-sectional Approx. 9 months	Peers of 6 suicide victims in 3 different secondary schools *N*= 89 48.3% female; No data on ethnicity; Age: 15.4 years (*SD*- 0.5)	Self-report only IES **Non-standardised:** Reactions to school crisis interventions	N/A	30% of classmates classified as being in PTSD high risk group. Classmates who were friends had greater risk of PTSD in comparison to those who were not (34.8% vs 7.5%, x^2= 9.25, *p*= 0.002).
Watkins and Gutierrez (2003) USA	Matched case-control 2 years (mean)	High school students identified as peers of suicide victims from one school *n*= 27 63% female; 55.6% white; 27.8% black; 5.6% 13% Hispanic; 6.3 years (*SD*- 1.47)	Self-report only RADS SIQ SBQ **Non-standardised:** Suicide exposure	High school students from the same school as exposed peers, who were identified as unexposed *n*= 27 63% female; 27.8% black; 5.6% white; 13% Hispanic; 16.3 years (*SD*- 1.47)	No significant difference between exposed and unexposed in terms of suicidal ideation, attempt or depression.

Key: ***No *p* value given;** [+]No comparison group**; DASS-21**- Depression Anxiety and Stress Scale-21; **STAI**- State Trait Anxiety Inventory**; BDI**- Beck Depression Inventory; **CBCL**- Child Behaviour Checklist; **K-SADS-P&E**- Kiddie Schedule for Affective Disorders and Schizophrenia Present and Epidemiological; **ARI**- Adolescent Relationship Inventory; **PTSDRI**- Post Traumatic Stress Disorder Reaction Index; **CED**- Circumstances of Exposure to Death**; SCS**- Suicide Circumstances Scale; **CES-D**- Centre for Epidemiologic Studies Depression Scale; **YSR**- Youth Self Report; **BSS**- Beck Scale for Suicide Ideation; **IES**- Impact of Events Scale; **SIQ**- Suicidal Ideation Questionnaire; **SBQ**- Suicidal Behaviour Questionnaire; **RADS**- Reynolds Adolescent Depression Scale

Table 6

Characteristics and Main Findings of Longitudinal Studies

Authors, year, country	***Study details (design, follow-up period)***	***Exposed group (description, demographics)***	***Measures***	***Control group (description, demographics)***	***Main findings***
Brent et al. (1994) ***USA***	Matched case control 12–18-month follow-up	Friends and acquaintances identified by the families of 26 suicide victims *n*= 121 45.8% female; 97.5% white; 19.8 years (*SD*-2.0)	Child and parent report K-SADS- P&E PTSDRI TRIG ARI CED	Non-exposed controls from similar but separate community that had not experienced adolescent suicides in past 2 years *n*= 138 46.4% female; 100% white; 18.8 years (*SD*-1.5)	Exposed had higher rates of new-onset depression (20% vs 7.2%; *p*= 0.01) and anxiety (5% vs 0%, *p*= 0.008). No significant difference in PTSD, suicide attempt or suicidal behaviour.
Brent et al. (1996a) ***USA***	Matched case-control 3-year follow-up	Friends and acquaintances identified by the families of 26 suicide victims *n*= 166 48.5% female; 96.4% white; 21.2 years (*SD*- 1.8)	Child and parent report K-SADS- P&E PTSDRI	Non-exposed controls from similar but separate community that had not experienced adolescent suicides in past 2 years *n*= 175 45.1% female; 99.4% white; 20.4 years (*SD*-1.8)	Exposed group showed higher rates of new onset depression (18.7% vs 4.6%; *p*< 0.0001) and anxiety 18.1% vs 6.3%; *p*< 0.001) up to 18 months post exposure, however rates then converged. Rates of PTSD remained elevated throughout the study (5.0% vs 0.0%; *p*< 0.001). No significant difference in risk of suicide attempt.

Authors, year, country	*Study details (design, follow-up period)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Brent et al. (1996b) ***USA***	Matched case-control 3-year follow-up	Siblings of 20 consecutive suicide victims *n*= 20 50% female; 100% white; 20.2 years (*SD*- 3.1)	Child and parent report K-SADS- P&E PTSDRI	Controls were drawn from a similar but separate community that had not experienced any adolescent suicides in past 2 years *n*= 22 54.5% female; 100% white; 20.2 years (*SD*-2.4)	No significant difference in incidence of depression and anxiety, PTSD or suicide attempt in comparison to controls.
Feigelman and Gorman (2008) ***USA***	Retrospective secondary analysis of cohort study 6-year follow-up.	Peers of adolescents who died by suicide *n*= 615 No demographic information	Parent and child report CES-D **Non-standardised:** Suicide behaviours	Unexposed cohort members *n*= 20125	Significant increase in risk at wave 1 in incidence of suicidal ideation (OR= 2.99, *p*= 0.001), attempts (OR= 2.47, *p*= 0.001) and depression (ß=0.031; *p*= 0.02). Wave 2 showed significant risk of suicidal ideation (OR= 1.79, *p*= 0.008), suicide attempt (OR= 2.54, *p*= 0.002) and depression (ß= 0.038; *p*= 0.027) in exposed participants. Findings no longer statistically significant at wave 3.

Authors, year, country	*Study details (design, follow-up period)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Kline et al. (2021) USA	Cohort study 4–6-year follow-up.	Adolescents from 7 high schools who had been exposed to a peer's suicide and reported their own suicidal ideation/ attempt. Included other relationships and attempts only experienced death of a friend/ peer by suicide *n*= 119 Whole sample (demographics not separated)- 72.5% female; 30% white, 30% black, 25% Hispanic; age 12-21 years	Self-report only CSS C-DISC-2.3 **Non-standardised:** Exposure to suicide	Participants who did not report exposure to the death of a peer by suicide (but may have been exposed to attempts of friends/ family members or deaths of family) *n*= 399	No significant association between exposure to a peer's suicide and subsequent suicide attempt.

Authors, year, country	*Study details (design, follow-up period)*	*Exposed group (description, demographics)*	*Measures*	*Control group (description, demographics)*	*Main findings*
Swanson and Colman (2013) Canada	Retrospective secondary analysis of cohort study 2-year follow-up.	Young people exposed to a peer's suicide Divided into 3 age groups: **12-13** (*n*= 631); 49.8% female (whole sample) **14-15** (*n*= 1490); 49.7% female (whole sample) **16- 17** (*n*= 1325); 51% female (whole sample) No information on ethnicity	Parent and child report **Non-standardised:** symptom checklist (based on DSM-III) Suicide exposure, suicidal behaviour.	Cohort members not exposed to suicide of a peer **12-13** (*n*= 8135) **14-15** (*n*= 6312) **16- 17** (*n*= 4172)	At baseline, exposure to schoolmate's suicide <1 year ago was associated with suicidal ideation among ages 12-13yr (OR= 6.76*), 14-15yrs (OR= 2.85*), 16-17yrs (OR-1.83*). Also found increased risk of suicide attempt among ages 12-13yrs (OR= 5.93*), 14-15yrs (OR= 3.41*), 16-17yrs (OR= 3.26*). At baseline, exposure to schoolmate's suicide >1 year ago was associated with increased risk of suicidal ideation among ages 12-13yrs (OR= 4.08*) 14-15yrs (OR= 2.35*), 16-17yrs (OR= 1.97*). Also found increased risk of suicide attempt among ages 12-13yr olds (OR-5.05*), 14-15yrs (OR= 2.98*), 16-17yrs (OR= 2.04*). 2-year follow-up showed that a schoolmate's suicide increased risk of suicide attempt among ages 12-13yrs (OR= 1.50*) and 14-15yrs (OR= 2.68*). Exposure was also associated with increased risk of suicidal ideation for 14-15yr olds (OR= 1.82*).

Key: * No p value given; ** No further statistical information reported; K-**SADS-P&E**- Kiddie Schedule for Affective Disorders and Schizophrenia Present and Epidemiological; **ARI**- Adolescent Relationship Inventory; **PTSDRI**- Post Traumatic Stress Disorder Reaction Index; **CED**- Circumstances of Exposure to Death**; SCS**- Suicide Circumstances Scale; **CES-D**- Centre for Epidemiologic Studies Depression Scale; **RADS**- Reynolds Adolescent Depression Scale; **CDISC-2.3-** Diagnostic Interview Schedule for Children**; CSS-** Columbia Suicide Screen

Table 7

Effect Sizes of Cross-Sectional Studies

Study	Depression	Anxiety	PTSD	Suicide attempt	Suicide Behaviour (ideation/ planning)	Notes
Bartik et al (2013)	*d*= 0.85 Large effect *p*= 0.03	*d*= 0.36 Medium effect NS	N/A	N/A	N/A	N/A
Brent et al. (1993a)	OR= 5.87 Medium effect NS	OR= 16.71 Large effect *p*= 0.03	OR= 10.53 Large effect NS	OR= 1.00 Small effect NS	N/A	Unadjusted odds
Brent et al. (1993b)	OR= 9.83 Large effect *p*< 0.0001	OR= 24.96 Large effect *p*= 0.02	OR= 17.90 Large effect *p*= 0.004	OR= 1.00 Small effect NS	OR= 3.48 Medium effect *p*< 0.05	Unadjusted odds
Brent et al. (1993c)	OR= 7.04 Large effect *p*= 0.004	OR= 10.67 Large effect NS	OR= 10.67 Large effect NS	OR= 10.67 Large effect NS	N/A	Unadjusted odds
Cerel, Roberts and Nilsen (2005)	OR= 2.96 Small effect *p*< 0.01	N/A	N/A	OR= 9.43 Large effect *p*< 0.01	OR= 5.41 Medium effect *p*< 0.01	Reported covariates adjusted for: age, adults in home, sex, parent education, ethnicity.

Study	Depression	Anxiety	PTSD	Suicide attempt	Suicide Behaviour (ideation/ planning)	Notes
Chan et al. (2018)						
> 1 year ago	N/A	N/A	N/A	OR= 2.01* Small effect	N/A	Reported covariates adjusted for: sex, age, ethnicity, SES, low mood
< 1 year ago	N/A	N/A	N/A	OR- 1.59* Small effect	N/A	
Dyregrov and Dyregrov (2005)	N/A	N/A	Unobtainable	N/A	N/A	No unexposed comparison group
Gould et al. (2018)						
Exposed group as whole	Unobtainable NS	N/A	N/A	N/A	Unobtainable NS	Reported covariates adjusted for: school exposure status
Negative life events	OR= 1.01 Small effect *p*< 0.0001	N/A	N/A	N/A	OR= 1.01 Small effect *p*< 0.0001	
Friends (but not close) of deceased	OR= 2.30 Small effect *p*= 0.0002	N/A	N/A	N/A	OR= 1.85 Small effect *p*= 0.006	

Study	Depression	Anxiety	PTSD	Suicide attempt	Suicide Behaviour (ideation/ planning)	Notes
Close friends	OR= 4.40 Medium effect $p < 0.0001$	N/A	N/A	N/A	OR= 1.12 Small effect NS	
Acquaintances	OR= 1.44 Small effect NS	N/A	N/A	N/A	OR= 1.11 Small effect NS	N/A
Hazell and Lewin (1993)	Unobtainable NS	N/A	N/A	N/A	Unobtainable NS	Numerator and denominator *df***** not given
Ho et al. (2001)						
	OR= 2.85 Small effect $p < 0.0001$	N/A	N/A	OR= 1.89 Small effect $p < 0.0001$	OR= 1.55 Small effect $p < 0.0001$	Reported covariates controlled for: age, sex and risk factors controlled for (close friends only)
Liu et al. (2021)	N/A	N/A	N/A	OR= 2.12 Small effect NS	OR= 1.57 Small effect $p < 0.05$	Reported covariates controlled for: SES, age, sex, school
Pirelli and Jeglic (2009)	N/A	N/A	N/A	N/A	Unobtainable NS***	N/A

Study	Depression	Anxiety	PTSD	Suicide attempt	Suicide Behaviour (ideation/ planning)	Notes
Poijula et al. (2001)						
Close friends vs. not close	N/A	N/A	OR= 13.12 Large effect *p*= 0.002	N/A	N/A	Unadjusted odds
Watkins and Gutierrez (2003)	N/A	N/A	N/A	*r*= 0.15 Small effect NS	*r*= 0.10 Small effect NS	N/A

Key: * No p value given; ** Covariates adjusted for not reported; *** No further statistical information reported; ****_df_- degrees of freedom

Table 8

Effect Sizes of Longitudinal Studies

Study	Depression	Anxiety	PTSD	Suicide attempt	Suicide Behaviour (ideation/ planning)	Notes
Brent et al. (1994)	OR= 8.18 Large effect *p*= 0.01	OR= 15.62 Large effect *p*= 0.008	OR= 8.18 Large effect NS	OR= 1.14 Small effect NS	OR= 2.30 Small effect NS	Unadjusted odds
Brent et al. (1996a)	OR= 2.80 Small effect *p*< 0.0001	OR= 7.58 Large effect *p*< 0.0001	OR= 33.37 Large effect *p*< 0.001	OR= 0.84 Small effect NS	N/A	Unadjusted odds
Brent at al. (1996b)	OR= 0.14 Small effect NS	OR= 0.21 Small effect NS	OR= 1.00 Small effect NS	OR= 1.00 Small effect NS	N/A	Unadjusted odds
Feigelman and Gorman (2008)						
Wave 1	F^2= 0.47 Large effect *p*= 0.02	N/A	N/A	OR= 2.47 Small effect *p*= 0.001	OR= 2.99 Small effect *p*= 0.001	Adjusted odds**
Wave 2 (1-year FU)	F^2= 0.22 Medium effect *p*= 0 .027	N/A	N/A	OR= 2.54 Small effect *p*= 0.002	OR= 1.79 Small effect *p*= 0.008	
Wave 3 (6-year FU)	F^2= 0.06 Small effect NS	N/A	N/A	OR= 1.98 Small effect NS	OR= 2.01 Small effect *p*= 0.006	

Study	Depression	Anxiety	PTSD	Suicide attempt	Suicide Behaviour (ideation/ planning)	Notes
Kline et al. (2021)	N/A	N/A	N/A	Effect size unobtainable NS	N/A	*df* not reported
Swanson and Colman (2013)						
Cross-sectional < 1 year since exposure						
12-13yrs	N/A	N/A	N/A	OR=5.93* Medium effect	OR=6.76* Large effect	Reported covariates adjusted for: sex, SES, risk factors.
14-15yrs	N/A	N/A	N/A	OR=3.41* Medium effect	OR= 2.85* Small effect	
16-17yrs	N/A	N/A	N/A	OR= 3.26* Small effect	OR= 1.83* Small effect	
> 1 year since exposure						
12-13yrs	N/A	N/A	N/A	OR= 5.05* Medium effect	OR= 4.08* Medium effect	

Study	Depression	Anxiety	PTSD	Suicide attempt	Suicide Behaviour (ideation/ planning)	Notes
14-15yrs	N/A	N/A	N/A	OR= 2.98* Small effect	OR= 2.35* Small effect	
16-17yrs	N/A	N/A	N/A	OR= 2.04* Small effect	OR=1.97* Small effect	
2-year follow up						
12-13yrs	N/A	N/A	N/A	OR=1.50* Small effect	OR= 0.93* Small effect	
14-15yrs	N/A	N/A	N/A	OR= 2.68* Small effect	OR=1.82* Small effect	

Key: * No p value given; ** Covariates adjusted for not reported; *** *df*- degrees of freedom

Quality Ratings

The quality ratings for each of the reviewed studies are displayed in Appendix A. Quality ratings ranged from low to high. Eight (40%) were rated as moderate, 11 (55%) as high and one (5%) as low. Seven (36.8%) of the studies did not include a representative sample. Reasons for this included low participation rates and samples being either self-selected or selected by families of the bereaved. Ten studies (52.6%) failed to use appropriate outcome measures, either through use of non-standardised questionnaires or measures with poor psychometric properties. Three (15.8%) studies either did not report complete outcome data or did not show evidence of completion rates. All 19 quantitative studies provided evidence of controlling for confounders at some level, usually through use of case control design or regression analysis. Seven (36.8%) studies received a 'yes' in response to question 3.5 on the MMAT (exposure administered as intended). These studies provided evidence of consideration of co-exposures such as other types of suicide exposure which may have influenced the study outcomes.

The only included mixed methods study (100%) was found to be of moderate quality. The study provided adequate rationale for using a mixed methods approach and satisfactorily integrated their quantitative and qualitative findings. However, the study did not provide evidence of meta-inference (i.e., explicitly described the added value of using a mixed-method approach to answer their research question), discuss inconsistencies and divergences between their qualitative and quantitative findings, or adhere to the quality criteria set out for non-randomised quantitative studies.

Synthesis of Studies for Peers Exposed to Suicide

The following section synthesises the findings of the 17 reviewed studies that reported results relating to peers exposed to death by suicide.

Depression and *A*nxiety

Seven cross-sectional studies reported results regarding depression following suicide among peers of the deceased. Of these, three also evaluated anxiety as an outcome of exposure to peer suicide. All but one of these studies (Ho et al., 2001; 85.7%) were of moderate or high quality.

Five cross-sectional studies (85.7%) reported that exposure to a peer's suicide was associated with increased risk of depression (Brent et al., 1993b; Bartik et al., 2013b; Cerel, Roberts and Nilsen, 2005; Gould et al., 2018; Ho et al., 2001). Although Ho et al. (2001) and Gould et al. (2018) reported an increased risk of depression, this finding was only significant for close friends of the deceased and young people who reported previous exposure to negative life events. The majority of findings regarding depression achieved medium to large effect sizes. In a later paper Brent et al. (1993d) showed that higher levels of grief and closer relationships with the deceased were both correlated with depression in their (1993b) sample. Significantly, effect sizes from Gould et al's (2018) study became progressively larger according to the closeness of the participant's relationship with the deceased.

On the other hand, Brent et al's (1993a) study found no significant increase in depression within exposed adolescents, however the sample did not include participants who were close to the suicide victim (only acquaintances). Interestingly, despite the fact that Brent

et al's (1993a) findings for depression were not statistically significant, they did show a medium effect size. This suggests that methodological limitations (e.g., small sample size) may have impacted the validity of their results. Hazel and Lewin (1993) found no significant result for depression in those exposed only to completed suicide (although findings were more complex for participants exposed to both suicide attempt and death, however these results do not fall within the scope of this review). Overall, these findings suggest that depression is a common outcome following the loss of a peer to suicide. Certain sub-sets of young people (close friends, individuals with experience of negative life events) may be particularly vulnerable.

Three cross-sectional studies looked at anxiety in addition to depression (Brent et al., 1993a; Brent et al., 1993b; Bartik et al., 2013). Brent et al. (1993a; 1993b) suggested that exposure to peer suicide was associated with increased risk of anxiety and achieved large effect sizes. Bartik and colleagues (2013) suggested that peers showed a trend towards higher anxiety in comparison to scale norms, however this finding was not statistically significant. Notably, their study was underpowered for meaningful statistical analysis and there was wide variation in time elapsed since exposure among the participants. However, Brent et al. (1993a) reported similar findings using a larger sample and matched case-control design. Brent et al. (1993a) found that participants reported increased incidence of anxiety but not depression. This finding is in contrast to other studies conducted by Brent et al. (1993b; reported above). A potential explanation for this discrepancy may be that none of Brent et al's (1993a) sample reported that they were close to the victim. This finding may suggest that the closeness of the relationship between the victim and the exposed individual may increase the likelihood of certain outcomes. Specifically, close friends may be more likely to develop depression, whereas acquaintances may be greater risk of anxiety.

Three studies presented longitudinal findings regarding depression, two of which also reported results regarding anxiety. These studies suggested that although peers appear to be at increased risk of depression and anxiety for approximately 18 months post exposure, this risk decreases over time (Feigelman and Gorman, 2008; Brent et al., 1994; 1996a). This result is supported by the fact that effect sizes for depression became progressively smaller as time progressed within both Brent and colleagues (1994; 1996a) and Feigelman and Gorman's (2008) cohorts. Brent et al's (1994; 1996a) effect sizes for anxiety, however, were large at both follow-ups. Notably, two of these studies (Brent et al., 1994; 1996a) used the same sample, therefore there is a risk that this finding may be over-emphasised. Additionally, Brent et al's (1993a; 1994; 1996a) cohort had significantly higher levels of pre-existing psychopathology in comparison to controls, which makes it difficult to determine the extent to which suicide exposure was responsible for their findings. Finally, none of the reported studies discuss whether participants received any postvention support, which may also have influenced their results.

Suicide Attempts and Suicidal Behaviour

Ten studies reported cross-sectional results regarding suicidal behaviour (i.e., ideation, plans) and attempts subsequent to a peer's suicide. All but one (Ho et al., 2000) were either of moderate or high quality. Many studies did not differentiate between suicidal behaviour and suicide attempt. Where a study made no specific mention of suicide attempt, suicide related outcomes were recorded as suicidal behaviour. Definitions of suicidal behaviour were varied and broad within the reviewed studies. Only a minority of studies used standardised measures of suicidal behaviour.

Three papers (30%) reported that exposed peers were at increased risk of suicide attempts (Cerel, Roberts and Nilsen, 2005; Ho et al., 2001; Chan et al., 2018). Small effect sizes were found by Ho et al. (2001) and Chan et al. (2018), however Cerel, Roberts and Nilsen's (2005) study achieved a large effect. In addition to this, five studies (50%) reported increased risk of suicidal behaviour (Cerel, Roberts and Nilsen, 2005; Brent et al., 1993b; Gould et al., 2018; Liu et al., 2021; Ho et al., 2001). However, the majority achieved small effect sizes.

As with depression and anxiety, the closeness of the relationship between the bereaved and the victim was a significant factor in terms of risk of suicidal behaviour. Ho et al. (2000), and Chan et al. (2018) found that risk of suicidal behaviour was greater for close friends of suicide victims. In contrast, Gould et al. (2018) reported that only friends who were not close to the victim had a statistically significant increased risk, as well as those who had experienced more negative life events. Notably, Gould et al. (2018) used four categories of relationship among exposed young person (didn't know the person, acquaintance, friend but not close, close friends), as opposed to the studies above which only included two (close friend or acquaintance).

Brent and colleagues (1993a; 1993b) found no increased risk of suicide attempt, however they did not separate their sample according to the closeness of the relationship, therefore their results may not accurately represent the risk of suicide for close friends. Watkins and Gutierrez (2003) found that exposure to a peer's suicide was not associated with current increased suicidal behaviour. However, the majority of the sample used by Watkins and Gutierrez (2003) indicated that a significant amount of time (>2 years) has passed since the death of their peer. As a result, these findings likely do not offer a true reflection of risk in the short-term.

Five studies reported longitudinal results regarding suicide risk. Four (80%) found that young people exposed to the suicide of a peer were not at increased risk of suicidal behaviour or attempt in follow-up assessments conducted up to six years post-exposure (Feigelman and Gorman, 2008; Kline et al., 2021; Brent 1994; 1996a.). However, Feigelman and Gorman (2008) found that risk of suicide attempt and behaviour was significantly increased up to 2 years post exposure (although this was no longer the case 6 years after the initial assessment). Additionally, Brent et al. (1994) found that a sub-set of participants with new-onset depression were at higher risk of suicidal behaviour approximately 18 months post assessment, however this finding was no longer evident at 3 year follow-up. In fact, Brent et al. (1996a) suggested that observing the impact of suicide on bereaved friends and family may even serve as an inhibitory factor in the long-term- this is reflected in the effect size achieved in their study. On the other hand, Swanson and Colman's (2001) secondary analysis of a cohort study, found that exposure to a schoolmate's suicide, predicted peer suicide risk (both attempt and behaviour) up to 2 years post exposure. Significantly, younger teenagers (aged 12-13 years) were shown to carry the greatest risk. Effect sizes for both suicide attempt and suicidal behaviour progressively decreased with each increase in age group. Notably, Swanson and Colman's follow-up period was shorter in comparison to the other longitudinal studies described above, which may explain the inconsistency in findings.

Post-Traumatic Stress Disorder

Three moderate to high quality cross-sectional studies reported results regarding PTSD following the suicide of a friend. Two of three studies found an increased risk of PTSD (Brent et al., 1993b; Poilula et al., 2001). However, all three studies reported a large effect size for the association between suicide exposure and PTSD. As with depression and anxiety,

and suicidal behaviour and attempt, factors including closer relationships with the victim (Brent et al.,1993a; Poijula et al., 2001) and increased exposure to the suicide (Brent et al., 1993b; 1993a) were specifically associated with higher risk.

It is notable that Poijula and colleagues (2001) found a significantly higher incidence of PTSD (approximately 30% of sample) in comparison to the studies conducted by Brent et al. (1993a, 1993b; 14%, 5.5% of the sample, respectively). This discrepancy may be because Poijula and colleagues (2001) used a different assessment tool for PTSD in comparison to the other studies (IES vs. PTSDRI). It is also possible that participants in this sample may have been more vulnerable to developing PTSD symptoms due to the particularly violent nature of one of the suicides (self-immolation). Finally, it is possible that differences in postvention support across studies may in part account for the divergent findings.

Two longitudinal studies attained mixed results regarding PTSD in peers, both using the same cohort. Brent and colleagues (1994) followed-up their (1993b) sample 12-18 months later and found no evidence of increased incidence of PTSD (despite observing a large effect size). However, their (1996a) 3-year follow-up concluded that peers exposed to suicide once again showed a higher rate of PTSD in comparison to controls. A possible explanation for these discrepant findings may be that Brent et al's (1994) 12–18-month follow-up included significantly fewer participants than their earlier and later assessments. Given that the same sample was used by all longitudinal studies in this area, these results should be considered cautiously.

Synthesis of Studies for Siblings Exposed to Suicide

The following section presents the findings of the three reviewed papers that reported mental health outcomes for siblings exposed to suicide. These outcomes included: depression, anxiety, PTSD, and suicidal behaviour and attempts.

Depression and Anxiety

Two studies reported findings regarding depression and anxiety as an outcome following exposure to a sibling's death by suicide. Both were rated as high quality. Findings were similar to those reported for peers, in that exposed siblings were more likely than non-exposed controls to suffer from depression (Brent et al., 1993c). Brent et al. (1993c) did not achieve statistically significant results in terms of anxiety, however odds ratio analysis of their findings revealed a large effect size for both anxiety and depression. Similar to peers, the severity of grief was initially found to be correlated with severity of depression, however this was no longer the case at follow up (Brent et al., 1993c; Brent et al., 1996b). This suggests that grief may be less of a long-term risk factor for depression in siblings in comparison to peers exposed to suicide.

As with peers, siblings exposed to suicide had significantly higher rates of pre-existing mental health conditions. This finding suggests that peers and siblings of suicide victims may share similar bio-psycho-social risk factors for mental health conditions and suicidal behaviour. However, in a 3 year follow-up study, Brent and colleagues (1996b) concluded that there was no difference in incidence of depression or anxiety between siblings and

controls. In fact, in terms of odds-ratios, siblings appeared to be less at risk of anxiety or depression in comparison to controls. This result suggests that although siblings are at increased risk of depression following exposure to suicide, by three years post-exposure, they may experience some level of recovery. This is particularly interesting given the fact that siblings may have greater social, genetic, and psychological risk factors in comparison to peers.

Suicide Attempts and Suicidal Behaviour

Two studies rated as high-quality reported results regarding siblings' suicidal behaviour and attempts. Brent et al. (1993c) found that siblings bereaved by suicide did not report increased incidence of suicidal behaviour or attempts in comparison to controls in the short-term. Notably, despite the fact that Brent et al's (1993c) initial study did not report statistically significant results in terms of suicide attempt, it did achieve a large effect size. Similarly, at follow-up, siblings exposed to suicide did not show an elevated risk of suicide attempt compared to controls. This finding should be interpreted cautiously given the small number of studies and the fact that both studies utilised the same small sample. It should be noted that the study conducted by Brent et al. (1993c) was not adequately powered to accept the null hypothesis (i.e., that exposure to a sibling's suicide is not associated with increased suicidal behaviour). This finding is also not consistent with previous research. For example, other studies have provided strong evidence for a genetic component to suicide (Mirkovic et al., 2016; Ruderfer et al., 2020), and have also shown that exposure to family suicide is associated with subsequent suicidal behaviour (Andriessen et al., 2016). Finally, methodological limitations, such as a relatively brief follow-up period and small sample (n= 25), may also have impacted the findings of Brent et al. (1993c; 1996b).

Post-Traumatic Stress Disorder

Three studies, all rated as high quality, reported results regarding PTSD following sibling exposure to suicide. As with peers, the findings relating to PTSD were mixed. Dyregrov and Dyregrov's (2005) results showed that younger siblings had higher incidence of PTSD in comparison to parents and older siblings of suicide victims. However, they did not include a control group comparison. In contrast to findings relating to peers, Brent and colleagues' (1993c) study found no statistically significant difference in risk of PTSD between siblings and controls, however (as with depression and anxiety) their data showed a large effect size. This suggests that further methodologically robust research with larger samples is needed into the short-term risk of PTSD in siblings exposed to suicide. At follow-up, siblings showed no increased risk of PTSD either in terms of effect size or statistical significance (Brent et al., 1996b). This finding is somewhat surprising given that peers were found to be at increased risk and that exposure to the unexpected death of a loved one is a significant risk factor for PTSD (Atwoli et al., 2017). Neither study reported participant's level of exposure to suicide or details of postvention support that might have been provided. These factors may have influenced the results and could potentially explain the discrepancy with studies of peers.

Discussion

This review assessed the short and longer-term mental health impact on young people of exposure to the death of a peer or sibling by suicide. The systematic literature search

identified 20 studies that utilised standardised measures and reported on at least one mental health condition (e.g., depression, anxiety, PTSD) and/or suicidal behaviour.

Summary of Findings for Peers

The cross-sectional studies included in this review reported that young people who lose a peer to suicide may be at increased risk of depression and anxiety, suicidal behaviour and PTSD. Findings regarding risk of suicide attempt were more mixed. Longitudinal results indicated that young people exposed to the suicide of a peer are not at increased risk of depression and anxiety, suicidal behaviour or attempt in the longer-term. However, peers appeared to remain at higher risk of PTSD. Several studies highlighted possible links between young people's mental health outcomes and factors such as the subjective quality/closeness of the relationship and exposure to additional negative life events.

Summary of Findings for Siblings

Cross-sectional results indicated that siblings experienced depression following the suicide of a brother or sister. No studies reported statistically significant increases in risk of anxiety, suicidal behaviour and attempts or PTSD in the short-term. One study investigated the longitudinal impact of sibling suicide. Brent and colleagues' (1996b) found that siblings of suicide victims were at no increased risk of anxiety and depression, suicidal behaviour and attempt or PTSD approximately 3 years following initial assessment.

Interpretation of Findings

The results of this review highlight the importance of friendship in adolescence and suggest that peers may be particularly vulnerable following exposure to suicide. As children age and mature, they generally become less family and more peer-oriented (Horsley and Patterson, 2006; Larson, 1996). Indeed, researchers such as Furman and Buhrmester (1992) have even suggested that during adolescence, friends often surpass parents as the primary source of social support for young people. It has been argued that the loss of a close friend is psychologically similar to the loss of a family member and grief reactions can often be more intense than anticipated (Ackerman, 2007; Balk, 2009).

The fact that the reviewed studies suggest that exposed siblings do not appear to share the same level of risk of mental health problems as peers, is somewhat surprising. However, the "hierarchy of grief" and its implications, as proposed by Robson and Walter (2012), may go some way to offering an explanation. Robson and Walter (2012) described siblings as "first reserves" in terms of the mourning hierarchy and argued that they can feel less deserving of their grief reactions, particularly in comparison to parents (Robson and Walter, 2012, p. 106). However, comparable sentiments have also been expressed by peers of suicide victims (e.g., Bartik et al., 2013b). Robson and Walter (2012) suggest that like siblings, friends are also "lesser mourners" in the hierarchy of grief, even ranking below siblings (Robson and Walter, 2012, p. 107). Brent and colleagues (1996b) proposed that the expression of grief following sibling bereavement is viewed as more acceptable by society in comparison to grief relating to the death of a peer. Consequently, siblings may be more likely to be encouraged to be open about their bereavement and its impact and may subsequently be offered greater support.

Previous research has illustrated the importance of young people talking about grief and receiving support in order to prevent future psychological problems (Pfeffer et al., 2002). The results of this review emphasise the need for support to be provided to siblings and peers following exposure to a suicide death. Unfortunately, research has suggested that peers of people who die by suicide are less likely to draw upon their social network for support (Hobbs and Burke, 2017). Liu, Forbat and Anderson's (2019) study illustrated that people with less support following the death of a close friend were impacted more severely and for longer by their grief. Similar findings have been reported for young people exposed to a family death (Dyregrov, 2009). Researchers including Andriessen (2019) and Ringler and Hayden (2000) conclude that adolescents who lose a friend or family member to suicide often receive insufficient support. Reported barriers to accessing support include issues such as stigma, lack of availability of support or lack of knowledge about what support is available, and lack of awareness regarding symptoms of mental health problems (Andriessen et al., 2019).

Overall, the findings of this review indicate that peers of suicide victims may experience an increased risk of depression, anxiety, suicidal behaviour and PTSD, however most of these risks appear to dissipate over the time. These findings are consistent with previous quantitative research that has looked into the impact of other types of deaths on adolescents (Melhem et al., 2011). In addition to this, qualitative studies of the impact of exposure to peer suicide have also reported similar results (Heffel et al., 2015; Bartik et al., 2013b); however, this finding should be interpreted with caution, as only one longitudinal study specifically investigated this outcome (Brent et al., 1996a). Previous studies looking into the traumatic loss of a friend in adolescence have found that levels of PTSD tend to progressively decrease over time (Arnberg et al., 2011; Giannopoulou, Richardson and Papadatou, 2021).

The results of this review indicate that siblings exposed to suicide are at no increased risk of suicide attempt or suicidal behaviour. It is important to highlight that this finding is not consistent with previous research in similar areas. For example, Andriesson and colleagues (2016) explain that several methodologically sound studies (Agerbo, Nordentoft and Mortensen, 2002; Niederkro-Tenthaler et al., 2012; Wilcox et al., 2010) have found evidence of an increased risk in adolescents exposed to family suicides. Adult studies of siblings exposed to the death of a brother or sister by external causes have also provided evidence of increased suicide risk in the surviving sibling. Specifically, Rostila, Saarela and Kawachi (2013) highlighted that suicide risk is greatest among adults who experience the loss of a sibling to suicide. Finally, there is also robust evidence to support the suggestion that suicide and suicidal behaviour is partly a heritable condition. For example, a systematic review of twin studies and suicide concluded that "The totality of evidence… strongly suggests genetic contributions to liability for suicidal behaviour" (Voracek and Loibl, 2007, p.463). Given the evidence gained from previous research, it is likely that the findings of this review were influenced by methodological limitations. These include the small number of studies available, small sample sizes, and the absence of longitudinal data regarding suicide attempt and suicidal behaviour in siblings exposed to suicide. Further methodologically robust studies in this area are required in the future.

Findings regarding suicidal behaviour in peers exposed to suicide were complex to interpret. The results indicate that peers may be at increased risk, particularly with regards to suicidal behaviours in the short-term. Maple and colleagues (2017) conducted a systematic review to investigate whether suicide in peers was associated with suicidal behaviour in exposed individuals. Consistent with the findings of this work, Maple et al. (2017) concluded that exposure to suicide was associated with short-term increased risk. Hawton et al. (2020), suggest that there may be several reasons for this including: social transmission and cohesion,

belief that suicide is common and the fact that vulnerable young people may be more likely to cluster together (assortative mixing). Certain studies within this review (e.g., Brent et al., 1993b; Hazell and Lewin, 1993; Pirelli and Jeglic, 2009) found that peers exposed to suicide were more likely to have pre-existing psychological problems, including past suicide attempts. These findings add weight to theories such as assortative mixing, whereby individuals with similar characteristics tend to cluster together. Finally, the results of the few longitudinal studies identified during the literature search suggest that the risk of suicidal behaviour and attempt does not endure in the longer-term. Additional longitudinal studies using representative populations that control for potential confounders such as previous mental health history are required.

It was not within the scope of this systematic review to report results relating to exposure to suicide attempt (rather than death). However, it is important to note that many of the studies reported above concluded that experience of a peer's suicide attempt may be more detrimental than exposure to suicide death. Specifically, Liu et al. (2020) found that friends of peers who attempted (but did not complete) suicide were more likely to experience suicidal thoughts, plans and attempts relative to participants who were not exposed to suicidal behaviour. Hazell and Lewin (1993) and Ho et al. (2000) reported that peers exposed to suicidal behaviour were at increased risk for suicidal behaviour themselves. Specifically, Ho et al. (2000) found that although exposure to any suicidal acts (attempts or completion) increased the risk of suicidal behaviour, the risk was greatest for friends of suicide attempters. Hazell and Lewin (1993) concluded that individuals who were exposed to both suicide attempts and death were at greatest risk. Ho et al. (2000) found that friends of people who had attempted suicide had high rates of previous suicidal behaviour. Somewhat similarly, Pirelli and Jeglic (2009) found that participants who had lost a friend to suicide

were more likely to have a history of suicide attempts. These findings suggest that peers exposed to suicide attempts should also be prioritised for postvention support.

Methodological Limitations of Reviewed Studies

The WHO reports that up to 77% of suicides occur in low-middle income countries. Yet, the literature search only included two studies that were conducted in non-western countries (Liu et al., 2020; Ho et al., 2000). Most studies also used majority white samples. Therefore, these findings may not generalise to all populations. The exclusion of studies that were published in languages other than English contributes to this bias. Future research should be conducted with more diverse samples and in non-western countries.

The majority of studies included in the review received either a moderate or high-quality rating and were conducted using a mixture of case-control, cross-sectional and cohort study designs. The selection of the control group likely influenced the findings. For example, three studies (Hazell and Lewin,1993; Ho et al., 2000; Watkins and Gutierrez, 2003) drew control groups from the same population as the experimental group, therefore all participants in these studies technically experienced some level of exposure. Other studies included young people who had been exposed to family suicides within the control group (e.g., Chan et al., 2018). Most studies did not assess previous mental health or control for which participants had received postvention support, which may have been confounding factors. This means that it is not possible to say whether exposure to suicide in and of itself led to the sequalae reported in this review. Therefore, future research that controls for these factors should be conducted. Furthermore, several studies failed to use standardised measures, particularly

when assessing variables such as suicidal behaviour. Finally, many of the studies reported relatively low participation rates. This may reflect the sensitive nature of this subject area.

Limitations of this Review

The current study provides an up-to-date review of the literature on the mental health sequalae experienced by young people following the death of a sibling or peer to suicide. There are caveats and methodological limitations to hold in mind when appraising the conclusions. Of the included studies, six were conducted by the same research group which may have biased the conclusions of this review. Only three studies investigated outcomes relating to siblings exposed to suicide, therefore the conclusions that can be drawn regarding this specific population are limited. Studies were grouped into cross-sectional or longitudinal categories according to their research design. However, some of the cross-sectional studies included participants for whom exposure to suicide occurred up to 8-years previously. This may have limited the validity of the findings due to a memory recall bias. The review did not include qualitative research, which may have added more richness to the synthesis helping to contextualise the statistical trends with participant's experiences. Finally, a relatively large number of studies (n=20) were included, but no meta-analysis was conducted due to the heterogeneity of the study designs and methodology.

Future Research

Given the fact that the reviewed studies indicate that issues including depression and anxiety and suicidal behaviour are likely to be relatively short lived, it may be important for

future research to determine what factors are specifically associated with resilience and recovery in this population. Studies that look into post traumatic growth following the suicide of a friend or sibling may also be beneficial. Although some qualitative research has been conducted, there is a lack of methodologically robust quantitative research in this area. Neimeyer and Hogan (2001) point out that measures of grief generally overly-rely on scales of psychiatric symptomology and therefore preclude assessment of important outcomes such as post-traumatic growth. Previous research has shown that post-traumatic growth is associated with bereavement, particularly in younger people (Michael and Cooper, 2013; Helgeson, Reynolds and Tomich, 2006). Post-traumatic growth has also been shown to have clinical applications. For example, Tedeschi et al. (2015) suggest that listening out for and labelling examples of post-traumatic growth may be a therapeutic cognitive experience for the bereaved.

In addition to looking at protective factors, future research should also aim to identify risk factors that may increase the likelihood of negative outcomes. This review suggests that factors including close relationships and negative life experiences may be important in determining the mental health outcomes of young people exposed to suicide. Notably, these factors have been found to be associated with more negative outcomes (e.g., PTSD, depression) in young people who have been parentally bereaved (Brent et al., 2009; Melhem et al., 2011). A systematic review by Andriessen et al. (2016) concluded that mental health outcomes following the suicide of a peer are impacted by pre and post loss features (e.g., family history of mental health problems, personal mental health issues, feelings of accountability). The closeness of the relationship was also found to be a significant factor with regards to reactions including depression, anxiety and PTSD in bereaved peers. Again, these findings echo previous research which have looked at causes of death other than suicide (Servaty-Seib and Pistole, 2006). By identifying young people who may be at particularly

high risk following the suicide of a sibling or a peer help to identify who postvention services should target and prioritise.

Clinical Implications

Young people exposed to suicide may be at increased risk of detrimental psychological outcomes, particularly in the short-term. The fact that this review suggests that these issues may not persist in the longer-term should not detract from the fact that these young people are likely to need support. Peers of suicide victims may be especially vulnerable, however further research with suicide bereaved siblings is needed. It may be beneficial for postvention services to offer interventions that target anxiety, depression, PTSD and suicidal behaviour. Although there was some evidence to suggest that the risk of mental health problems following exposure to suicide is highest for those closest to the victim, this was not always the case. These findings suggest that appropriate postvention support should be made readily available to all young people following the death of a young person by suicide.

The fact that many of the reviewed studies report that certain life experiences may increase the risk of poor outcomes following exposure to suicide illustrates that postvention support should be tailored to the needs of the individual, rather than adopt a "one size fits all" approach. Andriessen et al. (2019) argue that postvention programmes that follow a public health model by offering different tiers of support according to individual circumstances and need might be most beneficial. Finally, this review suggests that individuals who possess certain risk factors, such as having had a close relationship with the deceased, the experience

of prior negative life events and an increased level of exposure to the death should be prioritised for professional support.

References

Ackerman, J. M., Kenrick, D. T., & Schaller, M. (2007). Is friendship akin to kinship? *Evol Hum Behav, 28*(5), 365-374. doi:10.1016/j.evolhumbehav.2007.04.004

Agerbo, E., Nordentoft, M., & Mortensen, P. B. (2002). Familial, psychiatric, and socioeconomic risk factors for suicide in young people: nested case-control study. *BMJ, 325*(7355), 74. doi:10.1136/bmj.325.7355.74

Andriessen, K. (2009). Can postvention be prevention? *Crisis* 30, 43–47. doi: 10.1027/0227-5910.30.1.43

Andriessen, K., Draper, B., Dudley, M., & Mitchell, P. B. (2016). Pre- and postloss features of adolescent suicide bereavement: A systematic review. *Death studies, 40*(4), 229–246. https://doi.org/10.1080/07481187.2015.1128497

Andriessen, K., Krysinska, K., & Grad, O. T. (2017). Current understandings of suicide bereavement Hogrefe Publishing. doi:10.1027/00493-000].

Andriessen, K., Lobb, E., Mowll, J., Dudley, M., Draper, B., & Mitchell, P. B. (2019). Help-seeking experiences of bereaved adolescents: A qualitative study. *Death studies, 43*(1), 1-8.

Arnberg, F. K., Rydelius, P.-A., & Lundin, T. (2011). A longitudinal follow-up of posttraumatic stress: From 9 months to 20 years after a major road traffic accident. *Child and Adolescent Psychiatry and Mental Health, 5*(1), 8. https://doi.org/10.1186/1753-2000-5-8

Atwoli, L., Stein, D. J., King, A., Petukhova, M., Aguilar-Gaxiola, S., Alonso, J., Bromet, E. J., de Girolamo, G., Demyttenaere, K., Florescu, S., Maria Haro, J., Karam, E. G., Kawakami, N., Lee, S., Lepine, J. P., Navarro-Mateu, F., O'Neill, S., Pennell, B. E., Piazza, M., Posada-Villa, J., … WHO World Mental Health Survey Collaborators (2017). Posttraumatic stress disorder associated with unexpected death of a loved one: Cross-national findings from the world mental health surveys. *Depression and anxiety*, *34*(4), 315–326. https://doi.org/10.1002/da.22579

Balk, D. E. (2009). Sibling bereavement during adolescence. *Adolescent encounters with death, bereavement, and coping*, 199-216.

Balk, D. E. (2014). *Dealing with dying, death, and grief during adolescence.* Routledge/Taylor & Francis Group.

Bartik, W., Maple, M., Edwards, H., & Kiernan, M. (2013a). Adolescent survivors after suicide: Australian young people's bereavement narratives. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 34*(3), 211-217. doi:http://dx.doi.org/10.1027/0227-5910/a000185

Bartik, W., Maple, M., Edwards, H., & Kiernan, M. (2013b). The psychological impact of losing a friend to suicide. *Australasian Psychiatry, 21*(6), 545-549 doi:http://dx.doi.org/10.1177/1039856213497986

Bartik, W., Maple, M., & McKay, K. (2015). Suicide bereavement and stigma for young people in rural Australia: A mixed methods study. *Advances in Mental Health, 13*(1), 84-95. doi:http://dx.doi.org/10.1080/18374905.2015.1026301

Bartik, W. J., Maple, M., & McKay, K. (2020). Youth suicide bereavement and the continuum of risk. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 41*(6), 483-489. doi:http://dx.doi.org/10.1027/0227-5910/a000653

Brent, D. A., Kerr, M. M., Goldstein, C., Bozigar, J., & et al. (1990). An outbreak of suicide and suicidal behavior in a high school. *Annual Progress in Child Psychiatry & Child Development*, 532-546.

Brent, D. A., Moritz, G., Bridge, J., Perper, J., & Canobbio, R. (1996a). Long-term impact of exposure to suicide: A three-year controlled follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(5), 646-653. doi:http://dx.doi.org/10.1097/00004583-199605000-00020

Brent, D. A., Moritz, G., Bridge, J., Perper, J., & Canobbio, R. (1996b). The impact of adolescent suicide on siblings and parents: A longitudinal follow-up. *Suicide & Life - Threatening Behavior, 26*(3), 253-259.

Brent, D. A., Perper, J., Moritz, G., Friend, A., Schweers, J., Allman, C., . . . Balach, L. (1993a). Adolescent Witnesses to a Peer Suicide. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(6), 1184-1188. doi:10.1097/00004583-199311000-00011

Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Schweers, J., & Canobbio, R. (1994). Major depression or uncomplicated bereavement? A follow-up of youth exposed to suicide. *Journal of the American Academy of Child & Adolescent Psychiatry, 33*(2), 231-239. doi:http://dx.doi.org/10.1097/00004583-199402000-00012

Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Schweers, J., Roth, C., . . . Allman, C. (1993c). Psychiatric impact of the loss of an adolescent sibling to suicide. *Journal of Affective Disorders, 28*(4), 249-256. doi:http://dx.doi.org/10.1016/0165-0327%2893%2990060-W

Brent, D. A., Perper, J. A., Mortiz, G., Allman, C., Schweers, J., Roth, C., . . . Liotus, L. (1993b). Psychiatric sequelae to the loss of an adolescent peer to suicide. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*(3), 509-517. doi:http://dx.doi.org/10.1097/00004583-199305000-00004

Bridge, J. A., Day, N. L., Day, R., Richardson, G. A., Birmaher, B., & Brent, D. A. (2003). Major depressive disorder in adolescents exposed to a friend's suicide. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(11), 1294-1300. doi:http://dx.doi.org/10.1097/01.chi.0000084830.67701.9

Cerel, J., Brown, M. M., Maple, M., Singleton, M., Van de Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. *Suicide and Life-Threatening Behavior, 49*(2), 529-534.

Cerel, J., Fristad, M.A., Weller, E.B., & Weller, R.A. (1999). Suicide-bereaved children and adolescents: A controlled longitudinal examination. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 672–679.

Cerel, J., Roberts, T. A., & Nilsen, W. J. (2005). Peer Suicidal Behavior and Adolescent Risk Behavior. *Journal of Nervous and Mental Disease, 193*(4), 237-243. doi:http://dx.doi.org/10.1097/01.nmd.0000158377.45920.0a

Cero, I., & Witte, T. K. (2020). Assortativity of suicide-related posting on social media. *The American psychologist, 75*(3), 365-379. doi:10.1037/amp0000477

Chambers, W. J., Puig-Antich, J., Hirsch, M., Paez, P., Ambrosini, P. J., Tabrizi, M. A., & Davies, M. (1985). The assessment of affective disorders in children and adolescents by semi structured interview. Test-retest reliability of the schedule for affective disorders and schizophrenia for school-age children, present episode version. *Arch Gen Psychiatry, 42*(7), 696-702. doi:10.1001/archpsyc.1985.01790300064008

Chan, S., Denny, S., Fleming, T., Fortune, S., Peiris-John, R., & Dyson, B. (2018). Exposure to suicide behaviour and individual risk of self-harm: Findings from a nationally representative New Zealand high school survey. *Australian and New Zealand Journal of Psychiatry, 52*(4), 349-356. doi:http://dx.doi.org/10.1177/0004867417710728

Chen, H., Cohen, P. & Chen, S. (2010) How Big is a Big Odds Ratio? Interpreting the Magnitudes of Odds Ratios in Epidemiological Studies, *Communications in Statistics - Simulation and Computation*, 39(4), 860-864, DOI: 10.1080/03610911003650383

Cheng, Q., Li, H., Silenzio, V., & Caine, E. D. (2014). Suicide contagion: A systematic review of definitions and research utility. *PLoS One, 9*(9), e108724.

Cohen, J (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*. 20 (1):3746 doi:10.1177/001316446002000104. hdl:1942/28116. S2C ID 15926286.

Cohen J (1988) *Statistical power analysis for the behavioral sciences*. Lawrence Erlbaum Associates, Hillsdale

Cross, S. E., & Madson, L. (1997). Models of the self: self-construals and gender. *Psychol Bull, 122*(1), 5-37. doi:10.1037/0033-2909.122.1.5

Cvinar, J. G. (2005). Do suicide survivors suffer social stigma: a review of the literature. *Perspectives in psychiatric care, 41*(1), 14-21.

Doka, K. J. (1999). Disenfranchised grief. *Bereavement care, 18*(3), 37-39.

Dunst, C. J., & Hamby, D.W. (2012) Guide for calculating and interpreting effect sizes and confidence intervals in intellectual and developmental disability research studies. *Journal of Intellectual & Developmental Disability*, 37:2, 8999, DOI: 10.3109/13668250.2012.673575

Dyregrov, K. (2009). How Do the Young Suicide Survivors Wish to Be Met by Psychologists? A User Study. *OMEGA - Journal of Death and Dying, 59*(3), 221-238. doi:10.2190/OM.59.3.c

Dyregrov, K., & Dyregrov, A. (2005). Siblings after suicide--"The forgotten bereaved". *Suicide and Life-Threatening Behavior, 35*(6), 714-724. doi:http://dx.doi.org/10.1521/suli.2005.35.6.714

Faschingbauer, T. R., Zisook, S., & DeVaul, R. (1987). The Texas revised inventory of grief. *Biopsychosocial aspects of bereavement*, 111-124.

Feigelman, W., & Gorman, B. S. (2008). Assessing the effects of peer suicide on youth suicide. *Suicide and Life-Threatening Behavior, 38*(2), 181-194. doi:http://dx.doi.org/10.1521/suli.2008.38.2.181

Furman, W., & Buhrmester, D. (1992). Age and sex differences in perceptions of networks of personal relationships. *Child development, 63*(1), 103-115.

Giannopoulou, I., Richardson, C., & Papadatou, D. (2021). Peer loss: Posttraumatic stress, depression, and grief symptoms in a traumatized adolescent community. *Clinical child psychology and psychiatry*, *26*(2), 556-568

Gould, M. S., Lake, A. M., Kleinman, M., Galfalvy, H., Chowdhury, S., & Madnick, A. (2018). Exposure to Suicide in High Schools: Impact on Serious Suicidal Ideation/Behavior, Depression, Maladaptive Coping Strategies, and Attitudes toward Help-Seeking. *Int J Environ Res Public Health, 15*(3). doi:10.3390/ijerph15030455

Hawton, K., Hill, N. T. M., Gould, M., John, A., Lascelles, K., & Robinson, J. (2020). Clustering of suicides in children and adolescents. *The Lancet Child & Adolescent Health, 4*(1), 58-67. doi:https://doi.org/10.1016/S2352-4642(19)30335-9

Hazell, P., & Lewin, T. (1993). Friends of adolescent suicide attempters and completers. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*(1), 76-81. doi:http://dx.doi.org/10.1097/00004583-199301000-00011

Heffel, C. J., Riggs, S. A., Ruiz, J. M., & Ruggles, M. (2015). The aftermath of a suicide cluster in the age of online social networking: A qualitative analysis of adolescent grief reactions. *Contemporary School Psychology, 19*(4), 286-299. doi:http://dx.doi.org/10.1007/s40688-015-0060-z

Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2006). A meta-analytic review of benefit finding and growth. *J Consult Clin Psychol, 74*(5), 797-816. doi:10.1037/0022-006x.74.5.797

Ho, T.-p., Leung, P. W.-l., Hung, S.-f., Lee, C.-c., & Tang, C.-p. (2000). The mental health of the peers of suicide completers and attempters. *Journal of Child Psychology and Psychiatry, 41*(3), 301-308. doi:http://dx.doi.org/10.1111/1469-7610.00614

Hobbs, W. R., & Burke, M. K. (2017). Connective recovery in social networks after the death of a friend. *Nature Human Behaviour, 1*(5), 0092. doi:10.1038/s41562-017-0092

Hogan, N. S., Greenfield, D. B., & Schmidt, L. A. (2001). Development and validation of the Hogan Grief Reaction Checklist. *Death Stud, 25*(1), 1-32. doi:10.1080/07481180125831

Hogan, N. S., Schmidt, L. A., Howard Sharp, K. M., Barrera, M., Compas, B. E., Davies, B., . . . Gerhardt, C. A. (2021). Development and testing of the Hogan Inventory of Bereavement short form for children and adolescents. *Death studies, 45*(4), 313-321. doi:10.1080/07481187.2019.1627034

Horsley, H., & Patterson, T. (2006). The Effects of a Parent Guidance Intervention on Communication among Adolescents Who Have Experienced the Sudden Death of a Sibling. *The American Journal of Family Therapy, 34*(2), 119-137. doi:10.1080/01926180500301519

Kessing, L. V., Agerbo, E., & Mortensen, P. B. (2003). Does the impact of major stressful life events on the risk of developing depression change throughout life?. *Psychological medicine, 33*(7), 1177-1184.

Kline, E. A., Ortin-Peralta, A., Polanco-Roman, L., & Miranda, R. Association Between Exposure to Suicidal Behaviors and Suicide Attempts Among Adolescents: The

Moderating Role of Prior Psychiatric Disorders. *Child Psychiatry and Human Development.* doi:10.1007/s10578-021-01129-2

Kübler-Ross, E. (1973). *On death and dying*: Routledge.

Liu, W. M., Forbat, L., & Anderson, K. (2019). Death of a close friend: Short and long-term impacts on physical, psychological and social well-being. *PLoS One, 14*(4), e0214838. doi:10.1371/journal.pone.0214838

Liu, Z.-Z., Wang, Z.-Y., Bo, Q.-G., Qi, Z.-B., Xu, R.-J., Jia, C.-X., & Liu, X. (2018). Suicidal behaviours among Chinese adolescents exposed to suicide attempt or death. *Epidemiology and psychiatric sciences, 29*, e12-e12. doi:10.1017/S2045796018000756

Maciejewski, P. K., Maercker, A., Boelen, P. A., & Prigerson, H. G. (2016). "Prolonged grief disorder" and "persistent complex bereavement disorder", but not "complicated grief", are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. *World Psychiatry, 15*(3), 266-275.

Maple, M., Cerel, J., Sanford, R., Pearce, T., & Jordan, J. (2017). Is exposure to suicide beyond kin associated with risk for suicidal behavior? A systematic review of the evidence. *Suicide and Life-Threatening Behavior, 47*(4), 461-474.

Melhem, N. M., Day, N., Shear, M. K., Day, R., Reynolds, C. F., III, & Brent, D. (2004). Traumatic grief among adolescents exposed to a peer's suicide. *The American Journal of Psychiatry, 161*(8), 1411-1416. doi:http://dx.doi.org/10.1176/appi.ajp.161.8.1411

Melhem, N. M., Day, N., Shear, M. K., Day, R., Reynolds, C. F., III, & Brent, D. (2004). Predictors of Complicated Grief Among Adolescents Exposed to a Peer's Suicide.

Special Issue: Risk and Resiliency Following Trauma and Traumatic Loss., 9(1), 21-34. doi:http://dx.doi.org/10.1080/1532502490255287

Melhem, N. M., Porta, G., Shamseddeen, W., Walker Payne, M., & Brent, D. A. (2011). Grief in children and adolescents bereaved by sudden parental death. *Arch Gen Psychiatry, 68*(9), 911-919. doi:10.1001/archgenpsychiatry.2011.101

Michael, C., & Cooper, M. (2013). Post-traumatic growth following bereavement: A systematic review of the literature. *Counselling Psychology Review, 28*(4), 18-33.

Mirkovic, B., Laurent, C., Podlipski, M. A., Frebourg, T., Cohen, D., & Gerardin, P. (2016). Genetic association studies of suicidal behavior: a review of the past 10 years, progress, limitations, and future directions. *Frontiers in psychiatry, 7*, 158.

Montano, S. A., Lewey, J. H., O'Toole, S. K., & Graves, D. (2016). Reliability generalization of the Texas revised inventory of grief (TRIG). *Death studies, 40*(4), 256-262.

Nader, K., & Salloum, A. (2011). Complicated Grief Reactions in Children and Adolescents. *Journal of Child & Adolescent Trauma, 4*(3), 233-257. doi:10.1080/19361521.2011.599358

Neimeyer, R. A., & Hogan, N. S. (2001). Quantitative or qualitative? Measurement issues in the study of grief. In (pp. 89-118). Washington: American Psychological Association.

Niederkrotenthaler, T., Floderus, B., Alexanderson, K., Rasmussen, F., & Mittendorfer-Rutz, E. (2012). Exposure to parental mortality and markers of morbidity, and the risks of attempted and completed suicide in offspring: an analysis of sensitive life periods. *Journal of Epidemiology and Community Health, 66*(3), 233-239. doi:10.1136/jech.2010.109595.

Nieminen P, Lehtiniemi H, Vähäkangas K, Huusko A, Raution A (2013) Standardised regression co-efficient as an effect size index in summarising findings in epidemiological studies. *Epidemiol Biostat Publ Health* 10(4):e8854-15

Niedzwiedz, C., Haw, C., Hawton, K., & Platt, S. (2014). The definition and epidemiology of clusters of suicidal behavior: a systematic review. *Suicide and Life-Threatening Behavior*, *44*(5), 569-581.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group*. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine*, *151*(4), 264-269.

Patalay, P., & Fitzsimons, E. (2020). *Mental ill-health at age 17 in the UK: Prevalence of and inequalities in psychological distress, self-harm and attempted suicide*.

Pfeffer, C. R., Jiang, H., Kakuma, T., Hwang, J., & Metsch, M. (2002). Group intervention for children bereaved by the suicide of a relative. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(5), 505-513. https://doi.org/10.1097/00004583-200205000-000070.

Pfeffer, C.R., Karus, D., Siegel, K., & Jiang, H. (2000). Child survivors of parental death from cancer or suicide: Depressive and behavioral outcomes. *Psycho-Oncology, 9,* 1–1

Pirelli, G., & Jeglic, E. L. (2009). The Influence of Death Exposure on Suicidal Thoughts and Behaviors. *Archives of Suicide Research, 13*(2), 136-146. doi:10.1080/13811110902835064

Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *The Lancet Psychiatry, 1*(1), 86-94. doi:https://doi.org/10.1016/S2215-0366(14)70224-X

Pitman, A. L., Osborn, D. P., Rantell, K., & King, M. B. (2016). The stigma perceived by people bereaved by suicide and other sudden deaths: A cross-sectional UK study of 3432 bereaved adults. *J Psychosom Res, 87*, 22-29. doi:10.1016/j.jpsychores.2016.05.009

Poijula, S., Dyregrov, A., Wahlberg, K.-E., & Jokelainen, J. (2001). Reactions to adolescent suicide and crisis intervention in three secondary schools. *International Journal of Emergency Mental Health, 3*(2), 97-106.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., ... & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version*, *1*(1), b92.

Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M., Goodkin, K., . . . Neimeyer, R. A. (2009). Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS medicine, 6*(8), e1000121.

Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., . . . Miller, M. (1995). Inventory of complicated grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research, 59*(1), 65-79. doi:https://doi.org/10.1016/0165-1781(95)02757-2

Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., 3rd, Bierhals, A. J., Newsom, J. T., Fasiczka, A., . . . Miller, M. (1995). Inventory of Complicated Grief: a scale to

measure maladaptive symptoms of loss. *Psychiatry Res, 59*(1-2), 65-79. doi:10.1016/0165-1781(95)02757-2

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., . . . Fairbanks, L. (1987). Life threat and posttraumatic stress in school-age children. *Archives of general psychiatry, 44*(12), 1057-1063.

Radloff, L. S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. *Applied Psychological Measurement, 1*(3), 385-401. doi:10.1177/014662167700100306

Renberg, E. S., & Jacobsson, L. (2003). Development of a questionnaire on attitudes towards suicide (ATTS) and its application in a Swedish population. *Suicide and Life-Threatening Behavior, 33*(1), 52-64.

Robson, P., & Walter, T. (2012). Hierarchies of loss: a critique of disenfranchised grief. *Omega, 66*(2), 97–119. https://doi.org/10.2190/om.66.2.a

Rostila M, Saarela J, Kawachi I. (2013). Suicide following the death of a sibling: a nationwide follow-up study from Sweden. *BMJ Open***,** *3*(4), 1-6. doi: 10.1136/bmjopen-2013-0026188

Ruderfer, D.M., Walsh, C.G., Aguirre, M.W. *et al.* Significant shared heritability underlies suicide attempt and clinically predicted probability of attempting suicide. *Mol Psychiatry* **25**, 2422–2430 (2020). https://doi.org/10.1038/s41380-018-0326-8

Shaffer, D., Scott, M., Wilcox, H., Maslow, C., Hicks, R., Lucas, C. P., . . . Greenwald, S. (2004). The Columbia SuicideScreen: Validity and reliability of a screen for youth

suicide and depression. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(1), 71-79.

Shulla, R. M., & Toomey, R. B. (2018). Sex differences in behavioral and psychological expression of grief during adolescence: A meta-analysis. *Journal of Adolescence, 65*, 219-227. doi:https://doi.org/10.1016/j.adolescence.2018.04.001

Steiger JH (2004) Beyond the F test: effect size confidence inter vals and tests of close fit in the analysis of variance and contrast analysis. *Psychol Methods* 9(2):164–182

Steinberg, A. M., Brymer, M. J., Kim, S., Briggs, E. C., Ippen, C. G., Ostrowski, S. A., . . . Pynoos, R. S. (2013). Psychometric Properties of the UCLA PTSD Reaction Index: Part I. *Journal of Traumatic Stress, 26*(1), 1-9. doi:https://doi.org/10.1002/jts.21780

Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017

Swanson, S. A., & Colman, I. (2013). Association between exposure to suicide and suicidality outcomes in youth. *Canadian Medical Association Journal,, 185*(10), 870-877. doi:10.1503/cmaj.121377

Tedeschi, R. G., Calhoun, L. G., & Groleau, J. M. (2015). Clinical applications of posttraumatic growth. *Positive psychology in practice: Promoting human flourishing in work, health, education, and everyday life, 2*, 503-518.

Voracek, M., Loibl, L. (2007). Genetics of suicide: a systematic review of twin studies. *Wien Klin Wochenschr.* 11, 463–475. https://doi.org/10.1007/s00508-007-0823

Watkins, R. L., & Gutierrez, P. M. (2003). The relationship between exposure to adolescent suicide and subsequent suicide risk. *Suicide and Life-Threatening Behavior, 33*(1), 21-32. doi:http://dx.doi.org/10.1521/suli.33.1.21.22787

Wilcox, H. C., Kuramoto, S. J., Lichtenstein, P., Långström, N., Brent, D. A., & Runeson, B. (2010). Psychiatric morbidity, violent crime, and suicide among children and adolescents exposed to parental death. *J Am Acad Child Adolesc Psychiatry, 49*(5), 514-523; quiz 530. doi:10.1097/00004583-201005000-00012

Postvention Support for Friends and Siblings of Young People who Die by Suicide: A Delphi Study

Sarah Rook

Doctoral Programme in Clinical Psychology, Cardiff University, Cardiff, UK

Correspondence address: 11th Floor, Tower Building, 70 Park Place, Cardiff, CF10 3AT
Email: Rooks@cardiff.ac.uk

**Manuscript prepared in line with author guidelines for Death Studies (Appendix B). For the purpose of thesis submission tables and figures have been embedded in the main text, however these will be placed in supplementary information for journal submission. Death Studies does not stipulate a word-limit, therefore the 8000-word limit set for the thesis has been applied.*

Word count: 7987

Postvention Support for Friends and Siblings of Young People who Die by Suicide: A Delphi Study

Exposure to the suicide of a friend or a sibling can have serious psychological consequences for young people. Despite this, there is little postvention guidance specific to this population. This study was co-produced with charity partners and used a two-round Delphi method with two groups of experts, defined as professionals (clinicians and/or researchers with expertise in suicide) and experts by experience (parents, siblings or friends of young people who died by suicide). Professionals completed a survey, whereas experts by experience answered the same questions in individual interviews. The survey/interview schedule focused on aspects of postvention support that could be beneficial for young people. Findings indicate that the way in which support is accessed and provided is important and highlighted the role of schools and caregivers. These findings illustrate the importance of postvention support and represent a first step toward co-producing postvention guidance for young people bereaved by suicide.

Keywords: *Co-production, Postvention, Young People, Suicide, Delphi Study*

Introduction

Exposure to suicide is relatively common for young people (YP). Andriessen et al. (2017) concluded that approximately 5% of adolescents are bereaved by suicide in any 12 month period. Jordan and McIntosh (2011) argue that bereavement by suicide is distinct from other types of loss. Individuals bereaved by suicide are more likely to experience deleterious family system effects (e.g., decreased emotional availability, loss of cohesiveness, stigma) and receive less social support. Feelings such as grief, shock, anger, and self- blame may also be present (Jordan and McIntosh, 2011; Sveen and Walby, 2008; Andriessen et al., 2015). Research that has looked at the impact of exposure to a peer's suicide has reported outcomes including, severe grief, depression and anxiety, suicidal behaviour, post-traumatic stress disorder (PTSD), and drug/

alcohol abuse (Brent et al., 1993b; Bartik, Maple and Mckay, 2013b; 2020; Hazell and Lewin, 1993; Chan et al., 2018; Swanson and Colman, 2013). Few studies have investigated the impact of bereavement by suicide on siblings. Of those that have, results indicated that siblings report more severe grief and may experience adverse mental health outcomes including depression and anxiety. Studies have reported mixed findings in terms of suicidal behaviour and PTSD in siblings exposed to suicide (Brent et al., 1993c; Dyregrov and Dyregrov, 2005). There is a lack of longitudinal studies in this area, however the available research indicates that some of these impacts, particularly PTSD and prolonged grief, may endure in the longer-term (Brent et al., 1996).

Andriessen et al. (2016) determined that various pre and post loss features can impact adolescents' reactions to suicide. These included factors such as, personal and family history of mental health problems, closeness of the relationship, level of exposure to the suicide, and feelings of guilt and responsibility following the death. Pitman et al. (2016) conducted a large cross-sectional cohort study with young adults bereaved by suicide. They concluded that the impact of the bereavement did not appear to be different for people who were related to the victim versus those who were not. Research has also highlighted that bereaved siblings and friends may experience a type of disenfranchised grief whereby the individual's experience of grief is not acknowledged or accepted by the wider community (Robson and Walter, 2012).

Postvention is defined as "prevention strategies that target individuals after (*post*) an event" (Szumilas and Kitcher, 2011, p.18). Suicide postvention aims to support the wellbeing of the bereaved. Postventions take many forms, such as debriefing, grief counselling, and internet support groups and take place in a variety of settings including schools, workplaces, religious

institutions, and within the wider community (Andriessen et al., 2019a). Supporting people bereaved by suicide has been identified as a priority for the Welsh Government as part of their suicide prevention strategy (Talk to Me, 2009; Talk to me 2, 2015). Such strategies recognise that interventions that focus on the wellbeing of bereaved YP following a suicide are crucial to prevent the development of mental health problems and suicidal behaviour in the future.

Several postvention techniques and services have been suggested to be helpful. Examples include, developing community response plans, the screening of high-risk individuals, psychotherapy, and support groups (Robinson et al., 2013; Andriessen and Krysinska, 2011). However, there is a sparsity of evidence available to guide the development of effective postvention services for YP. A systematic review of the effectiveness of suicide postvention services found that the quality of evidence to support the reviewed postventions was low (Szumilas and Kutcher, 2011). Andriessen et al. (2019b) conducted a systematic review of suicide postvention service models and guidelines for adults and YP. Five out of eight studies showed positive results in areas including, mental health, grief, and suicidality. However, the quality of the reviewed studies was low which limited the extent to which the authors could endorse their effectiveness.

A recent survey of mental health experts regarding research priorities in postvention, highlighted the need for further research to strengthen the evidence base for postvention. Evidence is needed to determine which interventions are effective for specific populations (e.g., children) and outcomes such as grief and suicidality (Andriessen et al., 2017). Furthermore, Andriessen and Krysinska (2011) suggested that the majority of postvention services have been created without the input of service-users. The importance of including service-users is

emphasised by Peters (2009) who explained that suicide survivors are the experts in this area and are best placed to describe what postvention techniques aid their recovery.

This study was co-produced with The Mindstep Foundation and The Jacob Abraham Foundation- mental health charities that fund research, raise awareness, and provide support to family and friends bereaved by suicide. Co-production involves researchers, practitioners, and members of the public working collaboratively to develop and carry out research (Hickey et al., 2018). This process has been shown to generate information that is more relevant and useable, thus allowing it to be translated into practice more effectively (Staniszewska et al., 2018). The design of this study was informed by INVOLVE guidance on how to use co-production ethically and effectively (Hickey et al., 2018).

There is currently no formal guidance relating to postvention support for friends and siblings of YP who die by suicide. This study included YP bereaved by suicide (friends and siblings), their parents, and professionals who work with them. The aims of this study were firstly to identify and gain consensus about what aspects of postvention support are important for YP bereaved by suicide and secondly, to use this data to co-produce postvention support guidelines for this population.

Method

This study used a two round Delphi survey approach to gather participants' opinions regarding support for YP following the suicide of a friend or sibling. Hasson, Keeney and McKenna (2000) explain that The Delphi method "is a group facilitation technique, which is an

iterative multistage process, designed to transform opinion into group consensus" (Hasson, Keeney and McKenna, 2000, p.1008). The Delphi method is appropriate for areas of research where there is a lack of current evidence, as it allows data to be generated from participants with significant knowledge of the subject area (Iqbal and Pippon-Young, 2009). The methodology, analysis and reporting of findings of this study were informed by The Conducting and Reporting Delphi Studies (CREDES) guidance (Jünger et al., 2017). Due to the sensitive nature of the topic, the first round of this study was adapted with professionals completing an on-line survey and EBEs answering questions via an interview.

Participants

Professionals with Expertise in Young People's Mental Health

Clinicians and academics with expertise or knowledge of suicide in YP were identified using a snowball sampling approach. This involved searching the literature to identify expert authors and drawing on the professional networks of the research team. Professionals in the third sector working within the field of suicide postvention were identified through the National Suicide Prevention Alliance (NSPA) website. Thirty-seven professionals were invited to take part and 18 (49%) responded. 83% of the professional sample were female. Professions included: 5 Clinical Psychologists working across England and Wales who specialised in YP's mental health; 4 research academics from university institutions in England and Ireland; 2 postvention charity directors; 5 postvention support professionals (working for third sector organisations); 1

GP; and 1 Health Psychologist specialising in postvention work in Wales. See Table 1 for demographics.

Experts by Experience

Experts by experience (EBE) were recruited through The Mindstep Foundation and The Jacob Abraham Foundation. The research team were aware of the sensitive nature of this topic area. Recruiting EBE through referral via partnership charities ensured that only appropriate potential participants were approached. It also meant that participants had a robust support system already in place. EBE included close friends and siblings bereaved by suicide. In order to be included, the bereavement had to have occurred over 1 year ago and before the participant was 25 years old. Parents of siblings or close friends of YP who died by suicide were also invited to take part. In all, 14 EBE were contacted and 10 (71%) agreed to take part. One was a close friend, five were mothers of bereaved siblings, two were mothers of bereaved friends, and two were bereaved siblings. 90% of the EBE sample were female. Demographics are shown in Table 3.

Table 1

Demographics of Professional Participants (n= 18)

Gender	
Male	17%
Female	83%
Ethnicity	

White British	100%
Age	
18-29	0%
30-39	39%
40-49	33%
50-59	33%
60+	0%
Profession	
Clinical psychologist	28%
Postvention support professional	28%
Academic	22%
Charity director	11%
Clinical health psychologist	6%
GP	6%

Table 2

Charities Invited to Participate

Charities approached that participated
The Mindstep Foundation
Hector's House
Child Bereavement UK
Mind
National Centre for Suicide Prevention and Training (NCSPT)
Jacob Abraham Foundation
Charities approached that did not participate

Papyrus
Suicide Safer London
Survivors of Bereavement by Suicide (SOBS)
In Charley's Memory
The Matthew Welvidge Trust
Suicide Bereavement UK
To Wish Upon a Star
Winston's Wish

Table 3

Demographics of Expert by Experience Participants (n= 10)

Gender of participant	
Male	10%
Female	90%
Ethnicity	
White British	100%
Gender of suicide victim	
Male	90%
Female	10%
Age (at time of bereavement)	
18-29	30%
30-39	0%
40-49	40%
50-59	30%
60+	0%
Age (at time of interview)	
18-29	30%
30-39	0%

40-49	0%
50-59	70%
60+	0%
Relationship to victim	
Close friend	10%
Sibling	20%
Mother of close friend	20%
Mother of sibling (and victim)	50%

Design

This study was reviewed and approved by The Cardiff University School of Psychology Research Ethics Committee (Appendix C). All participants provided full informed consent to take part in the study.

This study adopted a mixed-methods Delphi approach. Qualitative data were collected from professionals through the use of an online questionnaire via Qualtrics. EBE completed a semi-structured interview over Zoom. The questions contained in the interview and the questionnaire were identical, therefore all participants answered the same questions. This aspect of the design was important to the research team as we were keen to ensure that EBE felt supported when thinking about personally challenging information.

Interviews and responses from the questionnaires were analysed together using thematic analysis (Braun and Clarke, 2006; 2019). This allowed major themes and sub-themes to be generated. The sub-themes were later combined and transformed into summary statements. These statements were used to collect quantitative data through an online questionnaire distributed at stage two of the Delphi process. This survey was distributed to all participants.

Respondents were asked to rate their level of agreement with statements relating to supporting YP following the suicide of a friend or sibling using a 5-point Likert-scale (1-strongly agree; 2-agree; 3- neither agree nor disagree; 4- disagree; 5-strongly disagree). Similar approaches have been used in previous guideline development research (e.g., Temkin-Greener et al., 2015; Nurek et al., 2021).

Procedure

A search of the scientific and grey literature was conducted to gain an understanding about the current postvention support available for YP, and to identify gaps or inconsistencies in the evidence. The research team then met with EBE stakeholders from The Mindstep Foundation to discuss the findings. The qualitative first round was developed in partnership with stakeholders from The Mindstep foundation. Firstly, this ensured the questions were relevant and targeted meaningful areas. Secondly, this allowed the research team to confirm that the wording of the questions was sensitive and appropriate. A draft of the first-round questionnaire was piloted with a small group of EBE from The Mindstep Foundation, The Jacob Abraham Foundation (n= 3) and Trainee Clinical Psychologists (n= 3). Minor changes to the wording of the questions to improve their clarity were subsequently made. Appendices F and G show the questionnaire/ interview schedule.

EBE took part in a 45-minute semi-structured interview using the first-round questionnaire as the interview schedule. Participants were emailed information packs (Appendix J) and consent forms which were returned prior to the interview. Participants were offered the

opportunity to ask questions before the interview. Interviews were conducted over Zoom. All interviews were audio recorded for later transcription with the consent of participants. Professionals were sent an email that contained an information pack, cover letter and a Qualtrics link to the first-round questionnaire (Appendix K). Participants had to complete a consent form via Qualtrics in order to complete the questionnaire. Reminder emails were sent to potential participants who had not responded.

Transcription of EBE interviews was completed by SR. The interview transcriptions and questionnaire responses were collated and analysed separately for each participant. A thematic analysis approach (Braun and Clarke, 2006; 2019) was utilised. Sub-themes were transformed into summary statements (Table 5). These statements were used to create the second-round consensus survey which was distributed using Qualtrics. An email was sent to each participant which included the link to the survey (Appendix L). The survey was the same for both EBE and professionals. Reminder emails were sent to participants who had not responded. The survey (Appendix M) asked participants to rate their level of agreement with survey questions regarding the provision of support to YP following the suicide of a sibling or peer. Ratings for each item were made on a Likert Scale of 1 – 5, ranging from "strongly agree" to "strongly disagree". Responses were exported to Microsoft Excel for analysis.

Data Analysis

A thematic analysis approach was used to analyse the first-round qualitative data. This involved the six-stage process suggested by Braun and Clarke (2006; 2019; Table 4).

Table 4

Stages of Thematic Analysis (Braun and Clarke, 2006)

Step 1: Familiarisation with data
Step 2: Generation of initial codes
Step 3: Search for themes
Step 4: Review and refine themes
Step 5: Define and name themes
Step 6: Write up analysis

This study used an inductive, data-driven approach whereby codes and themes were derived directly from the content of the data (Braun and Clarke, 2006). NVivo 12 software was used. Transcripts were read twice, and initial codes were generated. Codes were later sorted into themes and sub-themes which were discussed and refined in supervision. Finally, example quotes were assigned for each theme. Table 5 shows themes, sub-themes, and example quotes.

Analysis of the second-round questionnaires involved calculation of descriptive statistics (mean, standard deviation, range) and level of consensus for each statement. There is no standardised definition of consensus with regards to Delphi studies (Hasson et al., 2000). The research team therefore agreed that statements that obtained a response of 'strongly agree' or 'agree' from 80% or more of panellists would be defined as showing consensus. This method has been used effectively in previous Delphi studies (e.g., Law and Morrison, 2014).

Quality Assurance and Reflexivity

The process of triangulation increases a study's internal validity by using more than one method of data collection (Mays and Pope, 2000). Triangulation was applied to this study in several ways. Firstly, by drawing on participants from different backgrounds/ groups (professionals and EBE), and secondly by using semi-structured interviews and quantitative questionnaires to collect data. This enabled the research team to develop a comprehensive understanding of the subject area and to identify patterns of convergence. Respondent validation also formed part of the quality assurance process. Specifically, the second-round questionnaire enabled respondents to agree or disagree with the researcher's interpretation of the first-round of data, thereby ensuring conformity (Mays and Pope, 2000).

Braun and Clarke (2019) explain that reflexive practice is crucial in order to appreciate how assumptions and personal experiences impact qualitative research. The researcher is a white, British, trainee clinical psychologist and therefore holds Westernised assumptions about the grieving process. In addition, the author had personal experience of familial and peer suicide bereavement. It is possible that this may have influenced factors such as the information given to participants and the interpretation of qualitative data. However, all materials were cross-checked by the research team and Mindstep Foundation stakeholders. The researcher endeavoured to adopt an open and neutral position throughout.

Results

Round 1

Table 5 illustrates the themes, sub-themes and example quotes that were collated through analysis of round 1 data. Examples of a coded interview excerpt and questionnaire can be found in Appendices N and O. Table 6 shows which participants contributed to each theme/ subtheme.

Table 5

Themes and Subthemes with Relevant Quotes from Parents, Young People, and Professionals

Themes	*Subthemes*	*Quotes*
Immediate support	Trained professionals present when informing YP	*"You need to have someone who guides you through this process that almost needs to be an officer who can literally take you through the steps because you don't have a clue what is going on in those early days. I didn't even know really what suicide was, I didn't know. I didn't know what any of it meant, so I almost needed someone who specialized in it to just be like, OK, this is what happened. This is the process of what's going to happen next."* (EBE 2)
		"I believe the system for support after suicide should involve outreach, via police and coroners' services, who have access to the real-time suspected suicide deaths, as they occur." (Professional 8)
	Support with practical issues	*"Someone to almost, you know, check if there's family who need to be notified because that's a massive task ringing relatives to tell them that their loved one has died."* (EBE 5)
		"Provide practical support, sorting affairs if needed including funeral, money, support with time off work/school." (Professional 12)
	Opportunity to ask questions	*"It doesn't have to be, you know, giving them the right answers because there are no right answers when you've lost someone this way, but more so just t being there with them and saying it's ok to ask questions about it."* (EBE 1)
		"They need opportunities to ask questions if they have any." (Professional 3)
	Explanation of procedures	*"They were strangers who came into our home and asked very invasive questions, you know…Why do you think he did it? And those are all perfectly valid questions for an investigation, but I was totally unprepared for that."* (EBE 2)
		"Open and honest conversations with opportunity to revisit information and ask questions. Support to understand what is grief, what is suicide, what to expect in the process such as inquest proceedings." (Professional 18)
	Written information helpful	*"There should be children packs created when the police/liaison attends to the family, there should be a specific pack available to children, i.e., Help is at Hand for kids and young people*." (Professional 7)

Themes	*Subthemes*	*Quotes*
		"I didn't even know who was a good funeral director or anything like that. So, I believe all that sort of information and what happens at what stage should all be in a booklet or something. And maybe if it had help lines that you could phone and groups who you could contact. But as it was, we were left with absolutely nothing." (EBE 8)
How support is provided	Consideration of context of the suicide	*"I think he should have been offered immediate support because he was the one that discovered his brother. He was totally traumatised by that."* (EBE 8)
		*"We should take into account the circumstances of the death. E.g.- if a YP discovered their sibling's body they may require access to a trauma expert." (*Professional 2)
	Two levels of support	*"Not everyone needs professional intervention- many people will require only social support (e.g., parents, friends, teachers)."* (Professional 4)
		"I think probably some people are okay just being supported by their family or school counsellors. But there are definitely others, like (NAME) who needed more intensive therapy." (EBE 6)
	Informal support from range of sources	*"Everyone involved in that in that child really, professionally…it's everyone's job. You know, everyone should be made aware of everything and try and help and support these youngsters."* (EBE 8)
		"Many people can offer psychoeducation, empathy and skills-building. It could be parents, youth workers or anyone who can talk to young people, as long as they have enough training, support and supervision to be able to manage this safely for themselves and young people." (Professional 11)
	Intensive support provided by MH professionals	*"Some [YP] may need therapy work - rescripting or reprocessing of stuck emotions in relation to the suicide. This needs to be done by an appropriately trained and accredited professional."* (Professional 15)
		"I think having like. a dedicated counselling service who understands suicide was what I needed. You know, people who were mental health professionals who really know what they were doing." (EBE 9)
	Access through a range of mediums	*"Everyone is different; use as many options as possible; by direct contact (GP/school nurse), phone lines and of course the internet."* (Professional 1).
		"I think where things are accessed is really important. I think maybe thinking outside the box a little bit, I guess beyond the usual hospitals, GPs, things like that and maybe looking more like, I don't know, things in sports clubs or social media. I know there are major downsides to it, but actually it can be quite good for sharing information. And that's where kids might go to look." (EBE 2)
	Available in a range of formats	*"In a range of ways to suit what fits best for them, in person either in a school or community venue, one to one, family and peer group options. Location and ability to travel to appointments can limit support options so a wide range should be available*." (Professional 1)

Themes	*Subthemes*	*Quotes*
		"You've got to kind of, there has to be tailored support for age groups, personality traits and relationships in the family, religion. People will benefit from different things." (EBE 5)
Training for people who provide support	All professionals working with YP should have basic training	*"Any adults whose role includes working with CYP should have Suicide Intervention training e.g., Suicide First Aid: Understanding Suicide Interventions (SFA:USI) with the attached City & Guilds accredited unit of learning as mandatory/essential CPD and DBS requirements."* (Professional 18)
		"There are courses that some people go on. It's a week long and then they train up all the people in the workplace. You know, people who are like champions, people who are those people who go around sort of making sure people are OK. I think that's helpful for anyone working with kids." (EBE 4)
	GP awareness of support options	*"My son went to the doctor a few weeks ago. He's got psychological problems now. I know he has, and he asked for help, and he just didn't get anything. He got some tablets which are not really going to work."* (EBE 8)
		"GPs could be helpful, but only if they have close relationship with family and are suicide aware/trained." (Professional 17)
	Training school staff	*"Mostly it* [support] *will happen through the schools, but is the school ASIST trained? Do the teachers and principal know how to deal with suicide bereavement?"* (Professional 3)
		"I suppose maybe more staff in school need to be trained... I think there just needs to be a whole heap more people who are trained in school to understand these things so that it could be offered by a range of different people." (EBE 5)
	First responders need training regarding talking to YP about suicide	*"Police etc. are not sufficiently trained for these scenarios."* (Professional 3)
		"They kind of just said what had happened and that was it. They didn't leave any leaflets or anything. I wouldn't say they were terribly helpful." (EBE 8)
How to access support	Needs to be straightforward	*"Need options for support without waiting lists and bureaucratic hurdles or costs*." (Professional 15)
		"So, in terms of what they need. I just couldn't find it. Or at least I couldn't access it. You know, um, it was huge waiting lists and then, why don't you refer them to Cruse, but I knew Cruse, didn't have the expertise with adolescents." (EBE 4)
	No referral system	*"It's important to provide self-referral options such as a central online resource that actively links young people to online support that is immediate. The range of online support services might include peer support, telephone support, etc."* (Professional 6)

Themes	*Subthemes*	*Quotes*
		"The GP said, oh I can refer you, but it will be a long wait. And that was the worst thing he could have said, because [NAME] then, he said, I'm fine. I got lots of friends and family members I could talk to. I'm fine where whereas I think he would have accessed support if it hadn't been so complicated." (EBE 8)
	Long-term	*"Ongoing availability to dip in and out of …support because needs change over time, and I think there'll be times when they're okay and then there'll be times when they're not."* (EBE 3)
		"Some YP won't really start processing what has happened until months after the event. They may also need to revisit the processing at various moments after the event, so support needs to be there in the long-term." (Professional 12)
	Outreach	*"I think young people might not have the confidence to seek out support, so it might be better if comes to them, where they are."* (Professional 15)
		"Um, I'm not sure you should wait for young people to ask for support. I think it should almost be a sort of standard that, you know, if you are deemed to be a fairly close contact of that person, that maybe it should be just standard, that you are offered a couple of sessions. Really, I think to put the onus on young people, deciding they need it…It's very dangerous." (EBE 10)
	Offered quickly	*"They should have contact within 24hrs of the death by a [support] team (working closely with Coroner)."* (Professional 10)
		"So, I think that the intervention needs to happen as soon as you hear the news, at least that was what me and my siblings needed." (EBE 2)
	YP should have support around milestones	*"Support around anniversaries: Christmas, birthdays, Halloween, school dances, rites of passage in childhood, i.e., communion/confirmation (if Catholic/Christian)."* (Professional 4)
		"I think maybe it would be quite helpful to just have a couple of sessions throughout the year when you need them. Like around the anniversary." (EBE 2)
Tailored to the individual	Support needs to meet needs of different individuals	*"I think that people respond very differently. So, trying to find something that is universal. And I think it'd be really difficult, I noticed major variations in my own family in the way that we wanted to deal with things...when we wanted to speak, how long it took us to speak, whether we wanted counselling...there was a huge variation, even among us*." (EBE 7)
		"Needs will differ according to a wide range of individual circumstances at play for any young sibling bereaved by suicide." (Professional 17)

Themes	*Subthemes*	*Quotes*
	Needs to be flexible	*"The whole construct of adolescence in itself creates challenges. It may be helpful that these are acknowledged with the YP and that they are heavily involved in the process and planning of the support. These may change quickly according to immediate needs of YP's age, stage and development*." (Professional 12)
		"Not everyone is going to fit the mould. My loss isn't the same as someone's loss down the road. And that's why we need tailored and flexible support." (EBE 2)
	Incorporate YP's interests	*"He needed someone to kind of to get to know his interests. Maybe [NAME] liked football. Maybe if there's someone who can play a game of football with him and then subtly ask questions, you know, "oh, how are you doing, by the way?"* (EBE 1)
		"It can be challenging to engage YP. Sometimes we find it helpful to provide support whilst engaging them in something they enjoy (e.g., going for a walk)." (Professional 18)
	Engage YP in activities	*"My brother needed something where it wasn't pushing them to talk about, oh, your sibling died? I'm so sorry about that. Let's talk about how it makes you feel. He just needed someone to take him out for food or to go out for a walk." (EBE 2)*
		"Can be helpful to engage in activities (e.g., walk and talk)." (Professional 18)
	Person centred/ choices	*"Probably the most important need is to not forget about them and include them in decision-making about what support they want."* (Professional 4)
		"I think you have to give them lots of choices and just go with what makes them feel comfortable, really". (EBE 9)
	Led by YP	*"I think it has to be person centred. So, it's around that person. What works best for them? What you find most comfortable support, would you like to meet indoors. It has to be a person-centred approach to the support."* (Professional 17)
		"So, I think it has to be around what the young person wants. What works best for them? What they'd find most comfortable. Would you like to meet indoors? Go out? What do you want to happen?" (EBE 6)
Importance of caregivers	Need advice/ information about how to support YP	*"I wasn't that close to the family, but my children were, And I suppose just helping that parent understand what their children might be going through would be quite important because they're the people that are going to be probably most likely to be assessing whether their own children are coping with that."* (EBE 6)
		"Young people need support for their existing networks to support them daily such as support for parents in relation to parenting bereaved children / young people." (Professional 5)

Themes	*Subthemes*	*Quotes*
	increased risk	*"If expressions indicating DSH or suicidal ideation are present, then parents/ caregivers' needs would change include safety planning and support with how to talk to their young person*." (Professional 1)
		"There's that just total fear as a parent… You know, it puts it [suicide] in their minds. Something that they probably would never have thought about before but suddenly now it becomes a real option." (EBE 4)
	Social media monitoring	*"It's unhelpful to retreat into the world of social media. Someone needs to monitor images/video that they post."* (Professional 8)
		"I think part of it is just keeping an eye on what they're posting and looking at on social media. Because there is all kinds of stuff out there which I think is just really unhelpful sometimes, especially if you're already a bit vulnerable, you know?" (EBE 6)
"	Awareness of warning signs	*"Knowing how to spot signs of someone who is considering suicide and also how to go about asking them about it is really important. I did some training called ASIST with the charity Papyrus and it was fantastic."* (Professional 14)
		"You've just got to be observant; I suppose. Because I think it's very important as a parent and a person who's close to those people, that you understand that obviously once they've experienced that they are more likely to have feelings of suicide. So, it sort of makes you a bit more vigilant." (EBE 10)
	Normalising grief	*"We were very honest. I think that's one thing you have to be and not worrying about, you know, uh, showing that you're very upset. I mean, you know, I couldn't not show it because obviously we were all devastated."* (EBE 1)
		"Parents need to normalise grief in all of its stages/phases." (Professional 12)
	Encourage accessing support	*"Yeah. So, I think you have to keep saying, well, this is available for you or even, you know, books, there's fact sheets. There's lots of other stuff out there. It's OK to ask for some help if you need it".* (EBE 10)
		"Make sure you don't push anything onto them but keep repeating options and have them ready when the young person is ready to reach out for help." (Professional 17)
	Spend time with YP	*"We had about two weeks just the 5 of us to kind of debrief and reflect on what happened. Just to spend time with each other. That was so important."* (EBE 7)
		"It can be helpful for parents/ caregivers to make sure the family have time to be together and support one another." (Professional 8)

Themes	*Subthemes*	*Quotes*
	Maintain routine	*"Having a structure routine was quite important during that time. And it's quite easy for all to fall by the wayside because you think, Oh God, I can't possibly get up today, you know, or do anything when this happened."* (EBE 7)
		"I think in the few days following the death of a sibling or close friend, parents need to provide a sense of routine - the young person should still be able to go to school and carry out their normal activities." (Professional 6)
	Show empathy	*"I think they need space, and they need understanding, and they need care, and they need time."* (EBE 5)
		"Empathy from caregivers/ supporters is important." (Professional 1)
	Encourage to connect with friends	*"Often young people want to be supported by the people they already know. Friends in particular can be helpful."* (Professional 3)
		"I think spending time with his friends was really helpful for him after [NAME*] died. It made him feel like life was still going on."* (EBE 4)
	Access help from wider support networks	*"Parents need to be encouraged to accept/ mobilise support from wider network (e.g., friends, family)."* (Professional 13)
		"I know for me and [NAME] *we just couldn't have done it without my sister and her husband. They were really there for the kids, for whatever they needed, you know like driving them around to their friends, all that kind of stuff, which I think made a big difference to all of us."* (EBE 6)
	Awareness of support options	*"Parents need to be given a summary of the available support options and explained what they would entail."* (Professional 2)
		"Um, yeah, you almost want somebody to say, look this is what there is for them [young people], this is how you contact them. Not to have to go searching for it all yourself." (EBE 9)
	Seek support on YP's behalf	*"Really, it's only because my mum reached out to them [third sector organisation] for me that I ended up seeing them. I wouldn't have done it myself. I couldn't have. I just didn't even know what I needed."* (EBE 7)
		"Sometimes young people might need caregivers to reach out to sources of support for them. Young people may not have the confidence/ self-awareness etc. to do this independently." (Professional 5)
	Acknowledge limits	*"I think as a parent, I needed someone to help with the kids. That would have helped. Because what I can say is, even though you think you doing the right thing. I look back now, and I think I couldn't support them. Because your brain is all over the place."* (EBE 10*)*

Themes	*Subthemes*	*Quotes*
		"Often families can process the circumstances in different ways and at different paces, potentially limiting their ability to support each other. Parents/ carers should be aware of this." (Professional 16)
Role of education settings	Encourage openness about mental health	*"Schools need to be creating and responding to more opportunities to break the taboo around talking about suicide."* (Professional 4)
		"I think, you know, lots and lots and lots of general work in schools about mental health is vital." (EBE 6)
	Counsellors	*"I think…all schools, should have some type of counsellors."* (EBE 8)
		"School counsellors can be a good source of support, if available". (Professional 12)
	Emotional literacy	*"I see a lot of children that just don't understand their emotions. This should be addressed by schools at least at a basic level."* (Professional 4)
		"I think it can feel like a very indulgent thing, but actually I think it is part of, you know, mental health and being healthy. You have to teach kids to recognize your own feelings and you know, know what to do with them. We should be doing that for young people, and it should be the norm in schools." (EBE 3)
	Staff show empathy	*"Those around them in school need to be aware, empathetic, and supportive." (Professional 17)*
		"I know [NAME] *found the care and empathy he received from his form tutor and actually all the school staff to be really invaluable*." (EBE 5)
	Flexible deadlines and workload	*"Extra time on schoolwork, exams--could be extensions."* (Professional 1)
		"I just couldn't believe the school were on our backs because he was late, or he handed his homework in late or whatever. It was just extra stress that none of us needed at that point." (EBE 4)
	Support to continue with education	*"Education and workplaces to understand how grief affects young people and provide support such as catch-up lessons or time out spaces as needed."* (Professional 12)
		"The school were really good about making sure that [NAME] *was supported while he was in school. I think that made it much easier for him to go back after it happened."* (EBE 6)
	Ability to refer	*"School should be primary pathway for support but may need ability to refer onwards for more complex cases."* (Professional 5)

Themes	*Subthemes*	*Quotes*
		"…you have that low level support from teachers, but it would be good if they could refer on to more qualified people if they felt that there were pupils in there that were more vulnerable or needed more help." (EBE 4)
	Teachers training re suicide	*"I think really… more teachers in school that are trained to be able to help with this. They already have good relationships with pupils, you know, and they have all sorts, opportunities so if they were trained to recognize difficulties and to be able to talk about it, that could be something massive."* (EBE 10)
		"There is a need for teachers/ heads of school to have a level of understanding/ training about suicide." (Professional 13)
Personal qualities	Take time	*"You need to build up to it slowly as well. You know, they've got build up that trust first before they're going to open up."* (EBE 2)
		"Need to take time to develop rapport and therapeutic relationship with the young person." (Professional 7)
	Lived experience	*"You need to have gone through it to have the knowledge/ understanding of the toll and utter earth-shattering sense of safety that has suddenly been taken away." (EBE 1)*
	Listening skills	*"Just have a chat with me and I'll tell you everything. I'm very open, but I don't want to feel like you're psychoanalyzing me. Just present to me, like, you're interested, instead of just, oh, this is an interesting case. Just listen to what I have to say."* (EBE 2)
		"Good active listening skills" (Professional 15)
	Empathy	*"They need an empathic person to help them understand and normalise their response to the loss and find healthy ways of managing their emotional response."* (Professional 17)
		"I think I think a lot of people in the field need to be a bit more human. I'm going to say it. Just show a bit more care." (EBE 2)
	Non-judgemental	*"Some professionals can be too eager to get involved and wanting to 'make' the YP talk about what happened. We need to take a more respectful and non-judgemental approach." (*Professional 10)
		"I remember just being really, kind of, worried about what they would think about my parents and my family. Like, are they going to think they were terrible parents and that's why this has happened?" (EBE 7).

Themes	*Subthemes*	*Quotes*
	Consistency	*"I think in the longer term, I think it needs to be more consistent because someone rang me and said, "oh, we've got a really good counsellor. She's ready to speak to you." And I was thinking, "that's great, amazing". And I never heard back from them." (*EBE 2)
		"Consistency from professionals is important for the therapeutic relationship and can make the young person feel contained." (Professional 9)
	Appropriate training	*"A huge well meant-but-not-well-done-risk, if people supporting are not well prepared and trained; this is demanding work and can only be delivered by well-trained supporters."* (Professional 6)
		"Suicide is such a massive thing to go through and I think the people, like professionals who give support, need to know what they're talking about and what the implications are." (EBE 2)
Role of intensive/ specialist support	Should address harmful coping strategies	*"I mean he was using cannabis, he probably used amphetamines… so they just ticked, it "oh it's drug-induced psychosis or oh his drug use is making the anxiety worse", you know, kind of go away, um, rather than seeing about, well, why is he using these substances? What is that doing for him? What has he been through losing his sibling?"* (EBE 4)
		"Professional support may be needed if the young person has been using strategies such as substance abuse or externalising behaviours to cope with their grief." (Professional 12)
	Sleep	*"Sleep patterns are another danger. We noticed that the sleep patterns went completely out the window. Lack of sleep was awful." (*EBE 9)
		Supporting with general issues such as sleep (e.g., psychoeducation/ CBTi) can be valuable." (Professional 10)
	Psychoeducation for support network	*"Everyone in their close circle should receive psychoeducation. This includes family, friends, school, primary care providers already in their lives and others. First activate what/who is already connected before you send in extra support."* (Professional 5)
		"[NAME] *has a massively close group of friends. I think, sometimes especially when a younger person dies, the friends are basically the family…They spend more time with their friends than anyone. But I think they just didn't know what to say or how to help. Even though I know they really wanted to."* (EBE 10).
	Psychoeducation to YP about suicide	*"Those around them in school need to be aware and supportive about suicide. Psychoeducation provided by a mental health professional could help to achieve this.* (Professional 17)
		"Teenagers need to be aware about suicide. They need to know about the kinds of things that increase a person's risk and what to do if they think someone is having suicidal thoughts." (EBE 6)

Themes	*Subthemes*	*Quotes*
	PTSD	*"YP need close mental health monitoring with an expert in trauma, to be able to identify if they have PTSD and treat it appropriately."* (Professional 13)
		"You know, he got lots of trauma. Um, it's just, I didn't feel that services really did anything with that. They wrote it down and they ticked all their little risk history off." (EBE 4)
Role of informal/ universal support	Include whole family	*"Working with the family as a whole can help with difficult questions. Often if I can support the caregivers to answer the difficult questions, they are better equipped when the young people ask questions outside of the session."* (Professional 2)
		"I think everyone who has someone commit suicide, the whole family, just need to have people checking in on them. Like, how are you doing? Do you need help with anything?" (EBE 2)
	Facilitate communication	*"Postvention support needs to engage with families in order to help them communicate with one another, as well as the wider community (e.g., schools) about what their needs are."* (Professional 8)
		"From my experience, you all sort of go like that in your own direction. You've got to learn to come back together as a family and just talk to each other. And I think sometimes you need to be encouraged to do that." (EBE 2)
	Education re suicide risk	*"Awareness raising and discussion of their own (potential) vulnerabilities with signposting and support networks in place to enable this."* (Professional 7)
		"The meltdown that [NAME] *had when she finally admitted to it, she nearly took her own life as well because of it. I think they're trying to just mask everything. But really, they need to know, look this [the risk of suicide]is something you need to be aware of too."* (EBE 10)
	Normalise and validate emotional responses	*"I think young people need the option to speak about how they are feeling. Often grief following suicide can involve a whole host of conflicting emotions and it's important for young people to be able to speak about this and to understand that it is normal to feel a lot of different things."* (Professional 3)
		"But just to be able to have someone explain this is how you're going to feel and that's totally normal, you know, to teach you about the stages of grief and stuff like that. I'm sure that would be really useful." (EBE 1)
	Increase self-awareness	*"I think she needed more self-awareness. Because she just wasn't even able to see that she wasn't OK after he died. You need that level of self-awareness."* (EBE 10)
		"Young people need the self-awareness and insight to recognise if they need further support." (Professional 4)

Themes	*Subthemes*	*Quotes*
	Space for asking questions	*"It can be hard hearing the story of how someone died by suicide and the young person may have questions. I have had young people in the past who haven't understood how they died, for example how paracetamol can make you better but also make you die. These questions need to be answered in an age-appropriate way."* (Professional 15)
		"They need to be encouraged to ask questions if they need to. Otherwise, they just internalize all those questions and confusion that they've got." (EBE 6)
	Refer for complex issues	*"If they've developed complex grief or any other mental health difficulties, e.g., depression, this needs to be referred to the appropriate service and treated professionally."* (Professional 3)
		"I think they were just out of their depth, to be honest. She just had too much going on for them to deal with. What she needed was a specialist, you know?" (EBE 10)
	Encourage enjoyment/ engagement	*"I think there should be social prescribing for suicide bereavement support, whereby young people are directed towards activities in their community that they might enjoy - e.g., sports clubs, drama societies, walking groups, yoga classes, meditation, mindfulness."* (Professional 1)
		"They almost need to be told, you know, it's OK, you can still enjoy yourself. You can still see you mates and have a life. That's a healthy thing to do." (EBE 4)
	Help with social situations	*"I just had no idea how to talk to my friends or people at school about it [sibling's suicide]. In hindsight, I think that's something that people need some help with after suicide."* (EBE 2)
		"Often their friends can ask too many questions and aren't aware if that person doesn't want to discuss it. It can be beneficial to provide coping strategies regarding how to deal with these scenarios." (Professional 2)
	Encourage peer support	*"I think definitely support groups need to be encouraged, especially for younger people, get them talking about it, get it doesn't even have to be talking about the death. It can be sharing those memories, set up things where young people can go to where they can feel the therapeutic atmosphere without having to talk about the loss."* (EBE 2)
		"Group support from other young people with lived experience of suicide death can be very beneficial (if the young person is willing to engage- some might need prompting/ scaffolding for this)." (Professional 12)
	Make plans for future	*"They need to see that life continues to go on…they need to be keep making plans for their future and working towards their goals."* (EBE 4)
		"They should be encouraged to continue to engage with life. For example, continuing with hobbies, education, friendships." (Professional 7)

Themes	*Subthemes*	*Quotes*
	Facilitate disclosures	*"We need to be asking, are you thinking about suicide? I think it's asking kind of, you know, are they thinking about suicide themselves, if they have suicidal thoughts?"* (EBE 8)
		"It's such an impressionable time in people's lives - i.e., adolescence - young people tend to be particularly susceptible to the potential knock-on effect of 'suicide contagion'. Therefore, it's important that they are able to disclose any ideation/ plans." (Professional 6)
	Support with ADL/ self-care	*"I think basic functioning, like just eating a meal, was really difficult and I didn't really have anyone who was checking on that kind of thing."* (EBE 5)
		"[They need support with] stripping everything down back to basics, getting outside, breathing, sunshine, grounding techniques, nourishing foods. Radical self-care " (Professional 12)
	Enable YP to be open	*"I think they needed someone to help them just to be able to talk about* [NAME], *you know, without shutting down."* (EBE 4)
		"Siblings and friends need to have the opportunity and space to openly express grief and associated emotions." (Professional 3)
	Positive ways to remember victim	*"To be able to find a connection with the person who died is really important. Often schools will plant a tree or create a memorial, but young people have found it helpful to make their own scrapbooks, playlists, photo albums etc."* (Professional 18)
		"I mean, he's got on his dressing table, the battered ball was the last fall they played football with. So, he's kept this ball. So it was, it was kind of a fun thing they did together, but it's been really important for us to help him remember him in that way." (EBE 6)
	Appropriate acknowledgement	*"I am mindful of the Werther effect, particularly within our YP community, however not acknowledging a death by suicide can be as detrimental as potential glorification."*. (Professional 3)
		"You've got to be careful, haven't you? young people really crave that kind of approval from their peers, and I think if suicide deaths are normalised or maybe even glamorised, it can be quite dangerous. But of course, it also has to be marked in some way" (EBE 6)
	Space to talk about victim	*"What I find more difficult is that people tend to stop talking about it and people are very much there for you in the first few months and obviously then people move on with their lives. I just needed to be able to talk about him."* (EBE 7)

Themes	*Subthemes*	*Quotes*
		"Not giving the young person the opportunity to talk about and remember the person they have lost is unhelpful. E.g., everyone trying to move on too quickly, or closing down any discussions about the person and how (and why) they died." (Professional 18)
	Indirect work	*"You need support for parents in how to support children through it. Because some parents, I imagine they struggle on an everyday basis."* (EBE 10)
		"It may be necessary for caregivers to receive advice on how to support the young person, particularly if the young person is reluctant to engage with support themselves." (Professional 12)
	Safe space	*"Often grief following suicide can involve a whole host of conflicting emotions and it's important for young people to have safe space be able to speak about this and to understand that it is normal to feel a lot of different things."* (Professional 3)
		"I had like a space whenever I needed it and I could reflect on what's happened and speak it through with somebody in a place where I felt very safe. Yeah, because sometimes it can feel like you can't quite go there because it's so sad that you almost need a certain environment." (EBE 7)

Table 6

Contributors to each Theme/ Subtheme

Themes Subthemes	Experts by Experience										Professionals																	
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Immediate support	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓		✓	✓	✓	✓	✓			✓	✓	✓		✓		✓
Explanation of procedures	✓	✓						✓					✓		✓				✓				✓	✓				✓
Support with practical issues		✓			✓			✓		✓			✓				✓					✓	✓					
Opportunity to ask questions	✓					✓		✓					✓			✓			✓			✓						✓
Trained professionals	✓	✓								✓								✓				✓						
Written information helpful		✓		✓	✓			✓	✓	✓	✓	✓					✓		✓				✓			✓		
How support is provided	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Consideration of context	✓	✓	✓	✓		✓		✓	✓			✓			✓			✓					✓					✓
Two levels of support			✓	✓		✓	✓	✓		✓			✓	✓			✓	✓	✓			✓		✓			✓	
Informal support from range of sources	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓	✓		✓		✓	✓				✓
Intensive support from MH profs.		✓	✓			✓	✓	✓	✓	✓					✓			✓	✓					✓	✓	✓	✓	✓
Access through range of mediums	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			✓		✓	✓	✓		✓	✓	✓				
Available in range of formats	✓				✓		✓	✓		✓	✓	✓		✓	✓	✓		✓	✓	✓				✓				
Training for people who provide support		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓		✓		✓	✓

Themes Subthemes	Experts by Experience										Professionals																	
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
All profs. Working with YP need basic training			✓	✓		✓	✓			✓	✓		✓	✓		✓			✓	✓			✓		✓			✓
GP awareness of support options			✓	✓				✓	✓	✓				✓					✓				✓				✓	
Training school staff					✓	✓			✓	✓	✓	✓	✓	✓			✓						✓		✓			
First responders need training		✓		✓				✓		✓			✓								✓							✓
How to access support	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Needs to be straightforward	✓	✓	✓	✓	✓	✓	✓			✓	✓		✓			✓			✓		✓	✓	✓	✓			✓	
Self-referral		✓	✓			✓		✓		✓			✓			✓	✓			✓		✓	✓					✓
Long-term	✓		✓	✓	✓	✓		✓		✓	✓		✓	✓	✓				✓	✓	✓	✓	✓	✓	✓			
Outreach	✓	✓		✓	✓	✓	✓	✓	✓	✓				✓		✓				✓			✓		✓	✓		
Offered quickly	✓	✓		✓		✓	✓	✓		✓	✓					✓				✓	✓	✓				✓		
Support around milestones	✓					✓	✓				✓	✓	✓	✓				✓			✓				✓			
Tailored to the individual	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Needs to meet needs of different people	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓								✓	✓		✓	✓	✓			✓	
Needs to be flexible	✓	✓		✓	✓	✓	✓	✓			✓		✓				✓			✓		✓		✓				
Incorporate YP's interests	✓	✓							✓				✓	✓					✓					✓				✓
Engage YP in activities		✓		✓			✓	✓	✓	✓			✓						✓					✓				✓
Person centred choices	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓		✓	✓	✓		✓	✓	✓			✓	
Led by YP			✓	✓		✓	✓	✓			✓			✓						✓		✓		✓	✓		✓	✓

Themes Subthemes	Experts by Experience										Professionals																		
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
Importance of Caregivers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Awareness of support options	✓		✓			✓	✓	✓	✓	✓		✓			✓				✓	✓		✓			✓				
Need advice about how to support YP	✓		✓	✓	✓	✓				✓	✓				✓		✓		✓			✓				✓		
Awareness of increased risk	✓	✓		✓		✓				✓	✓			✓			✓	✓		✓			✓				✓		
Social media monitoring					✓	✓			✓	✓	✓	✓		✓				✓	✓						✓				
Awareness of warning signs	✓	✓	✓	✓	✓	✓			✓	✓				✓			✓						✓	✓	✓				
Normalising grief	✓					✓	✓		✓	✓		✓				✓	✓			✓		✓					✓		
Encouraging accessing support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓				✓	✓			✓			✓		✓	✓	
Spend time with YP	✓			✓			✓		✓			✓			✓			✓			✓			✓					
Maintain routine		✓					✓		✓		✓	✓		✓		✓										✓			
Show empathy	✓			✓	✓	✓					✓				✓			✓		✓									
Encourage to connect with friends				✓		✓			✓		✓		✓				✓					✓					✓		
Access help from wider support networks		✓	✓	✓	✓	✓	✓					✓			✓				✓				✓	✓				
Seek support on YP's behalf	✓		✓	✓		✓	✓	✓			✓	✓	✓		✓					✓					✓				
Acknowledge limits	✓	✓	✓	✓			✓	✓		✓	✓								✓	✓				✓		✓			
Role of education settings	✓		✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓			✓	✓		✓	✓	✓			✓	✓	✓	
Encourage openness about mental health	✓		✓			✓			✓	✓			✓	✓							✓							✓	
Counsellors	✓		✓			✓		✓						✓									✓			✓			

Themes Subthemes	Experts by Experience										Professionals																	
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Emotional literacy			✓			✓				✓			✓	✓					✓								✓	
Staff empathy	✓				✓				✓	✓	✓	✓							✓			✓					✓	
Flexible deadlines and workloads	✓			✓					✓	✓	✓	✓	✓	✓					✓			✓						
Support to continue with education	✓			✓		✓							✓						✓			✓					✓	
Ability to refer			✓	✓		✓				✓		✓			✓												✓	
Teachers training regarding suicide	✓				✓	✓				✓	✓	✓		✓					✓				✓				✓	
Personal qualities and skills	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓		✓	✓		✓	✓
Take time		✓		✓					✓	✓	✓					✓	✓							✓				✓
Lived experience	✓	✓			✓	✓	✓		✓																			
Listening skills	✓	✓		✓					✓	✓	✓					✓								✓	✓			✓
Empathy	✓	✓		✓		✓		✓		✓					✓				✓					✓			✓	✓
Non-judgemental	✓	✓			✓		✓	✓		✓	✓		✓		✓		✓		✓	✓								
Consistent		✓		✓					✓	✓		✓			✓				✓			✓						✓
Appropriately trained		✓	✓		✓		✓		✓	✓					✓		✓	✓				✓		✓	✓			✓
Role of specialist support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓			✓	✓	✓
To address harmful coping strategies		✓	✓	✓	✓			✓		✓	✓	✓				✓	✓	✓				✓					✓	
Help with sleep issues			✓					✓	✓					✓						✓								✓
Psychoeducation for support network	✓		✓		✓	✓	✓		✓	✓	✓						✓		✓	✓		✓				✓	✓	

Themes Subthemes	Experts by Experience										Professionals																	
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Psychoeducation to the YP re suicide	✓	✓			✓	✓	✓		✓						✓	✓			✓							✓		
PTSD intervention		✓	✓	✓		✓		✓				✓			✓			✓					✓			✓	✓	✓
Role of informal support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Whole family		✓	✓					✓		✓	✓							✓	✓				✓	✓			✓	
Facilitate communication	✓	✓			✓	✓					✓	✓		✓				✓										✓
Education re suicide risk		✓			✓	✓	✓	✓		✓	✓			✓		✓	✓	✓		✓	✓			✓	✓			
Normalise and validate emotional responses	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓		✓	✓
Increase YP's self-awareness		✓			✓	✓	✓	✓	✓	✓	✓			✓							✓	✓						✓
Space for asking questions	✓	✓	✓			✓	✓									✓	✓		✓					✓	✓			
Refer for complex issues	✓		✓			✓				✓			✓					✓				✓	✓					
Encourage enjoyment/ engagement with life	✓		✓	✓	✓	✓	✓				✓	✓		✓	✓					✓				✓				
Help with social situations		✓					✓		✓	✓		✓	✓		✓													
Encourage peer support	✓	✓		✓	✓	✓	✓		✓		✓	✓		✓	✓	✓		✓				✓	✓					
Help make plans for future	✓			✓				✓				✓					✓			✓				✓				
Facilitate disclosures		✓				✓		✓					✓	✓		✓						✓					✓	✓
Support with ADL/ self-care			✓	✓	✓	✓	✓	✓					✓		✓					✓		✓			✓			
Enable YP to be open	✓	✓		✓		✓	✓	✓			✓	✓				✓	✓	✓	✓	✓	✓			✓	✓	✓		
Facilitate appropriate acknowledgement	✓			✓		✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓					✓					

Themes Subthemes	Experts by Experience										Professionals																	
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Provide opportunity to talk about the victim	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓				✓	✓	✓	✓						✓		✓	✓
Provide indirect support			✓	✓		✓				✓				✓								✓		✓		✓		
Provide a safe space	✓	✓		✓		✓	✓	✓	✓			✓	✓			✓	✓	✓					✓					

Immediate Support

A key theme, referred to by both professionals and EBE, was the need for immediate support, particularly for siblings. EBE felt that there should be a *Trained professional present* when first-responders inform families about the suicide of a YP. Participants discussed that the role of this professional might include to help the family with *Support regarding practical issues.* This might involve notifying other family members, arranging to view the body, and funeral planning. All participants highlighted the importance of YP having the *Opportunity to ask questions*. In particular, YP may need support with preparing for and *Understanding procedures* such as the inquest process. EBE commented that they felt they were not prepared for or made aware of what an inquest might entail and how distressing the experience can be. Finally, participants acknowledged that it is difficult to retain information in this situation. They felt it would be helpful for families to be provided with *Written information*, such as a booklet specifically written for YP and their parents. This might include information regarding practical issues (e.g., arranging a funeral, inquest process), signposting to support resources, basic psychoeducation aimed at normalising and validating grief responses, and information for parents regarding how to support their child.

How Support is Provided

The way in which support is provided to friends or siblings bereaved by suicide was identified as important. Participants described the need for *Two levels of support*. 1. Universal/ informal support that should be offered to any YP exposed to the suicide of a friend or sibling; and 2. More specialised/ formal interventions that should be offered by mental health professionals to those who have more complex needs (e.g., trauma,

complicated grief). The *Context of the suicide* was frequently cited as a key consideration regarding deciding the level of support a YP might need. Specifically, it was felt that YP who have a high level of exposure to the suicide (e.g., discovering the body), should receive more specialist intervention.

It was felt that YP should be able to access *Informal support through a range of source*s, that is, any professional that they might commonly have close contact with. Importantly, participants did not feel that this needed to be a mental health professional. The most common examples provided were teachers and sports coaches. However, there was also agreement that it was important that more *Specialist intervention should be provided by mental health professionals* with appropriate training. Examples included Psychologists and Counsellors. The idea that support should be provided through a *Range of formats* (e.g., group, one-to-one) and a *Range of mediums* (e.g., online, text, face-to-face) was also commonly discussed. Participants highlighted that the experience of each YP will be unique, therefore services should cater for a range of preferences and needs.

Need for Training

The need for appropriate training for people who may be called upon to provide support to bereaved siblings or peers was highlighted. Participants suggested that *All professionals who work closely with YP* (e.g., teachers, sports coaches, GPs) *should have a basic level of training* in this area. Courses such as Suicide First Aid (SFA) were thought to be potentially appropriate. Specific professionals were also identified as requiring further training in post-suicide support. These included *Teachers, Police Officers* and *GP*s. Sadly, many experts by experience described having experienced unhelpful (and sometimes

distressing) interactions when seeking support from professionals who they felt lacked appropriate knowledge and skills regarding suicide bereavement.

How Support is Accessed

The way in which support is accessed by young people was identified as an important theme. People felt that accessing support *Needs to straightforward.* It was thought that long waiting lists and "bureaucratic hurdles" were unhelpful and would likely dissuade YP from asking for help. Participants believed that any support should be accessed through a system of *Self-Referral*. Many participants felt that support needs to be *Long-term* and ongoing to be effective. It was acknowledged that YP's needs may change over time and that it is important that support remains available to them. Offering *Support around milestones* (e.g., anniversaries, birthdays) was also identified as potentially helpful.

Most participants felt that support should be offered on an *Outreach* basis as there were concerns that YP may not feel able to seek support independently. It was also mentioned that parents of bereaved siblings may not have the capacity to seek out support on behalf of their surviving children. The need for support to be *Offered quickly* was also seen to be important, with several participants suggesting that families should be contacted within 24-48 hours of the death.

Tailored to the Individual

Respondents indicated that any support received by bereaved siblings or peers should be uniquely adapted to *Meet the needs of different individuals.* It was acknowledged that the

way people experience grief can vary and that this needs to be normalised and reflected in postvention support. The need for support to be *Flexible w*as also identified. This was seen as particularly important for adolescents who are likely to be facing challenges and transitions that may change over time according to their developmental stage. *Engaging YP in doing something active,* such as going for a walk, was mentioned by many participants as important. EBE explained that many young people feel uncomfortable with the idea of sitting alone in a room with someone but feel less intimidated when engaged in an activity. It is particularly helpful if this activity *incorporates the YP's interests* as this may help them to feel listened to and valued. Any support should be *Person centred* and *Led by the YP*. It is important that they are consulted and included in all decisions regarding their care.

The Role of Caregivers

Caregivers were identified by all participants as playing an important role in supporting YP following the suicide of a sibling or peer. However, it was also acknowledged that caregivers may *Need advice regarding how to support YP* in this situation. In particular, it may be important for them to have an awareness of the possibility of *Increased risk* to the surviving sibling or peer. Caregivers should be made *Aware of the available support options* and educated regarding potential *Warning signs*. This might involve creating strategies such as safety plans to keep the YP safe. Similarly, there was suggestion that it may be helpful for caregivers to *Monitor the YP's social media* usage. However, it was noted that parents who have been bereaved may understandably struggle to support bereaved siblings. In these cases, it is important for parents to *Acknowledge limits* in terms of their capacity to provide support. In such situations, it is recommended that caregivers *Access help from wider support networks (e.g., extended family)* or even to *seek support on the YP's behalf.*

Participants explained that it is important for caregivers to *Normalise the experience of grief* and the many different emotions that can be part of it. Caregivers should also *Encourage the YP to access support* if needed. Several EBE suggested that it is important to *Spend time together* as a family following the suicide of a sibling, as this gives the family time and space to acknowledge and reflect on the loss. Similarly, *Expressing empathy* and care towards the YP was identified as important. *Maintaining routines* and structure was suggested to be beneficial, as participants acknowledged that this can be challenging for YP who have been bereaved. *Encouraging YP to connect with their friends* and draw on them for further support was also discussed.

The Role of Education Settings

Both professionals and EBE indicated that educational settings such as schools or colleges play a pivotal role in supporting YP following the loss of a sibling or peer. Participants felt that schools should *Encourage openness about mental health* and increase *YP's Emotional literacy.* Many EBE's felt that schools should have *Counsellors* available to support YP with mental health issues and spoke about having found this helpful in their own experiences. There was agreement that *Teacher training* regarding suicide bereavement would be beneficial. Teachers were seen as important in providing postvention support as participants highlighted that they are likely to have existing relationships with the YP. Both EBE and professionals reported that teachers should have the *Ability to refer* the YP for more formal support if they felt that this was necessary. Participants highlighted that it was important for school staff to *Show empathy* and compassion to bereaved young people. Certain adjustments such as *Flexible deadlines and workloads* were suggested as participants reported that this would *Support YP to continue to access education.* Several EBE's spoke

about having found this challenging when coping with their own experiences of suicide bereavement.

Personal Qualities

Participants agreed that people providing support to YP following suicide bereavement should possess certain personal qualities and skills that are needed to form effective therapeutic relationships. For example, *Taking time* to build up the therapeutic relationship was identified as important. This was felt to be particularly important for YP who have been exposed to suicide due to their own potentially increased risk. Other skills and/ or qualities including *Listening skills*, *Empathy*, and Taking a *Non-judgemental* approach were frequently referred to by both EBE and Professionals. The importance of *Consistency* was discussed. For example, participants felt it was best if the YP was able to be supported by one primary person as this might enable them to develop a more secure therapeutic relationship. Some EBE felt that YP would benefit most from being supported by people with *Lived experience* of suicide bereavement. These participants felt the only way another person could understand or empathise with a YP in this situation was if they had experienced it themselves.

The Role of Formal/ Specialist Support

The role of specialist support (i.e., support needed by a minority of YP who may present with more complex issues, such as PTSD) emerged as a theme. Professionals and EBE agreed that in the context of sibling or peer suicide, specialist support might be needed

for YP who use *Harmful coping strategies* (e.g., substance abuse) or are at risk of *PTSD (*e.g., discovered the body). Participants indicated that it would be important for issues such as these to be addressed by a trained mental health professional. *Sleep problems* were also cited as a potential issue that may require professional input.

Psychoeducation for the YP's wider support network (e.g., teachers, parents) was seen as a potentially useful service that should be provided by mental health professionals. This might involve giving practical advice regarding how best to help the bereaved YP. Similarly, *Psychoeducation for the YP regarding suicide* was identified as important. Specifically, EBE's spoke about the fact that they found it helpful to hear from a mental health professional that their sibling or friend's suicide was not their fault.

The Role of Informal/ Universal Support

Finally, the importance of informal/ universal postvention support and the role that it might play, was identified as a theme. For the purposes of this study, informal/ universal support was defined as postvention input that should be received by all young people exposed to the suicide of a friend or sibling. This support does not necessarily need to be provided by a mental health professional. Participants felt that a key focus of informal support should be to *Facilitate communication* between the bereaved YP and other people/ organisations. This might include facilitating communication within the YP's family or helping the YP advocate for their needs in school. Where appropriate, it was thought that it would be helpful to *Include the whole family* in this support as this might help caregivers to provide more effective support to YP at home. EBE and professionals acknowledged that some YP may not want or feel able to engage with support themselves. In these cases, participants felt that it

was important that universal support be provided *Indirectly* by working through caregivers. Important elements of informal support that were identified by participants included, *Normalising and validating emotional responses* as well as supporting the YP to *Increase their self-awareness*. This was thought to be particularly important as participants suggested that increased self-awareness would enable YP to identify if and when they needed further support in the future.

Both professionals and EBE raised concerns regarding the possibility of increased risk of suicidal behaviour in YP exposed to suicide. For this reason, participants felt that all YP bereaved by suicide and their support network (e.g., caregivers) should be *Educated about suicide* risk and signposted to relevant services or resources. There was acknowledgement regarding the potential for suicide victim's deaths to be "glamourised" or "glorified" by young people, which may lead to increased suicide risk in other YP. For this reason, EBE and professionals felt that it was important for informal support to help YP find ways to *Appropriately acknowledge* the death of their friend or sibling. This might include providing YP with *Space to talk about the victim* and exploring *Positive ways to remember the deceased.* EBE gave examples such as getting involved with mental health charities that helped their adjustment following the loss.

Participants spoke about universal/ informal support needing to provide a *Safe space* for the YP. It was hoped that this would *Facilitate disclosures* regarding the YP's own suicidal thoughts or behaviours. Universal/ informal support should also make *Space for YP to ask questions* relating to the bereavement. EBE and professionals suggested that YP can often be confused about the events that led up to the victim's death, and that this can be distressing. This might be particularly problematic for siblings as they are likely to feel the need to protect their parents and therefore might not feel able to ask questions. Another

aspect of informal support that was felt to be especially important for bereaved siblings, was to ensure that the YP is able to carry out normal *Activities of daily living*, such as eating regularly or maintaining their personal hygiene. Working with the YP to *Make Plans for the future* was also suggested. It was thought that this might instil a sense of hopefulness and encourage YP to continue working towards their goals. Similarly, *Encouraging YP to engage with pleasurable activities* was cited as helpful. EBE explained that they often felt guilty for enjoying themselves following the death of their friend or sibling, and that it would have been helpful for an adult to normalise this experience and provide reassurance. Finally, help with thinking about *Managing social situations* following the suicide of a friend or sibling was identified as important. Many EBE's described feeling distressed and anxious about returning to school and having to face their peers' questions. They believed that it would have been beneficial to have support with planning for situations like this.

Round 2: Consensus Survey

From the sub-themes identified in round one, 80 summary statements were created. The summary statements were sent to all participants who took part in the first-round. Almost all participants (27 of 28; 96.4%) completed the consensus survey. The participant who did not complete the second round was a professional (Postvention Support Professional). The summary statements and consensus results are displayed in Table 7. Three statements (1, 30 and 51) did not achieve the 80% agreement threshold to be endorsed as support that should be provided to YP bereaved by the suicide of a friend or sibling.

Table 7

Consensus Table

No.	*Statement*	*Mean*	*SD*	*Mode*	*Min*	*Max*	*Consensus %*
1	Professionals specifically trained in working with young people and suicide bereavement should be present when informing young people about the death of a sibling or friend to suicide	2.37	1.27	2	1.00	5	62.96*
2	Young people should be supported with practical issues (e.g., informing school, contacting family)	1.48	0.74	1	1	4	92.59
3	The young person should be given the opportunity to ask questions when being informed of the death	1.07	0.27	1	1	2	100
4	Practical issues (e.g., the inquest process) should be explained to the young person	1.30	0.54	1	1	3	96.29
5	Young people should be given a booklet with details of how to access further support	1.33	0.68	1	1	4	96.29
6	There should be two 'levels' of support. E.g., a universal/ informal level that everyone receives and a specialist/ formal level for YP with more complex needs.	1.11	0.42	1	1	3	96.29
7	Informal support should be provided by a range of people/ sources such as caregivers, teachers, or peer support groups	1.15	0.36	1	1	2	100
8	More formal/ intensive support should be provided by trained mental health professionals (e.g., Psychologists)	1.30	0.79	2	1	4	96.29
9	Support should be available through a range of mediums (e.g., online, face-to face)	1.30	0.81	1	1	5	96.29
10	Support should be provided in a range of different formats (e.g., one-to-one, groups)	1.37	0.62	1	1	3	92.59
11	Young people whose experiences have been particularly traumatic (e.g., discovering the body of a sibling or friend) may require specialist support from a trained mental health professional	1.37	0.67	1	1	4	96.30
12	All professionals who work closely with young people (e.g., sports coaches, teachers, GP's) should receive a basic level of training regarding suicide and mental health	1.33	0.82	1	1	4	92.59
13	GPs should receive more in-depth training provided by a mental health professional regarding suicide and suicide bereavement	1.33	0.77	1	1	4	88.89
14	Some school staff (e.g., those involved in pastoral care) should receive more in-depth training provided by a mental health professional regarding suicide and suicide bereavement	1.11	0.31	1	1	2	100
15	Training should be given to first responders	1.11	0.42	1	1	3	96.29
16	Accessing support should be straightforward	1.04	0.19	1	1	2	100
17	Accessing support should not require a referral	1.56	0.87	1	1	4	88.89
18	Support should be long-term and continue for as long as needed	1.56	0.79	1	1	3	81.48

19	Support should be automatically offered to young people and families rather than waiting for them to seek it out	1.48	0.74	1	1	4	92.59
20	Support should be provided in a timely manner	1.41	0.62	1	1	3	92.60
21	Young people should be encouraged to re-engage with support around significant milestones (e.g., birthdays, anniversaries)	1.70	0.81	1	1	4	85.19
22	Any support should be individually tailored according to the young person's age and developmental needs	1.04	0.19	1	1	2	100
23	Any support should be flexible in terms of meeting the needs of the young person	1.11	0.31	1	1	2	100
24	Support should aim to incorporate the young person's interests to maximise engagement	1.41	0.56	1	1	3	96.29
25	Support should involve engaging the young person in activities such as (e.g., going for walks, going for food)	1.70	0.94	1	1	5	85.18
26	Young people should be offered choices about what support they would find most helpful	1.11	0.42	1	1	3	96.29
27	Any support should be led by the needs and wants of the young person	1.30	0.66	1	1	4	96.30
28	Caregivers should be given advice/ information from a trained professional regarding how best to support young people after the suicide of a friend or sibling	1.31	0.46	1	1	2	100
29	Caregivers should be made aware about the possibility of increased risk to young people following the death of a sibling or friend to suicide	1.31	0.54	1	1	3	96.16
30	Caregivers should be encouraged to monitor young people's social media usage	2.15	0.91	2	1	4	65.38*
31	Caregivers should be made aware of possible warning signs that might suggest a young person may need more intensive/ formal support	1.12	0.32	1	1	2	100
32	Caregivers should normalise talking about grief and difficult emotions	1.04	0.19	1	1	2	100
33	Caregivers should reassure young people that it's OK to access further support	1.12	0.32	1	1	2	100
34	Caregivers should set aside time to be with the young person	1.23	0.50	1	1	3	100
35	Caregivers should try to maintain a sense of routine and structure at home	1.08	0.27	1	1	2	100
36	Caregivers should show empathy to the young person	1.04	0.19	1	1	2	100
37	Caregivers should support the young person to spend time with friends and wider family	1.42	0.63	1	1	3	92.30
38	Caregivers should be encouraged to draw on wider support networks (e.g., extended family/ friends)	1.35	0.62	1	1	3	92.31
39	Caregivers should be made aware of the support options available to young people (e.g., support groups, counselling) and discuss these with them	1.08	0.27	1	1	2	100
40	Caregivers should seek further support on behalf of the young people if they are unwilling/ unable to do this themselves	1.50	0.64	1	1	3	92.31
41	Caregivers may need to acknowledge that they might not be able to meet the person's emotional needs due to their own grief.	1.15	0.36	1	1	2	100
42	Schools should encourage young people to talk about mental health	1.15	0.36	1	1	2	100

43	Schools should provide counsellor	1.35	0.62	1	1	3	92.31
44	Schools should help young people with basic emotional literacy	1.19	0.48	1	1	3	96.16
45	Schools should encourage staff to show empath	1.04	0.19	1	1	2	100
46	Schools should be flexible regarding workload/ deadlines	1.15	0.36	1	1	2	100
47	Schools should support young people to continue accessing education	1.12	0.32	1	1	2	100
48	Schools should be able to refer young people to more formal support if school staff/ the young person feels it is needed	1.12	0.42	1	1	3	96.16
49	Schools should provide teachers with training regarding how to talk about suicide	1.15	0.46	1	1	3	96.15
50	Supporters should take time to build a relationship with the young person	1.27	0.52	1	1	3	96.15
51	Supporters should have lived experience of suicide loss themselves	3.27	0.98	3	1	5	19.23*
52	Supporters should have good listening skills	1.04	0.19	1	1	2	100
53	Supporters should be empathetic	1.04	0.19	1	1	2	100
54	Supporters should non-judgemental	1.00	0.00	1	1	1	100
55	Support should stable and consistent (e.g., support provided by the same person each week).	1.23	0.58	1	1	3	92.31
56	Supporters should have appropriate training	1.08	0.27	1	1	2	100
57	Mental health professionals should address harmful coping strategies (e.g., drugs, alcohol)	1.38	0.56	1	1	3	96.15
58	Mental health professionals should enquire about and address any issues relating to sleep	1.19	0.39	1	1	2	100
59	Mental health professionals should provide psychoeducation/ training to the young person's support network (e.g., school, caregivers) about how to interact with and support the young person	1.38	0.62	1	1	3	92.31
60	Mental health professionals should provide psychoeducation to young people about the reasons that people die by suicide to help them understand complexities involved	1.46	0.69	1	1	4	96.16
61	Mental health professionals should assess for and treat post-traumatic stress disorder	1.27	0.52	1	1	3	96.15
62	Informal support should include the whole family	1.65	0.73	1	1	3	96.15
63	Informal support should refer YP with more complex needs to appropriate services	1.46	0.57	1	1	3	96.15
64	Informal support should facilitate communication between young people and parents/ school etc	1.46	0.57	1	1	3	96.15
65	Informal support should educate young people about their increased risk for suicide and create awareness about things that may increase risk	1.15	0.36	1	1	2	100
66	Informal support should normalise confusing/ difficult/ conflicting emotions	1.31	0.46	1	1	2	96.16
67	Informal support should enable young people to increase their self-awareness	1.19	0.39	1	1	2	100
68	Informal support should provide a space for young people to be able to ask questions	1.27	0.52	1	1	3	96.15
69	Informal support should encourage and enable young people to seek opportunities for pleasure and enjoyment	1.31	0.46	1	1	2	96.16
70	Informal support should help young people with managing social situations	1.50	0.57	1	1	3	96.15
71	Informal support should help young people make plans for their future/ foster sense of hopefulness	1.27	0.52	1	1	3	92.31

72	Informal support should enable the young people to disclose their own thoughts about suicide	1.58	0.74	1	1	4	100
73	Informal support should ensure the young people is managing to engage in activities that are necessary for physical wellbeing (e.g., eating, washing)	1.19	0.39	1	1	2	92.30
74	Informal support should enable young people to talk openly about thoughts and feelings	1.23	0.50	1	1	3	100
75	Informal support should help to find positive ways for the young person to remember the person they have lost	1.15	0.36	1	1	2	96.15
76	Informal support should help the young person to acknowledge and understand what has happened in an appropriate way	1.46	0.57	1	1	3	96.15
77	Informal support should allow space for the young person to talk about the person they have lost	1.27	0.52	1	1	3	100
78	Informal support should work through parents (if possible) to support young people who won't engage directly with support	1.27	0.44	1		2	88.46
79	Informal support should provide opportunities for the young person to connect with other young people who have experienced similar losses (peer support)	1.54	0.69	1	1	3	88.46
80	Informal support should provide a space where the young person feels safe	1.69	0.77	1	1	4	100

Creating the Guidelines

The final guidelines (shown in Table 8) were composed following the consensus survey. The aim was to produce information that would be helpful for professionals and/ or service-users and could be easily accessed via a pamphlet or webpage. This was achieved by using the themes of the interviews and questionnaires as guideline headings. The themes 'informal support' and 'how support is provided' were combined in order to avoid repetition and ensure the guidelines were concise. Subthemes (which achieved consensus) relating to each guideline were then narratively summarised using accessible language.

Table 8

Guidelines for Supporting Young People

Young people need immediate support after bereavement by suicide
Support for bereaved young people needs to start from the point of being informed of a suicide. First responders involved in informing young people and families of a young person's suicide should receive specific training in this area in order to ensure this is conducted in a sensitive and compassionate manner. Other aspects of immediate support may include assistance with practical issues, providing explanations of procedures and next steps, as well as allowing the opportunity to ask questions. Families are likely to be extremely distressed and may not have the capacity to retain verbal information. For this reason, each family should be provided with written resources specifically designed for young people. These resources should include signposting information relevant to the young person's local area.
Support should be provided in different ways and by different people
Although the loss of a friend or sibling to suicide is deeply distressing for young people, the majority of these individuals are most effectively supported by people in their existing social network that they already know and trust (e.g., family, teachers, friends). People within the bereaved young person's existing support network should provide a safe space for the young person to talk openly about their feelings regarding the loss, or any concerns they may have. It is important that such support instils a sense of hopefulness within the young person by encouraging them to make future plans or take opportunities to enjoy themselves. Young people bereaved by suicide are likely to need reassurance that it is still okay to do these things. In addition to this, informal support should aim to ensure that the young person's physical wellbeing is being prioritised (e.g., they are eating/ washing) particularly in the short-term. It is important that people around the young person are aware of the possibility of increased risk and are vigilant for signs that the young person may need more professional support. In these cases, informal supporters might try to help the young person recognise this and suggest support options such as local peer support groups or visiting their

GP. Finally, young people bereaved by suicide need to be enabled to remember the person they have lost. Informal support networks can help young people to find positive and healthy ways to memorialise the deceased person and the bond they had with them (e.g., through volunteering for charities, participating in research, planting trees etc).

A minority of young people may need more formal, specialised support from a mental health professional. This is especially relevant for young people who have been exposed to particularly traumatic experiences (e.g., discovering the body of their friend or sibling). This support should be accessible for young people via a range of mediums (e.g., online, in person) and formats (groups, 1:1) based around the individual's needs and personal preferences.

It is important the people providing support have an appropriate level of training

The people who young people are most likely to turn to for support include professionals who they already have a relationship with, such as teachers, sports coaches and GPs. It is therefore essential that all professionals who work closely with young people have a basic level of understanding and training regarding suicide. GPs in particular need an awareness of the services available in the local area which might be able to offer support, as they are likely to be the first port of call for many young people. Any mental health experts providing more intensive treatment or input should be suitably qualified, particularly when addressing potentially complex problems such as PTSD.

Support should be easy to access for young people bereaved by suicide

Access to support services should be straightforward for young people and families. It is most helpful if young people are offered support on an outreach basis, rather than waiting for them to seek support themselves. Where young people or families do seek out support, they would like to be able to access this quickly, through a process of self-referral. Services that provide support should consider that some young people are likely to require long-term support. It might be particularly helpful if support services could regularly attempt to re-engage young people around times when they may be particularly vulnerable (e.g., anniversaries, birthdays).

All young people have unique needs and preferences. This should be reflected in the support options that are offered to those bereaved by suicide

There is no "one size fits all" when it comes to supporting people bereaved by suicide. Each young person will experience the suicide of a friend or sibling differently and will have different needs and preferences in terms of support. Young people should be offered options about how and when they would like to engage with support. Many young people may find it challenging to engage with more traditional types of support such as 1:1 therapy. Support services need to think creatively about ways that they might engage young people. For example, services should consider offering support whilst involving young people in activities that interest them (e.g., playing football, going to a coffee shop). This type of approach can feel less intimidating and pressurised for young people, which is likely to have a positive impact on their willingness to engage.

Caregivers are a key source of informal support; however, they may need support themselves

Caregivers play a central role in terms of supporting young people following bereavement by suicide. Young people need their caregivers to normalise their emotional response and provide them with care and empathy. It is also helpful for caregivers to try to maintain a sense of routine and predictability for the young person. Parents may benefit from advice from professionals regarding important issues such as increased risk following suicide exposure and subsequent safety planning. Caregivers will need to familiarise themselves with the potential support options available for the young person in their local area. If caregivers are concerned about a young person's wellbeing, they should encourage them to access professional support or consider facilitating this on their behalf. Importantly, Parents who have experienced the loss of a child are likely to be dealing with their own grief and trauma and may therefore, understandably struggle to emotionally support any surviving children. In such cases it will be important for wider support networks (friends, family, teachers) to reach out to the family and offer assistance wherever possible.

Y**oung people will require support from their school/ college/ university following bereavement by suicide**

Education settings (e.g., schools, colleges, universities) should encourage young people to be open about issues relating to mental health and should help young people to improve their emotional literacy. This will enable them to reach out in times of need and/ or to provide support to struggling peers. When a student is impacted by the suicide of a friend or a sibling, staff should show empathy and allow flexibility on issues such as punctuality or assignment deadlines in order to enable the young person to continue accessing education. School counsellors may be particularly helpful in supporting young people bereaved by suicide; however, all schools should ensure they have some staff appropriately trained in supporting young people with suicide bereavement. In situations where a teacher or school counsellor identifies a student in need of more intensive support, they should be able to make a referral to a more appropriate service for this.

Building a therapeutic relationship is vital

Certain personal qualities are vital in order to develop a therapeutic relationship with a young person bereaved by suicide. These include taking time to get to know the young person and to gain their trust, being empathetic, being consistently available, and being willing to listen in a non-judgemental way. These qualities are likely to be present in many people already in the young person's support network (e.g., teachers, sports coaches, GPs). People who provide more formalised support will also require the personal qualities listed above, in addition to an appropriate level of professional training. Finally, suicide bereavement is complex, and many people describe that grief following a suicide feels qualitatively different to other types of bereavement. For this reason, young people may appreciate being supported by people who have lived experience of suicide bereavement. This might be achieved by engaging with services that offer peer support groups.

Mental health professionals may be needed for more complex problems

More intensive/ specialist support, provided by mental health professionals may be needed to treat young people who develop maladaptive coping strategies (e.g., drug/ alcohol misuse) or mental health conditions that develop in response to the bereavement (e.g., PTSD, complicated grief). Mental health professionals may also have a role to play in providing psychoeducation and advice to a young person's support network regarding issues such as risk and how best to support young people. Finally, many young people express feelings such as guilt and confusion after losing a friend or sibling to suicide. Mental health professionals can assist with this by providing psychoeducation regarding suicide and it's causes to bereaved young people.

Discussion

This study identified how EBE and professionals believe YP should be supported following the suicide of a sibling or peer. Following consultation with our charity research partners, the first round of this Delphi study involved collecting qualitative data from EBE (parents, siblings, friends) and professionals with expertise in YP's mental health (Psychologists, Third sector workers, Academics, GPs). For ethical and practical reasons, EBE took part in an interview and professionals completed an on-line questionnaire that contained the same open-ended questions as the interview. The qualitative data were analysed together and themes and sub-themes regarding important elements of postvention support for YP were identified. Sub-themes were then transformed into summary statements which participants were asked to rate in terms of strength of agreement. Finally, the level of consensus for each statement was calculated.

Interpretation of Findings

The need for immediate support when YP (particularly siblings) were informed of the suicide, was identified as a major theme. Both EBE and professionals discussed that immediate support should include help with practical issues such as understanding procedures. Research has highlighted that not providing people with adequate information regarding the inquest process exacerbates the traumatic nature of the procedure and increases distress (Spillane et al., 2019). The only statement that did not achieve consensus within this theme regarded the need for a trained mental health professional to be present when the YP was informed. This statement was less likely to be endorsed by professionals. This may be due to concerns regarding the practicality of this suggestion (e.g., the costs involved with providing this service). Few formal evaluations of active postvention services have been published, however Cerel and Campbell (2008) reported that people who received immediate postvention at the time of their loved one's death were more likely to present for treatment sooner and access support groups. Campbell et al. (2004) also suggested that the presence of postvention supporters at the scene of the suicide, encouraged first-responders to deal with situation more sensitively.

How support is provided to bereaved YP was recognised to be important and all items within this category achieved consensus. Participants spoke about the need for two tiers of care: 1. an informal/ universal level, which should be given to everyone and does not need to be provided by a mental health professional and 2. a more specialist/ formal approach provided by professionals such as Psychologists or Counsellors that might be needed by those with complex needs. This finding is supported by previous research, including a large population-based study by Harrison and Harrington (2001) that concluded that 88.5% of

bereaved adolescents did not feel they needed professional input. Rather, YP preferred support from people they were already close to.

Although social support for YP following suicide bereavement has been associated with positive outcomes (e.g., healthier grief responses and attitudes to suicide; Abbot and Zakriski, 2014) qualitative studies have suggested that YP may not receive adequate social support (Bartik, Maple, Edwards and Kiernan, 2013; Dyregrov and Dyregov, 2005). These studies described that bereaved peers felt their social contacts were unable to empathise with or understand their experience. Bereaved siblings echoed these feelings and had the additional burden of feeling unable to seek support from their parents. Pitman et al. (2018) found that informal support systems were the most frequent source of support. Pitman and colleagues (2018) argued that if informal support systems are perceived to be inadequate, this can increase feelings of abandonment within the bereaved.

Research has illustrated that suicide bereavement may be experienced differently to other types of loss (Andriessen et al., 2017) and may be associated with sequalae including increased risk of suicidal behaviour (Andriessen et al., 2016; Pitman et al., 2014). In contrast to Harrsion and Harrington's (2001) findings, Dyregrov (2009) reported that up to 69% of their sample of YP bereaved by suicide felt they needed professional help but were unable to access it. Andriessen and colleagues (2018) reported that most referrals of YP to mental health professionals came from parents. These findings highlight the importance of equipping those around bereaved YP (e.g., caregivers) with the skills to provide an appropriate level of support as well as to know when professional input is needed.

The importance of caregivers was recognised by both EBE and professionals, and most items within this category were endorsed. There was acknowledgement that caregivers may need support to understand how best to help YP. Previous research has illustrated that

encouragement from caregivers to seek formal support is important for YP (Andriessen et al., 2019c). Gould et al. (2009) argued that "access to mental health services by youths depends on the recognition and actions of key adults, as well as on their own perception of a problem" (Gould et al., 2009, p. 1199). In this study, EBE and professionals agreed on the importance of caregivers being able to recognise when the YP may need formal support. This may be more complex for siblings bereaved by suicide, as their parents will be experiencing significant grief of their own. In these cases, participants agreed that parents and YP will need to draw upon their wider family support networks.

EBE and professionals were mindful of the possibility of increased risk of suicidal behaviour in YP and suggested that caregivers should monitor YP's social media usage. However, this statement did not achieve consensus, with EBE more likely to endorse it. Studies have suggested that social media posts regarding suicide may glorify or normalise suicidal behaviour and may increase risk (Sedgwick et al., 2019). However, other researchers (e.g., Robinson et al., 2016) have argued that engagement with social media may be beneficial as it provides an anonymous and non-judgemental forum for YP to share their experiences and receive support.

Participants felt that the way support is accessed by YP was important. All items in this area achieved consensus and participants agreed that access to support should be straight forward, timely and offered on an outreach basis. Andriessen and colleagues (2018) reported that YP may experience barriers to accessing support due to several factors including, feelings of shame, over reliance on social support, lack of emotional literacy and absence of knowledge regarding services. Similarly, Dyregrov (2009) found that YP bereaved by suicide reported lacking the motivation and energy to seek out formal support for themselves. This view was echoed by EBE in this study. These findings highlight the importance of ensuring

that support services are easy and quick to access. These findings support the work of researchers such as Pitman et al. (2018) who suggested that support should be offered to people bereaved by suicide on an outreach basis (i.e., health professionals or institutions make contact with the bereaved). It may also be important for bereavement support services to be publicised to facilitate and encourage help-seeking.

The need for training for people who support YP exposed to suicide was endorsed among all respondents. Participants identified the need for professionals who work closely with YP (e.g., teachers) to have a basic level of training in this area. The need for first-responders to receive more training in order to deal with these situations more sensitively was also agreed upon. These findings are in keeping with a recent qualitative study conducted by Nelson et al. (2020) with a sample of paramedics, which described that they had little or no training regarding handling bereaved family. Other studies (Dyregrov, 2009; Andriessen et al., 2019c) have emphasised the importance of appropriate training in this area. GPs were identified as important providers or gatekeepers of support. Many EBE expressed disappointment with their GP's handling of them or their children following their bereavement experience. In particular, EBE felt that GPs were more likely to suggest psychotropic medications rather than to refer for talking therapies. A recent cohort study conducted by Fenger-Grøn (2018) and colleagues, concluded that early treatment with talking therapies is associated with long-term reduced risk of suicide, self-harm, and psychiatric admission. The same study found no effect for anti-depressant treatment (Fenger-Grøn et al., 2018).

EBE and professionals acknowledged that YP's experiences of grief vary widely. All participants endorsed the need for support to be person centred, tailored to the individual and led by the needs of the YP. In previous research, Andriessen et al. (2019c; 2020) found that

YP valued the option of different forms of support. This is in keeping with studies (e.g., Binder et al. 2011; Gibson et al., 2016) that have suggested that YP engage best with psychological support that affords them a degree of autonomy and control over their care.

Education settings were seen as important and all statements in this area achieved consensus. Participants felt that schools should teach YP about emotional literacy and wellbeing, as well as provide support through teachers and counsellors. The need for schools to help bereaved students continue to access education was also endorsed. These findings are consistent with previous research which has emphasised the importance of school support. For example, Robinson et al. (2013) found that YP are most likely to seek support from school counsellors rather than health professionals.

Previous studies have reported that YP often feel that support offered by schools is inadequate (Andriessen et al., 2019c). In their systematic review Robinson et al. (2013) evaluated two studies relating to school postvention and concluded that neither reported significant benefits. Research has also shown that school staff report feeling ill-equipped to deal with student suicides (Ross et al., 2017). These findings suggest that mental health services need to work in partnership with schools to ensure that YP receive appropriate postvention support. Further research is needed to better understand how partnerships between CAMHS and schools could be operationalised.

Certain personal attributes and skills of people who provide support to YP were found to be important. EBE and professionals both agreed that the therapeutic relationship is a crucial element of postvention support. Aspects such as listening skills, showing empathy, and giving time were all endorsed. This is consistent with previous research which has shown that bereaved YP are more likely to engage with support when they feel they have formed a trusting and consistent relationship (Adriessen et al., 2019c; Dyregrov, 2009).

EBE suggested that it was helpful for people who provide support to have had lived experience of suicide bereavement themselves. This statement did not achieve consensus and was less likely to be endorsed by professionals. Again, this may be due to practical concerns. However, one way of achieving this may be to encourage bereaved YP to engage with support groups, allowing them access to peers who have experienced similar losses. Groos and Shakespeare- Finch (2012) illustrated that being able to connect with other suicide survivors helps to normalise the suicide bereavement experience and can generate a sense of hope.

The role of informal/ universal support was discussed and all items in this section were endorsed. It was felt that informal support should address both practical and emotional issues related to bereavement. Pitman et al. (2018) highlighted the importance of informal support through bereavement groups, family and friends, and educational settings. A recent systematic review (Scott et al., 2020) concluded that better informal support is associated with improved psychological wellbeing.

In keeping with the findings of this study, previous research has shown that informal support that includes practical and emotional elements can be valuable to people bereaved by suicide (Spillane et al., 2018). Despite this, there is evidence to suggest that many YP feel they do not receive adequate informal support (Pitman et al., 2018). In addition to this, participants identified that social support for YP needs to be tailored to the individual's developmental stage. Therefore, the type of social support that is needed may vary. It is recommended that future research explores how the quantity and quality of social support can be improved for YP bereaved by suicide.

The fact that some YP may require more formal/ specialist support and what this might entail, was discussed. All statements within this theme achieved consensus. Both EBE

and professionals agreed that issues such as the use of harmful coping strategies or the presence of PTSD require input from a mental health professional. Participants also endorsed statements that suggested that providing psychoeducation, both to the bereaved and the wider support network, was an important aspect of formal/ specialist support. It was recommended that mental health professionals provide information regarding the possibility of increased risk of suicidal behaviour and advice on how this might be mitigated. Previous research (e.g., Cha et al., 2018; Poijula et al, 2001) has demonstrated the importance of professional intervention for YP at high risk of complications such as PTSD or complicated grief and has suggested that this may prevent issues such as contagion. EBE and professionals also spoke about the need for formal support to include caregivers. Studies have highlighted that the inclusion of elements such as parental psychoeducation improves the efficacy of interventions (Pfeffer et al., 2002; Sandler et al., 2016).

Only three items did not achieve consensus. Two of these (statements 1 and 30) were strongly endorsed by EBE participants but not professionals. Much of the criticism around co-production research has focussed on the imbalance of power between EBE and professionals (Turnhout et al., 2020). Specifically, the views and opinions of professionals have tended to be considered more valuable (Rose and Kalathil, 2019). Given this criticism, the decision was made to retain items 1 and 30 to ensure that the views of EBE were heard and to counteract any possible imbalances of power in this study.

Limitations

The current study included certain limitations. For example, the qualitative first round of this study was conducted differently for EBE and professionals. The rationale for this was

two-fold. Firstly, given the sensitive nature of this subject area and the potential for distress, the priority of the research team was to conduct the study ethically and safely. Interviews were used for EBE as this allowed the researcher to monitor the participants' distress levels and make plans for further support if required. Secondly, many of the professionals involved in this study are clinicians who were unlikely to have for a 45-minute interview. Therefore, the most practical way to ensure professional involvement in the study was to allow them to complete the first round online at their convenience. The result is that much richer, more detailed data was collected from EBE in comparison to professionals, which may have biased the findings of this study. However, researchers such as Jorm (2015) have emphasised the importance of the inclusion of EBE in mental health research. Therefore, the richness of EBE data and the use of co-production at every stage of the research process, is a strength of this study.

The majority of participants in this study identified as female. This may be particularly problematic for EBE, as some research has suggested that boys and girls are impacted differently by suicide bereavement (e.g., girls may be more likely to develop PTSD; Andriessen et al., 2016). Therefore, this may mean that boys' postvention needs are under-represented within this study. In addition to this, all participants reported their ethnicity as 'white British', therefore these findings are unlikely to generalise to other populations.

Only two rounds (one qualitative, one consensus survey) were conducted within the current study. Traditionally, Delphi studies require three rounds. However, high levels of agreement were obtained in the second round of this study, suggesting that a third round was not necessary. Finally, it should be noted that these guidelines represent an ideal scenario regarding postvention support. Unfortunately, some of these recommendations may be challenging to implement in practice given the limited resources available. For example,

although YP should be able to access professional support for complex issues such as PTSD quickly and without the barrier of long waiting lists, this is unlikely to be achievable via the NHS. As such, these guidelines highlight the need for additional resources to be directed towards supporting this currently under-served population.

Clinical Implications

The findings of this study highlight the importance of providing support to YP bereaved by suicide. Both formal and informal support play an important role and there is a need for future research to investigate how these can be accessed and provided more effectively. Caregivers and other close adults play a crucial role and may require advice from appropriately trained professionals to help them support YP. Similarly, schools and mental health professionals should work jointly to provide postvention where required. Finally, it is important to appreciate that every situation will be unique, therefore any postvention should ultimately be led by the needs and wants of the individuals involved.

Conclusions

This study is a first step towards co-producing an information resource for young people, parents, and professionals regarding how to support peers and siblings following suicide bereavement. Using a Delphi survey method technique and following INVOLVE guidance for co-production, salient elements of the guidance have been determined. These included themes such as: considering how support is accessed and provided; the training and personal qualities needed by people who provide support; the importance of individualised

interventions; the role of different levels of support; and the importance of school and caregiver involvement. Taken together, these findings illustrate the importance of providing postvention support for this population. This can (and should) be provided by a range of sources and may involve a wide variety of resources in order to meet the individual needs and preferences of each YP.

References

Abbott, C. H., & Zakriski, A. L. (2014). Grief and attitudes toward suicide in peers affected by a cluster of suicides as adolescents. *Suicide and Life-Threatening Behavior, 44*(6), 668-681. doi:http://dx.doi.org/10.1111/sltb.12100

Andriessen, K., Draper, B., Dudley, M., & Mitchell, P. B. (2015). Bereavement After Suicide. *Crisis, 36*(5), 299-303. doi:10.1027/0227-5910/a000339

Andriessen, K., Draper, B., Dudley, M., & Mitchell, P. B. (2016). Pre-and postloss features of adolescent suicide bereavement: A systematic review. *Death Studies, 40*(4), 229-246.

Andriessen, K., Krysinska, K., Hill, N. T. M., Reifels, L., Robinson, J., Reavley, N., & Pirkis, J. (2019a). Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. *BMC Psychiatry, 19*(1), 49. doi:10.1186/s12888-019-2020-z

Andriessen, K., Krysinska, K., Kõlves, K., & Reavley, N. (2019b). Suicide Postvention Service Models and Guidelines 2014–2019: A Systematic Review. *Frontiers in Psychology, 10*. doi:10.3389/fpsyg.2019.02677

Andriessen, K., Lobb, E., Mowll, J., Dudley, M., Draper, B., & Mitchell, P. B. (2019c). Help-seeking experiences of bereaved adolescents: A qualitative study. *Death Studies, 43*(1), 1-8.

Andriessen, K., Rahman, B., Draper, B., Dudley, M., & Mitchell, P. B. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies. *Journal of Psychiatric Research, 88*, 113-120.

Bartik, W., Maple, M., & McKay, K. (2015). Suicide bereavement and stigma for young people in rural Australia: A mixed methods study. *Advances in Mental Health, 13*(1), 84-95. doi:http://dx.doi.org/10.1080/18374905.2015.1026301

Bartik, W. J., Maple, M., & McKay, K. (2020). Youth suicide bereavement and the continuum of risk. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 41*(6), 483-489. doi:http://dx.doi.org/10.1027/0227-5910/a000653

Bartik, W., Maple, M., Edwards, H., & Kiernan, M. (2013). Adolescent survivors after suicide: Australian young people's bereavement narratives. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 34*(3), 211-217. doi:http://dx.doi.org/10.1027/0227-5910/a000185

Bartik, W., Maple, M., Edwards, H., & Kiernan, M. (2013b). The psychological impact of losing a friend to suicide. *Australasian Psychiatry, 21*(6), 545-549. doi:http://dx.doi.org/10.1177/1039856213497986

Beiderbeck, D., Frevel, N., von der Gracht, H. A., Schmidt, S. L., & Schweitzer, V. M. (2021). Preparing, conducting, and analyzing Delphi surveys: Cross-disciplinary practices, new directions, and advancements. *MethodsX, 8*, 101401. doi:https://doi.org/10.1016/j.mex.2021.101401

Binder, P.-E., Moltu, C., Hummelsund, D., Sagen, S. H., & Holgersen, H. (2011). Meeting an adult ally on the way out into the world: Adolescent patients' experiences of useful psychotherapeutic ways of working at an age when independence really matters. *Psychotherapy Research, 21*(5), 554-566.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. http://.doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597. doi:10.1080/2159676X.2019.1628806

Brent, D. A., Moritz, G., Bridge, J., Perper, J., & Canobbio, R. (1996a). Long-term impact of exposure to suicide: A three-year controlled follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(5), 646-653. doi:http://dx.doi.org/10.1097/00004583-199605000-00020

Brent, D. A., Moritz, G., Bridge, J., Perper, J., & Canobbio, R. (1996b). The impact of adolescent suicide on siblings and parents: A longitudinal follow-up. *Suicide & Life - Threatening Behavior, 26*(3), 253-259.

Brent, D. A., Perper, J., Moritz, G., Friend, A., Schweers, J., Allman, C., . . . Balach, L. (1993a). Adolescent Witnesses to a Peer Suicide. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(6), 1184-1188. doi:10.1097/00004583-199311000-00011

Brent, D. A., Perper, J. A., Moritz, G., Allman, C., Liotus, L., Schweers, J., . . . Canobbio, R. (1993b). Bereavement or depression? The impact of the loss of a friend to suicide. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*(6), 1189-1197. doi:http://dx.doi.org/10.1097/00004583-199311000-00012

Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Richardson, D., Canobbio, R., . . . Roth, C. (1995). Posttraumatic stress disorder in peers of adolescent suicide victims:

Predisposing factors and phenomenology. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*(2), 209-215. doi:http://dx.doi.org/10.1097/00004583-199502000-00016

Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Schweers, J., & Canobbio, R. (1994). Major depression or uncomplicated bereavement? A follow-up of youth exposed to suicide. *Journal of the American Academy of Child & Adolescent Psychiatry, 33*(2), 231-239. doi:http://dx.doi.org/10.1097/00004583-199402000-00012

Campbell, F. R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. *Crisis, 25*(1), 30-32.

Cerel, J., & Campbell, F. R. (2008). Suicide Survivors Seeking Mental Health Services: A Preliminary Examination of the Role of an Active Postvention Model. *Suicide & life-threatening behavior, 38*(1), 30-34. doi:10.1521/suli.2008.38.1.30

Cha, J. M., Kim, J. E., Kim, M. A., Shim, B., Cha, M. J., Lee, J. J., et al. (2018). Five months follow-up study of school-based crisis intervention for Korean high school students who experienced a peer suicide. *J. Korean Med. Sci*. 33:e192. doi: 10.3346/jkms.2018.33.e192

Chan, S., Denny, S., Fleming, T., Fortune, S., Peiris-John, R., & Dyson, B. (2018). Exposure to suicide behaviour and individual risk of self-harm: Findings from a nationally representative New Zealand high school survey. *Australian and New Zealand Journal of Psychiatry, 52*(4), 349-356. doi:http://dx.doi.org/10.1177/0004867417710728

Dyregrov, K., & Dyregrov, A. (2005). Siblings after suicide--"The forgotten bereaved". *Suicide and Life-Threatening Behavior, 35*(6), 714-724. doi:http://dx.doi.org/10.1521/suli.2005.35.6.714

Dyregrov, K. (2009). How do the young suicide survivors wish to be met by psychologists? A user study. *OMEGA-Journal of death and dying, 59*(3), 221-238.

Fenger-Grøn M, Kjaersgaard MIS, Parner ET, Guldin MB, Vedsted P, Vestergaard M. Early treatment with talk therapy or antidepressants in severely bereaved people and risk of suicidal behavior and psychiatric illness: an instrumental variable analysis. *Clin Epidemiol*. 2018;10:1013-1026. doi:10.2147/CLEP.S157996

Gibson, K., Cartwright, C., Kerrisk, K., Campbell, J., & Seymour, F. (2016). What Young People Want: A Qualitative Study of Adolescents' Priorities for Engagement Across Psychological Services. *Journal of Child and Family Studies, 25*(4), 1057-1065. doi:10.1007/s10826-015-0292-6

Gould, M. S., Marrocco, F. A., Hoagwood, K., Kleinman, M., Amakawa, L., & Altschuler, E. (2009). Service use by at-risk youths after school-based suicide screening. *Journal of the American Academy of Child & Adolescent Psychiatry*, *48*(12), 1193-1201.

Groos, A. D., & Shakespeare-Finch, J. (2013). Positive experiences for participants in suicide bereavement groups: a grounded theory model. *Death Studies, 37*(1), 1-24.

Harrison, L., & Harrington, R. (2001). Adolescents' bereavement experiences. Prevalence, association with depressive symptoms, and use of services. *Journal of adolescence, 24*(2), 159-169.

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *J Adv Nurs, 32*(4), 1008-1015.

Hazell, P., & Lewin, T. (1993). Friends of adolescent suicide attempters and completers. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*(1), 76-81. doi:http://dx.doi.org/10.1097/00004583-199301000-00011

Hickey G, Brearley S, Coldham T, Denegri S, Green G, Staniszewska S, Tembo D, Torok K, Turner K (2018) Guidance on co-producing a research project. INVOLVE, Southampton

Iqbal, S., & Pipon-Young, L. (2009). The Delphi method. *Psychologist, 22*, 598-601.

Jordan, J. R., & McIntosh, J. L. (2011). Is suicide bereavement different? Perspectives from research and practice. In R. A. Neimeyer, D. L. Harris, H. R. Winokuer, & G. F. Thornton (Eds.), *Grief and bereavement in contemporary society: Bridging research and practice* (pp. 223–234). Routledge/Taylor & Francis Group.

Jordan, J. R. (2017). Postvention is prevention—The case for suicide postvention. *Death Studies, 41*(10), 614-621.

Jorm, A. F. (2015). Using the Delphi expert consensus method in mental health research. *Australian & New Zealand Journal of Psychiatry, 49*(10), 887-897. doi:10.1177/0004867415600891

Jünger, S., Payne, S. A., Brine, J., Radbruch, L., & Brearley, S. G. (2017). Guidance on Conducting and REporting DElphi Studies (CREDES) in palliative care: recommendations based on a methodological systematic review. *Palliative medicine, 31*(8), 684-706. https://doi.org/10.1177/0269216317690685

Journot-Reverbel, K., Raynaud, J.-P., Bui, E., & Revet, A. (2017). Support groups for children and adolescents bereaved by suicide: Lots of interventions, little evidence. *Psychiatry Research, 250*, 253-255. doi:https://doi.org/10.1016/j.psychres.2017.01.077

Law, H., & Morrison, A. P. (2014). Recovery in Psychosis: A Delphi Study With Experts by Experience. *Schizophrenia Bulletin, 40*(6), 1347-1355. doi:10.1093/schbul/sbu047

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *Bmj, 320*(7226), 50-52. https://doi.org/10.1136/bmj.320.7226.50

Nelson, P. A., Cordingley, L., Kapur, N., Chew-Graham, C. A., Shaw, J., Smith, S., . . . McDonnell, S. (2020). 'We're the First Port of Call' – Perspectives of Ambulance Staff on Responding to Deaths by Suicide: A Qualitative Study. *Frontiers in Psychology, 11*. doi:10.3389/fpsyg.2020.00722

Niederberger, M., & Spranger, J. (2020). Delphi Technique in Health Sciences: A Map. *Frontiers in Public Health, 8*. doi:10.3389/fpubh.2020.00457

Nurek, M., Rayner, C., Freyer, A., Taylor, S., Järte, L., MacDermott, N., & Delaney, B. C. (2021). Recommendations for the recognition, diagnosis, and management of long COVID: a Delphi study. *British Journal of General Practice, 71*(712), e815-e825. doi:10.3399/bjgp.2021.0265

Pfeffer, C. R., Jiang, H., Kakuma, T., Hwang, J., & Metsch, M. (2002). Group intervention for children bereaved by the suicide of a relative. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(5), 505-513.

Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *The Lancet Psychiatry, 1*(1), 86-94. doi:https://doi.org/10.1016/S2215-0366(14)70224-X

Pitman, A. L., Osborn, D. P., Rantell, K., & King, M. B. (2016). The stigma perceived by people bereaved by suicide and other sudden deaths: A cross-sectional UK study of 3432 bereaved adults. *J Psychosom Res, 87*, 22-29. doi:10.1016/j.jpsychores.2016.05.009

Pitman, A., De Souza, T., Khrisna Putri, A., Stevenson, F., King, M., Osborn, D., & Morant, N. (2018). Support Needs and Experiences of People Bereaved by Suicide: Qualitative Findings from a Cross-Sectional British Study of Bereaved Young Adults. *International journal of environmental research and public health, 15*(4), 666. doi:10.3390/ijerph15040666

Robinson, J., Cox, G., Malone, A., Williamson, M., Baldwin, G., Fletcher, K., & O'Brien, M. (2013). A systematic review of school-based interventions aimed at preventing, treating, and responding to suicide-related behavior in young people. *Crisis*.

Robinson, J., Cox, G., Bailey, E., Hetrick, S., Rodrigues, M., Fisher, S., & Herrman, H. (2016). Social media and suicide prevention: a systematic review. *Early intervention in psychiatry, 10*(2), 103-121.

Rose, D., & Kalathil, J. (2019). Power, Privilege and Knowledge: the Untenable Promise of Co-production in Mental "Health". *Frontiers in Sociology, 4*. doi:10.3389/fsoc.2019.00057

Ross, V., Kolves, K., & De Leo, D. (2017). Teachers' perspectives on preventing suicide in children and adolescents in schools: A qualitative study. *Archives of suicide research, 21*(3), 519-530.

Sandler, I., Tein, J. Y., Wolchik, S., & Ayers, T. 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 and Life-Threatening Behavior, 46*, S32-S38.

Scott, H. R., Pitman, A., Kozhuharova, P., & Lloyd-Evans, B. (2020). A systematic review of studies describing the influence of informal social support on psychological wellbeing in people bereaved by sudden or violent causes of death. *BMC psychiatry, 20*(1), 1-20.

Sedgwick, R., Epstein, S., Dutta, R., & Ougrin, D. (2019). Social media, internet use and suicide attempts in adolescents. *Current opinion in psychiatry, 32*(6), 534-541. doi:10.1097/YCO.0000000000000547

Spillane, A., Matvienko-Sikar, K., Larkin, C., Corcoran, P., & Arensman, E. (2018). What are the physical and psychological health effects of suicide bereavement on family members? An observational and interview mixed-methods study in Ireland. *BMJ Open, 8*(1), e019472. doi:10.1136/bmjopen-2017-019472

Spillane, A., Matvienko-Sikar, K., Larkin, C., Corcoran, P., & Arensman, E. (2018). What are the physical and psychological health effects of suicide bereavement on family members? An observational and interview mixed-methods study in Ireland. *BMJ Open, 8*(1), e019472. doi:10.1136/bmjopen-2017-019472

Staniszewska, S., Denegri, S., Matthews, R., & Minogue, V. (2018). Reviewing progress in public involvement in NIHR research: developing and implementing a new vision for the future. *BMJ Open, 8*(7), e017124.

Sveen, C.-A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behavior, 38*(1), 13-29.

Swanson, S. A., & Colman, I. (2013). Association between exposure to suicide and suicidality outcomes in youth. *Canadian Medical Association Journal, 185*(10), 870-877. doi:10.1503/cmaj.121377

Szumilas, M., & Kutcher, S. (2011). Post-suicide intervention programs: a systematic review. *Canadian Journal of Public Health, 102*(1), 18-29. doi:10.1007/BF03404872

Welsh Assembly Government. (2009). *Talk to me. The national action plan to reduce suicide and self-harm in Wales 2009-2014* 2009, WAG: Cardiff.

Welsh Assembly Government. (2015). *Talk to me 2: Suicide and self-harm prevention strategy for Wales 2015-2020* 2015, WAG: Cardiff.

Temkin-Greener, H., Ladwig, S., Caprio, T., Norton, S., Quill, T., Olsan, T., . . . Mukamel, D. B. (2015). Developing Palliative Care Practice Guidelines and Standards for Nursing Home–Based Palliative Care Teams: A Delphi Study. *Journal of the American Medical Directors Association, 16*(1), 86.e81-86.e87. doi:https://doi.org/10.1016/j.jamda.2014.10.013

Zoellner, T., & Maercker, A. (2006). Posttraumatic growth in clinical psychology—A critical review and introduction of a two-component model. *Clinical psychology review, 26*(5), 626-65

Appendix A- MMAT Quality Rating Tables

MMAT Ratings for Mixed Methods Studies																
Citation	**1.1.**	**1.2.**	**1.3.**	**1.4.**	**1.5.**	**3.1.**	**3.2.**	**3.3.**	**3.4.**	**3.5.**	**5.1.**	**5.2.**	**5.3.**	**5.4.**	**5.5**	**Score**
Dyregrov and Dyregrov (2005)	Yes	Yes	Can't tell	Yes	Can't tell	No	Yes	No	Can't tell	Can't tell	No	Yes	No	Yes	No	40%

MMAT Ratings for Non-Randomised Studies						
Citation	**3.1.** **Are the participants representative of the target population?**	**3.2.** **Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**3.3.** **Complete outcome data?**	**3.4.** **Confounders accounted for?**	**3.5.** **Exposure administered as intended?**	**Score**
Bartik et al. (2013)	No	Yes	Yes	Yes	No	60%
Brent et al. (1996a)	Yes	Yes	Yes	Yes	Can't tell	80%
Brent et al. (1996b)	Yes	Yes	Yes	Yes	Can't tell	80%
Brent et al. (1994)	Yes	Yes	Yes	Yes	Can't tell	80%
Brent et al. (1993a)	Yes	Yes	Yes	Yes	Can't tell	100%
Brent et al. (1993c)	Yes	Yes	Yes	Yes	Can't tell	80%
Brent et al. (1993b)	No	Yes	Yes	Yes	Can't tell	60%
Cerel, Roberts and Nilsen (2005)	Yes	No	Yes	Yes	Can't tell	60%

Chan et al. (2018)	Yes	No	Yes	Yes	Yes	80%
Feigelman and Gorman (2008)	Yes	No	Yes	Yes	Yes	80%
Gould et al. (2018)	No	Yes	Yes	Yes	Can't tell	60%
Hazell and Lewin (1993)	No	No	Yes	Yes	No	40%
Ho et al. (2000)	No	No	No	Yes	Can't tell	20%
Kline et al. (2021)	Yes	No	Yes	Yes	Yes	80%
Liu et al. (2020)	Yes	No	Yes	Yes	Yes	80%
Pirelli and Jeglic (2009)	No	No	Can't tell	Yes	Yes	40%
Poijula et al. (2001)	Yes	No	No	Yes	No	40%
Swanson and Colman (2013)	Yes	No	Yes	Yes	Yes	80%
Watkins and Gutierrez (2003)	No	Yes	Yes	Yes	Yes	80%

Appendix B- Death Studies author guidelines

About the Journal

Death Studies is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Death Studies accepts the following types of article:

- Full-length research articles or reviews of the literature and brief reports

Open Access

You have the option to publish open access in this journal via our Open Select publishing program. Publishing open access means that your article will be free to access online immediately on publication, increasing the visibility, readership and impact of your research. Articles published Open Select with Taylor & Francis typically receive 95% more citations* and over 7 times as many downloads** compared to those that are not published Open Select.

Your research funder or your institution may require you to publish your article open access. Visit our Author Services website to find out more about open access policies and how you can comply with these.

You will be asked to pay an article publishing charge (APC) to make your article open access and this cost can often be covered by your institution or funder. Use our APC finder to view the APC for this journal.

Please visit our Author Services website if you would like more information about our Open Select Program.

*Citations received up to 9th June 2021 for articles published in 2016-2020 in journals listed in Web of Science®. Data obtained on 9th June 2021, from Digital Science's Dimensions platform, available at https://app.dimensions.ai
**Usage in 2018-2020 for articles published in 2016-2020.

Peer Review and Ethics

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be double blind peer reviewed by independent, anonymous expert referees. If you have shared an earlier version of your Author's Original Manuscript on a preprint server, please be aware that

anonymity cannot be guaranteed. Further information on our preprints policy and citation requirements can be found on our Preprints Author Services page. Find out more about what to expect during peer review and read our guidance on publishing ethics.

Preparing Your Paper

Article Types

Full-length research articles or reviews of the literature and brief reports

- Should be written with the following elements in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
- Should contain an unstructured abstract of 100 words.
- Should contain between 3 and 5 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation".

Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word or LaTeX formats. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

Though exceptions can be made for methodologically complex studies, it is suggested that full-length articles not exceed 25 pages, including abstract, references, tables, and figures. Brief reports are encouraged and should be no longer than 15 pages

References

Please use this reference guide when preparing your paper.

Taylor & Francis Editing Services

To help you improve your manuscript and prepare it for submission, Taylor & Francis provides a range of editing services. Choose from options such as English Language Editing, which will ensure that your article is free of spelling and grammar errors, Translation, and Artwork Preparation. For more information, including pricing, visit this website.

Checklist: What to Include

1. **Author details.** Please ensure all listed authors meet the Taylor & Francis authorship criteria. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
2. You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
3. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
   For single agency grants
   This work was supported by the [Funding Agency] under Grant [number xxxx].
   For multiple agency grants
   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
4. **Disclosure statement.** This is to acknowledge any financial or non-financial interest that has arisen from the direct applications of your research. If there are no relevant competing interests to declare please state this within the article, for example: *The authors report there are no competing interests to declare*. Further guidance on what is a conflict of interest and how to disclose it.
5. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.
6. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of

submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

7. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.
8. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.
9. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
10. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
11. **Units.** Please use SI units (non-italicized).

Using Third-Party Material

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on requesting permission to reproduce work(s) under copyright.

Submitting Your Paper

This journal uses Routledge's Submission Portal to manage the submission process. The Submission Portal allows you to see your submissions across Routledge's journal portfolio in one place. To submit your manuscript please click here.

If you are submitting in LaTeX, please convert the files to PDF beforehand (you will also need to upload your LaTeX source files with the PDF).

Please note that *Death Studies* uses Crossref™ to screen papers for unoriginal material. By submitting your paper to *Death Studies* you are agreeing to originality checks during the peer-review and production processes.

On acceptance, we recommend that you keep a copy of your Accepted Manuscript. Find out more about sharing your work.

Data Sharing Policy

This journal applies the Taylor & Francis Basic Data Sharing Policy. Authors are encouraged to share or make open the data supporting the results or analyses presented in their paper where this does not violate the protection of human subjects or other valid privacy or security concerns.

Authors are encouraged to deposit the dataset(s) in a recognized data repository that can mint a persistent digital identifier, preferably a digital object identifier (DOI) and recognizes a long-term preservation plan. If you are uncertain about where to deposit your data, please see this information regarding repositories.

Authors are further encouraged to cite any data sets referenced in the article and provide a Data Availability Statement.

At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be asked to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers.

Where one or multiple data sets are associated with a manuscript, these are not formally peer-reviewed as a part of the journal submission process. It is the author's responsibility to ensure the soundness of data. Any errors in the data rest solely with the producers of the data set(s).

Appendix C- Ethical approval

Print Cancel

RE: Ethics Feedback - EC.21.06.15.6359R

psychethics <psychethics@cardiff.ac.uk>
Tue 03/08/2021 15:36
To: Sarah Rook <RookS@cardiff.ac.uk>
Cc: Helen Penny <PennyH@cardiff.ac.uk>

Dear Sarah,

The Ethics Committee has considered your revised staff project proposal: Postvention guidelines for young people who have lost a sibling or friend to suicide: A Delphi Study (EC.21.06.15.6359R).

The project has been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Thanks
Jo
(on behalf of Adam Hammond)

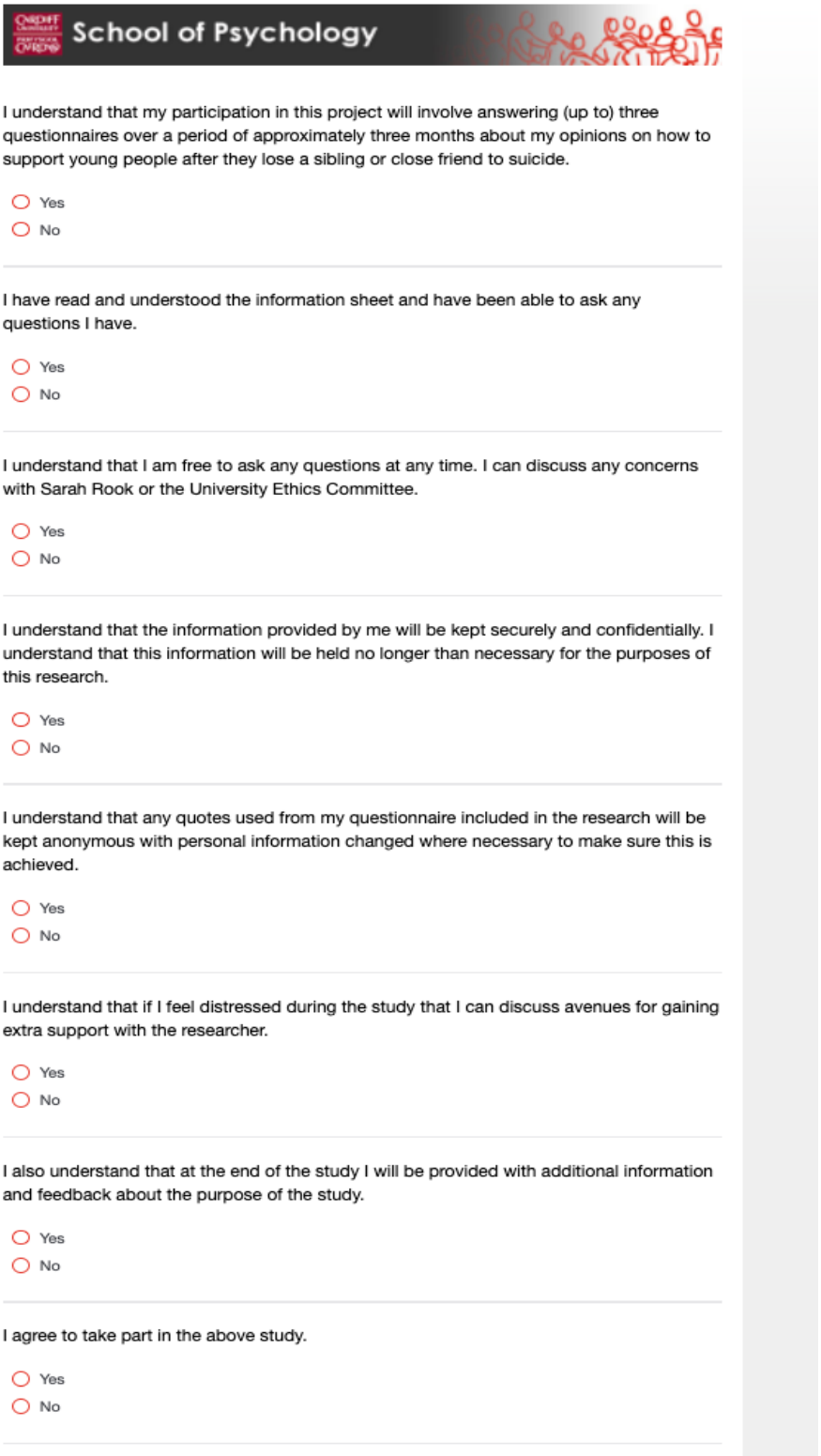
Appendix D- EBE Consent Form

	Please write your initials below:
1. I have read and understood the information sheet and have been able to ask any questions I have.	
2. I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time without giving a reason.	
3. I understand that I am free to ask any questions at any time. I can discuss any concerns with Sarah Rook or the University Ethics Committee.	
4. I understand that the information provided by me will be kept securely and confidentially. I understand that this information will be held no longer than necessary for the purposes of this research.	
5. I understand that any quotes used from my questionnaire included in the research will be kept anonymous with personal information changed where necessary to make sure this is achieved.	
7. I understand that if I feel distressed during the study that I discuss avenues for gaining extra support with the researcher.	
8. I also understand that at the end of the study I will be provided with additional information and feedback about the purpose of the study.	
9. I agree to take part in the above study.	
10. I agree to complete the first questionnaire via video link with the researcher.	
11. I agree for my responses to the first-round questionnaire to be audio recorded.	
12. I agree that my name can be included as a contributor in the acknowledgements to the guidance document produced as a result of this study.	

I, _____(NAME) consent to participate in the study conducted by Sarah Rook, School of Psychology, Cardiff University with the supervision of Dr Helen Penny.

Signed: **Date:**

Appendix E- Professional consent form



School of Psychology

I understand that my participation in this project will involve answering (up to) three questionnaires over a period of approximately three months about my opinions on how to support young people after they lose a sibling or close friend to suicide.

- ◯ Yes
- ◯ No

I have read and understood the information sheet and have been able to ask any questions I have.

- ◯ Yes
- ◯ No

I understand that I am free to ask any questions at any time. I can discuss any concerns with Sarah Rook or the University Ethics Committee.

- ◯ Yes
- ◯ No

I understand that the information provided by me will be kept securely and confidentially. I understand that this information will be held no longer than necessary for the purposes of this research.

- ◯ Yes
- ◯ No

I understand that any quotes used from my questionnaire included in the research will be kept anonymous with personal information changed where necessary to make sure this is achieved.

- ◯ Yes
- ◯ No

I understand that if I feel distressed during the study that I can discuss avenues for gaining extra support with the researcher.

- ◯ Yes
- ◯ No

I also understand that at the end of the study I will be provided with additional information and feedback about the purpose of the study.

- ◯ Yes
- ◯ No

I agree to take part in the above study.

- ◯ Yes
- ◯ No

Appendix F- Round 1 interview schedule for EBE

Interview Schedule

-------- START RECORDING

- Gender
- Age (16-17; 18-29; 30-39; 40-49; 50-59; 60-69; 70+
- Relationship to young person who died?

1a. What do you think the short-term needs are of young people who have lost a sibling or close friend to suicide (i.e. **first 6 months** after the loss)?

1b. What do you think the long-term needs are of young people who have lost a sibling or close friend to suicide (**after the first 6 months)?**

------- Check in------

2. What do you think is unhelpful for young people following the loss of a sibling or close friend to suicide?

3. How do you think we could judge whether the support a young person has received after losing a sibling or close friend to suicide has been helpful?

---------- Check in-------

4a. What challenges do you think are involved with supporting young people after the death of a close friend or sibling to suicide?

4b. How might you address these challenges?

-------- Check in---------

5a. What kind of people do you think should be involved in supporting young people who have lost a sibling or close friend to suicide?

5b. How do you think young people who have lost a close friend or sibling to suicide should be able access support?

6. Is there anything else you would like to add?

-------- STOP RECORDING

Appendix G- First round questionnaire for professionals

What is your email address (this will be used to send you the link to the next round of questionnaires)

What is your profession?

What is your gender?

- Male
- Female
- Non-binary
- Intersex
- Transgender
- Prefer not to say
- Other (please type below)

← →

What is your age?

- ○ 18-29
- ○ 30-39
- ○ 40-49
- ○ 50-59
- ○ 60-69
- ○ 70 and over

← →

What do you think the short-term needs are of young people who have lost a sibling or close friend to suicide (i.e. **first 6 months** after the loss)?

What do you think the long-term needs are of young people who have lost a sibling or close friend to suicide (**after the first 6 months)?**

←

→

What do you think is unhelpful for young people following the loss of a sibling or close friend to suicide?

←

→

How do you think we could judge whether the support a young person has received after losing a sibling or close friend to suicide has been helpful?

←

→

What challenges do you think are involved with supporting young people after the death of a close friend or sibling to suicide?

How might you address these challenges?

←

→

What kind of people do you think should be involved in supporting young people who have lost a sibling or close friend to suicide?

How do you think young people who have lost a close friend or sibling to suicide should be able access support?

←

→

Is there anything else you would like to add?

←

→

Appendix H- EBE debrief sheet

Debriefing Information

Thank you very much for taking part in this study. By participating in this research, you are helping us to create professional guidelines regarding how to best support the siblings and friends of young people who die by suicide. We think these guidelines have the potential to help many young people in the future and we could not achieve this without your contribution.

We hope that you have found participating in this study to be interesting. However, we understand that thinking about the loss of someone close to you can be upsetting. This is normal and understandable. If you do feel distressed after taking part in this study, please let the researcher (Sarah) know. You can let her know during the Zoom call or you can contact her afterwards via email. Sarah will spend some time chatting things through with you and if needed, she can help you to make arrangements to get some extra support. This might involve having a chat with your parents or guardians or writing a letter to your GP to recommend you are referred to an appropriate support service. You will also find the contact details of several mental health support resources for young people at the end of this letter. You can contact these organisations at any time, day or night.

What will happen next?

The information that you have provided in your questionnaire will be collated and analysed with the responses from the other panellists. We will send you a summary of all the responses along with another questionnaire in four weeks. You will also receive a voucher worth £10 via email.

The consent form that you previously completed is stored in a password protected file on the Cardiff University server and is only accessible by the researchers. Your questionnaire is identified only by your participant number and does not contain your name. You can withdraw from participation at any time by using the contact details below.

If you would like to discuss any element of the study, please contact Sarah Rook (Trainee Clinical Psychologist) using the details below.

Thank you again for your participation.

Yours sincerely,

Sarah Rook

Trainee Clinical Psychologist
Email: Rooks@cardiff.ac.uk
Telephone:
South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology,
Tower Building,
70 Park Place
Cardiff
CF10 3AT

Support Resources

Young Minds

Website: www.youngminds.org.uk

Text: 85258 (free from any phone)

Samaritans

Phone: 116 123 (Free from any phone)

Email: jo@samaritans.org

Papyrus/ Hopelink

Website: www.papyrus-uk.org

Email: pat@papyrus-uk.org

Phone: 08000 684 141 (Free from any phone)

Text: 0786 0200 39967

Appendix I- Professional debrief sheet

Thank you for taking part in this study. The information that you have provided in your questionnaire will be collated and analysed with the responses from the other panellists. We will send you a summary of all the responses along with another questionnaire in four weeks.

The final results of this study will be used to create guidelines to help professionals to support young people who have lost siblings to suicide in the future.

If you would like to discuss any element of the study, please contact Sarah Rook (Trainee Clinical Psychologist) using the details below. Alternatively, you can contact one of the support resources listed below.

Your consent and demographic information is stored in a password protected file on the Cardiff University server and is only accessible by the researchers. Your questionnaire is anonymous. You can withdraw from participation at any time by using the contact details below.

Thank you again for your participation.

Sarah Rook
Trainee Clinical Psychologist
Email: Rooks@cardiff.ac.uk
South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology,
Tower Building,
70 Park Place

Support Resources

Mind

Website: www.mind.org.uk

Samaritans
Phone: 116 123 (Free from any phone)
Email: jo@samaritans.org

Appendix J- EBE Information sheet

Dear Participant,

You are invited to participate in a research project which I am doing as part of my Doctorate in Clinical Psychology. The research is about finding ways to support the siblings or friends of people who have died by suicide. The team at the Mindstep Foundation believe that you might be interested in participating in this research. I have attached an information sheet so that you can find out more about the study.

It is your choice if you want to take part. Your decision will have no effect on your involvement with the Mindstep Foundation/ Jacob Abraham Foundation or any other services you may use. If you decide to take part, I will arrange a time to contact you via telephone to explain more about the study and to go through the information sheet and consent form with you.

If, after reading the attached information sheet, you decide you would like to participate in this study please send an email to the address below to let me know. Please also feel free to use the contact details below if you have any questions about the research.

Yours sincerely,

Sarah Rook

Trainee Clinical Psychologist

Email: RookS@cardiff.ac.uk

Telephone: 07789861294

Participant Information Sheet

We would like to invite you to take part in a research study. Before you decide whether or not you would like to take part, it is important for you to consider why the research is being done and what it will involve. Please read this information sheet carefully.

Why are we doing this study?

Having a sibling or close friend who dies by suicide can be extremely difficult for young people. It's very important that sibling and friends are given the right support. Support offered after someone is bereaved by suicide is called a 'postvention'.

The aim of this research is to find out what should be involved in a postvention for young people who have been impacted by the suicide of a friend or a sibling. We would like to do this by asking clinical experts, academic experts, and experts by lived experience (people who have lived through this experience) to create these guidelines together.

What is a Delphi study?

Delphi is name for a type of study. It has the following stages:

1) A video call where I will ask some open-ended questions about what sort of support would be helpful for young people. This will take about 45 minutes and I would like to audio record this conversation.
2) A few weeks later, I will send you a link to an online form and you will be asked to rate a list of statements. This will take about 15 minutes.
3) A few weeks later I will send you another link to an online form, and you will be asked to rate a list of statement again. This will take about 15 minutes.

Who can take part in this study?

You can take part in this study if you are over the age of 16 and have had personal experience of losing a sibling or friend to suicide as a teenager or young person, over 1 year ago. We think your knowledge and opinions are really important and could be used to help support other young people like you in the future.

You can take part in this study if you are a parent of a child or young person who has lost a sibling or friend to suicide over 1 year ago.

What happens if I take part?

If you decide you would like to take part, you will be asked to complete and return a consent form via email. If you have any questions that you would like to discuss before completing the consent form, please feel free to contact the researcher using the details at the end of this document. Taking part will involve completing a questionnaire on three separate occasions over three months (i.e. one questionnaire a month for three months).

Sarah Rook (Trainee Clinical Psychologist) will arrange a time to speak to you over Zoom. During this phone call Sarah will explain what the study involves and give you an opportunity to ask any questions. You can also ask to see a copy of the questions you'll be asked before you decide whether or not you'd like to take part.

This questionnaire should take no more than 45 minutes to complete and will involve answering questions about your views on what support you found helpful or would have found helpful following the loss of your sibling or friend.

The second and third questionnaires will be completed online. These questionnaires will ask you to rate how much you agree with a series of statements regarding what is important and helpful in terms of how siblings and friends are supported after they lose a loved one to suicide. The researchers will analyse the panels' responses after each round. During rounds two and three, you will be sent an anonymised summary of everyone in the panels' previous responses. After looking at this summary, you will be asked to either change or confirm your previous response. Rounds two and three will be multiple choice and should take no more than 20 minutes to complete.

The questionnaires will collect some demographic information (i.e. your age and gender). All questionnaires will be anonymised. Only the research team (Sarah Rook, Dr Helen Penny and Dr Cerith Waters) will be able to see your individual ratings and responses. The summary of responses sent to the panel in rounds two and three will not include any identifiable information.

Do I have to take part?

It is entirely up to you whether you would like to be involved with this research or not. You can also change your mind if you decide at a later date that you no longer want to participate. If you don't take part or decide to stop, it will not affect your involvement with the Mindstep Foundation or any other services you may use. If you're a young person, we would encourage you to discuss whether you'd like to take part or not with your parents or guardians.

Will what I say be anonymous and confidential?

If you take part in this research all of the information you give us will remain confidential. This means that no one will be able to access the information other than the researchers involved with this project.

The consent form you complete will ask for your permission to audio record the video call. This is so that the researchers can transcribe (type out) your answers so that they can then be analysed. The audio recording will be stored on a secure university server and will be deleted as soon as it has been transcribed. The transcription will not include your name or any other identifying details.

Your name will not be on any of the questionnaires that you complete. Once we receive your consent form we will allocate you a participant ID. The spreadsheet that links your ID to your name and email address will be password protected and stored within an encrypted folder within the Cardiff University server. Any other study materials (e.g. questionnaires) will only contain your participant number. Your email address will also be stored until the study finishes in December 2021. The only people who will be able to match your participant number to your name will be researchers involved with the study. All computer files will be password protected and only accessible by the lead researcher and her two supervisors listed below. No names will be used in the final report and any quotes used will contain made up names.

Once all of the data is collected, we will delete the file which connects your ID to your name. At this point, your data will be stored anonymous, which means we will not be able to link any specific answers back to any individual.

The aim of this study is to produce a guidance document for professionals and families. We will also ask for your consent to include your name as a contributor in the acknowledgements to the published guidance. This is entirely optional, and you can choose not to include your name if you prefer.

What are the possible disadvantages and benefits of taking part?

We hope that you will find participating in this study an interesting experience. It is possible that you will find that talking about your experiences upsetting. As such, it is important for you to be sure that you are currently feeling well and are happy to take part in this study.

If you feel upset during the interview, you can take as many breaks as you need. You can also choose to end the interview at any time- you will not need to give any reason for this. If you feel distressed after completing the questionnaires, you can contact the following organisations for support:

Young Minds

Website: www.youngminds.org.uk
Text: 85258 (free from any phone)

Samaritans

Phone: 116 123 (Free from any phone)

Email: jo@samaritans.org

Papyrus/ Hopelink

Website: www.papyrus-uk.org

Email: pat@papyrus-uk.org

Phone: 08000 684 141 (Free from any phone)

Text: 0786 0200 39967

Will I be paid for my involvement?

As a gesture of our gratitude for your participation, you will be given a £10 voucher once your completed questionnaire is received at the end of each round (there will be three rounds, so £30 worth of vouchers in total).

Who is funding the research?

Cardiff and Vale University Health Board is funding the research and Cardiff University is sponsoring the research.

Who has approved this study?

The research study has been reviewed and approved by the School of Psychology Research Ethics Committee at Cardiff University. If you have any concerns or complaints about the research, you can contact the School of Psychology Research Ethics Committee in writing at:

Secretary to the Research Ethics Committee School of Psychology
Tower Building
70 Park Place
Cardiff CF10 3AT
Email: psychethics@cardiff.ac.uk

What will happen to the results of the study?

Once all three rounds of the Delphi study are complete, the panellists' responses will be analysed and collated. The results will be used to create a set of guidelines to help professionals (e.g. Psychologists, GPs) understand how best to support young people who have recently lost a sibling to suicide. The results will be submitted as part of Sarah Rook's Doctorate in Clinical Psychology. They may also be written up and published in an article and presented to people who work and/or conduct research in similar areas. Anonymous quotes from your first

questionnaire might be used, using a made-up name to protect your identity. If you give your consent, we would like to include your name in the acknowledgements of these guidelines.

What do I do now?

Thank you for reading this information sheet and for considering taking part in this research. Please let us know whether or not you would like to take part by replying to this email.

If you have any questions about the study, please get in touch using the contact details below.

Contact details

Sarah Rook
Trainee Clinical Psychologist
South Wales Doctoral Programme in Clinical Psychology
11th Floor, School of Psychology, Tower Building,
70 Park Place,
Cardiff,
CF10 3AT
Email: RookS@cardiff.ac.uk

Academic supervisors:

Dr Helen Penny
Clinical Psychologist
Senior Therapies Tutor
South Wales Doctoral Programme in Clinical Psychology
11th Floor, School of Psychology, Tower Building,
70 Park Place, Cardiff, CF10 3AT
Email: PennyH@cardiff.ac.uk

Dr Cerith Waters
Clinical Psychologist and Senior Lecturer
South Wales Doctoral Programme in Clinical Psychology
11th Floor, School of Psychology, Tower Building,
70 Park Place, Cardiff, CF10 3AT
Email: WatersCS@cardiff.ac.uk

Appendix K- Professional information sheet

Dear Sir/Madam,

You have been identified as an expert currently working with young people who have experienced the loss of a sibling or close friend to suicide. We would like to invite you to take part in a study aiming to better understand the support needs of young people who have lost a sibling or friend to suicide. The aim of the research is to develop a set of guidelines to help professionals and families implement effective suicide postventions for young people. I have attached an information sheet so that you can find out more about the study.

Participation in the study is voluntary and you are free to withdraw at any time. If, after reading the attached information sheet, you decide you would like to participate please send an email to the address below to let me know. Please also feel free to use the contact details below if you have any questions about the research.

Yours sincerely,

Sarah Rook

Trainee Clinical Psychologist

Email: RookS@cardiff.ac.uk

Participant Information Sheet

We would like to invite you to take part in a research study using the Delphi consensus method. Before you decide whether or not you would like to take part, it is important for you to consider why the research is being done and what it will involve. Please read this information sheet carefully.

Why are we doing this study?

Suicide is a leading cause of death among young people in UK. One of the factors that can increase a young person's risk of suicide is having known another young person (e.g. a sibling or a friend) who has died by suicide. Having a sibling or close friend who dies by suicide also increases a young person's risk of many mental health problems such as anxiety or depression. For this reason, it's very important that young people who are exposed to the suicide of a friend or sibling are supported with an appropriate postvention.

Although suicide postventions for the siblings and friends of young people who have died by suicide are important, there isn't very much evidence to show that they are effective. This might be because there is no agreement among mental health experts about what an effective postvention for young people should involve.

This project will use a Delphi study methodology to find out what mental health experts and experts by experience believe should be involved in a postvention for young people who have been impacted by the suicide of a friend or a sibling. The researchers will use this information to create some clear guidelines about how to deliver effective suicide postvention for young people.

What is a Delphi study?

The aim of a Delphi study is to gather different experts' opinions over a period of time until everyone reaches a general sense of agreement.

The Delphi method involves asking a group of experts their opinion on a certain topic. The expert group is called a panel. Panel members may be professionals (e.g. Psychologists, Psychiatrists) or people who have lived experience of the topic being investigated.

Each panel member is asked to complete three questionnaires over a period of time. After each questionnaire is completed everyone's responses are summarised. This summary is sent out to the panel with the next round of questionnaires and each participant can either change or confirm their response until consensus is reached.

Why have I been invited to take part?

You have been invited to take part because you are a professional working within the field of adolescent mental health. You may have been identified through your membership of the IASP SIG for Postvention, or because you have recently published research in this area. You may also have been nominated to be involved by a colleague within your network.

What happens if I take part?

If you decide you would like to take part, you will be asked to complete and return a consent form via email. Taking part will involve completing an online survey questionnaire on three separate occasions. Your will be asked to give your email address and some demographic details (e.g. your age, gender and profession).

The first survey round will take a maximum of 45 minutes to complete. You will be asked to discuss what support you think is helpful or unhelpful for young people who are coping with the recent loss of a sibling to suicide. The second and third surveys should take no more than 20 minutes to complete. All surveys will be completed online via the Qualtrics platform.

The researchers will analyse the panels' responses after each round. During rounds two and three, you will be sent an anonymised summary of everyone in the panels' previous responses. After looking at this summary, you will be asked to either change or confirm your previous response. Rounds two and three will be multiple choice and should take no more than 20 minutes to complete.

All questionnaires will be anonymised. We will ask for some demographic information (i.e. profession). Only the research team (Sarah Rook and Dr Helen Penny) will be able to see your individual ratings and responses. The summary of responses sent to the panel in rounds two and three will not include any identifying information.

The aim of this study is to produce a guidance document for professionals and families. We will also ask for your consent to include your name as a contributor in the acknowledgements to the published guidance.

Do I have to take part?

It is entirely up to you whether you would like to be involved with this research or not. You can also change your mind if you decide at a later date that you no longer want to participate.

Will what I say be confidential?

If you take part in this research all of the information you give us will remain confidential. This means that no one will be able to access the information other than the researchers involved with this project.

Your name will not be on any of the questionnaires that you complete. Once we receive your consent form we will allocate you a participant ID. The spreadsheet that links your name, email address and ID will be password protected and stored within a password encrypted folder within the Cardiff University server. Your email address will be stored until the study finishes in December 2021. Any other study materials (e.g. questionnaires) will only contain your participant number. The only people who will be able to match your participant number to your email will be researchers involved with the study. All computer files will be password protected and only accessible by the lead researcher and her two supervisors listed below. No names will be used in the final report and any quotes used will contain made up names.

What are the possible disadvantages and benefits of taking part?

By participating in this research, you will be helping to develop of a set of guidelines to help professionals understand how to implement effective postventions for young people who have recently lost a sibling to suicide.

Who is funding the research?

Cardiff and Vale University Health Board is funding the research and Cardiff University is sponsoring the research.

Who has approved this study?

The research study has been reviewed and approved by the School of Psychology Research Ethics Committee at Cardiff University. If you have any concerns or complaints about the research, you can contact the School of Psychology Research Ethics Committee in writing at:

Secretary to the Research Ethics Committee School of Psychology
Tower Building
70 Park Place
Cardiff CF10 3AT
Email: psychethics@cardiff.ac.uk

What will happen to the results of the study?

Once all three rounds of the Delphi study are complete, the panellists' responses will be analysed and collated. The results will be used to create a set of guidelines to help professionals (e.g. Psychologists, GPs) understand how best to support young people who have recently lost a sibling to suicide. The results will be submitted as part of Sarah Rook's large scale research project (LSRP) for her training in Clinical Psychology. They may also be written up and published in an article and presented to people who work and research in similar areas. Small quotes from your first questionnaire might be used to make a certain point, but a made-up name will be used to protect your identity. No information that could identify individuals will be used, however if you consent, we would like to include your name in the acknowledgements section of the published guidelines.

What do I do now?

Thank you for reading this information sheet and for considering taking part in this research. Please let us know whether or not you would like to take part by replying to this email.

If you have any questions about the study, please get in touch using the contact details below.

Contact details

Sarah Rook
Trainee Clinical Psychologist
South Wales Doctoral Programme in Clinical Psychology
11th Floor, School of Psychology, Tower Building,
70 Park Place,
Cardiff,
CF10 3AT
Email: RookS@cardiff.ac.uk
Tel:

Academic supervisor:

Dr Helen Penny
Clinical Psychologist
Senior Therapies Tutor
South Wales Doctoral Programme in Clinical Psychology
11th Floor, School of Psychology, Tower Building,
70 Park Place, Cardiff, CF10 3AT
Email: PennyH@cardiff.ac.uk

Dr Cerith Waters
Clinical Psychologist
Senior Therapies Tutor
South Wales Doctoral Programme in Clinical Psychology
11th Floor, School of Psychology, Tower Building,
70 Park Place, Cardiff, CF10 3AT
Email: WatersC@cardiff.ac.uk

Appendix L- Second round email

Cardiff University Delphi Study- Second round questionnaire now open!

You forwarded this message on Tue 22/03/2022 13:27

SR Sarah Rook [redacted]

Fri 18/03/2022 11:41

Title of Study: Postvention guidelines for young people who have lost a sibling or friend to suicide: A Delphi Study
Principal investigator: Sarah Rook, Trainee Clinical Psychologist
Supervisor: Dr Helen Penny, Clinical Psychologist
Contact details: School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT.
Email: RookS@cardiff.ac.uk

Thank you for completing the first-round questionnaire for the study above.

Please use the highlighted link below to complete the second (and final) questionnaire round.
https://cardiffunipsych.eu.qualtrics.com/jfe/form/SV_7OQxmhsunEnLsRE

This link will take you to a multiple-choice style questionnaire. You will be asked to input your email address and to rate how much you agree with various statements relating to supporting young people who lose a sibling or friend to suicide. The questionnaire should take no more than 15 minutes to complete.

Please note that the survey will close on the 28th March, therefore please ensure you have completed it by this date.

If you have any questions or concerns about the study, please don't hesitate to get in touch using the contact details shown at the end of the survey.

Thank you again for participating in this study, this research could not be done without your support!

Regards,

Sarah Rook
Trainee Clinical Psychologist
Doctoral Programme in Clinical Psychology, Cardiff University
11th Floor, Tower Building, 70 Park Place, Cardiff CF10 3AT

Seicolegydd Clinigol dan Hyfforddiant
Rhaglen Doethurol mewn Seicoleg Glinigol, Prifysgol Caerdydd

Appendix M- Qualtrics round 2 example

The way that support is provided for young people who have lost a friend or sibling to suicide was identified as a theme.

To what extent do you agree with the statements below?

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Initial support should be provided by a range of people/ sources, such as caregivers, teachers, or peer support groups	○	○	○	○	○
More formal/ intensive support should be provided by trained mental health professionals (e.g. Psychologists)	○	○	○	○	○
Support should be available through a range of mediums (e.g. online, face-to face)	○	○	○	○	○
Support should be provided in a range of different formats (e.g. one-to-one, groups)	○	○	○	○	○
Young people whose experiences have been particularly traumatic (e.g. discovering the body of a sibling or friend) may require specialist support from a trained mental health professional	○	○	○	○	○

Appendix N- EBE coding excerpt

Transcript	Code	Sub-theme	Theme
SR: OK, so my first question, was what do you think the short-term needs of young people who lose a sibling to suicide? And when I say short term, I mean those first six months after the death? What, what do you think you needed?			
EBE: So, I think that the intervention needs to happen as soon as you hear the news, because in my experience, I've experienced, obviously my older brother was [age] when he passed and my younger brother was [age], so he was classified as a child when he died. So, I've experienced two, kind of experiences of losing a child and then losing an adult, and they both had really different processes.	Need intervention when hearing the news	Trained professionals present when informing YP	Immediate Support
So, with my oldest brother, we were told in the house, You know, your brother has died by hanging. And then it was kind of like, OK, we're going to leave you now, see you. And they left, which I understand that's the process they have to do. But they weren't helpful, I don't know maybe they need a bit more training or something, you know? I just feel like being handed a letter which, like here's a helpline you can ring, wasn't really the best option. Because when you were in that mindset of just finding out that someone who is such a big part of your life has passed away, you're not in the right mindset to be calling a helpline or making appointments yourself. Don't get me wrong, I think that having some written kind of, material is important and can be	First-responders weren't helpful and need more training	First responders need training regarding talking to YP about suicide	Training for people who provide support
	Not in right mindset to ask for support	Outreach	How to access support
	Written material important and can be helpful	Written information helpful	Immediate support

helpful and I think we did use it eventually. So, I find that the intervention needs to start as soon as that news comes out. With my younger brother because he was a child, my mum found him and there was more police involvement, and more of an investigation just to see if there was any foul play or wrongdoing. Which was something we just had no understanding about whatsoever. So, with his death, we did get a… oh, I think she was a family liaison officer. So right away we had more intervention straightaway in terms of there was a lot more involvement of people which was helpful. Just to have someone trained, who was there straight away But what I will say with that was that these people, they were strangers, they were strangers who came into our home and asked very invasive questions, you know, in terms of were there any warning signs. Why do you think he did it? And those are all perfectly valid questions for an investigation, but I just think it was very harsh when that just happened, and we weren't prepared for it. And they weren't exactly sensitive. So, what I think immediately needs to happen after someone dies by suicide is that the family... I almost think there should be someone in the community who maybe has got training in this area who can come along with the police when a death notification is served and just offer support for the whole family really. Not just the young people. I think everyone should have that.	Intervention needs to start at point of notification Had no idea about investigation procedure Helpful having someone trained right away Not prepared for investigation procedure Professionals were not sensitive Someone trained who can come with police Offer support for the whole family	Trained professionals present when informing YP Explanation of procedures Trained professionals present when informing YP Explanation of procedures Empathy Trained professionals present when informing YP Support whole family	Immediate support Immediate support Immediate support Immediate support Personal qualities Immediate support Role of universal/ informal support

SR: That's a really, I think that's a really eloquent answer, thank you.			

Appendix O- Professional coding excerpt

Response	Code	Sub-theme	Theme
Professional 1 In general: • Immediate intervention of bereavement support.	Immediate intervention	Trained professionals present when informing YP	Immediate support
• Understanding and empathy of teachers/school (they need to be trained/suicide aware)	Understanding and empathy of teachers	Staff show empathy	Role of education settings
	Teachers need to be trained	Teacher training re suicide	Role of education settings
• Extra time on schoolwork, exams--could be extensions	Extra time and extensions	Flexible deadlines and workloads	Role of education settings
• All young people should be encouragement to join suicide bereavement support group (with people their own age)	Encouragement to join peer support groups	Encourage peer support	Role of Universal/ informal support
• Support from other adults (parents might not have capacity if a sibling death- important they are aware of this)	Support from adults not necessarily parents	Access help from wider support network	Role of caregivers
	Parents may not have capacity to support	Acknowledge limits	Role of caregivers
• Someone to help explain feelings to them, or be aware of their feelings (especially guilt/blame/shame)	Someone to explain and be aware of feelings	Normalise and validate emotional responses	Role of universal/ informal support
• Might need support from appropriate services for unhealthy coping skills, i.e.. drugs/alcohol	Professional support for maladaptive coping strategies	Address harmful coping strategies	Role of specialist/ formal support
