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Review Article

Effectiveness of suicide postvention service models and guidelines 2014–2024: A scoping review

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ABSTRACT

Objective: Effective suicide postvention services provide immediate and ongoing support for suicide loss survivors. This review synthesizes peer-reviewed and grey literature exploring which suicide postvention service models have demonstrated effectiveness in reducing distress and supporting recovery in families, friends, and communities impacted by suicide.
Methods: The scoping review adhered to the updated Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR). We conducted searches in five databases which included MEDLINE, PsycINFO, Embase, EBM Reviews, and Web of Science for peer reviewed studies and through Google search for grey literature.
Results: We identified 19 peer-reviewed studies and 14 guidelines (2014-2024) from the US, Canada, Australia, New Zealand, and Europe, which varied in measures, settings, and populations but lacked quality and generalizability. Guidelines based on theoretical models, particularly the public health model, aligned postvention with addressing the diverse needs of suicide loss survivors.
Conclusions: The review identified potentially effective postvention components, such as the use of trained volunteers in support and therapy groups, workplace training programs and arts-based interventions, which could benefit those bereaved by suicide in Australia.

1. Introduction

Every life lost to suicide has broader impacts on family, friends and the wider community. These may be profound, often leaving survivors to navigate intense grief, guilt, and stigma surrounding the loss. In 2022, 3249 people died by suicide in Australia, an age-standardized rate of 12.3 per 100,000 population (Australian Bureau of Statistics, 2023). This equates to approximately nine deaths per day (Australian Institute of Health and Welfare, n.d.). There is a higher risk of adverse mental health and suicidal behavior among those exposed to suicide (Bartik et al., 2020). Between six family members and 135 community members can be exposed to an individual suicide (Erlangsen and Pitman, 2017), with 4.3 % of people exposed to suicide in a year and 22 % over the course of their life underscoring the need for urgent and coordinated responses (Andriessen et al., 2017). Suicide has been recognized as a major public health issue and the Australian Commonwealth and state and territories government response has been ratified in the *National Mental Health and Suicide Prevention Agreement* in 2022 (Australian Institute of Health and Welfare, n.d.).

Suicide postvention offers immediate and ongoing support for those bereaved by suicide, addressing specific grief challenges due to the sudden nature of the death (Andriessen et al., 2017; Pitman et al., 2014), feelings of rejection, shame, stigma, and distress caused by coronial inquests, legal proceedings and media (Sveen and Walby, 2008). Effective postvention contributes to suicide prevention, and is a key component of suicide prevention strategies (Hofmann et al., 2025; Andriessen, 2009; Schlichthorst et al., 2023). However, existing reviews of postvention services (Andriessen et al., 2019a) show mixed evidence of effectiveness, highlighting the complexity of implementing postvention services in varied settings.

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These existing reviews focus on implementation (Nicholls et al., 2024), acceptability (Abbate et al., 2024), feasibility and satisfaction with postvention services (Andriessen et al., 2019b), and suicide postvention in schools (Williams et al., 2022). This study extends a previous review of literature from 2014 to 2019 that includes both peer reviewed and grey literature, complementing the scope of other reviews to include guidelines as well as studies of postvention services (Andriessen et al., 2019a). The review aims to identify effective service models for postvention, bereavement and critical incident support, drawing on studies and high quality guidelines, providing the basis for mapping current support systems and establishing best practices in Australia. This review aimed to address the following question: Which suicide postvention service models and guidelines have been shown to be effective in reducing distress in family, friends and communities following a suicide? Consistent with the previous review, we defined "suicide postvention service model" as a "coordinated approach to providing support to people impacted by the death of a family member, friend or person in a network (such as a school, nursing home, workplace, etc.) through suicide." (Andriessen et al., 2019a) This includes targeted interventions, suicide bereavement support programs and guidelines.

2. Methods

2.1. Eligibility criteria

This review followed the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines, with a search strategy centered on postvention service models and their effectiveness for general and priority populations. The review focused on studies from Australia, the UK, the US, Canada, New Zealand, and Western Europe, using English-language sources published since 2014. The study was based on publicly available publications and guidelines, thus exempt from ethical review.

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

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

The Appraisal of Guidelines for Research & Evaluation (AGREE) II Instrument (AGREE Next Steps Consortium, 2017) defines guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances". Based on this, we included guidelines since 2014 that either self-identified as such or offered structured support for those bereaved by suicide. Exclusions were records that: 1) were resource collections without identifiable studies or guidelines; 2) offered general advice or self-care information; 3) contained invalid links; 4) were institution or workplace specific; 5) had no theoretical underpinning; or 6) heavily relied on another guideline.

2.2. Search strategy

2.2.1. Peer review literature

We used different search words and databases, refining the search string with advice from the University of Melbourne Library services before commencing the systematic search. The final search string (MEDLINE) comprising a combination of MeSH and keywords, was as follows:

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

We conducted systematic searches in five databases: MEDLINE, PsycINFO, Embase, and EBM Reviews (through Ovid), and Web of Science, using a consistent search string with similar subject headings and keywords in July 2024. Results were imported into Covidence for duplicate removal, with three duplicates manually removed. Researchers Ramamurthy, Reifels, and Hawgood screened the remaining records for eligibility by title and abstract, then independently reviewed the full texts against the inclusion and exclusion criteria. We examined the references and forward citations of selected studies to identify additional relevant studies. Researchers Krysinska and Hawgood reviewed portions of the included and excluded records, and disagreements were resolved by discussion with Andriessen.

2.2.2. Grey literature

The grey literature search included studies and guidelines on postvention service delivery using a strategy based on prior research (Andriessen et al., 2019a; Krysinska et al., 2019) and literature reflecting common health information search behaviors (Eysenbach and Köhler, 2002; Morahan-Martin, 2004; Jansen and Spink, 2006). Conducted in Google Chrome in July 2024, it was tailored to Google regions in Australia, UK, US, Canada and New Zealand, with each search term run in Guest Mode in each region, to prevent browser history bias. The search terms were:

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

We retained results from the first two pages per search term, screening secondary links for studies or guidelines that met the inclusion criteria. This process identified 1739 duplicates, including 41 from different links to the same reports. After screening 399 records, 92 records were retained for full-text screening. Researcher Fraser conducted full-text screening, with Andriessen, Reifels and Kõlves reviewing the included and excluded records. Disagreements (0.06 % on inclusion of guidelines, 0.08 % on data extraction and quality) were resolved through discussion. The adapted PRISMA-ScR flow diagram for both peer reviewed and grey literature is presented in Fig. 1.

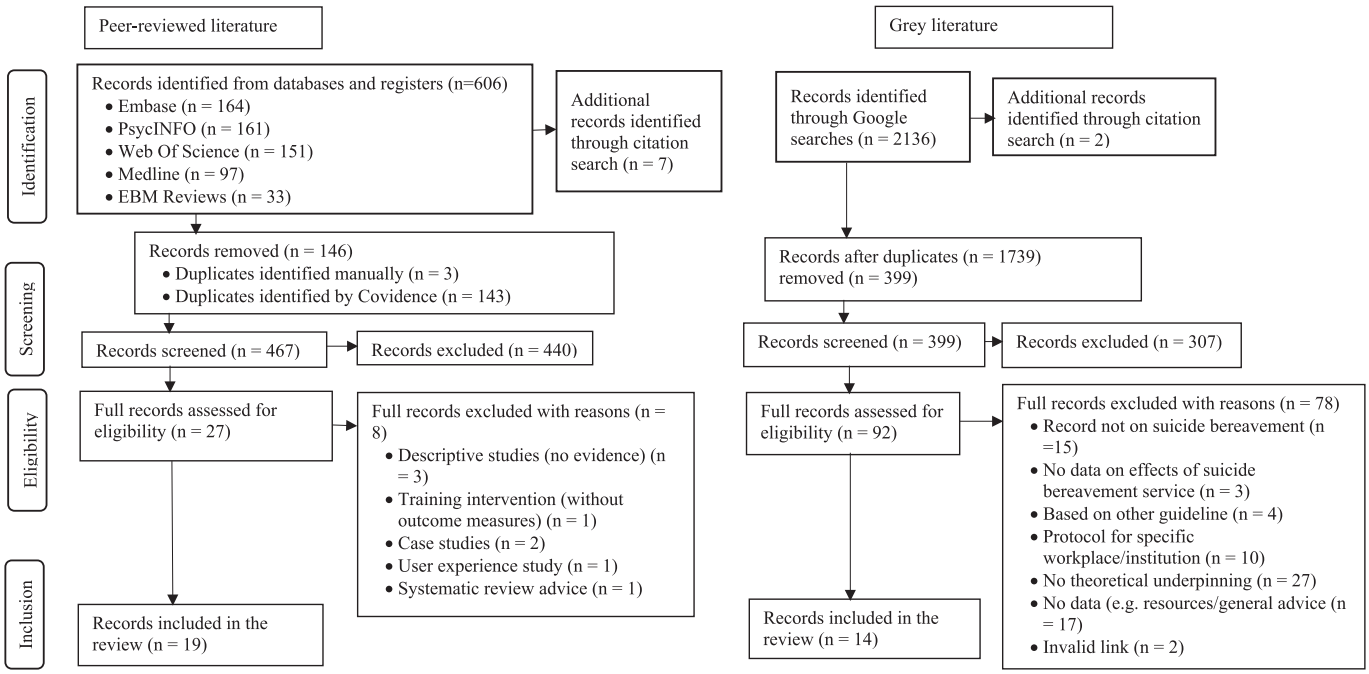

Fig. 1. PRISMA-ScR flow diagram for peer-reviewed and grey literature on suicide postvention service models and guidelines.

2.3. Data extraction and quality appraisal

2.3.1. Peer reviewed studies

Researchers Ramamurthy and Hawgood independently extracted data from selected peer-reviewed studies, including details such as author, year, location, study design, assessments, sample size, demographics, intervention setting, outcome measures, main findings, and limitations. Krysinska and Hawgood reviewed the extracted data, resolving disagreements with Andriessen. Study quality was assessed using two tools: the National Health and Medical Research Council (NHMRC) Levels of Evidence (National Health and Medical Research Council (NHMRC), 2009), ranking studies from systematic reviews of Randomized controlled trials (RCTs) (Level I) to case series (Level IV), and the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998a), which rates studies across six components. Discrepancies were resolved through discussion with Andriessen.

2.3.2. Grey literature

Data extraction and quality appraisal of guidelines were conducted using the AGREE II Instrument, which assesses guideline quality but does not provide a defined cut-off for high versus low quality (Hoffmann-Eßer et al., 2018). We applied a quality criteria cut-off by focusing on guidelines describing the theoretical models underpinning postvention. This allowed us to evaluate likely effectiveness based on the available evidence for the theoretical model. We extracted the following data from eligible guidelines: title, author, year, country, target users and population, development objectives and methods, involvement of target users, evidence base, theoretical model, and key recommendations. Researchers Fraser extracted the data, with Reavley and Kõlves reviewing portions of it.

3. Results

This section will present an overview of the study and guideline characteristics and results of the quality assessment. This is followed by a more in-depth discussion of the studies.

3.1. Study and guideline characteristics

3.1.1. Peer reviewed studies

The review identified 19 peer-reviewed papers published between 2014 and 2024. The review comprised six studies from the US (Ohye et al., 2022; Saindon et al., 2014; Strouse et al., 2021; Supiano et al., 2017; Williams and Rheingold, 2020; Zisook et al., 2018), six studies conducted in Australia (Clements et al., 2023; Gehrmann et al., 2020; Hill et al., 2022; Maple et al., 2019; Peters et al., 2015; Visser et al., 2014), four studies from Italy (Scocco et al., 2019; Scocco et al., 2022; Testoni et al., 2018; Testoni et al., 2021), two from Belgium (including one from Netherlands) (Kramer et al., 2015; Wittouck et al., 2014), and one from Ireland (Griffin et al., 2022).

The studies included two RCTs (Zisook et al., 2018; Wittouck et al., 2014), two case control studies (Testoni et al., 2018; Testoni et al., 2021), three mixed-methods studies (Clements et al., 2023; Maple et al., 2019; Peters et al., 2015), seven pre-post design studies without control groups (Ohye et al., 2022; Saindon et al., 2014; Strouse et al., 2021; Williams and Rheingold, 2020; Scocco et al., 2019; Scocco et al., 2022; Kramer et al., 2015), one prospective observational study (Supiano et al., 2017), one prospective longitudinal study (Griffin et al., 2022) and three retrospective cross-sectional studies (Gehrmann et al., 2020; Hill et al., 2022; Visser et al., 2014). Interventions settings varied, with six in community settings (Ohye et al., 2022; Saindon et al., 2014; Gehrmann et al., 2020; Hill et al., 2022; Peters et al., 2015; Visser et al., 2014), four in clinical settings (Supiano et al., 2017; Williams and Rheingold, 2020; Zisook et al., 2018), two in residential or group settings (Scocco et al., 2019; Scocco et al., 2022), two in schools (Testoni et al., 2018; Testoni et al., 2021), three online and by phone (Maple et al., 2019; Kramer et al., 2015; Griffin et al., 2022), one in an art studio (Strouse et al., 2021), and one in a funeral home (Clements et al., 2023).

The studies reported a variability in participant age and some studies did not specify the age range. Most studies focused on adults, with three involving older adults (ages 59–95) though not specifically targeting this group (Supiano et al., 2017; Zisook et al., 2018; Maple et al., 2019). Two school-based studies included children (Testoni et al., 2018; Testoni et al., 2021). Participants were predominantly female (64–92 %), including in school-based studies. Family members were the primary participants (Zisook et al., 2018; Gehrmann et al., 2020; Hill et al., 2022;

Maple et al., 2019; Peters et al., 2015; Kramer et al., 2015; Wittouck et al., 2014), some involving other relatives and non-relatives (Zisook et al., 2018; Visser et al., 2014; Scocco et al., 2019; Kramer et al., 2015; Wittouck et al., 2014), peers at school (Testoni et al., 2018; Testoni et al., 2021), and employees of a funeral home (Clements et al., 2023). Intervention settings varied from community-based programs (Ohye et al., 2022; Saindon et al., 2014; Gehrmann et al., 2020; Peters et al., 2015; Visser et al., 2014; Hill et al., 2022), school or retreat group interventions (Strouse et al., 2021; Supiano et al., 2017; Scocco et al., 2019; Scocco et al., 2022; Testoni et al., 2018; Testoni et al., 2021), and individual clinical interventions (Supiano et al., 2017; Williams and Rheingold, 2020; Wittouck et al., 2014; Zisook et al., 2018). Five were identified as manualised (Supiano et al., 2017; Williams and Rheingold, 2020; Zisook et al., 2018; Testoni et al., 2018; Testoni et al., 2021). The bereavement period among participants varied widely, and the interventions were administered early-within 48 hours (Maple et al., 2019) to much later -up to 30 years post bereavement (Scocco et al., 2019). The assessment timing also varied from shortly after the intervention (Peters et al., 2015; Scocco et al., 2019) to assessment at 12-months follow-up (Kramer et al., 2015).

Studies used various instruments to measure outcomes, most employing mental health measures with semi-structured interviews and scales for mindfulness, resilience and death anxiety. Ten studies measured suicidality and grief (Ohye et al., 2022; Saindon et al., 2014; Supiano et al., 2017; Williams and Rheingold, 2020; Zisook et al., 2018; Gehrmann et al., 2020; Visser et al., 2014; Kramer et al., 2015; Wittouck et al., 2014; Griffin et al., 2022), while nine focused on the emotional impacts of mitigating death anxiety and improving mindfulness (Strouse et al., 2021; Clements et al., 2023; Hill et al., 2022; Maple et al., 2019; Peters et al., 2015; Scocco et al., 2019; Scocco et al., 2022; Testoni et al., 2018; Testoni et al., 2021). Appendix 1 summarizes the studies according to types of interventions/ model of care and the NHMRC level of evidence.

3.1.2. *Grey literature*

Fourteen guidelines published from 2015 to 2023, were reviewed (see Appendix 2), including four from the US (McCommons and Rosen, 2020; U.S. Department of Defense and Defense Suicide Prevention Office, 2019; New York State Office of Mental Health's Suicide Prevention Center and New York State Office of Addiction Services and Supports, 2022; Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015), four from Australia (Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Headspace and The Department of Education and Training (VIC), 2021; Be You and Beyond Blue, 2023; StandBy Support After Suicide, 2022), three from the UK (Samaritans and NHS Confederation, 2023; National Police Wellbeing Service, 2022; Public Health England and National Suicide Prevention Alliance, 2016), two from Canada (Séguin et al., 2020; Ontario Youth Suicide Prevention Life Promotion Collaborative, 2022) and one in Ireland (McGuiness and Skehan, 2021). Four guidelines targeted schools/youth (McCommons and Rosen, 2020; Headspace and The Department of Education and Training (VIC), 2021; Be You and Beyond Blue, 2023; Ontario Youth Suicide Prevention Life Promotion Collaborative, 2022), six focused on workplaces (U.S. Department of Defense and Defense Suicide Prevention Office, 2019; New York State Office of Mental Health's Suicide Prevention Center and New York State Office of Addiction Services and Supports, 2022; StandBy Support After Suicide, 2022; Samaritans and NHS Confederation, 2023; National Police Wellbeing Service, 2022; McGuiness and Skehan, 2021), and four applied to various services and communities (Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Public Health England and National Suicide Prevention Alliance, 2016; Séguin et al., 2020).

Their quality was assessed using the AGREE II Instrument. All guidelines described their objectives and evidence base, which comprised mainly literature, and expert and lived-experience advisory groups. Eight guidelines described their developmental methods (U.S. Department of Defense and Defense Suicide Prevention Office, 2019; Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Samaritans and NHS Confederation, 2023; National Police Wellbeing Service, 2022; Public Health England and National Suicide Prevention Alliance, 2016; Séguin et al., 2020; Ontario Youth Suicide Prevention Life Promotion Collaborative, 2022). Target users were involved in the development of guidelines (U.S. Department of Defense and Defense Suicide Prevention Office, 2019; Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Samaritans and NHS Confederation, 2023; National Police Wellbeing Service, 2022; Public Health England and National Suicide Prevention Alliance, 2016; Séguin et al., 2020; Ontario Youth Suicide Prevention Life Promotion Collaborative, 2022; McGuiness and Skehan, 2021). Two guidelines provided a section on key recommendations (Headspace and The Department of Education and Training (VIC), 2021; Public Health England and National Suicide Prevention Alliance, 2016). Six guidelines (McCommons and Rosen, 2020; Headspace and The Department of Education and Training (VIC), 2021; Be You and Beyond Blue, 2023; Samaritans and NHS Confederation, 2023; Séguin et al., 2020; McGuiness and Skehan, 2021) provided sample material such as communication/ notification/email templates, scripts and meeting agendas. Ten guidelines referred to models addressing different levels of impact on those exposed to suicide to guide support needs and communication strategies for different affected groups (U.S. Department of Defense and Defense Suicide Prevention Office, 2019; Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Headspace and The Department of Education and Training (VIC), 2021; Be You and Beyond Blue, 2023; StandBy Support After Suicide, 2022; Samaritans and NHS Confederation, 2023; National Police Wellbeing Service, 2022; Public Health England and National Suicide Prevention Alliance, 2016; Ontario Youth Suicide Prevention Life Promotion Collaborative, 2022).

The guidelines specifically mentioned various population groups, tailoring postvention responses for culturally and linguistically diverse communities (McCommons and Rosen, 2020; New York State Office of Mental Health's Suicide Prevention Center and New York State Office of Addiction Services and Supports, 2022; Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Headspace and The Department of Education and Training (VIC), 2021; Be You and Beyond Blue, 2023; StandBy Support After Suicide, 2022; Samaritans and NHS Confederation, 2023; Public Health England and National Suicide Prevention Alliance, 2016; Ontario Youth Suicide Prevention Life Promotion Collaborative, 2022; McGuiness and Skehan, 2021), Aboriginal and Torres Strait Islander peoples (Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Headspace and The Department of Education and Training (VIC), 2021; Be You and Beyond Blue, 2023; StandBy Support After Suicide, 2022), and LGBTIQ+ individuals (McCommons and Rosen, 2020; Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Headspace and The Department of Education and Training (VIC), 2021; Be You and Beyond Blue, 2023; StandBy Support After Suicide, 2022; Samaritans and NHS Confederation, 2023). While two Australian school/youth guidelines included sections on Aboriginal and Torres Strait Islander people (Headspace and The Department of Education and Training (VIC), 2021; Be You and Beyond Blue, 2023), most emphasized the importance of tailored guidelines for these priority populations.

3.2. Risk of bias/quality assessment

3.2.1. Peer reviewed studies

The review identified two level II studies, two level II-2 studies, four level III-3 studies and eleven level IV studies. We have summarized the peer reviewed studies based on the NHMRC Levels of Evidence (National Health and Medical Research Council (NHMRC), 2009) showing that three components were rated 'D' for poor evidence base, consistency and clinical impact, while two components were rated 'C' for satisfactory generalizability and applicability to the target population in Australia. Appendix 3 provides a summary of the study quality based on the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998a).

Overall, the studies were rated as having weak quality with only one study (Wittouck et al., 2014) rated strong in four components and three in three components (Zisook et al., 2018; Testoni et al., 2018; Testoni et al., 2021). Ten studies were strong in two components (Ohye et al., 2022; Saindon et al., 2014; Strouse et al., 2021; Supiano et al., 2017; Williams and Rheingold, 2020; Gehrmann et al., 2020; Hill et al., 2022; Maple et al., 2019; Scocco et al., 2019; Scocco et al., 2022) and four studies in one component (Peters et al., 2015; Visser et al., 2014; Kramer et al., 2015; Griffin et al., 2022). One study (Clements et al., 2023) did not receive any strong rating. The weakest aspects included pre-intervention group differences, control of confounders, selection bias, blinding and handling of withdrawals and missing data. Only two studies used randomized designs (Testoni et al., 2018; Testoni et al., 2021) and none reported an intention-to-treat analysis. Most studies used valid measures and though some evaluated the intervention consistency (Ohye et al., 2022; Saindon et al., 2014; Strouse et al., 2021; Supiano et al., 2017; Zisook et al., 2018; Gehrmann et al., 2020; Scocco et al., 2019; Scocco et al., 2022; Griffin et al., 2022), it remains unclear if others accounted for additional treatment effects.

3.2.2. Grey literature

The 14 guidelines demonstrated adequate rigor, supported by a mix of literature and expert insights. The effectiveness was evaluated through their theoretical foundations including the continuum of suicide survivorship (U.S. Department of Defense and Defense Suicide Prevention Office, 2019; Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; StandBy Support After Suicide, 2022; Public Health England and National Suicide Prevention Alliance, 2016) and public health models (Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Public Health England and National Suicide Prevention Alliance, 2016; Séguin et al., 2020; McGuiness and Skehan, 2021). Based on a review of the literature, guidelines grounded in the public health model are found to be well-suited to meet the diverse needs of those affected by suicide, aligning with broader suicide prevention strategies (Andriessen et al., 2019b; Lichtenthal et al., 2024; Cerel et al., 2014). The continuum of suicide survivorship (Hawton et al., 2015) and similar frameworks like Hawton et al. (Bhullar et al., 2021), which consider different levels of suicide impact, offer a useful structure for adjusting communication, monitoring, and support levels, however empirical evidence suggests further research is needed to confirm specific groups, such as first responders, are included in these frameworks (Constantino et al., 2001).

4. Discussion

This scoping review focused on the effectiveness of postvention service models and guidelines in reducing distress following a suicide loss. We examined 19 studies and 14 guidelines which encompassed a diverse array of populations, settings, interventions and measurement methods. The discussion focusses on the observations from these studies and guidelines, providing an understanding of the effectiveness of suicide postvention service models and guidelines.

Our review identified six studies from Australia (Clements et al., 2023; Gehrmann et al., 2020; Hill et al., 2022; Maple et al., 2019; Peters et al., 2015; Visser et al., 2014), three of which focused on the StandBy Support After Suicide service in Australia (Gehrmann et al., 2020; Maple et al., 2019; Visser et al., 2014). These studied indicate that peer-support groups are effective in alleviating psychological distress among those bereaved by suicide. Additionally, the studies targeted specific bereaved populations, such as military widows (Ohye et al., 2022) and school children (Testoni et al., 2018; Testoni et al., 2021). Our review identified one study (Ohye et al., 2022) that examined an intensive outpatient program for suicide-bereaved widows of veterans with complicated grief and post-traumatic stress disorder. A similar study by Constantino et al. (2001) compared a group psychotherapy intervention with a social support program for military widows bereaved by suicide. While both approaches helped reduce grief symptoms, the long-term follow-up showed no significant differences between them. In line with this, our review identified six psychotherapeutic interventions (Ohye et al., 2022; Saindon et al., 2014; Supiano et al., 2017; Williams and Rheingold, 2020; Scocco et al., 2019; Scocco et al., 2022) that appeared to reduce grief and depression, further supporting the potential of psychotherapy in addressing the psychological challenges faced by suicide bereaved individuals.

Similar to the two school-based interventions in this review (Testoni et al., 2018; Testoni et al., 2021), another study (Pfeffer et al., 2002) demonstrated that a school-based crisis intervention reduced post-traumatic stress symptoms, anxiety, depression and complicated grief among trauma group students. Pfeffer and colleagues (Pfeffer et al., 2002) found that a bereavement group intervention addressing grief reactions to suicide while strengthening coping skills and supporting parents, alleviated distress in children bereaved by a parent or sibling's suicide. These findings underscore the importance of addressing the vulnerabilities of children and young adults affected by suicide.

Components contributing to positive outcomes in the reviewed service models were linked to the different levels of grief or distress experienced by the bereaved. These components align with public health models of postvention service delivery and include psychoeducation, informal social support, peer support, mutual recognition and experience sharing (Clements et al., 2023; Maple et al., 2019; Peters et al., 2015; Kramer et al., 2015). Some Australian studies (Gehrmann et al., 2020; Hill et al., 2022; Maple et al., 2019; Visser et al., 2014) indicated that peer-support groups effectively reduce psychological distress among those bereaved by suicide, emphasizing the need to address the postvention workforce's needs. Studies of StandBy Support After Suicide and Primary Care Navigator models highlight the crucial role of bereavement support groups in providing essential postvention services, helping individuals navigate the grieving process and offering vital emotional support.

A limitation of this review is the lack of comparability of results among the19 peer-reviewed studies, with only six including a control group (Gehrmann et al., 2020; Visser et al., 2014; Scocco et al., 2022; Testoni et al., 2018; Testoni et al., 2021; Wittouck et al., 2014). The studies were of low quality because of significant design, methodological and generalizability issues, raising concerns about the reliability and applicability of the interventions. While most studies showed improvements in depression scores (Saindon et al., 2014; Supiano et al., 2017; Williams and Rheingold, 2020; Scocco et al., 2019; Scocco et al., 2022; Kramer et al., 2015), the impact on grief scores were generally more limited (Ohye et al., 2022; Gehrmann et al., 2020; Griffin et al., 2022). This variation in outcomes underscores the limitations within the studies, which may have influenced the effectiveness of the interventions in addressing grief. Adopting standardized outcome measures in future studies may enhance comparison of outcomes across studies.

We categorized the findings by types of model of care and NMHRC

levels of evidence, identifying seven indicated interventions (Ohye et al., 2022; Williams and Rheingold, 2020; Supiano et al., 2017; Zisook et al., 2018; Scocco et al., 2019; Scocco et al., 2022; Wittouck et al., 2014) and twelve selective interventions (Saindon et al., 2014; Strouse et al., 2021; Clements et al., 2023; Gehrmann et al., 2020; Hill et al., 2022; Maple et al., 2019; Peters et al., 2015; Visser et al., 2014; Testoni et al., 2018; Testoni et al., 2021; Kramer et al., 2015; Griffin et al., 2022) but no universal interventions. The evidence regarding the effectiveness of postvention service models was limited due to a scarcity of research. However, some Australian studies indicated that peer-support groups effectively reduced psychological distress among those bereaved by suicide, emphasizing the need to address the requirements of the postvention workforce. Further studies may also clarify when particular interventions and follow-up assessment could be delivered.

The *public health model* best aligns postvention with suicide prevention programs and tailors service delivery to the varied needs of those bereaved by suicide (Andriessen et al., 2019b; Lichtenthal et al., 2024). Five guidelines (Survivors of Suicide Loss Task Force and National Action Alliance for Suicide Prevention, 2015; Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017; Public Health England and National Suicide Prevention Alliance, 2016; Séguin et al., 2020; McGuiness and Skehan, 2021) used the *public health model*, comprising universal, selective and indicated strategies (World Health Organization, 2012). Fig. 2 (based on the literature, and p.14 Séguin et al. (Séguin et al., 2020)) illustrates the public health model's applicability to specific populations. Universal strategies are for people with minimal grief, offering information and resources on postvention, grief and bereavement. Selective strategies are for those experiencing moderate-to-severe grief, providing training for service providers, therapeutic/psychoeducational interventions, peer support and self-help strategies. Indicated strategies serve people with grief and mental health challenges, including evidence-based psychological treatments and collaborative care.

These guidelines offer comprehensive plans, categorizing responses into immediate, short-term and long-term actions, emphasizing appropriate communication, identification of support or training needs, coordination with services, stabilizing, memorialization, transitioning into suicide prevention and further evaluation of crisis management. This approach aligns with development of system-wide/whole-school approaches that move beyond mere crisis response (Andriessen et al., 2019a; Williams et al., 2022; Arensman and McCarthy, 2017; Pirkis et al., 2024).

4.1. Strengths and limitations

The search was limited to English-language sources which may have introduced a geographic and linguistic bias, restricting generalizability and applicability across diverse populations. The weak quality of the studies also impacted the reliability of the interventions. The framework of the scoping review does not accommodate commentary on intervention effectiveness. There is a lack of good postvention research in specific population groups such as culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander peoples and individuals facing significant adversity. Additionally, research on the impact of postvention support for children and adolescents, and on the long-term effects of suicide bereavement support is limited, underscoring the need for more comprehensive studies to better understand and support these populations.

4.2. Implications for public health

Postvention is vital for suicide prevention efforts in Australia and globally (Schlichthorst et al., 2023; Pirkis et al., 2024). While evidence on the effectiveness of studies and guidelines is limited, the review underscores key components of postvention that could effectively support those bereaved by suicide, such as psychoeducation, social support, peer-based assistance, and spaces for sharing experiences. Implementing these components can address critical care gaps and better address the unique needs of suicide loss survivors. Also expanding postvention services and research to include diverse population and languages can ensure inclusivity particularly for rural or underserved areas. This approach also aligns with Australia's commitment to holistic suicide

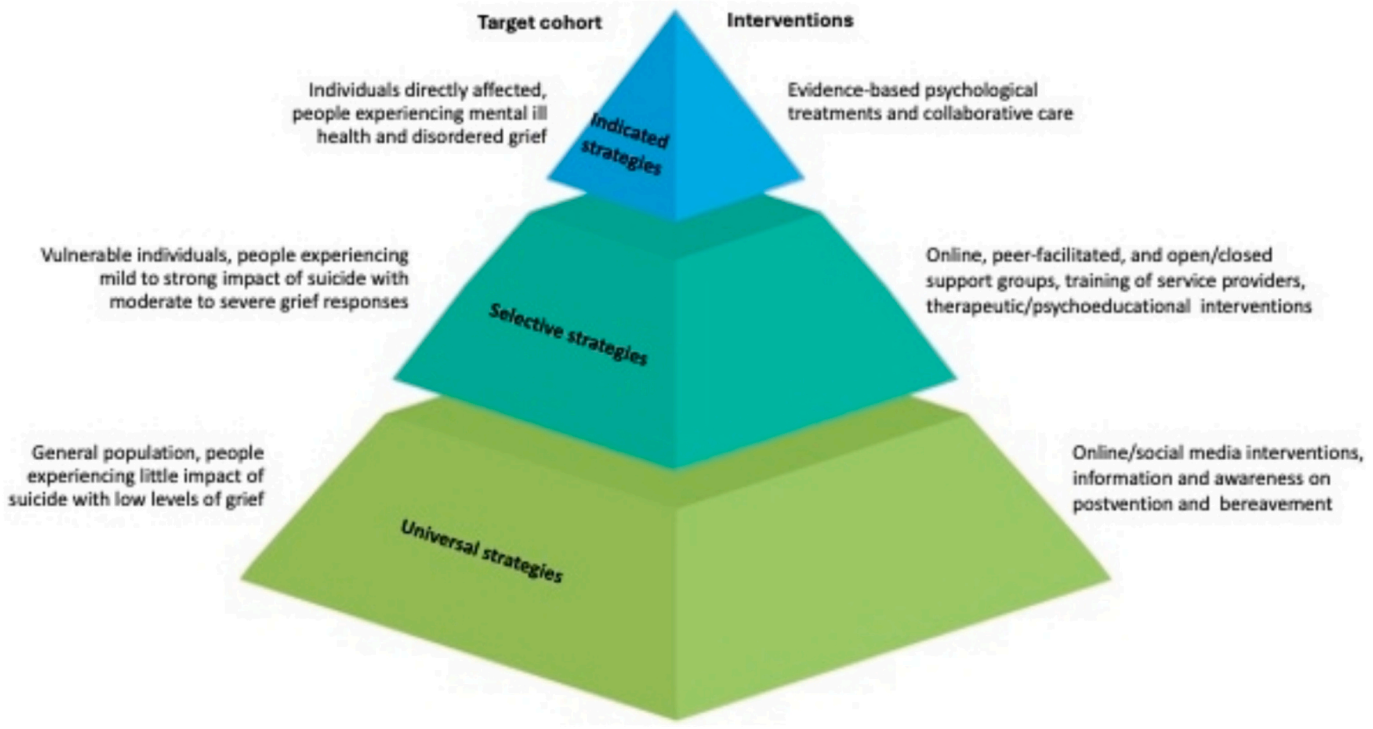

Fig. 2. Public health model of suicide postvention.

prevention, integrating postvention with broader, evidence-informed strategies at both national and international levels.

5. Conclusions

This systematic review evaluated the effectiveness of postvention service models and guidelines and found promising, although limited evidence of effectiveness, due to the lack of high-quality research, particularly on specific groups such as Aboriginal and Torres Strait Islander peoples, and those experiencing adversity. The review identified significant knowledge gaps, while identifying effective postvention components like involving trained peers in support groups, workplace training programs and arts-based interventions. Adopting a public health framework for postvention services could enable customized support for bereaved individuals, including information dissemination, peer support and specialized psychotherapy, based on the impact of suicide on their lives.

Disclosure of ethical compliance

The study was based on publicly available publications and thus exempt from ethical review.

CRediT authorship contribution statement

Chandra Ramamurthy: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation. **Trisnasari Fraser:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation. **Karolina Krysinska:** Writing – review & editing, Validation, Methodology, Investigation, Data curation. **Jacinta Hawgood:** Writing – review & editing, Validation, Investigation, Data curation. **Kairi Kõlves:** Writing – review & editing, Validation, Investigation, Formal analysis. **Lennart Reifels:** Writing – review & editing, Validation, Methodology. **Nicola Reavley:** Writing – review & editing, Supervision, Methodology. **Karl Andriessen:** Writing – review & editing, Supervision, Project administration, Methodology, Funding acquisition, Data curation, Conceptualization.

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Declaration of competing interest

The authors report no actual or potential conflicts of interest.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ypmed.2025.108279.

Data availability

The authors confirm that the data supporting the findings of the study are available within this article and/or its supplementary materials.

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