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Electronic Supplementary Material

Table S1

Contents of an Awareness Program Rated on Their Effectivity for Suicide Prevention

Content	*Median*	*IQR*
1. Information on where to find help (in the community, at school)	5	1
2. Awareness and definition of mental health	4	1
3. Strategies to maintain a good mental health	4	1
4. Risk taking behaviors and possible consequences	4	1
5. Awareness and definition of (non-pathological) emotional distress	4	1
6. Information on typical stressors and stress reaction	4	1
7. Strategies to cope with stress	4	1
8. Strategies to influence feelings	4	1
9. Information on anxiety	4	1
10. Information on self-injury	4	1
11. Information on mental disorders in general	4	1
12. Information on substance use	4	1
13. Myths and false believes about suicidality (e.g. asking someone about suicidality will cause him to take his/her own life)	4	1
14. Description of warning signs of suicidality	4	1
15. Experiences of real people around suicide	4	1
16. Communicate that suicidality requires professional treatment	4	1
17. Characterization of suicidality as a symptom of psychopathology (and not as a possible reaction to stress)	4	1
18. Communicate that suicide can be prevented	4	1
19. Create cognitive dissonance about suicide as an option for coping with extreme stress (i.e. "suicide is not an option/a solution")	4	1

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Content	*Median*	*IQR*
20. Information on treatment for mental health problems	4	1
21. Instructions on how to react helpfully to suicidal peers	4	1
22. Instruction on how to act if oneself is feeling suicidal	4	1
23. Elucidation of possible outcomes of help-seeking efforts	4	1
24. Communication training (e.g. how to talk about problems, how to ask for help)	4	1
25. Problem-solving training	4	1
26. Information and coping strategies for bullying	4	1
27. Awareness of stigmatization of mental disorders and help-seeking and its consequences	4	1
28. Awareness of suicidality as a problem of concern	4	1
29. Information on depression	4	2
30. Information on characteristics of suicidality as prevalence, causes, risk factors, protective factors	4	2

Note. Items for which consensus was reached are highlighted in bold. Items were rated on a 5-point Likert scale from 1 (*very detrimental*), 2 (*somewhat detrimental*), 3 (*neutral / mixed*), 4 (*somewhat effective*) to 5 (*very effective*).

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Table S2

Importance, Effectiveness and Feasibility of Outcomes of Awareness Programs

		Importance [a]		Effectiveness [b]		Feasibility [b]	
	Outcome	*n*	%	*Median*	*IQR*	*Median*	*IQR*
1.	Improvement of help-seeking behavior	10	83.3	3	1	3	2
2.	**Improvement of willingness to seek help for oneself if needed**	10	83.3	3	1	3	1
3.	Reduction of number of non-fatal suicide attempts [c]	8	66.7	-	-	2	1
4.	Improvement of helping behaviors towards peers	6	50.0	3	2	3	1
5.	**Improvement of readiness to communicate distress to others**	4	33.3	3	1	3	1
6.	**Increase of knowledge of warning signs for suicidality**	3	25.0	3	1	3	1
7.	Reduction of feelings of hopelessness	3	25.0	3	1	2	1
8.	**Improvement of knowledge of available professional help**	3	25.0	3	1	3	1
9.	Reduction of (severe) suicide ideation [c]	2	16.7	-	-	2	1
10.	Reduction of number of fatal suicide attempts [c]	2	16.7	-	-	2	1
11.	Improved confidence that help is possible/reduce feeling of entrapment	2	16.7	3	1	2.5	2

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	Importance [a]		Effectiveness [b]		Feasibility [b]	
Outcome	*n*	%	*Median*	*IQR*	*Median*	*IQR*
12. **More trusting attitude about helpers (e.g. school counsellor)**	2	16.7	3	1	3	1
13. Reduction of feelings of social isolation	1	8.3	3	2	2.5	1
14. **Improvement of willingness to seek help for peers if needed**	1	8.3	3	1	3	1
15. Decrease of stigmatization of suicidality	1	8.3	2.5	2	2.5	1
16. Decrease of stigmatization of help-seeking	1	8.3	3	2	3	1
17. Improvement of skills to deal with emotional distress	1	8.3	3	1	2	1
18. **Improvement of quality of reaction to disclosure of suicidality by peers**	1	8.3	3	1	3	1
19. **Reduction of mental health problems**	0	0	3	1	3	1
20. **Increase of knowledge of symptoms of depression**	0	0	3	1	3	1
21. **Increase of knowledge of causes and risk factors of suicide**	0	0	3	1	3	1
22. Better accessibility of knowledge (i.e. know where to find information)	0	0	3	1	2.5	1
23. Improvement of communication skills	0	0	2.5	1	3	1
24. More adaptive attitudes toward suicidality: suicidality is common/most individuals could become affected	0	0	3	1	2.5	1

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	Importance [a]		Effectiveness [b]		Feasibility [b]	
Outcome	*n*	%	*Median*	*IQR*	*Median*	*IQR*
25. More adaptive attitudes toward suicidality: suicide is preventable	0	0	3	1	3	2
26. More adaptive attitudes toward suicidality: suicidality must be taken seriously	0	0	4	1	3	2
27. Improvement of positive goals for the future	0	0	2.5	1	2.5	1
28. Improvement of problem-solving skills	0	0	2	1	3	1
29. More adaptive attitudes toward suicidality: suicidality requires professional treatment	0	0	3	2	3	2
30. More adaptive attitudes toward suicidality: it is important to take care of your mental health	0	0	3	1	3	2
31. Decrease of stigmatization of mental illness	0	0	2	1	3	2
32. Reduction of depressiveness	0	0	2	1	3	1
33. More adaptive attitudes toward suicidality: in case of suicidality, fetch a trusted adult	0	0	3	1	3	2
34. More adaptive attitudes toward suicidality: suicide is something you can openly talk about	0	0	3	2	2	2
35. Improvement of self-esteem	0	0	2	1	3	1

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	Importance [a]		Effectiveness [b]		Feasibility [b]	
Outcome	*n*	%	*Median*	*IQR*	*Median*	*IQR*
36. More adaptive attitudes toward suicidality: suicide is mostly a symptom of severe mental illness	0	0	2	2	2	2
37. Increase of knowledge of mental disorders	0	0	3	3	3	1
38. More adaptive attitudes toward suicidality: suicide is not an option	0	0	2	3	2	3

Note. **Outcomes in bold** are those where participants reached consensus both on their efficacy and feasibility.[a] Number of experts who chose the item as one of the five the most important, *N*=13. [b] Items were rated on following Likert-scale: 1 (*not at all*), 2 (*to a small extent*), 3 (*to a moderate extent*), 4 (*to a great extent*). [c] Outcome directly related to suicidality, question on the effectiveness for the reduction of suicidality long term is not applicable.

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Table S3

Items Regarding the Safety or Applicability of Awareness Programs

Item	*Median*	*IQR*
1. When delivering universal suicide prevention programs, one must pay attention to potential unanticipated effects	4	1
2. Prevention programs should be tailored on specific characteristics of the audience:		
a) Age	4	1
b) Gender	3	1
c) Mental health status	3	1
d) Culture	3	0
e) Suicidality	2.5	1
3. The benefits of suicide prevention programs outweigh the unanticipated consequences	3	1
4. Suicide prevention programs should target only high-risk groups	2	1
5. Suicide prevention is not a theme for groups and should be treated individually	2	1
6. Suicide prevention programs should be delivered only to interested students	2	1
7. Suicide prevention programs do not have any adverse effects	2	1
8. Other types of suicide prevention in schools (e. g. gate-keeper trainings) are preferable to universal programs for suicide prevention	2	1
9. Suicide prevention programs should not be disseminated in schools or areas already affected by suicide	1	1
10. Suicide prevention programs should be delivered universally	3	3
11. Talking about suicidality with young people lowers the threshold for suicidal behavior	2	2
12. Talking about suicidality leads to an increased cognitive availability of suicidal behavior	2	2

Note. Items for which consensus was reached and with a median above the middle value of the scale (**supported by the experts**) are highlighted in **bold,** items for which the participants did reach consensus but with a median below the middle value of the scale (rejected by the experts) are

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underlined. Items were rated on the 4-point Likert scale: 1 – *strongly disagree*, 2 - *disagree*, 3 - *agree*, 4 – *strongly agree.*

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Table S4

Precautions to Prevent Unanticipated Negative Effects

	Item	*Median*	*IQR*
1.	**...embed suicide prevention in more general mental health fostering programs**	4	1
2.	**...pilot the program with the target audience before delivering it more broadly**	4	0
3.	**...measure long-term effects when piloting the program (e. g. after one year)**	4	1
4.	**...not dramatize suicide**	4	1
5.	**...not mention details about suicidal behavior (e. g. methods)**	4	1
6.	**...redact a study protocol on how to react to individual risk prior to starting the program**	4	1
7.	**...address concerns of people about help-seeking in a credible and reassuring manner**	4	1
8.	**...inform about ways to help yourself and others**	4	1
9.	**...create the possibility to rapidly access appropriate treatment when needed as follow up to program**	4	0
10.	**...provide teachers with methods to observe and follow up on the well-being of participants**	4	1
11.	**...train teachers and other school professionals to better assess suicidality and react to it**	4	1
12.	**…train gatekeepers at school to discuss suicidality and motivate help-seeking**	4	1
13.	**...communicate openly with parents and teachers of students at risk of suicide**	4	1
14.	**...establish durable public relations between school and mental health providers**	4	1
15.	**...train parents to better assess suicidality and react to it**	4	1
16.	**...only use evidence-based interventions**	3.5	1
17.	**...only use videos produced by / in cooperation with mental health professionals**	3	1
18.	**...let two educators conduct the program together**	3	1
19.	**...conduct a program with more than one session over a longer period (i.e. no punctual intervention)**	3	1
20.	**...convey more adaptive attitudes towards suicide (e. g. "suicide is not an option")**	3	1

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Item	*Median*	*IQR*
21. ...inform participants about symptoms of depression	3	1
22. ...include testimonies of young people who considered suicide but ruled it out as an option	3	1
23. ...indicate safe places where students can discuss suicidality	3	1
24. ...involve adolescents in expert rounds when deciding the contents of the program	3	1
25. ...train gatekeepers to approach and inform parents of suicidal students	3	1
26. ...let participating schools adopt policies about dealing with suicidality	3	1
27. ...write a standardized script for the prevention program	3	1
28. ...only use short and clear messages when talking about suicidality (e. g. “if you are suicidal, talk to a trusted adult”)	2.5	1
29. ...conduct a screening for depression	2	1
30. ...use more general terms (e. g. “self-injurious behavior”) instead of mentioning “suicide”	1	1
31. ...document observations about the individual risk of suicidality of the participants	4	2
32. ...investigate the mental-health state of participants before starting the program	4	2
33. ...choose programs delivered by non-profit organizations	2	2
34. ...ask for the presence of a teacher in the class while the program is delivered	3	2
35. ...depict suicidality as mainly being a symptom of psychopathology	1	2
36. ...focus on the biological causes of mental disorders	2	2

Note. Items for which there was consensus and have a median above the middle value of the scale (**supported by the experts**) are highlighted in **bold,** items where the participants did reach consensus but have a median below the middle value of the scale (rejected by the experts) are underlined.

Items were rated on the 4-point Likert scale: 1 - *I do not recommend doing this*, 2 - *not very important*, 3 - *moderately important*, 4 - *very important.*

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Table S5

Useful Formats

Item	*Median*	*IQR*
1. A mix of intervention techniques	5	1
2. Signalize the presence of gate-keepers with whom to talk openly about suicidality	5	1
3. Brief and clear message about what to do in case of suicidality	5	1
4. Skills training for dealing with emotional distress	5	1
5. Peer-to-peer information	5	1
6. (Short) videos with discussion	4	1
7. Web-based self-management components (e. g. apps)	4	1
8. Group discussions	4	1
9. Information materials to take away	4	1
10. Posters	3	1
11. Short lecture	3.5	1
12. Screening for depression	3	1
13. Role plays	4	2
14. Tools that support help-seeking (e.g. addresses, internet pages)	5	2
15. Follow-up questionnaire	5	2
16. Communication training	4	2
17. Screening for suicidality	4	2

Note. Items for which there was consensus and have a median above the middle value of the scale (**supported by the experts**) are highlighted in **bold**. Items were rated on the 5-point Likert scale: 1 - *not necessary*, 2 - *not very useful*, 3 - *somewhat useful*, 4 - *moderately useful*, 5 - *very useful*.

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Table S6

Important Characteristics of Educators

Item	*Median*	*IQR*
1. Experience in working with youth	5	1
2. Experience in working with mentally ill or suicidal youth	5	1
3. Appropriate training in delivering the prevention program	5	1
4. Founded knowledge on suicidality	5	1
5. Trusted by youth	5	0
6. Believe in the program	5	1
7. Calm, balanced	5	1
8. Open, can relate to youth	5	1
9. Is sensitive to the well-being of participants	5	1
10. Good knowledge of own professional limits	5	1
11. Pedagogical training/knowledge	5	1
12. Mentally healthy	5	2

Note. Items for which there was consensus and have a median above the middle value of the scale (**supported by the experts**) are highlighted in **bold**. Items were rated on the 5-point Likert scale: 1 - *detrimental*, 2 - *not very important*, 3 - *somewhat important*, 4 - *moderately important*, 5 - *very important*.

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Table S7

Most Indicated Profession of Educators

Profession	*Mean Rank*
1. School psychologist	1.93
2. Psychologist	2.93
3. Trained teachers	4.00
4. Psychotherapists	4.20
5. Social workers	4.20
6. Doctors	4.53
7. Other health professionals	6.20