

## **Centerstone Postvention Guidelines**

### **Response After A Completed Suicide of a Client**

The following guidelines have been developed to aid surviving family members, other clients, and staff in the event of a completed suicide by a Centerstone client. Every case is unique and presents its own issues including legal parameters we must follow.

There are three groups who need assistance following a client suicide:

- The family
- Other clients (if they were acquainted with the deceased)
- Staff

#### ***Surviving Family Members***

There is no greater anguish or suffering than that brought on by the suicide of a loved one. Clinical experience suggests family members are suffering the greatest shock and grief during the first few hours to days after a suicide. When allowed by law, we will need to gauge their receptiveness to telephone calls or visits from providers regarding their need for support, referral or treatment.

#### **Recommended steps:**

- a. Upon learning of a client's suicide, the Care Coordinator or their designee will check to the client record to see if there are any Releases of Information for any of the client's family.
- b. If there is a Release of Information on record the Care Coordinator will consult with all Centerstone providers who have seen the client in the last 90 days. The Care Coordinator will brief the Director who will make the decision on whether it is appropriate to reach out to any family members where there is a Release of Information.
- c. If the decision is made to contact any of these family members the Director or their designee shall call to express condolences and offer support. This call should be sincere and brief using simple, heartfelt language.
- d. In addition to condolences, the family members should be offered a telephonic or face-to-face appointment (free of charge) to discuss the aftermath of the suicide. The appointment may either be with the client's former treatment provider or another Centerstone provider, depending upon clinical judgment. This is a time to evaluate the family members need for support services, or to determine if anyone is experiencing suicidal ideation - a frequent occurrence in survivors of suicide.
- e. The family members should be offered available resources for suicide survivors including Survivors-of-Suicide Support Groups.
- f. The Director or their designee should again call to check in with the family between three and four weeks following the suicide unless sooner contact has been requested.
- g. When there is no Release of Information in the client record for family members but family member(s) of the deceased client contacts Centerstone about the suicide, the above process can be followed.

- h. In cases where there is no Release of Information and the deceased client's family does not contact Centerstone, we are not to make any contact with the family, attend the funeral, or send flowers.

The following considerations are strongly recommended:

- Do not blame the family members for the suicide or in any way imply that they may have had an unseen hand in their family member's death.
- Do not imply or state that more could have been done. In the event it appears there may have been some negligence, do not suggest a treatment failure or preventable error occurred.
- Avoid becoming defensive and be prepared for anger that may be directed at you. Anger following a death by suicide is quite common, and should be understood and responded to therapeutically.
- Staff should only attend the memorial/funeral upon invitation. Confidentiality resides with the deceased.
- However badly any staff may feel about the client's death, it is important the family members not be exposed to the clinician's pain and grief. The family members may then feel obliged to be of help to the clinician, thereby avoiding their own necessary grief work.
- Because a person has completed a suicide does not give any staff permission to divulge harmful or personal clinical details to the family members.
- Since a completed suicide within a family increases suicide risk in the survivors, it is important to be proactive in our contacts with the family members, and to do everything we reasonably can to remove the curse and taboo of a completed suicide. If possible, surviving family members should be assessed for complicated grief reactions, depressive disorder and suicidal ideation.

**\*Staff must record in the client record all interactions with family members**

### ***Fellow Patients as Survivors***

In some instances, a suicide will create "survivors" among other patients. Clearly, this death creates a risk factor for other patients who may already be suicidal. Therefore, staff should be cognizant of this fact and to take all reasonable action to forestall and prevent any "contagion" of suicidal ideation or action on the part of surviving patients as follows:

- a) Staff should try to avoid the spreading of rumors regarding the suicide. This can be done by containing the source of information about the suicide to a single authoritative person, preferably the Care Coordinator
- b) Following a suicide leadership of the program should schedule a meeting of staff as soon as possible to discuss a plan for informing other clients as applicable and to debrief the incident.
- c) Clinicians whose patients know of a completed suicide should provide for this emotional crisis in their scheduled session, or schedule additional sessions so that this shock/grief can be expressed and dealt with in a therapeutic fashion. A current suicide risk screening/assessment via the Columbia Suicide Severity Rating Scale should be completed
- d) The family should be consulted regarding any desire on the part of other patients or staff to have a memorial, donate money/flowers/food to the family.
- e) For previously suicidal or actively suicidal clients, the following steps are indicated, a) increase the number of sessions as desirable and b) investigate suicidal ideation and any exacerbation of

risk. Generally, such extra efforts and attention need to be in place for at least 60 days following the death of a patient, and should be reviewed again at six months.

- f) Lastly, it is important to return to routine as quickly as possible and be reminded that the structure and usual comings and goings of staff and clients are both comforting and reassuring. Staff members may wish to use their own emotional barometers as a guideline for the interval at which time we are back to "normal routine." Clearly, a completed suicide by a person well known by other patients is hardly "business as usual," and we should never treat it this way.

### ***Staff as Survivors***

As mental health professionals, we are no different than others with respect to being survivors of suicide. We experience many of the same emotions as family members and friends, some of them even more acutely. For our own mental health and wellbeing, we need to be tolerant of each other's needs during these times and to be understanding, kind, and supportive.

The following guidelines are suggested:

- a) Help your colleagues and yourself. The loss of a client to suicide is never an easy subject to discuss, but avoiding an obvious clinical fact is seldom helpful. Following a completed suicide, staff involved may experience feelings of guilt, or fear that their professional reputation has been damaged. It is important to discuss these feelings with your supervisor or trusted colleague. It is important to support your colleagues and report any concerns you have about others following the death of one of their clients to program leadership so that we can reach out to him/her.
- b) Should staff begin to experience persistent ideation about the death, intrusive memories about the suicide, guilt, anger, numbing, avoidance or other potentially negative emotional reactions to the loss of a patient through suicide, consultation with a Clinical Supervisor is recommended. Otherwise, it is possible these post-traumatic emotional states *may impair clinical response and therapeutic judgment when working with other patient's at-risk for suicidal behaviors*. Following a client death by suicide, we have a personal and professional responsibility to work through these powerful residual emotions and come to a healthy resolution of them.

\*Centerstone has a Peer Support Program available to staff after a completed suicide of a client (see program Handbook and Manual).