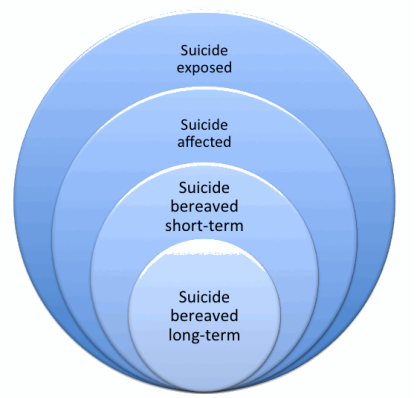
Postvention

Goal 7: Agencies will develop a suicide postvention plan that addresses individuals who may be affected by the suicide death of an individual in care or an agency employee.

Rationale

Although there is an oft-quoted statistic that every death by suicide significantly impacts six additional individuals, research has actually shown the impact to be even greater. A study by Berman (2011) found that there is an average of 4.5 to 7.5 immediate family members and around 15 to 20 extended family, friends, and colleagues who can be considered "intimately and directly affected" by a suicide. Additional individuals exposed to the death, such as first responders, witnesses, or care providers, may not have a personal relationship with the individual, but may still be significantly impacted by their experience.

Definitions vary for the term "suicide survivor." One model (Cerel et al., 2014) categorizes individuals across levels of impact, including individuals exposed to suicide, affected by suicide, bereaved with short-term impacts, and bereaved with long-term impacts. Using this scheme, the number of individuals impacted would vary, based on the level of impact that occurs across time.



Research has clearly established that exposure to the suicide behaviors (ideation or attempts) or a suicide death of another person increases the risk of suicide for the person exposed (National Action Alliance for Suicide Prevention, 2015). One large population-based study found that individuals who were exposed to the suicide death of a first-degree relative were between 3 times more likely to die by suicide (Agerbo, 2005). This study also showed that individuals whose spouses died by suicide showed between a 3 and 16 fold increase in risk. Adolescents also seem to be particularly impacted by this elevated risk related to the exposure of the suicide of a family member or friend. Research has also shown that risk is increased about threefold for men exposed to the suicide death in the workplace compared to men not exposed (Hedström, Liu, & Nordvik, 2008).

Due to the increased risk that accompanies a suicide death, a comprehensive suicide prevention program must include postvention planning. Behavioral health organizations have a clear role in reducing the immediate distress following a suicide death, reducing risk for subsequent suicide, and assisting individuals struggling with complicated bereavement in situations where a client or employee has died by suicide.

Defining Postvention Terms

The Survivors of Suicide Loss Task Force (2015) define **postvention** as "an organized response in the aftermath of a suicide to accomplish any one or more of the following: (a) to facilitate the healing of individuals from the grief and distress of suicide loss; (b) to mitigate other negative effects of exposure to suicide; and (c) to prevent suicide among people who are at high risk after exposure to suicide." In postvention, efforts are made to encourage resilience and coping and reduce long-term negative impacts.

The terms suicide loss survivor and suicide attempt survivor also need to be clarified to reduce confusion. The term suicide loss survivor is used to refer to someone who is bereaved by the loss of someone to suicide. In the U.S., this term is sometimes shortened to "loss survivor" or "survivor," which may cause confusion with individuals who have survived a suicide attempt. This document will use the full term for both to reduce opportunities for confusion. As noted previously, some individuals may not meet the definition of a suicide loss survivor, yet still be impacted by their exposure, and so the document will also refer to individuals "exposed" or "affected" by suicide.

Postvention Planning

It is important for organizations to develop a plan for postvention in advance of a death. An organizational plan should address the possible event of a death by a consumer or former consumer of services, as well as the possible death of a staff member. The plan should identify the administrative official(s) tasked with managing communication and lay out steps in response, including immediate practical and emotional needs as a result of the crisis, short-term actions to facilitate recovery, and long-term tasks to reduce risk in a vulnerable population. The organization may choose to develop a team designated to respond in the immediate and short-term aftermath, with team members prepared to serve in specific roles. An example postvention plan/protocol is provided in the appendix. The agency should have a community resource list identifying services and supports that may be helpful to survivors of suicide loss. Research has shown that information about available resources decreases the time before individuals seek behavioral health assistance.

Stages of Postvention

The Carson J. Spencer Foundation and partnering organizations (2013) specify key phases and activities for postvention in the workforce. With minor modification, these stages can also apply to planning postvention activities for consumers within the organization, as well.

Immediate Phase. During this phase, the goal is to minimize the trauma impact and provide psychological first aid to those exposed. One initial consideration is the privacy of the individual and his or her family. If the decedent is a consumer, the organization will need to determine if there is consent to communicate with family members. If no consent has been provided, the agency should not communicate with the survivors, unless they reach out. Similarly, staff members from the organization should not plan to attend memorial events or services. If the death was of a staff member, the family may also request that the manner

of death be kept confidential. Privacy of the individual and his/her family must take precedence, although the agency may not be able to fully control information obtained in other ways. If deemed clinically appropriate, an agency representative should reach out to the family in the first few days. Initial communication to the family should be to express condolences. It should be brief and heartfelt. The family should be offered a

Within the agency, one individual should be identified to coordinate communication. No official statement should be made until the death is confirmed by an immediate family member or a public official, such as a police officer or medical examiner. An example death notice is provided in the appendix. Consideration should also be made about whether other agency consumers who may have had a relationship with the individual (a peer or staff member) should also be notified by their primary provider. Agency leadership should be aware that the death may trigger suicidal thoughts or feelings in vulnerable individuals and that care should be taken to limit information around details of the death, as well as memorializing the death in a dramatic manner. Suggestions on how to honor a person who died by suicide and minimize contagion are provided by SPRC. Full staff meetings should be held to debrief the incident and to provide an opportunity for further formal or informal processing. Discretion for the privacy of the person and family members should be reiterated to staff.

During this phase, practical support may be more helpful than counseling. The agency representative may ask the family how others can help, including bringing prepared food, offering to pack of belongings in the office, or communicating plans for services.

Short-term Phase. During this phase, the goal is to promote healthy grieving and provide additional support and services to those most affected. The agency should make available counseling services to individuals who need or desire additional support. If appropriate, the agency should reach out to the family a second time three or four weeks after the death. For family members, this may involve offering to provide counseling services or to make community referrals. Survivors of suicide loss report that making connections with other survivors can be especially meaningful, so referrals to suicide bereavement groups or other peer-to-peer supports should be strongly considered.

For coworkers, this phase may involve bringing in Employee Assistance Program staff or other behavioral health providers and setting a culture that encourages help-seeking. The behavioral health professional can consult with agency leadership to determine the best plan, which may include education of employees about self-care and coping and availability of support services, individual or group meetings with affected employees, and referrals of individuals with complicated grief responses to mental health professionals. In addition, clinical supervisors should be aware of signs of on-going struggles in staff and provide time for discussion in supervision. Trainees and new providers may need additional help navigating the grief process related to the loss of an individual in services. As with any other staff member, a safe space to process should be created for the trainee and the trainee's emotional response over the course of time should be monitored in the case of needed referrals. It is expected that all staff may be impacted by the suicide, both personally and professionally, and a structured yet empathic atmosphere is crucial for

health of the work environment. During this phase, management should also begin to re-establish functioning and routine within the workplace and move staff towards a "new normal".

Long-term Phase. Research has shown that most individuals show remarkable resiliency and will return to previous levels of functioning over time. However, anniversaries or major events may trigger reminders and lead to sad or traumatic memories. Organizing opportunities to remember or honor the individual's life, while still maintaining safe memorial practices, may be helpful for those who wish to participate. Activities with all staff are generally not recommended in this phase. The long-term phase also reflects the shift from postvention to prevention, with a goal of offering multiple strategies for identifying and engaging individuals at risk of suicide. Providing education and gatekeeper trainings, offering universal screening for suicide, and other prevention strategies within the zero suicide framework are intended to support both consumers and staff members within the agency.

Additional Postvention Resources

LOSS teams. LOSS teams (Local Outreach to Suicide Survivors) is a model of suicide prevention in which trained suicide loss survivors are dispatched to the scene of a suicide to provide information about community resources and begin to install hope for the future. The developer of the model has found that individuals who receive active postvention through LOSS teams seek assistance on average 39 days after the death, as compared to an average of 4.5 years with passive postvention strategies (Campbell, n.d.). The developer also found that team members had no greater risk as a result of their exposure; in contrast, they reported that the experience helped them in their own recovery. More information on LOSS teams and available training can be found on the LOSS team website.

Psychoeducation and Support Groups. Survivors of a suicide death frequently lack basic information about grief responses and available community resources. The Suicide Awareness Voices of Education (SAVE) website offers free online resources and brief booklets on loss that can be purchased for a low cost. The website also offers a list of suicide survivor and bereavement support groups within Texas; the American Foundation for Suicide Prevention (AFSP) also offers a list. For those interested in developing a suicide survivor support group, the AFSP offers a training program for facilitators. Additionally, the Towards Good Practice: Standards and Guidelines for Suicide Bereavement Support Groups has been identified as a best practice by SPRC and can provide guidance in the implementation of a suicide bereavement support group. Some individuals will also benefit from participation in online support through chat rooms or listserves, such as those offered by Survivors of Suicide and Didi Hirsch's Survivors after Suicide.

Treatments for Trauma and Complicated Bereavement. When bereaved individuals have been surveyed, many indicate the desire for professional assistance with grief and trauma responses. There is very limited research to identify evidence-based practices for individuals with complicated bereavement. Trauma and grief interventions, such as

Complicated Grief Therapy, Trauma-Focused CBT for Traumatic Grief, Prolonged Exposure Therapy, and Cognitive Processing Therapy should be strongly considered treatment modalities. Several available resources offer clinicians guidance on some of the unique issues facing individuals following a suicide loss, including

Postvention Guidelines

The following postvention guidelines provide additional information and guidance:

- Responding to Grief, Trauma, and Distress after a Suicide: U.S. National Guidelines (Survivor of Suicide Loss Task Force)
- A Manager's Guide to Suicide Postvention in the Workplace (Carson J. Spencer Foundation, Crisis Care Network, the Workplace Prevention Task Force of the American Association of Suicidology and the Workplace Task Force of the National Action Alliance for Suicide Prevention)
- After a Suicide: A Postvention Primer for Providers (Montgomery County Emergency Services)
- Coming Together to Care: A Suicide Prevention and Postvention Toolkit for Texas Communities (Mental Health America of Texas and the Texas Suicide Prevention Council; chapter 6)

Moving Beyond – Community Expansion

Although initial policies and procedures will be focused on establishing a postvention plan for the behavioral health organization, agencies should consider ways in which crisis interventions and suicide postvention efforts may be directed toward the broader community. The development and support of a LOSS team to respond to both the immediate and short-term needs of individuals exposed to suicide is one concrete strategy. Organizations may also explore avenues to provide postvention responses to community providers who are most likely to be exposed, such as schools, first responders, health care staff, clergy, and funeral directors. Specialized resources are available from SPRC offering guidance for postvention to schools, clergy, early responders, and funeral directors. Through community partnerships, organizations can provide guidance to other community entities to develop best practice postvention plans. Organizations can also help ensure local media is aware of safe messaging guidelines and that any media coverage following a death by suicide aims to inform the public about resources, support, and warning signs and minimizes the risk of contagion.

References

Agerbo, E. (2005). Midlife suicide risk, partner's psychiatric illness, spouse and child bereavement by suicide or other modes of death: A gender specific study. *Journal of Epidemiology & Community Health, 59(5)*, 407–412.

Berman, A. L. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior, 41(1)*, 110–116

Campbell, F. R. (n.d.). *Suicide Survivors as First Responders: The LOSS Team*. Retrieved from http://www.lossteam.com/LOSSteamOVERVIEW.pdf.

Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The continuum of survivorship: Definitional issues in the aftermath of suicide. *Suicide and Life-Threatening Behavior, 44*, 591–600.

Carson J Spencer Foundation, Crisis Care Network, National Action Alliance for Suicide Prevention and American Association of Suicidology (2013). *A Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of Suicide*. Denver, CO: Carson J Spencer Foundation.

Hedströöm, P., Liu, K.-Y., & Nordvik, M. K. (2008). Interaction domains and suicide: A population-based panel study of suicides in Stockholm, 1991–1999. *Social Forces, 87(2)*, 713–740.

Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention (2015, April). *Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines*. National Action Alliance for Suicide Prevention. Retrieved from http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/NationalGuidelines.pdf