



**Office of
Mental Health**

Suicide Prevention Office

The Impact of Suicide on Professional Caregivers: A Guide for Managers and Supervisors

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Part I: Overview

Introduction

Suicide is a significant public health issue in the United States and in New York State. Each year, more than 800,000 individuals worldwide take their own lives, with more than 47,000 Americans dying by suicide in 2017 (the most recent data available). Over the last two decades, rates of leading causes of death -such as cardiovascular disease, cancer, homicide, AIDS and motor vehicle accidents- have been steadily decreasing while the suicide death rate has continued to climb. These deaths leave in their wakes an estimated 283,000 survivors of suicide loss a year. According to the Center for Disease Control and Prevention [1] the number of survivors of suicide loss in the U.S. is more than 5.3 million (1 every 62 Americans in 2017).

While agencies, lawmakers, families, and communities contend with this public health crisis, professionals in the behavioral health field are facing another growing issue: how do we respond to the emotional and psychological toll the suicide of a client has on professional caregivers? What are the best ways to support both staff and clients? While this remains a relatively new area of research, it has been estimated that each year 15,000 mental health professionals experience the loss of a patient or client to suicide. For professional caregivers, concerns about litigation, stigma around suicide, and the feared negative reactions of colleagues can exacerbate the pain caused by the loss itself [2].

This guide is intended to provide an overview of the main issues that can arise when clinical providers and staff experience the death of a client by suicide. It includes how to address grief, debriefing staff and clients, supporting those affected by the death, and contact with family and other survivors of the suicide loss. It was developed as a *guide*, rather than a blueprint, to assist administrators in responding to this traumatic event in a way that is informed by best practices.

The document was developed as a collaboration between the New York State Office of Mental Health's Suicide Prevention Office and the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and it mirrors in language and content OASAS' *Clinical Response Following Opioid Overdose: A Guide for Managers* [3]. We are grateful to Brigette Hartman-DeCenzo and Crystal Hewitt-Gill of the Learning and Development Unit, who have shared their work with our team.

We would like to dedicate this guide to our friend and colleague Fred Meservey, the first Director of the Suicide Prevention Center of New York and a survivor of suicide loss.

Grief and loss in a clinical setting

Grief is a complex and unpredictable phenomenon. Grief, as distinguished from depression, can be defined as the emotional and psychological response to a significant loss [4]. Grief symptoms can include feelings of shock or disbelief, horror, numbness, intense sadness, increased anxiety and fear, anger, nihilism, and emotional withdrawal [5]. Grief symptoms can last anywhere from a few weeks to many years, and can include both psychological (e.g., sadness or anger) and behavioral components (e.g., sleeplessness, substance use). Some people additionally report acute somatic symptoms during periods of grief, such as shortness of breath, stomach pain, headaches, and generalized joint pain.

The intensity of grief a person experiences may not correspond to the quality of their relationship with the deceased: in other words, some people may grieve very intensely after losing someone with whom they had a difficult or complex relationship. Conversely, other people may find that they cope quickly after losing someone with whom they had a strong and healthy relationship. Grief has few parameters and no set time limit. Grief is not inherently maladaptive; however, grief symptoms may become maladaptive over time if they are not addressed and treated.

The intensity and duration of grief and bereavement symptoms can be compounded by numerous factors, including the age of the victim and the circumstances surrounding the death. Violent, traumatic, or unexpected deaths, or deaths where there is some ambiguity surrounding the intention of the victim (e.g., accidental overdose or suicide) have been shown to frequently result in stronger grief symptoms compared to natural deaths [6].

Who is a survivor?

A suicide **survivor** is someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person [7]. The terms **survivor**, **loss survivor**, and **survivor of suicide loss** are used somewhat interchangeably to describe someone who is bereaved by suicide.

The term **clinician-survivor** is used to specifically describe clinicians who experience the suicide loss of a patient or client.

Part II: Postvention

Introduction

When a program receives news of a client's death, the agency must take on several different responsibilities. Managers must provide comfort and support to clients and their employees, while simultaneously coping with their own emotions and reactions. Additionally, the program must review the death from an ethical and regulatory standpoint, determine next steps, and may have to make programmatic changes in response to the death. This can cause significant stress among behavioral health providers. At these times, it can be useful to have a "Response Roadmap" to help guide managers and supervisors in handling the situation. This section will focus on techniques and strategies to address the issue with staff and with other clients.

What is postvention?

Postvention is an organized response in the aftermath of a suicide which provides support to affected individuals or the workplace as a whole, and mitigates the possible negative effects of the event. Edwin Shneidman [8], the father of modern suicidology, coined the term postvention to refer to helping people who are bereaved by suicide. Over the years, postvention has come to mean not only assistance to the bereaved but also assistance to anyone whose risk of suicide might be increased in the aftermath of someone else's suicide, as well as people such as first responders who might suffer negative effects from exposure to suicide.

First response - staff debriefing

When deciding and prioritizing whom to notify, it is important to keep in mind that a suicide death may have an impact on all staff, including receptionists, peer support specialists, van drivers, janitorial and other support staff. Suicide affects everyone differently, and sometimes a person who had little contact with the deceased might be deeply impacted. Even so, it is generally advisable to first attend to those who worked directly with the patient or client.

When the provider is notified of a patient's death, management may find it helpful to conduct a staff debriefing. Debriefing can be an efficient and effective way for managers and administrators to address the news and gauge staff reactions [9]. The main purpose of debriefing is to review the event and to have an open discussion with all involved staff members. The debriefing should take place in a private setting (away from clients) and as soon as possible after the program is notified of the death (ideally within one business day of the notification). This also helps clarify staff roles and delineates immediate actions to be taken. Additionally, a meeting gives staff an opportunity to openly discuss their feelings and reactions in a non-judgmental environment.

The debriefing can be extended on an invitational basis to all clinical staff, but management may find it more helpful to keep the initial debriefing small, with only the core clinical staff in attendance. It is preferable to avoid large assemblies and to communicate first with those who worked closely with the deceased. The basic format of a debriefing is straightforward: review the event in a factual way; identify key factors in the patient's treatment episode; gauge staff

reactions; identify any immediate follow-up actions to be taken; encourage self-care; and review existing postvention protocols and procedures.

Tips for conducting a successful debriefing:

- Keep the conversation factual and the tone non-accusatory: it is important to not place staff on the defensive.
- Ask open-ended questions: this encourages staff to contribute more to the conversation.
- Keep things simple: debriefings answer the “who, what, when, where” of a patient death.
- Avoid going into details of the death, and avoid sharing suspicions or spreading rumors.
- Keep the meeting short: a debriefing should take between 30 minutes to an hour.
- As you prepare for debriefing, identify your own feelings and reactions and understand that the person communicating the news sets the tone for subsequent communications.
- Be prepared for a wide range of reactions, including no reaction at all.

Impact of suicide: an ecological model

Suicide deaths occur in the context of the deceased’s interpersonal relationships, community, and society; its impact is felt by family, friends, peers, coworkers, caregivers, and community [10]. When deciding and prioritizing who needs to be notified or supported, the ecological model can help establish who had the closest relationship and may be the most impacted.



Supporting staff members

Program staff members can have complex emotional responses to the news of a client’s suicide death; particularly if they were the client’s therapist, psychiatrist, or case manager. In addition, as consumer/survivor participation has become the rule rather than the exception at all levels of the mental health system in New York State, peer recovery support specialists can be profoundly impacted by a service recipient’s suicide.

A staff member who has lost a client to suicide may experience responses similar to the emotions and reactions of survivors after the loss of a loved one. These include sadness, shock, self-blame, denial, numbness, helplessness, disbelief, anger, intrusive thoughts, detachment, dissociation, and intense distress.

Professional caregivers may also experience diminished confidence in their clinical skills or abilities and may replay their last interactions with the client, wondering if there were warning signs they failed to notice. They may feel upset that their client was not forthcoming with them,

or that the client did not utilize supports when he/she felt vulnerable to relapse. Some clinicians have self-reported feelings of numbness or dissociation after experiencing multiple client deaths in their agency, particularly when these deaths occur within a short period of time [11]. Often professional caregivers are in the position of having to strike a balance between their own personal needs and providing support to other service recipients, to the deceased's family, and to non-clinical staff that were also affected by the suicide (e.g., administrative assistants, interns, volunteers, aides, etc.).

What is twin bereavement?

When clinicians lose a client to suicide, they can experience an episode of *twin bereavement*: in addition to the personal grief reaction, the loss can impact their professional identity and their relationship with colleagues and their clinical work [12]. Clinicians may experience insecurities about their own competence, or feel that the work is too sad and too emotionally draining to continue. Sometimes clinicians, especially trainees or less seasoned professional caregivers, consider leaving the field. A 2017 study found that 10% of surveyed psychiatrists stopped accepting potentially suicidal clients [13]. Hypervigilance in relation to any perceived suicide risk is one of the most common early responses reported by clinician-survivors who continue to work with suicidal clients [14].

Staff members may be hesitant to openly discuss their feelings with supervisors and managers. They may question whether their feelings are in some way “unprofessional,” or they may feel that they are “not allowed” to grieve. This reticence can stem from the long-standing, incorrect perception that clinician grief is a sign of enmeshment, codependency, counter-transference, or overinvestment in their patient [15]. There is no empirical evidence that clinicians who experience grief reactions after the loss of a client are in some way acting outside the ethical standards of the profession [16]. Rather, grief is simply a normal response to a significant loss, whether the relationship was personal or professional in nature.

Some professional caregivers can recount experiences in which they lost patients to suicide and did not receive support from their employer or peers [17]. It is critical that staff receive support from their supervisor or manager during the period after a patient's death. Conversely, it is important that professionals experiencing grief symptoms do not try to ignore or suppress their feelings. Unresolved, unexplored grief is a contributing factor to staff turnover, compassion fatigue, vicarious traumatization, and burnout [18].

When providing initial support, it is best not to correct statements that staff members may express. The immediate effects of grief can result in irrational beliefs, for example that the clinician should have prevented the suicide or that the clinician is responsible for the death of the client. Provide validating, supportive statements and use active listening and reflection with staff members. Understand that grieving is a process and that the clinician may be working through the initial shock. The clinician may need to take a few days off or it may be necessary, if possible, to reduce the caseload for a while until the staff member has had some time to process the loss.

Because clinicians may be reluctant to share personal feelings and reactions with supervisors or managers, programs might want to consider offering peer support and facilitating contact with other clinicians who have experienced the suicide loss of a client [19].

It is important for administrators and program managers to consider the resources of the agency and the needs of their staff when constructing a response plan to a suicide death. It may be necessary to look for other local resources for additional assistance with grief and trauma counseling. Some questions managers may want to ask while developing their plan include:

- Does the agency have an Employee Assistance Program (EAP) office? If so, what sort of counseling/crisis assistance does it provide?
- Are there any trained grief or trauma therapists available through the agency to work with staff as peer support? If so, can they attend staff debriefing and/or individual follow-ups with clinicians?
- What are the agency policies regarding time off for bereavement? Does the agency offer additional supports to clients or staff after an unexpected loss in the workplace?
- Are there any local resources available to professionals who are working with grief and loss?

Self-care for clinicians

Professionals who encounter high levels of interpersonal stress and loss in their jobs are at an increased risk for mental health symptoms, vicarious traumatization, and compassion fatigue [18]. It is critical that people who work in the human services field, regardless of their credentials or professional role, are educated about and encouraged to practice self-care. Frequently, self-care falls by the wayside when caregivers are busy, overwhelmed, experiencing stress in their personal lives, or have a negative perception that self-care practices are too involved or time-consuming.

Managers and supervisors can help promote self-care practices in their agency by integrating wellness into the agency culture. They can first conduct an informal assessment of the agency's dedication to maintaining a healthy workforce. Managers may want to ask the following questions first, before determining next steps:

- Are staff members allowed or encouraged to use vacation time or personal time? Can staff members typically take time off when they have requested it?
- Does the organization offer time off for bereavement? Does this time off include any option for grieving the loss of a client?
- What is the turnover rate of the agency? What reason(s) do staff members provide for leaving the organization?
- Do staff members frequently work overtime hours, or past the 8-hour workday?
- Has the agency experienced an increase in client deaths in the past year? How has the agency responded in the past?
- Do staff members frequently experience colds or flus, or have there been complaints around feelings of exhaustion or overwork by staff?
- Are there any current activities at the agency designed to promote and strengthen staff morale (potluck lunches, walks, celebrations, recognition awards, etc.)?
- Are there current counseling options available for staff members struggling with personal issues (e.g., an EAP office)?

- Does the current organizational culture create a positive, supportive environment for staff members?

After reviewing these questions, managers can determine what activities can be put in place to encourage clinician self-care and wellness. Therapeutic work is often inherently demanding, and clinicians greatly benefit from working at an organization that supports and recognizes the work that they do. Creating a positive organizational culture does not require huge shifts in protocols, or great financial investments on the part of management. Only a commitment to supporting staff and recognizing the difficulty in their jobs is required to effect organizational change.

Below are some ideas for managers to consider in promoting staff wellness in their agency:

- Setting aside time every month for staff members to meet for a potluck and discussion.
- Encouraging staff members to develop and maintain extracurricular activities outside of the workplace.
- Limiting the amount of overtime that staff can put in/hiring additional staff to help keep caseloads manageable.
- Placing caps on the patient population when there are staff shortages.
- Taking time to process upsetting and traumatic events with staff members (e.g., patient death).
- Empowering staff by using shared decision-making and encouraging feedback and input from staff.
- Advocating for staff members, particularly when there is a need for a change to agency protocols.
- Modeling wellness in their own role: delegating responsibilities, taking time off when needed, and not taking on the burden of “ownership” of an agency.

When people are grieving, it is important to encourage them to maintain healthy routines. People often feel unmotivated to take care of themselves when they are mourning a personal loss; however, a lack of self-care can result in physical or emotional exhaustion, worsening mental health symptoms, and immunosuppression, which can lead to more episodes of physical illness [20]. Daily self-care practices can also provide a sense of security and routine for people.

Supporting other clients

While any death within the clinical community can have consequences from which service recipients will need to recover, suicide deaths require additional consideration. Administration will want to have a plan to address issues such as communications, identifying vulnerable clients who might be at increased suicide risk, grief support, and appropriate memorial activities.

After the suicide of a client, it is important that the program responds appropriately and promptly towards the other service recipients. The program should directly address the loss, and allow the other clients time to process and explore their feelings. The suicide death of a peer can be frightening and demoralizing. In some settings, for example residential programs, staff may decide to arrange a time to speak about the death with the other service recipients, preferably in a small group. If the clients present for a group session within the next day, this may be the best time to discuss news of the death and process client reactions.

Talking points

- You can start by asking clients what they know and how they feel
- Give accurate information about suicide: suicide is a complex behavior, it is not caused by a single event
- Do not talk about the method
- Avoid blaming and scapegoating
- Address anger: one can be angry at someone's behavior and still care deeply
- Address feelings of responsibility
- Encourage help-seeking behavior and self-care
-

Some key points for program staff in addressing suicide loss with the client population in a group setting:

- Discourage speculation – in a treatment milieu, it is common for there to be rumors and gossip surrounding a patient death among the service recipients. It is important that staff do not encourage or validate any unsubstantiated rumors, or provide any details about the client's death.
- Protect the client's privacy – understand that confidentiality regulations continue to apply even after the death of a patient. Keep the group's focus on remembering the client, discussing feelings and reactions, and promoting help seeking behavior - rather than responding to questions regarding the circumstances of the patient's death (see **Legal and Ethical Considerations** for more information).
- Validate the feelings of the group – unexpected deaths, particularly when they are sudden, can evoke mixed reactions, including anger (“He was so stupid!”) and contempt (“She had three kids! How can someone be so selfish?”). Clients may be fearful of “being next” or may exhibit signs of traumatic stress, particularly if they have personal experience with suicide or suicide loss. Allow clients to express their emotions without judgement; however, gently redirect the conversation if they begin to make irrelevant or potentially offensive statements. Emphasize that there is always help available when someone needs it.
- If any client appears to be especially impacted by the news, it is recommended that the program manager and responsible clinical staff speak with the client immediately after meeting with the group. It may be necessary to schedule an additional individual session, or to refer the client for additional mental health or grief counseling.
- Pay attention to clients who might be at increased suicide risk as result of the suicide loss and be prepared to screen them, preferably utilizing a standardized screening tool such as the Columbia Suicide Severity Rating Scale (C-SSRS) [21].
- In addition to meeting with clients as a group, it is recommended that program managers keep an “open door” policy for clients who want to talk on an individual basis. Some service recipients may not feel comfortable sharing in a group setting, or may require time for additional processing. It may also be helpful for clinicians to “check in” with their clients about their reaction to the death in their next individual session.

- When discussing a suicide avoid stigmatizing language. For example, it is preferable to say ‘died by suicide’ or ‘killed himself/herself’ instead of ‘committed suicide’; ‘suicide’ instead of ‘successful suicide’; ‘attempt’ instead of ‘failed suicide’.
- When deciding whether to inform clients of funeral, viewing, or other public memorial service, be mindful of the family’s wishes and consider issues of confidentiality.
- Similarly, be cautious before participating in any type of agency-sponsored memorial service or remembrance. Always consider issues of confidentiality. Should the agency be consulted or involved in the planning, follow **Suggested Memorial Service Guidelines**.

Suggested memorial service guidelines

- Avoid activities that may influence people already at risk for suicide
- Avoid activities that romanticize or glorify the deceased (especially with youth)
- Avoid oversimplifying causes and overstating the frequency of suicide
- Avoid detailed descriptions of the method
- Provide counselors during and after the service
- Provide information about suicide prevention and encourage help-seeking behavior
- Keep public displays of remembrances time-limited
- Hold service at a time when adults can accompany youth

The suicide of a child or adolescent can result in especially intense feelings of shock, sadness, and responsibility. When preparing to provide postvention support, it is critically important that professional caregivers take the time to deal with their own feelings before approaching a child. Grief is different in children: they generally have less tolerance for strong emotions, including the caregivers’ feelings. They may feel the loss very intensely one moment, and be playing with friends the next.

What do children need from us?

- Simple and honest answers to their questions.
- Age-appropriate explanations of what happened.
- Reassurance that their feelings are acceptable.
- Reassurance that their safety and security needs will be met.
- Reassurance that the suicide death was not their fault.
- Reassurance that help is available, should it be needed.
- Normal routines, and regular activities.

Because adolescents are particularly at risk for imitation, it is very important to identify youth who may have been exposed to the death, and assess their suicide risk. Youth who may be at

higher risk for imitation include: siblings, friends, neighbors, classmates, teammates, children with psychological vulnerability or history of suicidal behavior, children who feel responsible for the death, children who identify with the deceased, witnesses, and children who are being blamed.

Screening tools and clinical interventions for service recipients

Grief responses are highly individualized, and influenced by many variables. However, there are some general guidelines for clinicians to help them assess the severity of grief in their client population. Mental health professionals generally separate grief into two main categories: typical and complicated grief [22]. When a person experiences typical grief, the grief can be intense at the beginning, but usually lessens over time. The grieving person may experience feelings of sadness and loss in waves, but the intensity of these emotions becomes more manageable as a person processes the loss. There is no set time frame for typical grief, and clinicians should refrain from advising or suggesting clients to seek closure from the loss. Additionally, early grief often mimics the symptoms of Major Depressive Disorder – sleeplessness, loss of purpose, etc. – so it is important to regularly follow up with clients on how they are coping, to provide an ongoing clinical picture and to apply interventions or additional services as needed.

Is grief different after suicide loss?

Bereavement after a suicide contains elements common to all deaths, unexpected deaths, and violent deaths. However, a growing body of *research* suggests that it often contains unique features and themes [23] such as abandonment and rejection, shame and stigma, concealment of the cause of death as suicide, blaming, and heightened risk for suicide.

Anecdotal accounts and clinical experience (*but requiring additional research*) suggest that survivors may also experience many of the following: guilt, anger, searching for explanation/desire to understand why, relief, shock and disbelief, and social isolation. In some instances, suicide loss becomes an opportunity for profound personal transformation and post-traumatic growth [14].

In complicated grief, people will experience an intense and enduring sense of sadness and loss for the person who died. They may yearn to be with the deceased, or their feelings may be so intense that they interfere with the person's daily functioning. These feelings, left untreated, can persist for years and significantly impact a person's health and well-being. If a client continues to experience intense and unabating grief symptoms, it may be advisable to screen them for complicated grief. Complex grief symptoms can cause a person to develop clinical depression over time.

There are a few simple clinical tools to assess for complicated grief, including the Brief Grief Questionnaire (BGQ), a 5-question self-assessment tool that assesses the severity of a person's grief. Other tools that can be used with clients are:

- **The complicated grief assessment** – a self-assessment tool that measures grief symptoms over the preceding month based on 4 different criteria dimensions.
- **The inventory of complicated grief** – a 19-question self-assessment tool with high consistency and reliability, that concerns the grief-related thoughts and behaviors of the client. (Note: these tools can be located under the **Resources** subsection).

If a client appears to be suffering from complicated grief, a referral for additional therapeutic services might be indicated. While a clinician can broach the topic of grief and loss, bereavement-related disorders are generally considered a subspecialty of trauma-related disorders. Clinicians who do not have specific training in grief counseling should refrain from providing treatment for complicated grief.

Contact with family members

Family members' reactions to suicide loss may differ greatly depending on many factors, including: the cultural and religious background of the family; the gender roles in their family and community; the family's resources and outlets for expressing grief; their knowledge and understanding of suicide and mental health issues; and the quality and nature of their relationship to the deceased. These grief reactions may be intensified by a lack of acknowledgement and support for suicide deaths by the family's friends or community.

Working with families following a patient's suicide can be a particularly sensitive undertaking for professional caregivers. It is important that managers, in collaboration with their agency's administration and available legal counsel, determine guidelines or protocols for their staff. While there are numerous factors to consider when developing standards for agency staff, there are no clear best practices for this type of situation. Regardless, before reaching out to family or friends of the deceased, it is advisable to prepare for a variety of responses and to identify appropriate resources for the grieving family members (see **Resources for Families**).

Areas which require special consideration are:

Contacting family directly to extend condolences

Unless the client was in a residential level of care and it is necessary to notify the family of the passing, it might not be advisable to contact the family without an invitation or in the absence of a signed consent. Although regulations do not expressly prohibit clinical providers from contacting the family of a deceased client, there are still confidentiality issues (see **About Confidentiality**). Also, families might be experiencing their own grief process and not be receptive to the counselor's attempts to reach out, even when they are well-meaning.

On the other hand, many families do welcome a call, a card, or the opportunity to meet with the professional caregiver. In addition, contact with family can help clinicians' own sense of closure [24], though clinicians should consider the possibility that the family may express anger or blame the clinician for the suicide of their loved one [25]. One school of thought encourages clinicians to avoid contact with family to protect themselves and the agency from legal repercussions. Another school of thought suggests that distance from family members may instead increase the likelihood of litigation [26].

Attending the wake or funeral service

Always be cognizant and respectful of the family's wishes. It is advisable to ask for permission from the family of the deceased prior to attending. Staff members who attend a memorial or funeral service must not disclose that they were involved in the deceased's treatment. If a staff member wants to attend a memorial service for the deceased, first discuss the matter in clinical supervision. The decision to attend a funeral should always be made with the

foreknowledge and approval of the staff member's supervisor and/or manager, and there should be a policy in place about whether to provide staff with time off to attend.

About confidentiality

- Is the family aware that their loved one was in treatment?
- Is there a signed consent on file?
- Has the provider had previous contact with the family?
- Would attending the funeral or sending a card violate confidentiality?
- Families may not always understand the complexities of confidentiality ... what do you think the family expects you to do?

Part III: Additional considerations

Legal and ethical considerations

In addition to navigating their own emotional responses, as well as the responses of their clients, staff members may have questions or concerns regarding the increasingly complex legal and regulatory considerations in the behavioral health field. They may not know whether they are permitted to reach out to the family of the deceased, or what to do if an oversight agency decides to investigate the death.

What do the regulations say?

To properly guide staff members, it is important to understand how the regulations surrounding confidentiality and death reporting requirements intersect. We have provided relevant excerpts from different federal and state sources that outline the current standards and expectations for behavioral health agencies.

Federal regulations:

Under the Code of Federal Regulation 42 Part 2.15, release of information is allowed when there are laws that require the notification of death to regulatory bodies to permit inquiry into the cause of death (e.g., the Justice Center). Otherwise, it is necessary to obtain consent from the executor or spouse of the deceased patient prior to releasing any information about the patient.

The Health Insurance Portability and Accountability Act (HIPAA) typically covers the patient for a period of 50 years after their death. The HIPAA Privacy Rule states that disclosures following a patient's death may be made under the following circumstances:

- 1. To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct*
- 2. To a family member or other person who was involved in the individual's health care or payment for care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the deceased individual that is known to the covered entity.*

If there are any questions or issues that require clarification regarding confidentiality and disclosures following a patient death, agencies should first consult with their attorney.

State regulations:

New York State Justice Center and OMH reporting requirements

The suicide death of a patient must be reported both to the NYS Justice Center and OMH only when the client was receiving services from an OMH-licensed residential or inpatient program at the time of the death, (this includes any patient death occurring within 30 days after the discharge from said program). The death of an individual receiving services from all other OMH-licensed programs (including those occurring within 30 days of discharge from said program), however, are reportable **only** to OMH.

It is often helpful to meet with a staff member to address any questions they may have about a Justice Center investigation. Investigations are often quite stressful, so it is important to emphasize that an investigation should not be construed as an accusation of misconduct on the part of the staff member. Clinicians may exhibit significant fear and anxiety towards being interviewed by the Justice Center or OMH representatives or being named as the subject of an investigation. In response, managers may need to arrange ongoing meetings with the involved staff member(s) to offer support and clarification as appropriate.

Medical records

All staff members should be aware that no medical records can be **directly** released to the family after a client's death unless the family member is an Executor to the deceased's estate.

Privacy regarding the client's treatment should always be maintained, even if the client previously signed a release form for their family. Clinicians should refrain from discussing any personal aspects of the client's treatment.

Next steps

The death of a client by suicide can have a significant impact on clinical and non-clinical staff. Optimal postvention practices balance the need to immediately support staff, other clients and the family, with the tasks of conducting root cause analyses and adhering to increasingly complex legal and regulatory considerations.

If your organization does not already have postvention protocols, a next step might be to develop an agency postvention plan with the help of a multi-disciplinary team representing a variety of programs, services, and departments to assure that the plan reflects the realities and the culture of the organization. You might find that this process can apply to other situations, including the suicide of an employee or other sudden and traumatic deaths.

As result of the suicide of a client, health and behavioral health organizations might decide, or be required, to review their current suicide prevention practices. Completion of a root cause analysis [27] may reveal opportunities for changes or corrective actions. In the aftermath of a suicide, the American Association of Suicidology (AAS) Clinician Survivor Task Force recommends to wait 3-4 months before asking employees to participate in suicide prevention training activities [28] which potentially can heighten fear and guilt and could have a negative effect on the clinicians' sense of competency.

Managers might want to use this time to consider, as a next step, becoming familiar with the New York State's Suicide Prevention Plan, *1,700 Too Many* [29], which was developed by the NYS OMH Suicide Prevention Office (SPO) to advance suicide prevention in our state. The plan offers a multifaceted systems approach that targets both health/behavioral healthcare and community settings, with a commitment to use data to inform and evaluate the efforts. New York State's strategic approach to prevention in health and behavioral healthcare settings is modeled on the adoption and implementation of the Zero Suicide [30] framework, a system-wide, organizational commitment to patient safety and to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

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Resources

Resources and grief assessment tools for clinicians

- Clinician Survivor Task Force – http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm
- The Center for Complicated Grief - <https://complicatedgrief.columbia.edu/professionals/complicated-grief-professionals/overview>
- The Complicated Grief Assessment – www.npcrc.org/files/news/complicated_grief_assessment.pdf
- The Inventory of Complicated Grief – www.goodmedicine.org.uk/files/assessment.%20traumatic%20grief.%20tahoma.doc
- Grief Counseling Resource Guide: A Field Manual – <https://www.omh.ny.gov/omhweb/grief.org>
- Zubin Institute – http://www.zurinstitute.com/clients_death_resources.html

Support groups for survivors of suicide loss

- The American Foundation for Suicide Prevention – <https://afsp.org/find-support/ive-lost-someone/resources-loss-survivors/>
- Survivor Outreach Program - <https://afsp.org/find-support/ive-lost-someone/survivor-outreach-program/>
- Alliance of Hope - <https://allianceofhope.org>
- Parents of Suicides (POS) – Friends and Families of Suicides (FFOS) - <http://www.pos-ffos.com/>
- Legacy Connect - <http://connect.legacy.com/>
- Samaritans Safe Place (in NYC) - <http://samaritansnyc.org/attend-a-meeting/>
- The Dougy Center - <https://www.dougy.org>

For schools and colleges

- After a Suicide: A toolkit for Schools - <https://afsp.org/our-work/education/after-a-suicide-a-toolkit-for-schools>
- POSTVENTION: A Guide for Response to Suicide on College Campuses - <http://hemha.org/wp-content/uploads/2018/06/jed-hemha-postvention-guide.pdf>
- JED Foundations - <https://www.jedfoundation.org>

For children

- Talking to children about the death by suicide in the family - https://www.mentalhealth.va.gov/docs/talking_to_your_9-13_year_old.pdf
- Coping with a Parent's Suicide - <https://childmind.org/article/coping-with-a-parents-suicide>
- When a child's friend dies by suicide - <http://www.sptsusa.org/parents/when-a-childs-friend-dies-by-suicide>
- National Child Traumatic Stress Network - <https://www.nctsn.org/what-is-child-trauma/trauma-types/traumatic-grief>

For the media

- Recommendations for Reporting on Suicide - <https://theactionalliance.org/resource/recommendations-reporting-suicide>

Suicide prevention resources

- Zero Suicide in Health and Behavioral Health Care - <https://zerosuicide.sprc.org>
- Zero Suicide Institute - <http://zerosuicideinstitute.com>
- Suicide Prevention - Training, Implementation and Evaluation Program - <http://practiceinnovations.org/i-want-to-learn-about/Suicide-Prevention>
- American Association of Suicidology - <https://www.suicidology.org>
- Suicide Prevention Resource Center - <https://www.sprc.org>
- National Suicide Prevention Lifeline - <https://suicidepreventionlifeline.org>
- Suicide Prevention Center of New York - <https://www.preventsuicideny.org>
- International Association for Suicide Prevention - <https://www.iasp.info>
- American Foundation for Suicide Prevention - <https://afsp.org>
- The Trevor Project - <https://www.thetrevorproject.org>
- The Connect Program - <https://theconnectprogram.org>
- National Action Alliance for Suicide Prevention - <https://theactionalliance.org>