Evidence In-Sight:
Suicide postvention for mental health staff after a discharged patient takes their own life

Date: February, 2012
This report was researched and written to address the question(s):

- Are there evidence-informed or other leading postvention protocols in the event of a patient suicide after discharge?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.
1. Overview of inquiry

A hospital in-patient psychiatry unit has been working in the context of high profile youth suicides and is concerned about incidences where youth who receive services on the unit subsequently take their lives after discharge. While postvention services need to be available for family and friends and community, the hospital is looking for guidance on postvention support for staff who worked with the patient. They would like to know if there are any existing evidence-informed protocols and/or frameworks that can provide support for current patients, staff, and families if a patient who was in their care commits suicide after discharge.

Question statement: Are there evidence-informed or other leading postvention protocols to support hospital staff after a discharged patient takes their own life?

2. Summary of findings

- In studies that have focused on adolescents recently discharged from hospital, the greatest risk for suicide attempt occurs within 6 months to 1 year following discharge and during this period, approximately 10%-18% of youth attempt suicide.
- The loss of a client to suicide is relatively common; one in five psychologists and counselors and one in two psychiatrists can expect to lose a patient to suicide in the course of their careers (includes adult clients).
- Client suicide can cause a wide range of long-lasting reactions and changes in the working practices and personal lives of social workers and other mental health professionals, so pre-established protocols and practices are recommended to ensure that appropriate resources and supports are available and readily mobilized. The mental health and emotional concerns of staff should be considered to be just as important as those of family and other patients.
- A single systematic review of postvention research on school, community, and family-focused postvention programs found some promising outcomes but was otherwise inconclusive. We found no formal research or program evaluations of hospital focused postvention.
- Group based bereavement support for survivors is recommended.
- In the event of a client suicide, it should be openly discussed immediately and outside resources including consultation should be available for staff.
- The Riverside Trauma Center Postvention Guidelines (see Section 4.4) are a set of postvention practices that others could look to for guidance.
- In general, there is a lack of clear guidelines for postvention protocols, so what does exist for school and community postvention might need to be adapted to fit an organization’s circumstances.

3. Answer search strategy

- We searched the following database: MEDLINE, PsycINFO, CINAHL, Health Business Elite, Nursing & Allied Health Collection
- A combination of search terms was used: postvention; health worker; social worker; psychologist; psychiatrist; suicide postvention; suicide after discharge; review.
- A Google search was used to search for existing frameworks, best-practice listings, or other links to grey literature

4. Findings
Although the literature on suicide prevention and postvention is robust, it is largely dedicated to school and community-based efforts and we found relatively little that is specific to postvention for clinicians or hospital staff. We identified no material that is explicitly intended for hospital department planning in the event of a patient suicide after they have been discharged. However, we did find some best-practice recommendations and a suicide postvention framework developed by a hospital.

**4.1 Adolescent suicidal behaviour following hospitalization**

Suicidal behaviour in adolescents is often repetitive and is itself a risk factor for suicide attempt. Multiple studies of adolescent suicidal behaviour following discharge from a psychiatric hospital indicate that a variety of risk factors have a role, and that understanding predictive behaviours is important for developing specific treatment interventions to facilitate a safe transition from the inpatient environment (Brent et al, 1993; King et al, 1999; Goldston et al, 1999). Of the few studies that have focused on adolescents recently discharged from hospital, the greatest risk for suicide attempts occurs within 6 months to 1 year following discharge and during this period, approximately 10%-18% of youth attempt suicide (Prinstein et al, 2008). Interestingly, the 6-month and 1-year rates of suicide attempt among previously non-suicidal youth are similar to the rate of attempted suicide among previously suicidal youth, which indicates that the high risk of suicidal behaviour after discharge is not limited to those with previous suicidal behaviour (Goldston et al, 1999).

In a meta-analysis of controlled studies of suicide in adults within a year of discharge, several factors emerged as risk indicators for suicide. The strongest association was found to be a history of both self-harm and depressive symptoms. Weaker associations were found in unplanned discharge, recent social difficulty, a diagnosis of major depression, being male, or those who reported suicidal ideation (Large et al, 2011). However, high and low risk categorizations were not useful in predicting patient suicide.

**4.2 Impact of patient suicide on healthcare workers**

There is a literature on the impact of patient suicide on healthcare workers, particularly psychologists and psychiatrists, and annotated references can be found through the American Association of Suicidology ([http://www.suicidology.org/home](http://www.suicidology.org/home)). Although this current request is somewhat unique in that the question pertains to the loss of adolescent patients after they have left the care of the hospital, the postvention concept and general grief mechanisms are likely similar and thus relevant. This also extends to postvention for current patients who knew the deceased.

For mental health professionals in general, the loss of a client to suicide is relatively common (note that these figures are not broken out by adult or adolescent patients). One in five psychologists and counselors and one in two psychiatrists can expect to lose a patient to suicide in the course of their careers (Gutin et al, 2010). Patient suicide can cause a wide range of long-lasting reactions and changes in the working practices and personal lives of social workers and other mental health professionals (Gulfi et al, 2010). Personal grief reactions typically include initial shock, denial, numbness, intense sadness, anger, anxiety, and intense distress (Gutin et al, 2010). Suicide loss may also be accompanied by intense confusion and existential questioning, which reflects a blow to core beliefs and assumptions. Guilt and shame may be socially reinforced by the general stigma around suicide, all of which are very similar experiences to what other survivors experience after the loss of a loved one to suicide (Gutin et al, 2010).
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For professionals, losing a patient to suicide can impact their professional identity, relationships with colleagues, and their clinical work. In their review research, Gutin et al. (2010) found that many clinicians reported a pattern of isolation and interpersonal discomfort with their colleagues after they had lost a client to suicide. In general, therapists questioned their clinical abilities and experienced a sharp loss of confidence in their work. Common responses such as sadness and anxiety can lead to at least some temporary disruption of a clinician’s optimal functioning.

4.3 Postvention research
Postvention is an intervention to attend to the needs of the three groups that require assistance after the suicide of a patient: the family, other patients acquainted with the deceased, and clinical and administrative staff. The intention of postvention programming is to aid the grieving process and, as a wider community level intervention, bereavement counseling and education are meant to reduce the incidence of suicide contagion (Szumilas & Kutcher, 2010).

Postvention programs and crisis debriefing are common practice within school settings in response to adolescent suicide. A recent systematic review examined the existing outcomes research to determine the effectiveness of suicide postvention programs on bereavement, mental distress, mental health, and to investigate their cost-effectiveness. The review reported findings pertaining to school-based, family-focused, and community-based programs. Key findings, based on the limited existing outcomes research, are summarized here, although the recommendations are not listed because the outcomes of interest were limited by a shortage of quality research. There is not enough study of cost-effectiveness to draw any conclusions on that domain (Szumilas & Kutcher, 2010):

- **School-based suicide postvention programs, outcomes for students**
  - No protective effect could be determined for the number of suicide deaths or suicide attempts, based on available studies. One study reported negative effects.
  - A counseling intervention for close friends of the deceased had no sustained effects on psychological outcomes or suicide ideation, current suicidal behaviour, or hospitalization for suicide attempt after 8-month follow-up compared to no contact.
  - The only significant effect of a youth group-based psychological debriefing and educational session aimed at close friends of the deceased sustained at the two-month follow-up was an increased score on self-efficacy.
  - Gatekeeper training for proactive postvention was effective in increasing knowledge pertaining to crisis intervention among school personnel.

- **Family-focused suicide postvention programs**
  - No protective effect could be determined for the number of suicide deaths or suicide attempts, based on available studies. One study reported negative effects.
  - Outreach at the scene was found to be helpful in encouraging survivors to attend a support group and seek help in dealing with their loss at a crisis centre.
  - Any contact with a nurse-led group counseling postvention for spousal survivors of suicide helped reduce depression symptoms, obsessive-compulsive traits, anxiety and phobic anxiety, and grief experiences immediately after intervention, with most effects sustained at one year.
  - Although group treatment for parents bereaved by the violent death of their children had immediate positive effects on overall mental distress and PTSD-like symptoms, the effects were not maintained at six months. In contrast, positive effects on the grief experiences scale were more evident at follow-up.
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- A group intervention for children and adolescents bereaved by the suicide of a relative had positive effects on depression and anxiety scales immediately after the intervention, but no effect on stress reactions or social adjustment was observed.

- Community-based postvention programs
  - There is some promising evidence that guidelines for responsible media reporting of suicide are associated with a decrease in subsequent suicide attempts and in completed suicide.

4.4 Postvention best practices

**Patients**
A systematic review (Szumilas and Kutcher, 2010) provided very limited findings, and given the lack of literature their recommendations are tentative. Based on the rigor of the review and the subsequent lack of detailed recommendations, all we can suggest is that certain elements of previous school-focused postvention work may be relevant to hospitals for current patients in the event of the suicide of a discharged patient. Practitioners who actually conduct postvention work in schools and communities would argue that, while the literature is inconclusive, the needs of students and communities are very real and very pressing.

The general literature on postvention for children and youth after the suicide of a peer is much more extensive than the literature for mental health care workers. The Suicide Prevention Resource Centre has an extensive set of resources it is linked to, most of which were developed for schools and communities to implement in the event of the suicide of a student: [http://library.sprc.org/browse.php?catid=40](http://library.sprc.org/browse.php?catid=40)

**Staff**
In one review article, the author reported that the optimal response to the suicide of a patient should include a “psychological autopsy” conference on the event (Farberow, 2005). This would be conducted by an external expert who is trained in suicide prevention and knowledgeable about the reactions that occur with a suicide of a patient and all staff who were involved in the patient’s care would contribute information about the patient in a manner that objectively aims to learn about the suicide, not to fix blame. Psychological autopsy is not common policy in Ontario, and it is very time intensive. More general protocols specific to support for clients and staff may be more important to identify in the short term.

*Example: The Riverside Trauma Centre Postvention Guidelines*
The Riverside Guidelines summarize generally accepted postvention protocols and adapt the predominantly school-based literature to make it applicable in other types of organizations. They were developed based on the practice literature on postvention services, the guidelines for safe messaging for suicide prevention, and the Riverside Trauma Center team’s experience providing postvention services in Massachusetts.


- Postvention tasks (see above PDF for explanation of each point)
  1. Verification of death and cause
Suicide Postvention for Staff

2. Coordination of external and internal resources
3. Dissemination of information
4. Support for those most impacted by the death
5. Identification of those at risk and prevention of contagion
6. Commemoration of the deceased
7. Psychoeducation on grieving, depression, PTSD, and suicide
8. Screening for depression and suicidality
9. Provision of services if one or more additional suicides occur
10. Linkage to resources
11. Evaluation and review of lessons learned
12. Development of a system-wide prevention plan

Dr. Nina Gutin, Chair of the American Association of Suicidology Clinician-Survivors Task Force, recommends reviewing a postvention protocol that was developed by Paul Quinnett (N. Gutin, personal communication, January 22, 2012). Dr. Quinnett is the director of the QPR Institute, an organization that provides training based on the Question-Persuade-Refer model for suicide prevention. He has provided free overview guidelines of postvention activities for professionals (http://mypage.iu.edu/~jmcintos/PostventionGuidelinesforProfessionals.pdf) including a section on staff as survivors.

Dr. Quinnett states that clinicians and staff are no different than others with respect to being survivors of suicide (Quinnett, 2009). They experience many of the same emotions and may even experience them more acutely. For their own mental health and well being, staff and clinicians need to be tolerant of each other’s needs and to be understanding, kind, and supportive. Guidelines include:

1. Have an open discussion about the suicide with a goal for the process to be educational. Someone has to be the lead on making certain that this happens.
2. Some staff may need a referral to a professional counselor.
3. Any formal fatality review study (if conducted) should be conducted by Peer Review Committee, according to its review procedures. “Official” accounting of the suicidal death should not be placed on the surviving treatment staff, although their input is needed as part of the review.
4. Have mechanisms in place for outside consultation and support to be available if any staff begins 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.

5. Next steps and other resources

Dr. Nina Gutin recommended two books that deal with professionals as survivors of client suicide:

- *Grief After Suicide*, edited by Jordan and McIntosh (2010)
- *Therapeutic And Legal Issues For Therapists Who Have Survived A Client Suicide: Breaking The Silence* by Kayla Weiner (2005)

The American Association of Suicidology has a dedicated Clinician-Survivors Task Force to provide consultation, education, support, and resources to clinicians. The Task Force provides a listserve and a website with basic information, a bibliography of resources, links to clinicians who can consult on this topic, and postvention protocols. Access these resources here:
The *Connect* program is a comprehensive suicide prevention and postvention system with training for individuals and organizations who are involved across communities. The Suicide Prevention Resource Center (SPRC) and the American Foundation of Suicide Prevention (AFSP) have designated it a best practice program and it uses a public health approach to bridge systems and customize training to local needs. [http://www.theconnectprogram.org/](http://www.theconnectprogram.org/).

The *Lifelines* postvention manual is a best practice book (as rated by the Foundation for Suicide Prevention) that provides a template for creating a school-based response to the death of a member of the school community by suicide or other traumatic means. It is based on principles of grief theory and crisis intervention and can help to develop policies and procedures to identify and train a crisis response team, to link with community resources, and to respond immediately in the event of a suicide. More information at: [http://www2.sprc.org/sites/sprc.org/files/LifelinesPostvention.pdf](http://www2.sprc.org/sites/sprc.org/files/LifelinesPostvention.pdf)


For a broad array of evidence-informed resources on suicide prevention and intervention in general, including the above postvention resources, see the American Foundation for Suicide Prevention Best Practices Registry: [http://www2.sprc.org/bpr/index](http://www2.sprc.org/bpr/index)

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit: [http://www.excellenceforchildandyouth.ca/what-we-do](http://www.excellenceforchildandyouth.ca/what-we-do) or check out the Centre’s resource hub at [http://www.excellenceforchildandyouth.ca/resource-hub](http://www.excellenceforchildandyouth.ca/resource-hub).

For general mental health information, including links to resources for families: [http://www.ementalhealth.ca](http://www.ementalhealth.ca)
References


Farberow, N.L. The Mental Health Professional as Suicide Survivor. Clinical Neuropsychiatry, 2, 1, 13-20.


