Sample Agency Practices for Responding to Client Suicide

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Guidelines Following Client Suicide

The suicide death of a client or patient is a dreaded potential outcome in mental health treatment. Death by suicide requires an agency to respond in a manner that provides support for the clinical team while fulfilling regulatory requirements. Agency responsibilities include communication within and outside the organization, reporting the death, risk management, administrative case review (morbidity/morality conference), media coverage, staff support and education. A major challenge for an agency is the balancing of potentially conflicting priorities between safety-focused administrative needs for information and staff-focused emotional needs for support.

The desired outcome of this process is the completion of immediate responsibilities and the gradual resolution of emotional responses in a manner that promotes personal and professional growth and responsibility. Review of the circumstances of the death can suggest systemic changes that will improve care of future clients.

Please note that this document does not constitute legal advice. The guidelines and recommendations outlined below are intended to help identify immediate responsibilities and potential resources and sources of support following a client suicide. Since every case is unique and presents its own issues, these are intended only as general guidelines, to be modified as appropriate for the individual situation in conjunction with an agency's risk management or legal counsel. Developing a written agency policy with orientation and training of staff in its use will help to ensure a coordinated response in the event of a client death.

Summary of Recommendations

Please refer to accompanying text for more detailed discussion

1. **Attend to responsibilities with a coordinated agency response**
   - Individual clinicians should notify immediate supervisors
   - Notify administrative and clinical leaders
   - Notify risk management or legal counsel for guidance on maintaining confidentiality
   - Form a multidisciplinary team with administrative and clinical leadership
   - Make a plan to attend to responsibilities
   - Offer immediate support to any staff members involved in direct care of the client
   - Assess for immediate need for changes in staffing or safety procedures
   - Hold a staff meeting to convey information and assign tasks
   - Understand and respect client confidentiality
   - Prior to contacting surviving family:
     - Clarify with legal counsel state law regarding who holds the privilege to lift confidentiality restrictions of a clinical record
     - Have a list of resources for suicide survivors
   - Contact surviving family to offer condolence and support
   - Complete the written clinical record
   - Notify other clients if needed
   - Engage in administrative case review
   - Address unpaid bills

2. **Manage emotional responses**
   - Agency support
   - Peer support
   - Supervision
   - Literature review
   - Personal psychotherapy
   - Individual coping strategies
   - Participation in the rituals of death

3. **Suicide case review**
   - Ensure proper timing – allow time for some integration of the loss before conducting an educational review
   - Review details of the treatment for education and growth

4. **Professional growth and responsibility**
   - Review suicide risk assessment, management and treatment practices
   - Engage in altruistic activity to support others

Checklist of Immediate Responsibilities:

- ☐ Notify administrative and clinical leaders.
- ☐ Notify risk management or legal counsel for guidance on maintaining confidentiality.
- ☐ Form a multidisciplinary team to make a plan to attend to immediate responsibilities.
- ☐ Offer immediate support to staff members involved in the direct care of the client.
- ☐ Assess for immediate need for changes in staffing or safety procedures.

Notifications:

- ☐ Hold a staff meeting to notify team members affected by the suicide death.
- ☐ Contact surviving family members to offer condolence and support.
- ☐ Attend to client confidentiality during communication with family members.
- ☐ Notify other clients (if relevant) according to agency protocols.
- ☐ Notify regulatory agencies (administrative case review for external or internal quality assurance and client safety).

Tasks:

- ☐ Complete the medical record.
- ☐ Support and care for other clients affected by the suicide.
- ☐ Support staff affected by the suicide.
- ☐ Work with outside organizations (police, media, medical examiner) according to agency protocols.
- ☐ Establish a plan for ongoing plan for staff support – team meetings, outside counselors.
- ☐ Plan for participation in any rituals of death (attending funeral, sending condolences).

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General Information

Mental disorders are implicated in 90% of suicide deaths (Arsenault-Lapierre, Kim & Turecki, 2004), and clinicians often work with individuals at risk of suicide. In national surveys, the number of clinicians having experienced the suicide death of a client or patient varies by discipline. Approximately 53% of psychiatrists (Chemtob, Hamada, Bauer, Kinney & Torigoe, 1988), 22% of psychologists (Chemtob, Hamada, Bauer, Torigoe & Kinney, 1988) and 23% of counselors (McAdams & Foster, 2000) report having had this experience. Regarding suicides in a hospital or within 72 hours of discharge, The Joint Commission (2013) notes 733 suicides reported from 2003-2013.

The impact of this event on clinicians relates to the bereavement, incoherence and trauma of violent death (Rynearson, 2005) as well as a professional response to an adverse outcome (Scott, Hirschinger, Cox, McCoig, Brant & Hall, 2009). Mental health practitioners, especially trainees, may be further vulnerable to a feeling of personal failure based on a blending of the person of the therapist with the therapeutic work itself (Bloom, 1987).

Coping with violent death in the setting of social and professional isolation or stigmatization, confidentially restrictions on the discussions of the relationship with the deceased and fears of wrongful death litigation can understandably result in a circumstance that has been described as “the most profoundly disturbing event” of a clinician’s professional career (Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000). With these guidelines, we hope to improve the organization of an agency response, decrease professional isolation and stigma and enhance the process of healing from suicide loss.

Stages of Response

Reviews of the process of coping with client suicide or other adverse outcomes suggest stages of response with an immediate stage of shock and disbelief, a middle stage of overwhelming emotions and a final stage of resolution (Bartels, 1987; Cotton, Drake, Whitaker and Potter, 1983; Little, 1992; Scott, Hirschinger, Cox, McCoig, Brant & Hall, 2009). While not specific to client suicide, Scott et al. (2009) define second victims as “healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event.” Second victims progress through stages of response to adverse patient outcomes in a manner analogous to the response to client suicide.

In detailed review of managing suicide in a hospital setting, Ballard, Pao, Horowitz, Lee, Henderson and Rosenstein (2008) describe three phases of response, each of which has four components: communication and administration, clinical assessment and management, environment of care and policy and procedures. During each phase, administrative and support needs and the potential conflict between the two must be clarified, acknowledged and balanced.

Stages of response	Response to patient suicide			Second victim
	Bartles, 1987	Cotton et al., 1983	Little, 1992	Scott et al., 2009
Immediate	Shock	Shock	Phase I: Stunned disbelief	Chaos and accident response
Middle	Recoil	Emergence of overwhelming feelings	Phase II: Emotional turmoil	Intrusive reflections
	Post-trauma			Restoring personal integrity
				Enduring the inquisition
				Obtaining emotional first aid
Final	Recovery	New growth around emotional scars	Phase III: Decrease in emotions and opportunity for growth	Moving on: dropping out, surviving or thriving

Attend to Immediate Responsibilities

Institutions and clinicians have a number of responsibilities following client suicide. Addressing these tasks often occurs during a period of shock and disbelief. Following the principles of crisis intervention, Cotton, et al. (1983) described three components of an initial response: information, protection and support. Information refers to having an organized protocol for immediate responsibilities. Protection refers to ensuring safe care of other clinicians, staff and clients affected by the suicide. Support refers to emotional care of the affected clinician. The immediate responsibilities below expand on elements described by Ballard et al. (2009) and Kaye and Soreff (1991).

1. **Gathering a team and making a plan:**
    a. Immediately after learning of the suicide death of a client, a clinician should notify his or her supervisor who can then notify other clinical and administrative leaders. These leaders should form a multidisciplinary team.

    b. Make a plan to attend to immediate responsibilities with a coordinated response that avoids independent/disjointed or redundant activity. The shock and grief of the suicide should be acknowledged. The purpose of this first stage is to attend to immediate tasks outlined below rather than to process emotional experiences, and this should be made explicit. Part of the team's responsibility will be to designate a place and time for staff to access emotional support.

    To support the treating clinician, immediate responsibilities may be divided into tasks that are best completed by or can only be completed by the treating clinician (direct contact with the family, completing the written clinical record) and other tasks (contacting risk management, notifying other staff, etc.). A supervisor can function as a point of contact for the treating clinician to forward other tasks to other team members.

2. **Contact risk management**: Because a client suicide represents an adverse outcome with the potential for litigation, risk management should be involved immediately and as needed throughout the process of responding to a client suicide. Follow any recommendations for completing the clinical record, contacting family members and facilitating disclosure of the written clinical record. In cases where an adversarial relationship has developed between the clinician and family, consultation with risk management may help to guide contact with the family.

   Administrative and clinical staff should be aware that any discussions about the circumstances of the suicide that occur outside of designated quality improvement programs may be discoverable evidence in any legal proceedings. For example, in Washington State, quality improvement programs must be specifically approved by the Department of Health through an application process (RCW 43.70.510).

3. **Offer immediate support to staff directly involved in the client's care:** Leaders should directly contact any staff members involved in the client's care to meet and offer immediate support. Leaders should acknowledge emotional responses, orient clinicians to any administrative procedures that will occur, offer immediate support and follow-up with contact.

4. **Assess for immediate need for changes in staffing or safety procedures:**
   Clinicians affected by the suicide of a client may be experiencing emotions that affect the ability to provide optimal care to other clients. Supervisors should work with clinicians to determine how to cancel or re-schedule existing appointments or meetings in order to attend to immediate responsibilities and to engage in self-care.
   a. Staffing: The suicide death of a client may have emotional effects on staff that affect care of surviving clients. Leaders should assess for the need to modify staffing to allow affected team members to recover emotionally.
   b. Safety: The suicide death of a client may suggest a role for immediate changes in practice (assuring safety of an inpatient environment, assuring clinical coverage for crisis calls, etc.). To avoid conveying a sense of blame to the treating clinician, administrative and clinical leadership rather than the treating clinician should participate in an immediate administrative review of safety issues (see below).

      Any non-emergent policy changes may be implemented after some resolution of the immediate distress around the death, as policy changes made during a period of shock and disbelief may not be effective long-term changes. When these ineffective policies are not followed, this may risk litigation or lack of belief in the policy. Alternatively, ineffective policies created out of immediate distress may be followed and lead to iatrogenic effects (Comtois, personal communication, 2014).

5. **Inform other staff members:** A client suicide in an agency setting may affect many staff members. Hold a staff meeting as soon as possible to provide relevant staff members with information that is accurate, timely and sensitive to the nature of the death. During this meeting, staff should be informed of plans to carry out immediate responsibilities, and tasks may be assigned. For agencies with staff members across multiple shifts of work, secure e-mail or phone communication may be appropriate for disseminating information.

6. **Respect client confidentiality with surviving family and friends**: In therapeutic work with clients, *confidentiality* is the clinical and ethical principle that limits the clinician's disclosures of the contents of the treatment to others. These privacy rights continue after the death of a client, and disclosures of protected health information about the deceased are still limited by HIPAA privacy regulations. After the death of a client, *privilege* is the legal principle that determines who has the authority to lift the restrictions of confidentiality on a clinical record. Laws will differ from state to state regarding who holds the privilege to authorize disclosures of the clinical record. This individual may be a personal representative, executor of the estate or next of kin (spouse, adult child, parent).

   Prior to contacting the surviving family, a supervisor/clinician will need to consult with risk management or legal counsel to determine state law regarding the hierarchy of who holds the privilege to authorize disclosures of the clinical record as well as how to prepare a consent form that will allow written authorization to lift confidentiality. In cases where surviving family members have not initiated contact with the clinician or agency where the client was receiving care, the supervisor/clinician will need to consult with risk management or legal counsel regarding whether it is advisable to initiate contact with surviving family members.

   Until written consent from the person holding the privilege to authorize lifting of confidentiality is obtained, a supervisor/clinician will need to explain with compassion and understanding to surviving family members that disclosures about information discussed in treatment are limited by privacy laws. The supervisor/clinician will also need to describe the process by which an authorized representative can provide written consent to lift confidentiality in order to facilitate a more open, narrative discussion that includes information that was discussed in treatment. Peterson et al. (2002) reported that 70% of the surveyed family survivors expressed a belief that the clinician should not be bound by confidentiality after the death of the client.

   Before confidentially is lifted, supervisors/clinicians can still provide important information regarding suicide in general: risk and protective factors, relationship to mental illness, normal patterns of grieving following suicide loss. Without disclosing information specific to the individual client's death, the clinician can still highlight general principles that are most relevant to the deceased client's particular circumstances.

   Balancing initial feelings of shock and disbelief, responsiveness to the grieving family's need for information and respect for client confidentiality is difficult and may require consultation with professional colleagues and risk management. In the previously mentioned survey (Peterson et al., 2002), among the 33 suicide survivors who made face-to-face contact with the treating clinician, 42% believed the clinician had not told them all they wanted to know, 48% felt that the clinician was withholding information, and 40% reported a belief that the clinician held back information that may have been damaging to themselves.

7. **Contact surviving family members:**
   Following a client suicide, contacting surviving family members is recommended. In regard to concerns about litigation and in contrast to a purely legalistic recommendation to restrict contact with surviving family members, Drs. Nina Gutin, Vanessa McGann (co-chairs of the The American Association of Suicidology's Clinician Survivor Task Force) and John Jordan, in consultation with attorneys familiar with suicide litigation, advise an approach based on "compassion over caution" in choosing to proceed in manner guided by a desire to comfort and

care for the surviving family members rather than only to protect against litigation (McGann, Gutin & Jordan, 2010). The type of contact (phone, face-to-face meeting) and level of contact (one or more meetings) should be guided by the needs and desires of surviving family members.

As described above, prior to contacting surviving family members, staff should consult with risk management or legal counsel to determine state law regarding the hierarchy of which individual holds the privilege to lift confidentiality on the clinical record. Staff should also prepare a list of suicide survivor resources to give to the family if these are desired:

- **American Association of Suicidology**: http://www.suicidology.org/suicide-survivors
- **Suicide Prevention Resource Center**: www.sprc.org/sites/sprc.org/files/library/survresources.pdf
- **Forefront: Innovations in Suicide Prevention**: www.intheforefront.org/help/bereaved
- **After A Suicide**: www.personalgriefcoach.net

a. An agency manager or supervisor should call the client's legally authorized representative and/or those in the family who were known to be involved in the care of the client to express condolence and support.
    i. The call is expected: LoboPrabhu, Molinari, Pate and Lomax (2007, 2008) reviewed the literature on the "after-death call to family members" and found that in nearly all cases, the family expected a call from the treating clinician.
    ii. The call is appreciated: In a survey of 72 surviving family members, Peterson, Luoma and Dunne (2002) reported that 21% reported that the clinician making contact was the most helpful aspect of the clinician's behavior following the suicide.
b. Process and format of the telephone call: LoboPrabhu, et al. (2007, 2008) offered the following suggestions for making the call:
    i. Process: The supervisor/clinician must overcome feelings of shock, grief, guilt and other negative emotions prior to making the phone call. The call functions to: express sympathy; support the family; collect information about the circumstances leading up to the death; offer help in completing documentation, release of the body, and funeral arrangements; obtain feedback to improve future care. Not all of these may be applicable in all cases.
    ii. Format: The beginning of the call requires the supervisor/clinician to identify himself or herself and then to express sympathy. The middle of the call is characterized by listening rather than talking in order to gather information regarding the family's needs. The call ends with the staff member providing contact information for the family and any resources or referral information for suicide survivors.
c. Offer to meet with family members to discuss any emotional responses and needs for support. Arranging a meeting within 1-3 weeks allows the family time to complete immediate arrangements, prepare questions and provide written consent for disclosure of the clinical record. The time between an initial call and meeting with the family also allows the supervisor/clinician to access emotional support and clarify confidentially laws. The purpose of this meeting is to hear and respond to the emotional needs of the grieving family. The focus is on the sadness of the death and the needs of the family rather than details of the treatment (Bedell, Cadenhead & Graboys, 2001).

McGann et al. (2010) recommend allowing at least 2 hours for this initial meeting for which the family is not charged. If additional meetings are desirable, the clinician can discuss specific goals of the contact and any charges that may apply. For ongoing care, family members may benefit from a referral for individual psychotherapy or suicide survivor resources.

d. Provide the family with contact information so that they may set up any additional meetings or share information about a funeral or memorial service.
e. Avoid any communications to suggest guilt or blame on the part of the family or treating clinician. Clinicians affected by a client's suicide may be experiencing grief and guilt that may affect objective description of the work done with the client.
f. Avoid engaging in therapeutic work with the family (i.e. grief counseling). If family members require mental health assistance, facilitate a referral for care. Engaging in therapeutic work with surviving family members creates a dual relationship that confounds an objective decision as to whether family members wish to pursue a claim of wrongful death.

8. **Complete the written clinical record:**
    a. Document that the client is deceased and include factual information obtained regarding how the client died, including the source of the information.
    b. Do not alter or revise any previous documentation.

9. **Notify other clients if necessary**: If other clients were involved in treatment settings (i.e. group therapy) with the deceased, make a plan around disclosing the information regarding the suicide.

    a. Guidelines for disclosing information:
        - A general guideline is to disclose only information that has been available through third-party, public sources – i.e. information that is not confidential protected health information, and/or only provide that information which had already been available to the other clients in the treatment setting and public sources.

          While sharing no information whatsoever with other clients represents the most conservative approach to managing the confidentiality of the deceased, failing to acknowledge factual information that is known to other clients through non-confidential sources may lead to distrust between clinicians and clients as well as a problematic situation where clients believe they can only speak with one another about the death.

        - Discuss the death in factual terms without sensationalizing the events.
        - In group settings, notify all clients individually before meeting as a group to avoid the need to repeat and discuss the information if clients arrive late for the group session.
        - Guidelines for news reporting that may inform how to disclose news of a suicide: http://reportingonsuicide.org/Recommendations2012.pdf
        - Guidelines for school response, including a sample death notification under circumstances when death by suicide has been confirmed, not confirmed or asked

not to be disclosed (p. 17-18): http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf?sid=16191

b. Clinical/therapeutic aspects:
   - Therapeutic role: Express genuine feelings while avoiding excessive displays of emotion that might convey that surviving clients must care for a distressed clinician.
   - Suicide risk management: Assess for increase in suicide risk in surviving clients.
   - Therapeutic aspects: For clients at risk of suicide, encountering the suicide death of another client risks a contagion effect that increases risk in survivors. This is especially the case if negative consequences of suicide are minimized, the deceased appears forgiven for negative behavior or if it is implied that it was reasonable for the deceased to give up and choose suicide (Comtois, personal communication, 2014). According to the internal suicide debate hypothesis (Harris, McLean, Sheffield & Jobes, 2010; Jobes & Mann, 1999), suicidal individuals are embroiled in an internal struggle over whether to live or die. The suicide death of another client may shift the balance towards death, and clinicians must be aware of this.

     Cultural norms and the stigma of suicide place pressure on the clinician to avoid discussion of suicide, to express empathy only for emotional pain, to avoid "speaking ill of the dead," and to suggest that the deceased is "in a better place." All of these are therapeutically problematic if they convey to a suicidal client that suicide cannot be discussed, that some emotional pain is impossible to bear without resorting to suicide, that negative behavior has been forgiven, that the client is better off dead or that others are better off without the client.

     To counter these problematic perceptions and support surviving clients' struggle towards life, the clinician may use the death of a client to explore feelings about the suicide death. Clinicians can use the opportunity to express disagreement with the decision to choose suicide, emphasize alternative solutions to emotional pain and reflect collectively on how it feels to be left behind by a suicide. In work with suicidal clients, these interventions are meant to support positive coping and challenge the perceived burdensomeness and thwarted belongingness (Joiner, 2005) beliefs that people are better off without the client or that no one will be affected by their death.

10. **Unpaid bills:** Kaye and Soreff (1991) describe the difficulty of billing a family for past services while suggesting that it is generally the correct approach. The outcome of mental health treatment is never certain, and fees are collected for time and knowledge rather than a defined outcome. While not an immediate responsibility, collecting unpaid bills may become relevant after short-term tasks are completed. Individual agency preferences and circumstances will influence this decision whether to seek payment.

11. **Engage in administrative case review**:
    Following a suicide death, administrative case review is necessary to collect information regarding circumstances of the death. The review may be for internal (patient safety and quality assurance) and/or external (Joint Commission) regulatory purposes. The timing of the

review, however, often conflicts with the emotional needs of the staff participating in the review. Following an adverse outcome, Scott et al. (2009) referred to a stage of "enduring the inquisition" characterized by anxieties over job security, licensure and litigation. Ballard et al. (2008) noted that any changes to policies and procedures may be experienced as implicit blame of clinicians involved in the suicide. Hendin, Haas, Maltsberger, Szanto, and Rabinowicz (2004) noted that negative institutional response was a factor involved in "severe distress" in therapists whose patients had died by suicide. Given the necessity of a review and the potential for harmful effects on clinicians, steps can be taken to address this.

a. Purpose of the review: Administrative case review focuses on gathering information that clarifies circumstances surrounding the client death. The purpose is to improve safety and modify policies and procedures. This process is distinct from a suicide case review (described below) that has an educational purpose of expressing emotions and learning from cases with an adverse outcome. This distinction should be made explicit to any staff members involved in the review.
b. Staff protection: Cotton et al. (1983) recommended that senior leadership staff assume responsibility for interactions with people or agencies outside of the treatment team, including administration. When possible, managers and supervisors should meet individually with the clinicians directly involved in the client's care and then participate in the administrative case review on behalf of the individual clinicians. When individual clinicians must participate, they should be supported by senior staff. The senior staff member gathering information or conducting a review with direct clinical staff should:
    1. Acknowledge any emotions prompted by the suicide death: *I know that this process is painful and brings up feelings of shock and disbelief. It must be overwhelming.*
    2. Orient directly to the need for the case review and the process of gathering information: *This review is necessary for administrative purposes. These questions are to collect information – not to assign blame or question your work.*
    3. Provide support and follow-up: *Is there anything I can do now to help support you? I will check in again later to see how you are feeling.*

Access support for managing emotional experiences

Following an initial response of shock and disbelief, common emotional responses to client suicide include grief, guilt, anger, betrayal, sadness and sometimes relief. Emotions may shift as clinician survivors move through phases of response: shock and disbelief, acceptance of reality, self-appraisal and working through to a resolution (Sacks, Kiebel, Cohen, et al., 1987).

Levels of distress in the therapist survivor are sometimes comparable to distress in clinical populations of bereaved individuals seeking treatment after the death of a relative (Chemtob et al., 1988). "Severe distress" is often characterized by grief and guilt (Hendin et al., 2004) and is known to affect clinical work (Gitlin, 1999; Gutin et al., 2010. Effective understanding, support and management of emotional responses following client suicide facilitate personal and professional growth. In contrast, a lack of support carries the risk of creating a "second victim" (Scott et al., 2009) out of a clinician traumatized by the adverse treatment outcome of client suicide.

Working through the personal and professional responses engendered by a client suicide is essential for care of the clinician and of future clients. Unresolved emotions may contribute to iatrogenic effects

as clinicians make counter-therapeutic practice changes in an effort to avoid another traumatic experience: inappropriate hospitalization, defensive distancing from suicidal clients, hostility or over-reaction to risk that inhibits clients from being truthful about suicide risk.

As the process of bereavement is highly individualized, it is difficult to prescribe a clear set of guidelines. The strategies listed below are meant to provide a range of options that have been used by other clinician survivors.

1. **Agency support**: As described above, clinicians involved in care of clients who have died by suicide may experience high levels of personal and professional distress. Within agency settings, the additional risk of turning clinicians into "second victims" arises of out of institutional responses that are blaming or focus only on administrative review while failing to care for the clinician who is traumatized by the adverse outcome (Wu, 2000; Wu & Steckelberg, 2012). While primary responsibility is to the client and family, agencies carry an ethical obligation to treat affected clinicians with compassion and respect (Denham, 2007). As such, agencies may benefit from having a system to offer immediate and intermediate-term support specifically for the emotional needs of affected clinicians.

   As circumstances of the death become clearer and as part of a 'just culture' of patient safety that emphasizes systems-based accountability and learning rather than blame of individual clinicians (Khatri, Brown & Hicks, 2009; Leape, 2010), clinicians involved in the suicide death may be included in the case review to provide the best quality information about the care provided as well as to have an opportunity to contribute to institutional learning that will enhance the safety of future patients (Denham, 2007).

   At the individual level, routine deployment of peer support can provide emotional assistance as well as education to affected clinicians about second victim phenomena. At a supervisory level, supervisors can provide immediate emotional support, orient the clinician to what to expect in the process of administrative case review and make referrals for individual psychotherapy as needed.

   Additional resources on agency-based responses to improve support for clinicians involved in adverse outcomes:
   - University of Missouri's 'forYOU' program (Scott, Hirschinger, Cox, McCoig, Hahn-Cover, Epperly, Phillips & Hall, 2010): http://www.muhealth.org/secondvictim
   - Medically Induced Trauma Support Services (MITSS)'s Clinician Support Tool Kit for Healthcare: http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html
   - Zero Suicide in Health Care – Creating a "Just Culture" for Caregivers: http://zerosuicide.actionallianceforsuicideprevention.org/

2. **Informal peer support**: Case reports and surveys of therapist survivors consistently report that informal peer support from family, friends and professional colleagues is the most beneficial factor in managing emotional experiences following client suicide (Cotton et al., 1983; Goldstein & Buongiorno, 1984; Ruskin et al., 2004). Discussions with peers should focus on the emotional response to the suicide rather than details of the treatment. If any legal action results from the suicide death, discussions about the treatment with colleagues may be discoverable evidence

that is not protected by the privilege of a psychotherapeutic or attorney-client relationship. In an agency based setting, time during staff meetings may be designated for expressing thoughts and feelings about the suicide death.

To facilitate peer support, **The American Association of Suicidology's Clinician Survivor Task Force** maintains a list of clinicians available to discuss the effects of client suicide as well as a listserv for sharing information and personal experiences: http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm

2. **Supervision**: Discussions with past and current supervisors or mentors are often helpful in managing responses to client suicide. This is especially the case if the supervisor can share personal experiences about having coped with this. As clinician survivors may be fearful or reluctant to seek assistance, supervisors should ask directly about any responses to the suicide and follow-up regularly on this topic as needed. Specific interventions by the supervisor that may be helpful include (Schutz, 2005):

    - Allowing the supervisee to search for the "why" of suicide in physical or psychological clues from within or outside of (in meeting with family survivors) the therapeutic relationship.
    - Addressing inevitable guilt by acknowledging the emotion and adding education about suicide (incidence, predictability, risk and protective factors) to provide perspective on the limits of clinical work with suicidal clients.
    - Advocating for the supervisee to prevent stigmatization: encouraging expressions of support for the therapist, providing accurate information about the suicide to other staff and participating in administrative proceedings.
    - Providing education about the process of grief following a suicide – i.e. likelihood of post-traumatic responses, incomplete nature of grief due to inability to participate in rituals of mourning, need for more support if a complicated grief response persists.
    - Monitoring of effects on clinical work: development of mistrust of clients or mistrust of clinical judgment.
    - Facilitating contact with other clinician survivors.

3. **Literature review**: Many therapist survivors have written detailed first-hand accounts describing their experiences with client suicide (Gitlin, 1999; James, 2005; Kolodny, Binder, Bronstein & Friend, 1979; Perr, 1968; Reeves, 2003; Valente, 2003). Reviewing these reports may decrease the sense of isolation that results from this experience. Professional responses to client suicide include:

    - Shame and guilt over failing to prevent the suicide.
    - Fear of condemnation or actual stigmatization from colleagues.
    - Ruminations over missed clinical signs that may have indicated imminent suicide risk or that indicate acute suicide risk in current clients – i.e. the "search for omens" (Gitlin, 1999).
    - Questioning of professional role.
    - Thoughts of leaving the profession.
    - Over-reactions to suicidal clients, hypervigilance regarding suicide risk or defensive distancing from suicidal clients.
    - Fear of treating suicidal clients.

4. **Personal psychotherapy**: Individual psychotherapy may be helpful to understand and manage emotional responses to a client suicide. The legal protection of this relationship may allow the clinician to speak more freely about treatment decisions and emotional responses, especially in circumstances where institutional regulations on confidentiality or professional stigmatization are significant. Within an agency, managers and supervisors should maintain awareness of staff members who may benefit from a referral for psychotherapy, and information regarding where to access care should be made available.

5. **Group meetings**: Meeting as a group with other clinicians has been used as means of decreasing isolation, expressing emotions and facilitating group learning in the process of working though the suicide death of a client. One case report describes four psychotherapists meeting every two weeks for three to four sessions and then monthly for a year (Kolodny et al., 1979).

6. **Individual coping strategies**: Valente (2003) recommends use of coping exercises in the form of questions to examine the clinician's responses to bereavement and their own mortality. These questions can form the basis of organizing an individual plan for managing emotional responses.

    - What types of patients distress me most when they die?
    - What are my typical patterns of expressing grief?
    - What type of support and assistance is most acceptable to me when I grieve and how do I access this support?
    - What type of assistance do my teammates and colleagues seek and give?
    - What are my personal stressors and stress busters at this time?
    - How can others assist me with my difficulties and distress?

7. **Participation in the rituals of death:** Literature reports regarding client suicide have noted that participation in the common rituals of death (sending flowers, offering condolences, attending the funeral) can have positive effects for clinicians and surviving family members when done in consultation and collaboration with the family (Campbell & Fahy, 2002; Cotton et al., 1983; Kaye & Soreff, 1991; Markowitz, 1990; Peterson et al., 2002).

    Following the surviving family's lead, clinicians may discuss the possibility of attending a deceased client's funeral as a way of caring for the family and participating in the grieving process. Prior to attending the funeral, clinicians should review guidelines regarding maintaining client confidentiality and discuss with the family how they would like the clinician to identify his or her relationship with the deceased.

    Attending the funeral can provide the clinician with a shared, rather than isolated, experience of loss. Whereas other clinical staff may care for the clinician, they may not have had strong feelings for the client if they did not provide direct clinical care. Grieving with family members also can provide a broader perspective of the client's life, given that the clinician's perspective may have been restricted to knowledge of the client's struggles discussed in treatment. If an individual clinician does not feel comfortable attending the funeral, another clinician or supervisor can represent the agency if this is desired by the family. In a survey of 172 Swiss psychiatrists and psychologists, 13.3% of therapists in institutional settings and 25% in private practice attended the funeral of a patient (Wurst, Mueller, Petitjean, Euler, Thon, Wiesbeck & Wolfersdorf, 2010). Among suicide survivors, Peterson et al. (2002) reported that when clinicians did not attend the funeral, 44% would have wanted the clinician to attend.

8. **Supporting a colleague**: Clinicians who have experienced the suicide death of a client often feel guilt and shame and fear negative responses from colleagues. Proactive contact and expressions of support from colleagues and supervisors may therefore be helpful in reducing isolation and managing negative emotional responses. Empathic validation of emotions and sharing of personal experiences of client suicide are especially helpful. Reassurances that the death was inevitable or that the treatment had been successful may be experienced as empty gestures (Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000).

Suicide Case Review

After some resolution of distressing emotions conducting a case review allows for an opportunity for learning and professional growth. A case review, also called a psychological autopsy (Shneidman, 1969), examines the circumstances surrounding the client's death: details of the treatment, life circumstances preceding the suicide, suicide risk factors, protective factors and warning signs and interventions for suicide.

An ill-timed case review or a review conducted with a blaming tone can be harmful to clinicians (Goldstein & Buogiorno, 1984; Hendin et al., 2004). To avoid these iatrogenic effects, a case review should be conducted after some resolution of negative emotions (especially grief and guilt) and with the acknowledgement of the uncertainty involved in predicting and preventing suicidal behavior. In their review of 36 cases of psychotherapy that ended in the suicide death of the patient, Hendin et al. (2006) noted:

> "It is important not to be judgmental in reviewing this case material, as the problems that we, and the therapists themselves, identified became evident largely through retrospective review. Although inadequate interventions could be identified in virtually all cases we have studied of patients who died by suicide while in treatment, these retrospective findings do not mean that these suicides could have been predicted or prevented. Even if the problems we noted had been avoided or successfully resolved, there is no certainty that the outcome for these patients would have been different…Examining problems encountered in psychotherapy with suicidal patients should help to improve the effectiveness of their treatment."

Thus, while it may never be clear whether any specific action or inaction played a causal role in client suicide, case review fosters professional responsibility by allowing the agency and individual clinician to learn from the negative outcome in a way that may benefit future clients. Because outcomes in mental health treatment are never certain, the case review focuses on whether care deviated from existing policies and procedures rather than assigning blame to individual clinicians for an adverse outcome.

1. **Setting of a case review**: Because any discussions following a suicide death are potentially discoverable in the event of malpractice litigation, it is essential to consult with risk management or legal counsel regarding the setting of a case review of suicide death. A case review may be conducted during a staff conference or larger morbidity and mortality conference, which should be approved by the Chief of Service to ensure that appropriate institutional confidentiality requirements are observed.
2. **Components of a case review**: For educational purposes, a case review should consist of the following components:
    a. General circumstances of the case: treatment setting, presenting symptoms, precipitating events leading up to the suicide.

b. Risk factors: demographic, situational, symptomatic, suicide-specific.
c. Protective factors.
d. Warning signs.
e. Overall assessment of risk.
f. Treatment interventions for suicide, including safety planning.
g. Other short-term or long-term interventions that may have been implemented to modify risk or protective factors.

Professional Growth and Responsibility

Following an experience with client suicide and after the loss has been integrated into a personal and professional identity, clinicians may benefit from modifying their professional practices and engaging in altruistic activities to help others prepare for or cope with this experience. Scott et al., (2009) noted that the "moving on" stage of responding to an adverse event was characterized by one of three outcomes: dropping out, surviving or thriving. Clearly, the desirable outcome of this process is "thriving" such that clinical staff members learn from a painful experience in a manner that promotes patient care and support for others.

1. **Suicide risk assessment, management and treatment:** Agencies should review suicide risk assessment, management and treatment practices to identify systemic or individual practice changes that could improve care (Hendin et al., 2006; Mills, Huber, Watts & Bagian, 2011). Documentation should include a review of relevant risk factors, assessment of suicide risk, interventions to modify suicide risk and justification for the level of care. Examples of recommended practice changes that have arisen out of case reviews of suicide death include:

    a. Systemic changes:
        - Improving communication and coordination of care with suicidal clients.
        - Additional training on or systematic implementation of suicide risk assessment and management practices.
        - Additional training on or systematic implementation of treatment interventions to resolve suicidality among known suicidal clients.
        - Improving access to care (i.e. timeliness of initial and follow-up appointments).
        - Improving outreach to clients who miss appointments or refuse care.
        - Improving after-hours crisis services.
        - Increased supervision for teams or individual clinicians when suicide risk is identified.
        - Routine screening, assessment and ongoing monitoring of suicide risk with use of structured tools (PHQ-9, Columbia Suicide Severity Rating Scale).

    b. Individual practice changes (Hendin et al., 2006):
        - Active communication among all treatment providers.
        - Exploring the meaning of a client's condition for living rather than supporting an unrealistic goal.
        - Persisting in helping a client talk about a difficult topic that appears relevant to suicide risk.
        - Explicit exploration of a client's feelings about medication noncompliance to optimize medication treatment of symptoms.
        - Discussion of sexual issues that appear relevant to suicide risk.

- Decisive action regarding hospitalization if suicide risk is judged to be extreme. Therapists should explore feelings of desperation and present hospitalization as a means of gaining short-term relief without needing to surrender ultimate control over the choice to live or die.
- Inquiring about dreams to gain access to information about suicide risk.
- Optimizing medication treatment of psychiatric symptoms, especially anxiety or psychosis.
- Addressing substance use, especially alcohol abuse.

2. **Altruistic activities**
    a. Sharing of experiences with colleagues.
    b. Organizing educational activities related to client suicide (Lerner, Brooks, McNiel, Cramer & Haller, 2012; Prabhakar, Anzia, Balon, Gabbard, Gray, Tatzis, Lanouette, Lomax, Puri & Zisook, 2013).
    c. Publishing literature.
    d. Reaching out to other clinician survivors.

References:

Arsenault-Lapierre, G., Kim, C. & Turecki, G. (2004). Psychiatric diagnoses in 3275 suicides: A meta-analysis. *BMC Psychiatry; 4*:37.

Bartels, S.J. (1987). The aftermath of suicide on the psychiatric inpatient unit. *General Hospital Psychiatry; 9*(3):189-197.

Bedell, S.E., Cadenhead, K. & Graboys, T.B. (2001). The doctor's letter of condolence. *New England Journal of Medicine; 344*(15): 1162-1164.

Campbell, C. & Fahy, T. (2002). The role of the doctor when a patient commits suicide. *Psychiatric Bulletin; 26*, 44-49.

Chemtob, C.M., Hamada, R.S., Bauer, G., Kinney, B. & Torigoe, R.Y. (1988). Patients' suicides: frequency and impact on psychiatrists. *American Journal of Psychiatry*; *145*,224-228.

Chemtob C.M., Hamada, R.S., Bauer, G., Torigoe, R.Y. & Kinney, B. (1988). Patient suicide: frequency and impact on psychologists. *Professional Psychology: Research and Practice; 19*, 416-420.

Cotton, P.G., Drake, R.E. Jr., Whitaker, A. & Potter, J. (1983). Dealing with suicide on a psychiatric inpatient unit. *Hospital and Community Psychiatry; 34*(1):55-9.

Denham, C.R. (2007). TRUST: The 5 rights of the second victim. *Journal of Patient Safety; 3*(2): 107-119.

Gitlin, M.J. (1999). A psychiatrist's reaction to a patient's suicide. *American Journal of Psychiatry; 156*:1630-1634.

Goldstein, L.S. & Buongiorno, P.A. (1984). Psychotherapists as suicide survivors. *American Journal of Psychotherapy; 38*(3): 392-398.

Gutin, N., McGann, V. & Jordan, J.R. (2010). The impact of suicide on professional caregivers. In J.R. Jordan and J.L. McIntosh (Eds.), *Grief after suicide: Understanding the consequences and caring for the survivors*. New York: Routledge.

Harris, K.M., McLean, J.P., Sheffield, J. & Jobes, D.A. (2010). The internal suicide debate hypothesis: Exploring the life versus death struggle. *Suicide and Life-Threatening Behavior; 40*(2): 181-192.

Hendin, H., Haas, A.P., Maltsberger, J.T., Koestner, B. & Szanto K. (2006). Problems in psychotherapy with suicidal patients. *American Journal of Psychiatry; 163*(1):67-72.

Hendin, H., Haas, A.P., Maltsberger, J.T., Szanto, K. & Rabinowicz, H. (2004). Factors contributing to therapists' distress after the suicide of a patient. *American Journal of Psychiatry*; *161*(8), 1442-6.

Hendin, H., Lipschitz, A., Maltsberger, J.T., Haas, A.P. & Wynecoop, S. (2000). Therapists' reactions to patients' suicides. *American Journal of Psychiatry; 157*(12):2022-7.

James, D.M. (2005). Surpassing the quota: Multiples suicides in a psychotherapy practice. In K.M. Weiner (Ed.), *Therapeutic and legal issues for therapists who have survived a client suicide: Breaking the silence*. New York, NY: Haworth Press.

Jobes, D.A. & Mann, R.E. (1999). Reasons for living versus reasons for dying: Examining the internal debate of suicide. *Suicide and Life-Threatening Behavior; 29*(2): 97-104.

Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.

Kaye, M.S. & Soreff, S.M. (1991). The psychiatrist's role, responses and responsibilities when a patient commits suicide. *American Journal of Psychiatry; 148*(6):739-43.

Khatri, N., Brown, G.D. & Hicks, L.L. (2009). From a blame culture to a just culture in health care. *Health Care Management Review; 34*(4): 312-322.

Kolodny, S., Binder, R.L., Bronstein, A.A. & Friend, R.L. (1979). The working through of patients' suicides by four therapists. *Suicide and Life-Threatening Behavior; 9*(1)33-46.

Leape, L.L. (2010). Who's to blame? *The Joint Commission Journal on Quality and Patient Safety; 36*(4): 150-151.

Lerner, U., Brooks, K., McNiel, D.E., Cramer, R.J. & Haller, E. (2012). Coping with patient suicide: A curriculum for psychiatry residency training programs. *Academic Psychiatry; 36*:29-33.

Little, J.D. (1992). Staff response to inpatient and outpatient suicide: What happened and what do we do? *Australian and New Zealand Journal of Psychiatry; 26*:162-7.

LoboPrabhu, S., Molinari, V., Pate, J. & Lomax, J. (2007). The after-death call to family members: A clinical perspective. *Aging & Mental Health; 11*(2):192-196.

LoboPrabhu, S., Molinari, V., Pate, J. & Lomax, J. (2008). The after-death call to family members: Academic perspectives. *Academic Psychiatry; 32*(2):132-135.

McAdams, C.R. & Foster, V. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling*; *22*(2).

McGann, V., Gutin, N. & Jordan, J.R. (2010). Guidelines for postvention care with survivor families after the suicide of a client. In J.R. Jordan and J.L. McIntosh (Eds.), *Grief after suicide: Understanding the consequences and caring for the survivors*. New York: Routledge.

Mills, P.D., Huber, S.J., Watts, B.V. & Bagian, J.P. (2011). Systemic vulnerabilities to suicide among veterans from the Iraq and Afghanistan conflicts: Review of case reports from a national Veterans Affairs database. *Suicide and Life-Threatening Behavior; 41*(1):21-32.

Perr, H.M. (1968): Suicide and the doctor-patient relationship. *American Journal of Psychoanalysis; 28*(2): 177-88.

Peterson, E.M., Luoma, J.B. & Dunne, E. (2002). Suicide survivors' perceptions of the treating clinician. *Suicide and Life-Threatening Behavior; 32*(2): 158-166.

Prabhakar, D., Anzia, J.M., Balon, R., Gabbard, G., Gray, E., Hatzis, N., Lanouette, N.M., Lomax, J.W., Puri, P. & Zisook, S. (2013). "Collateral Damages": Preparing residents for coping with patient suicide. *Academic Psychiatry; 37*(6):429-430.

Reeves, G. (2003). Terminal mental illness: Resident experience of patient suicide. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry; 31*(3):429-41.

Ruskin, R., Sakinofsky, I., Bagby, R.M., Dickens, S. & Sousa, G. (2004). Impact of patient suicide on psychiatrists and psychiatric trainees. *Academic Psychiatry; 28*(2): 104-110.

Rynearson EK (2005). The Narrative Labyrinth of Violent Dying. *Death Studies*. 29:351-360.

Sacks, M.H., Kiebel, H.D., Cohen, A.M, et al. (1987). Resident response to patient suicide. *Journal of Psychiatric Education; 11*:217-226.

Scott, S.D., Hirschinger, L.E., Cox, K.R., McCoig, M., Brandt, J. & Hall, L.W. (2009). The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Quality & Safety in Health Care; 18*:325-330.

Scott, S.D., Hirschinger, L.E., Cox, K.R., McCoig, M., Hahn-Cover, K, Epperly, K.M., Phillips, E.C. & Hall, L.W. (2010). Caring for our own: Deploying a systemwide second victim rapid response team. *The Joint Commission Journal on Quality and Patient Safety; 36*(5): 233-240.

Shneidman, E.S. (1969). Suicide, lethality and the psychological autopsy. *International Psychiatry Clinics; 6*(2):225-50.

The Joint Commission (2013). Sentinel Event Data: Event type by year 1995-June 2013. http://www.jointcommission.org/assets/1/18/Event_Type_by_Year_1995-2Q2013.pdf

Valente, S.M. (2003). Aftermath of a patient's suicide: A case study. *Perspectives in Psychiatric Care; 39*(1): 17-22.

Wu, A.W. (2000). Medical error: The second victim: The doctor who makes the mistake needs help too. *British Medical Journal; 320*: 726-727.

Wu, A.W. & Steckelberg, R.C. (2012). Medical error, incident investigation and the second victim: Doing better but feeling worse? *BMJ Quality and Safety; 21*(4): 267-270.

Wurst, F.M., Mueller, S., Petitjean, S., Euler, S., Thon, N., Wiesbeck, G. & Wolfersdorf, M. (2010). Patient suicide: A survey of therapists' reactions. *Suicide and Life-Threatening Behavior; 40*(4): 328-336.