Suicide postvention: A guide to using resources

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DISCLAIMER: This document contains an overview of tool vetting and practice related to suicide prevention, intervention and postvention. Recommendations proposed in this document do not preclude the possibility that other approaches or practices are valid and relevant. Occupational therapists and occupational therapist assistants must use their clinical judgment and consider factors such as personal knowledge and skill related to suicide assessment and intervention, clients' preferences and resource availability when applying these recommendations. These documents are meant to support practice but are not a substitute for gatekeeper training. Any provincial regulations related to occupational therapy practice and those of occupational therapist assistants should be followed. To ensure the readability of the text, the term "occupational therapists" is used throughout. As most of the roles and recommendations proposed here are also relevant to occupational therapist assistants, we hope this document will support the practice of both occupational therapists and occupational therapist assistants. Recommendations presented in this document are based on the best information available. Should new information become available and modifications to the recommendations be warranted, the Addressing Suicide in OT Practice Network will make every effort to update and issue a new version of this guide at any time. Concerns or questions related to this document can be directed to the Tool Vetting Committee Chair Theresa Straathof (tstraathof@toh.ca) and/or the Network Chair Kim Hewitt-McVicker (khewitt@cmhaww.ca).

This document was created in the spirit of being a complimentary document to the Addressing Suicide Prevention in Occupational Therapy Role Paper. The best practice recommendations were pulled from the role paper and tailored to each section in this document. Role Paper Best Practice Recommendations in this document are not an exhaustive list. Please refer to the Suicide Prevention in Occuapational Therapy CAOT Role Paper document for a full list of recommendations.

This document was prepared in June 2021 and will be updated as new evidence emerges. When referencing this article, please use APA style, citing both the date retrieved from our web site and the URL. For more information, please contact: copyright@caot.ca.
Suggested Citation: Straathof, T., Starc, C., Larry, C., & Taylor, E. (2021). Suicide prevention: A guide to using resources. https://www.caot.ca/site/pd/otn/sot?nav=sidebar

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Suicide Continuum Phase: Postvention

Gatekeeper Training

Gatekeeper training sessions are designed to teach lay people and professionals about warning signs related to suicide crisis and response strategies. These sessions often provide a structured process to follow related to assessing risk, questioning, providing support and getting assistance to the individual in crisis. There may be a cost associated with training as well as a time commitment to complete the training. Gatekeeper training is often recommended as best practice for those working with populations at high risk for suicide. Gatekeeper training is beyond the scope of this document.

For the Gatekeeper Training Inventory document, please visit the CAOT website or click here

For the Gatekeeper Training Decision Making Tool, visit the CAOT website or click here

Suicide Continuum Phase: Postvention

Suicide postvention is defined as "helping support those affected after the loss or experience of suicide as well as providing follow-up education/prevention to reduce the risk of future crises" (Public Health Agency of Canada, 2016). Postvention may include support for friends and family after a death by suicide; staff support; and re-evaluation of risk management procedures.

The goals of postvention can be divided into institutional and individual domains. At the institutional level, the goal is to restore equilibrium in the care setting and healthcare team to continue to provide quality care for clients. At the individual level, the goal of postvention is to promote healthy grieving, commemorate the deceased, provide comfort to all affected, and reduce the risk of suicide contagion and other detrimental personal outcomes. (Berkowitz, et al, N.D)

The term postvention is sometimes used to describe the interventions offered after an individual presents with a suicide attempt, in order to prevent a future suicide attempt. For clients with this presentation, please return to sections for prevention and intervention in this document series.

CPPF: Evaluate Outcome; Conclude/Exit

Role Paper Best Practice

- Evidence Based Recommendation
  - Following a person's death by suicide, engage in postvention activities, such as providing information and 1:1 support sessions for peers, family and staff (Robinson et al., 2013).
  - Evaluate the status of community suicide preparedness and whether key community stakeholders have received adequate suicide prevention training (Cox et al., 2012).

General Guidelines for Postvention

General guidelines for all postvention tasks include:

- Avoid suggesting the death by suicide was inexplicable or unavoidable.
- Acknowledge the complexity of suicide, that there are many factors which interact in the decision to die by suicide.
- Emphasize alternative to suicide when experiencing distress, and identify resources for those alternative actions.
- Avoid romanticizing and conversely demonizing the person who died by suicide.
- Emphasize the strong correlation between mental health and suicide. Most suicide is associated with a psychiatric disorder and impairment in decision making occurs when experiencing high levels of mental distress.
- Discourage a focus on the method or details of the suicide, which can contribute to gossiping.
- Provide details of ongoing suicide prevention efforts occurring within this context.

Adapted from the Rivermead Trauma Centre Postvention guidelines (Berkowitz, McCauley & Mirick, N.D.)

CPPF: Monitor/Modify; Evaluate Outcome; Conclude/Exit

Role Paper Best Practice

- ❖ Evidence Based Recommendation
  - ➢ Following a death by suicide, implement a concerted postvention strategy to heighten awareness and ensure quick responses to avoid a cluster of suicides. Be attentive to emerging risk factors in high-risk groups following a suicide, such as poor social functioning and poor school adjustment in youth (Cox et al., 2012).
- ❖ Consensus Based Recommendation
  - ➢ Understand that each person will grieve in unique ways depending on their past relationship with the person who has died and context (DeRanieri et al., 2002).
- ❖ Practice Point
  - ➢ Consider collecting program process outcomes during debriefing sessions with family members, caregivers and/or key stakeholders. Ensure that the facilitator of these sessions has received adequate orientation and training, and is not too close to the person who died by suicide.
  - ➢ Offer individual- or group-based services to support suicide survivors' health and wellbeing while moving through the grief process.

Support for Those Affected by Suicide

- ❖ Those left grieving may be at a higher risk themselves for suicide and could be screened and questioned for suicidality (Perlman et al, 2011).
- ❖ Ensure support and resources are explored for these individuals to mitigate their risk and help with grieving.

- Local organizations offer groups for family and friends after a loved one dies by suicide. The occupational therapist is encouraged to stay current with programs and resources offered in their local community.
- There are many practical guides available to family members which range from providing information on stages of grief to delineating steps to obtain a death certificate and plan a funeral.
- Some Canadian guides for survivors can be found below with a brief summary, with various practice context examples. This is not an exhaustive list and information contained may be specific to the local area.

Guide	**Description**
Hope and healing after suicide (from CAMH)	❖ Outlines natural reactions to grief, resources to support healing, as well as practical tips for planning funerals and other arrangements ❖ Targeted to Ontario residents
What to do after a suicide Webinar from The Centre for Suicide Prevention	❖ Targets practical support for school staff to support friends of a school-aged child who died by suicide
After suicide: a practical and personal guide for survivors From Klinic Community Health Care in Manitoba	❖ Reviews local resources for support groups ❖ Provides psychoeducation about grief reactions ❖ Reviews practical information regarding police involvement, investigation, and arrangements for funeral planning
Talking to Children About Suicide From The Mental Health Commission of Canada	❖ Provides practical information for parents or caregivers about how to talk to children under 12 about suicide in their family or community. ❖ Reviews local resources targeted to children 12 and under
Note for OTs: Before attempting to support family/friends of a client who died by suicide, ensure a clear understanding of the legislation and standards for confidentiality.	

CPPF: Evaluate Outcome; Conclude/Exit

Role Paper Best Practice

- Evidence Based Recommendation
  - Evaluate the status of community suicide preparedness and whether key community stakeholders have received adequate suicide prevention training (Cox et al., 2012).
  - Consider implementing a community suicide preparedness strategy and/or advocating that community stakeholders and gatekeepers receive suicide prevention training (Cox et al., 2012).
- Consensus Based Recommendation
  - Connect clients with existing community services and networks that provide support and resources (CAOT, n.d.-b).

Community Care Management

- Providing community resources to clients can expand both professional and personal support.
- Having resources available for clients and families who have been dealing with suicidality is helpful (Stanley & Brown, 2012).
- Phone apps can be another area of self-help.

Case study: Using community resources

Dawn is a young woman living on the streets for about 5 years. Her roommate recently died by suicide. She just lost custody of her daughter due to her housing becoming unstable and questions about her parenting skills. She recently started working with an occupational therapist from a community agency to assess her living skills in order to find stable housing. She did not arrive for her appointment at the agency today which is unusual, and her occupational therapist hears from another community member that she is talking about "ending it all" as she may never see her daughter again. The occupational therapist calls her but she has no message system on her phone. The occupational therapist then checks several known locations with a community worker and finds her sitting close to the river. She is sad, depressed and talks about going into the river or jumping off the bridge. In discussion with Dawn it is clear that she is very distressed about her daughter. She is overwhelmed by all the changes she needs to make to get her daughter back. Her plan for suicide is not clear, and she agrees that she wants a future with her daughter but sees no other solution in the moment. Her therapist helps her see all the skills she has recently worked on. She suggests Dawn calls both an emergency housing program, which provides temporary accommodation, and her social worker to organize a supervised visit with her daughter. Dawn agrees and asks the occupational therapist to help her make those calls. Together, they also review some support services to assist Dawn who is grieving the death of her roommate.

***Case studies have been de-identified and names have been changed to protect client confidentiality*

CPPF: Conclude/Exit

Role Paper Best Practice

- Evidence Based Recommendation
  - Continuously reflect on the emotional impacts of helping clients who are suffering and seek out supervision and support for yourself when needed (RNAO, 2009; StefanowskiHarding, 1990).

Support for Staff Following Death of a Client by Suicide

(Gutin et al., 2010)

- For occupational therapists working in the mental health sector, suicide can be a relatively common phenomenon. The death of a client by suicide can impact the occupational therapist and staff team profoundly with feelings of shock, denial, confusion, anger etc.
- Losing a client to suicide can lead to questioning one's professional identity and clinical work. Many mental health professionals report increasing isolation and discomfort with their colleagues after a death by suicide. Others reported a loss of confidence in their skill and abilities.
- Recognizing the impact that client suicide can have on staff is an important step in mitigating the grief response, and returning the staff team to optimal functioning.

Employee Assistance Programs

- Medium to large sized organizations often offer their staff an Employee (& Family) Assistance Program, referred to as EAP or EFAP.
- This program offers free and rapid access to counsellors experienced in addressing grief, over the phone or in person. Employees should be reminded of access to this program and the nature of services available.

Team Debriefing

- Sherba et al (2019) surveyed a wide array of mental health clinicians and found many adverse effects amongst clinicians post-client-suicide.
    - Many participants felt their organization could have better supported them after death by suicide.
    - Less than half of the participants reported having training in postvention, and of those who received training, 98% of participants found it helpful.
    - Organizational responses post-suicide varied, and most often involved a team meeting and/or a critical incident review.
- Participants identified the most helpful support as informal and formal debriefings, team support, the ability to connect with other professionals who had the same experience, using EAP services, and implementing self-care strategies.
- Recommendations to improve post-suicide management include the development of formal protocols for debriefing, and future training of supervisors and clinicians.
- One such approach is Critical Incident Stress Debriefing, a seven phase approach to managing a wide range of traumatic workplace incidents (Livingworks, 2021).
- Another approach is the SUPPORT program, a postvention program specific to professionals after a client dies by suicide (Leaune et al., 2020).
- Commonalities amidst approaches in the literature include prioritizing team intervention within the first 24-72 hours; facilitating the communication of thoughts and feelings about the event from those impacted; and providing psychoeducation about normal responses and local resources.
- Some organizations have adapted a colour chart from the Mental Health Continuum Model (2017) here as a resource for staff wellness monitoring.

Role Paper Best Practice Recommendations in this document are not an exhaustive list. Please refer to the Suicide Prevention in Occuapational Therapy CAOT Role Paper document for a full list of recommendations.

Last Updated 04/20/2021

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*citations from the Role Paper

Appendix 1

Further resources for health care organizations that may be of benefit include the following:

- https://www.sprc.org/resources-programs - best practices registry sorted by context
- https://www.patientsafetyinstitute.ca/en/toolsResources/SuicideRisk/Documents/Suicide%20Risk%20Assessment%20Guide.pdf - a resource for health care organizations
- https://www.cafconnection.ca/getmedia/eaed6f1e-759d-446a-aa41-941181532602/road-map-to-optimum-mental-health.pdf.aspx