Suicide Postvention is Prevention

A Proactive Planning Workbook for Communities Affected by Youth Suicide

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BC COUNCIL *for* FAMILIES

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To the individuals, families and communities
who strive to heal from the painful loss felt when someone
dies by suicide. May this work offer hope, guidance
and learning for others whose lives may
be touched by suicide.

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About the Workbook

The *Suicide Postvention is Prevention: A Proactive Planning Workbook for Communities Affected by Youth Suicide* is designed to help communities both anticipate and effectively respond to the tragedy of youth suicide.

Workbook objectives

- To provide tools to assist communities in organizing a compassionate, collaborative, planned postvention response following a youth suicide
- To clarify the roles and responsibilities of each community agency
- To suggest a coordinated approach to guide the actions of the service providers
- To ensure that
  1) youth at risk of suicide are identified and receive the appropriate intervention and support
  2) support is forthcoming for suicide survivors.
- To encourage communities to conduct a follow-up suicide postvention review to determine what worked well, and what could be improved upon.

This workbook is **not**:

- A clinical tool for assessing individuals for suicide risk
- A guide to providing therapy to individuals at-risk for suicide
- A prescriptive, one-size-fits-all blueprint for developing a postvention protocol.

Target audience

The intended target audience includes, but is not limited to:

- Government ministries
- Regional governing bodies (e.g. Health Authorities)
- Child and youth mental health practitioners
- Social workers
- School districts
- Aboriginal communities
- Media representatives
- Suicide prevention committees
- Community planning coalitions
- Coroners
- RCMP and/or local police
- Victim services
- Clergy
- Funeral home staff
- Suicide survivor advocate groups.

Principles guiding this work

This work is:

- Empirically informed
- Culturally relevant
- Community focused
- Proactive
- Flexible
- Informed by survivors' experiences
- User-friendly.

Workbook content

This workbook contains:

- Information to assist communities in developing a postvention strategy
- Chapter overviews and summaries of key points
- Resources and checklists to help communities develop, implement, and monitor a postvention strategy
- Chapter references
- Appendices
- Bibliography.

CHAPTER ONE

Introduction to Suicide Postvention

A proactive community postvention response can "alleviate the distress of affected peers, reduce the risk of imitative suicidal behavior, and promote the healthy recovery of the affected community" (Hazel & Lewin, 1993).

Chapter overview

No community is immune to suicide. However, communities that are aware of the possibility of suicide contagion ("copycat suicide") and are prepared to respond after a youth suicide can be assured that they have done everything possible to prevent further suicides. At the same time, such communities will be better equipped to deal sensitively and compassionately with suicide survivors and other individuals who may have been negatively affected by a suicide.

This chapter introduces the reader to the term postvention, the place of postvention in overall suicide prevention, the components of a postvention response, and the specific factors that elevate risks for contagion.

For the purpose of this workbook, the term postvention refers to those activities and processes that are undertaken *following* a death by suicide.

Background

When the authors were previously asked to develop a *Suicide Postvention Protocol* for a Northern BC community, they discovered that there was little information available regarding the community development process specific to suicide postvention protocol planning. They thought the learning gained from this past experience might serve to inform and help other communities wishing to develop a proactive postvention strategy.

Suicide statistics

The statistics related to suicide deaths in Canada are compelling (see Table 1). In the past three decades, more than 100,000 Canadians died by suicide. Suicide remains one of Canada's most serious public health issues, with suicide deaths and suicide attempts costing the Canadian economy over $14.7 billion annually (Canadian Association for Suicide Prevention, 2004).

TABLE 1: Facts about suicide in Canada

- The suicide rate in Canada is higher than in many industrialized countries
- Over 4,000 Canadians die by suicide every year
- Over 400,000 Canadians deliberately harm themselves every year
- Over 2,800,000 Canadians are affected by suicidal behaviour every year
- Suicide is the leading cause of death for Canadians between ages 10 and 49
- After automobile accidents, suicide is the second leading cause of death for youth aged 10-24 in Canada.

(Canadian Association for Suicide Prevention, 2004)

Why postvention?

Suicide always has a ripple effect. Each suicide directly impacts family, friends, and the community at large, while indirectly affecting many others. In small communities almost everyone is affected by a suicide or suicide attempt. Non-fatal suicide attempts also have serious impact on individuals, families, and communities (Hazell, 1993).

The importance of a planned postvention response following a death by suicide cannot be underestimated. Guidelines assist individuals, organizations, and communities to respond to a suicide in a manner that is most likely to reduce contagion. How a suicide is dealt with in the media, by schools, in communities, and by friends and family can have a significant impact on the level of trauma experienced by families, friends, professionals, and communities.

Vision for this workbook

It is rare that a community has articulated in advance the considerations and responses necessary when a youth dies by suicide. Reactive responses are often the usual and only response. The goal and vision in developing this workbook is to encourage communities to identify, ahead of time, postvention plans and resources that will support professionals, families, and youth during the crisis period following a youth suicide.

The research evidence[1]

When a young person dies by suicide, the focus of most schools and community service providers is on responding to the crisis in a safe and responsible way. Most studies in postvention represent natural research designs, i.e. studying the effects of "typical postvention responses" in schools and communities as they occur naturally.

Ethical issues, such as withholding potentially helpful interventions from those exposed to a suicide, can seriously hamper the use of well-controlled evaluation studies. It is not surprising, therefore, that the available evidence regarding the effectiveness of postvention efforts is scant. However, insufficient evidence is not the same as evidence of "no effect."

Some studies show that youth exposed to suicide are themselves at risk of subsequent mental health problems, including depression, anxiety, and post-traumatic stress disorder (Brent et al., 1996), and that evidence regarding the significant negative impact of sensational coverage about suicide continues to mount (Gould et al., 2003).

Other studies have found that postvention strategies have shown no evidence of effectiveness (Hazell & Lewin, 1993), while other authors have questioned the overall usefulness of postvention efforts (Goldney & Berman, 1996).

As suicide prevention leaders and practitioners, we need to make space for all these voices to be heard in the aftermath of a young person's suicide. We need to respectfully listen to what people are saying, but at the same time we have a responsibility to articulate what we know about the risks of copycat suicide based on the scholarly literature, using plain and accessible language. Instead of silencing people with "studies and data" and instead of pulling the "expert card," we need to cultivate conditions that enable people to make meaning together about the best way to go forward — a way which reflects the collective wisdom of the group in this particular circumstance (White, 2002).

One study investigated the effects of different school-based postvention responses, including "first talk-throughs" and psychological debriefings, following six adolescent suicides in one school year in rural communities in Northern Finland (Poijula et al., 2001a; Poijula et al., 2001b). Following the suicides, some schools and classrooms received an adequate postvention response, while others did not. Incidences of new suicides in the three schools were followed for four years. Results indicated that:

"A carefully planned postvention response can also enable youth (or adults)who have previously lost a sibling, parent or other family member to suicide, to risk breaking their silence and feel the support of a caring community."
Bonny Ball, Suicide Survivor.

- In schools where a first talk-through and psychological debriefing were conducted by a mental health professional, no new suicides appeared during the four year follow-up period
- At the school where teachers conducted a classroom meeting in *all but one* Grade 8 class, a second suicide took place two months after the first suicide, by a student whose class had *not* had the classroom meeting
- Those students who did not receive an adequate crisis intervention had a greater risk for high-intensity grief than those who evaluated the intervention as good.

Despite the lack of clear research evidence supporting its effectiveness, postvention efforts have been identified as an important suicide prevention strategy by a number of national organizations, including the Centers for Disease Control & Prevention (1988), the American Association of Suicidology, and the Canadian Association for Suicide Prevention.

A postvention response

A systematic postvention response, designed to support relatives, close friends, and acquaintances of a youth who has died by suicide, can be effective in reducing psychological, physical, and social difficulties for both youth and adult survivors.

An effective postvention response can provide information and education to help "break the silence" and lift the stigma related to suicide, ensuring compassionate community support for survivors, while also encouraging others who are struggling to reach out for help.

Future suicides may be prevented by ensuring that at-risk and vulnerable youth receive a coordinated, timely, and effective response that includes education, assessment, treatment, follow-up, and caring support. Hazell (1993) identified that postvention efforts are typically short-term and designed to:

- Provide accurate information about the suicide
- Allow for the expression of feelings and reactions about the deceased
- Reduce the risk of imitative suicidal behaviour and subsequent mental health problems
- Identify and refer those at risk of suicide, and
- Facilitate a return to pre-crisis levels of functioning.

According to Bonny Ball, a survivor who lost her son to suicide, suicide postvention efforts can also:

- Provide a safe, caring environment in which to both grieve and reach out for additional help
- Balance the need of family and friends to honour the deceased, while not glorifying the deceased and risking contagion
- Facilitate and/or acknowledge the safe expression of blame, anger, and "fingerpointing" that may occur among family, school, health care providers, and others in the youth's life.

Suicide postvention is prevention

Suicide postvention is part of the overall spectrum of suicide prevention activities. Although postvention occurs after a death by suicide, it is preventative in that it reduces risk by identifying and supporting the emotional and mental health needs of the survivors, including those people most impacted by the suicide itself.

Suicide prevention is primarily related to educational efforts aimed at reducing suicide through building awareness of warning signs and risk factors, while teaching what to do to help a person during a suicide crisis. Primary prevention also includes education related to increasing self-esteem, managing stress, and developing problem-solving and help-seeking skills to foster personal support networks. Suicide prevention efforts can also help to demystify and de-stigmatize mental health issues, including mental illness.

The purpose of postvention is not just to prevent subsequent suicide, but to ameliorate the emotional trauma associated with the particular suicide (Goldney & Berman, 1996).

Suicide intervention refers to the identification, treatment, and care of a suicidal individual. It involves intervening directly with an individual to reduce the likelihood that they will die by suicide.

Suicide postvention includes all the activities undertaken after a suicide. After a suicide death, postvention efforts address the traumatic after-effects for survivors of suicide, including bereavement and trauma recovery needs, as well as ensuring education and screening efforts to reduce the risk of further suicides.

Suicide prevention, intervention and postvention are part of a continuum of services whose ultimate aim is to prevent death by suicide, while also raising awareness and reducing stigma about suicide within our communities.

Although each of the three areas has a primary focus, they are directly related to one another. For example, effective postvention responses can lead to suicide prevention, and suicide prevention can raise awareness, ensuring that suicide intervention takes place when required (see Figure 1). Suicide prevention, intervention and postvention all require a caring and humanistic response from both formal and informal caregivers.

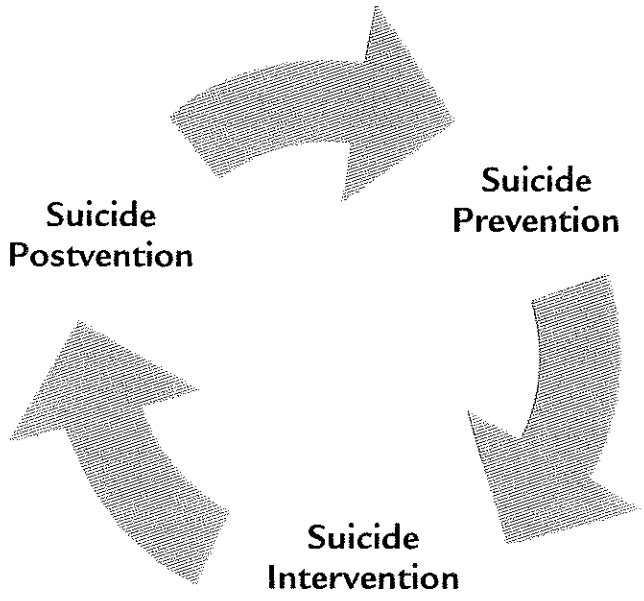

Figure 1: Suicide postvention is prevention[2]

Contagion

Suicide contagion can be viewed within the context of behavioural contagion, a situation in which the same behaviour spreads quickly and spontaneously through a group (Gould, 1990). In the context of this workbook, contagion refers to the process in which one person's suicide may facilitate suicide by others.

There is ample evidence from the literature on suicide to support the idea that suicide can be "contagious" under some circumstances (Gould et al., 2003). A suicide death can result in intense feelings of fear and trigger preoccupation with death and/or suicidal thoughts in friends or acquaintances of the deceased. Some young people exposed to suicide may develop subsequent mental health problems such as depression, anxiety, and posttraumatic stress disorder (Brent et al., 1996).

Not everyone in a community is equally vulnerable to suicide contagion. Certain groups of youth appear to have a higher susceptibility to contagion following exposure to a peer's suicide. Studies suggest that perceived similarities between the observer and the person who died by suicide appear to facilitate imitation (Velting & Gould, 1997).

Individual characteristics that may increase susceptibility to imitative suicidal behaviour include (Brent et al., 1989; 1992):

- A prior history of suicide attempts, threats, or self-injurious behaviour
- Stressful life events
- Exposure to the violent death of someone significant
- A history of depression
- Substance abuse.

Contagion may be direct or indirect. Suicidal behaviour among friends or family, as well as sensationalized suicides in the media or on the Internet, may trigger additional suicides (Gould et al., 2003). The role of the media in suicide contagion is discussed in Chapter Three: Task 3 and Checklist 3, and in Appendix 3.

Suicide clusters

The term "cluster" refers to a closely-grouped series of events or well-defined patterns occurring in relation to time, space, or both (Hazell, 1993). Suicide clusters are statistically rare events (Velting & Gould, 1997). Researchers have found that the incidence of cluster suicides is highest amongst teenagers and young adults (Gould, et al., 1990).

Key points

- The primary purpose of suicide postvention is to support the emotional recovery of survivors while preventing contagion or imitative suicidal behaviour.
- Youth, particularly those who may have a history of previous suicidal behaviour or depression, may be influenced to attempt suicide in the aftermath of another's suicide.
- A planned response to support friends and acquaintances can be effective in reducing psychological, physical, and social difficulties in suicide survivors.

NOTES

1 This section is adapted from the paper, *Preventing Suicide in Youth: Taking Action with Imperfect Knowledge* by Jennifer White (2005). www.mheccu.ubc.ca/publications/.

2 Figure developed by Dafoe, B., Jeffs, C., MacCallum, S. and Monk, L. (2004).

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CHAPTER TWO

Building Local Commitment

"In order to be effective, postvention programs need to be developed before they are actually needed" (Mauk & Weber, 1991).

Chapter overview

This chapter describes a process for guiding your community through the development of a proactive community postvention response protocol. The information and suggestions are not rigid instructions to be followed by every community in the event of a death by suicide. Rather, they are meant to provide you with a guiding framework for developing your own suicide postvention plans and strategies – strategies that are adapted to the unique needs, resources, and cultural characteristics of your particular community.

As in any crisis, having a plan in place in advance of the crisis itself can reduce confusion and provide guidance regarding the actions that are required. Clarification of the roles of community agencies, services, and interest groups who may be involved in a suicide crisis situation ensures that the response to the crisis is immediate, appropriate, effective, thorough, and compassionate.

"A community commitment to immediate identification of, and intervention with, survivors can turn postvention reaction into prevention strategies" (Paul, 1995).

Your community

Each community is unique, and each community will be at a different stage in the development of a plan to respond to the death of a youth by suicide. Your community may be at the beginning stage of developing a suicide postvention response protocol. On the other hand, a suicide prevention committee may already exist, and postvention could become part of the committee's terms of reference.

Some communities may decide to hire an external expert for the community development and planning process (Jeffs, C., 2002).

Perhaps there are people in your community who have developed or initiated a community response to a different type of crisis situation, and who can lend their expertise to the development of a suicide postvention strategy. Or your community may have had recent experience in responding to the death of a youth by suicide. As with all community development efforts, it is important to start where your community is right now.

Your community may already be working on a postvention response to youth suicide. You and your colleagues may have concluded that a proactive response plan is needed after experiencing how difficult it can be, in the midst of a crisis, to coordinate the wide range of activities necessary following the death of a youth by suicide. Suicide crises affect not only peers of the youth who died, but also the entire community. Regardless of the degree of planning to date, your community will benefit from a planned community response in the event of a suicide-related crisis.

Gaining community support

Developing a proactive community response plan requires a group of people, such as yourselves, who are committed to the idea of suicide postvention and to the process of developing a postvention strategy. Gaining community support by holding a community information meeting to involve and inform community members and relevant service providers comes next. At this meeting community members, as well as agency representatives, are informed about, and given a voice in developing, a community postvention protocol.

Benefits of a community information meeting

- Focuses attention on postvention as prevention
- Informs and educates community members about suicide
- Involves the community in the planning process
- Encourages "buy-in" on the part of the community
- Identifies concerned community members who may be interested in being on the Suicide Postvention Coordinating Committee.

Before the community information meeting

Gather information for the purpose of discussion

- Document recent suicides and suicide-related events in the defined community
- Gather media reports of past suicide-related events
- Access local suicide statistics
- Compile a list of other community resources related to suicide.

Advertise the meeting

Posters advertising the meeting should include:

- Why a community meeting?
- Who should attend?
- What is it about?
- When?
- Where?
- Contact numbers for more information.

Invite key agency representatives

Encourage the involvement of key agencies and services, both public and private, in the development and implementation of the postvention strategy. Invite key agency representatives (see Checklist 1).

Key agencies are agencies that:

- Are connected to children, youth, and families
- Represent the cultural diversity of the community
- Provide leadership to the community
- Work in the area of youth suicide prevention
- Are involved in follow-up, treatment, or emergency medical care
- Are involved with youth, such as schools, youth probation, etc.
- Offer services to survivors of suicide
- Are advocates from survivor groups.

Invite local media representatives

Media representatives can be important partners in suicide prevention by providing suicide information and awareness to the public. If representatives of the media are aware of, and included in, the process of developing the postvention plan, it is far more likely that their legitimate need for information after a suicide is satisfied without the sensationalism and confusion that have often been associated with suicide reporting.

Consider inviting a survivor advocate to the meeting

A suicide survivor could give a presentation regarding their experiences following the death of their loved one, including suggestions about what worked and what didn't, in the aftermath of their loss. A survivor might also join the Suicide Postvention Coordinating Committee and act as a liaison person with the local

Survivors of Suicide (SOS) group and/or Compassionate Friends. This connection would ensure ongoing dialogue with survivors of a suicide in the most compassionate, effective, and respectful way possible.

At the community information meeting

- Introduce the postvention response strategy concept
- Introduce the reasons why a suicide postvention strategy is important
- Acknowledge that a coordinated response is difficult to establish in the midst of a crisis
- Suggest that a postvention response requires cooperation and coordination among various sectors of the community
- Introduce the concept of key agencies: Those agencies who will be involved in the many aspects of responding to a crisis
- Ask key agency representatives who by nature of their agency mandate are involved in suicide and, in particular, youth suicide, to identify the role that their agency or institution is equipped to play
- Establish the initial membership of the Suicide Postvention Coordinating Committee (SPCC)
- Ask for a volunteer chairperson to host the first meeting of the SPCC.

A postvention response involves a joint agreement between key agencies within a geographic area whereby service providers agree on their respective roles and responsibilities following a suicide.

After the community information meeting

Once your community has held a community meeting and agreed on the need for a coordinated, proactive, postvention response to the death of a youth by suicide, it is time to plan how this response will be managed by members of the coordinating committee. The volunteer chair:

- Invites key agency representatives who attended the community meeting and/or who expressed an interest in the committee, to the initial meeting of the Suicide Postvention Coordinating Committee
- Hosts the initial meeting of the Suicide Postvention Coordinating Committee.

In anticipation of a suicide cluster, each community should organize and convene a coordinating committee and response team and identify critical community resources (Askland et al., 2003).

The Suicide Postvention Coordinating Committee (SPCC)

There are a number of decisions (see Table 2) that help set the stage, purpose, and initial discussions within your community's SPCC. In some cases, your community may already have a suicide prevention and/or intervention committee; you may be attempting to include postvention needs within existing structures.

The SPCC has a number of core tasks, including the following:

- Identify and coordinate resources before a crisis occurs
- Ensure that all members are clear about their duties and the duties of other members in the event of a critical incident involving the suicide of a youth
- Ensure contact information is up to date
- Activate the suicide postvention response, similar to a "911" emergency (develop the notification mechanism so that the postvention plan can be activated)
- Ensure a media contact person is designated and available (see Chapter 3, Task 3)
- Liaise with communities affected by the suicide
- Deactivate the suicide postvention response (to indicate closure to the postvention response)
- Track each postvention review (see Chapter 3, Checklist 4) and use the results to continue to inform the community's postvention response
- Develop a mechanism for informing and involving new participants, made necessary through attrition and as community make-up and composition change.

TABLE 2: **Important decisions for the Suicide Postvention Coordinating Committee**

- Under what circumstances will the postvention response plan be implemented?
- What geographic area will be served by the postvention strategy?
- What role is each community agency equipped for, and willing, to play?
- How will our notification mechanism, to alert the committee to a potentially evolving suicide cluster, operate?
- How will information be shared across agencies and between impacted communities? Discuss confidentiality.
- In what circumstances does a case conference take place?
- Who will provide psychological debriefing and bereavement counselling, if needed and appropriate?
- Who will facilitate a follow-up suicide postvention review process?

Key points

- A postvention response strategy requires community coordination to ensure buy-in and support, as well as the ability to operationalize the plan when a crisis occurs.
- Communities can benefit from developing a response strategy, organizing and convening a suicide postvention coordinating committee, and identifying critical community resources to respond during the aftermath of a youth suicide.
- Response details, including under what circumstances the postvention response plan is implemented, are identified, discussed, and agreed upon by key agencies.
- Clarification of the roles of community agencies, services, and interest groups ensures that the response to a crisis is immediate, appropriate, and effective.

CHECKLIST 1

Key community representatives

- ☐ RCMP and/or local police
- ☐ Coroner
- ☐ Child and Youth Mental Health, MCFD
- ☐ Victim services
- ☐ School district representatives
- ☐ Provincial government ministries (child welfare workers, guardianship workers, resource workers, etc.)
- ☐ Aboriginal community representatives
- ☐ Probation services
- ☐ Hospital emergency
- ☐ Physicians
- ☐ Hospice
- ☐ Funeral home
- ☐ Clergy
- ☐ Survivor advocate groups
- ☐ Grief support groups, such as Compassionate Friends
- ☐ Parent groups (e.g., Parent Advisory Committee)
- ☐ Suicide crisis centres/hotlines
- ☐ Representatives of education, public health, mental health, and local government
- ☐ Alcohol and drug counsellors
- ☐ Existing suicide prevention groups (crisis lines, etc.)
- ☐ Employee Assistance Programs responsible for supporting teachers, RCMP/police, health care professionals, etc.
- ☐ Individual community members who can provide an element of neutrality, and who have the personal commitment and time to participate on the SPCC
- ☐ Others as identified.

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CHAPTER THREE

Suicide Postvention Tasks

Boldt (1985) urged the inclusion of postvention activities within his suicide prevention model for the Province of Alberta, maintaining that a coordinated community postvention outreach was as important as prevention or intervention.

Chapter overview

When a youth dies by suicide, there is a complex set of needs that require immediate attention. These needs guide the crisis intervention tasks necessary for an effective community postvention response. The tasks discussed in this chapter are based on best practice recommendations in the field of suicide, draw upon various theoretical models (see Appendix 2), and reflect input from community consultation processes (Prince George, BC, 2003; Sechelt, BC, 2004).

Although the tasks are listed in a linear fashion, keep in mind that a crisis always demands the ability to be flexible. Several tasks often occur simultaneously and may be addressed by a variety of service providers; therefore, task coordination is a requirement of a comprehensive postvention response protocol.

Suicide response plan

The suicide postvention response plan is implemented by the Suicide Postvention Coordinating Committee (SPCC) (or designated representative) under either of the following two conditions:

- When one or more deaths from suicide occur in the community, particularly among adolescents or young adults, which may potentially influence others to attempt or die by suicide, or
- When a suicide cluster occurs in the community.

TABLE 3: Overview of a postvention response plan

- The person/agency first "on the scene" contacts the SPCC
- Contact those who will play key roles in the first days of the response
- Notify the family, if they were not on the scene, and other key stakeholders (i.e. school)
- Offer support to suicide survivors, including family members and close friends of the deceased (for example, you might obtain permission for a trained "veteran" survivor to contact them)
- Assist the family to find balance between their natural need to honour the person who died, while not over-glorifying the suicide victim, thereby minimizing sensationalism
- Identify others who may be at high risk of suicide and arrange for a screening interview
- Refer for counselling services as needed
- Provide accurate, appropriate information to the media.

Postvention tasks

The SPCC chairperson or designate initiates the following postvention tasks and signs off the task checklist to indicate delegation and/or completion of each task (see Checklist 2). The coordination and implementation of the following tasks involve information-sharing between family members, service providers, and others. It is imperative that confidentiality guidelines be adhered to by all who are responding in the aftermath of a suicide.

All communications need to be in compliance with the Freedom of Information and Protection of Privacy Act[3] (FOIPPA) and, in the case of BC, the Child, Family and Community Service Act. Under some circumstances, including when a person's health or safety is judged to be at risk, information may be shared without a person's consent, but then it should be shared only on a "need to know" basis. Any other relevant legislation regarding information-sharing in your specific jurisdiction, including your particular professional code of ethics or practice standards, should act as your guide.

Task 1: Gather the facts

The SPCC or designate:

- Confirms the facts regarding the suicide with the coroner and the RCMP or local police
- Ensures the family has been notified
- Obtains accurate information regarding circumstances of death
- Determines whether the family has been made aware of SPCC support
- Encourages and supports the family to tell their children the truth about the suicide death in an age-appropriate way (Calgary Health Region, 2004)
- After family members have been notified, publicly acknowledges the death as soon as practical and in a manner that respects the family, honours the person who died, and avoids glorification of the suicide victim and sensationalism of the suicide itself
- Provides accurate and appropriate information to the media by the SPCC media spokesperson (see Appendix 3).

Task 2: Notify the school, other relevant agencies and impacted communities

If the deceased is a member of the school community, the school principal should be notified immediately. The school representative on the SPCC should keep a current list of school principals, including their home phone numbers, and have it available in the event of a crisis. The school representative ensures that the principal or designate (as per school district protocol):

- Contacts the designated district Critical Incident Response Team (CIRT)[4] Leader, who contacts the other CIRT team members[5]
- Informs the school district media spokesperson
- Contacts the school team and calls them together for a meeting

- Informs staff of the suicide at an emergency staff meeting attended by the School Critical Incident Response Team (or equivalent)
- Reaches out to the parents and family with condolences and acknowledgement of their loss to suicide
- Informs parents of other youth that there has been a suicide in the school community
- Provides information to school staff about the suicide and how best to support youth survivors, including siblings of the deceased.

If the youth was not attending school, a designated representative from the SPCC notifies staff in potentially impacted schools (e.g. a school that the deceased youth recently attended). Relevant service agencies and other affected communities are also notified of the suicide on a need-to-know basis; these parties then proceed with their respective postvention roles.

Task 3: Ensure responsible media coverage

The World Health Organization, the American Association of Suicidology, and the Canadian Association for Suicide Prevention all offer guidelines for the media. All say that it is important to report a suicide in a straightforward manner (see Appendix 3). To ensure responsible media coverage, the Suicide Postvention Coordinating Committee should:

- Designate a media spokesperson
- Meet with the media in the community before a crisis occurs, to provide the most current recommendations for responsible journalistic reporting related to suicide in print, radio, and television
- Introduce the committee's designated spokesperson to the local media
- Review media guidelines before talking with the media
- Provide up-to-date official information about the suicide and what the community is doing for those who are affected
- Provide "where to get help" contact information for inclusion as a sidebar to the article
- Evaluate media reporting of an incident using the follow-up checklist
- Consider meeting with the appropriate media representatives to discuss and give constructive feedback regarding the reporting related to suicide coverage (see Checklist 3).

Task 4: Identify and assist youth at increased risk of suicide

The SPCC contacts agencies that have a postvention role and initiates an emergency interagency meeting, if possible. At this meeting agency staff:

- Identify and share information about youth who may be at risk of suicide (see Tables 4 & 5) such as relatives, close friends of the deceased, adolescents with a previous history of depression or suicidality, and/or youth who have experienced a previous suicide in their family
- Arrange for a suicide risk assessment by a mental health professional, when necessary
- Develop case management plans for at-risk youth in consultation with parents or guardians, where possible, being sure to articulate specific safety plans
- Ensure that any planned activities, such as a funeral or memorial service, are carefully monitored (see Task 7)
- Arrange for follow-up consultation with parents or guardians.

TABLE 4: Strategies to identify youth who may be at increased risk of suicide

- Verify the status of school absentees in the days following the suicide of a student
- Enlist the aid of teachers and students in identifying possible high-risk students
- Identify and refer youth with a history of depression or with concurrent mental illness and substance abuse issues, who were exposed to suicide
- Identify youth with known stressors such as bullying, gambling problems, etc.
- Identify youth who have previously lost a family member or close friend to suicide
- Identify and refer youth who may have weak social supports, for example:
  - Students who have recently moved into the school district
  - Students who have recently broken up with a boyfriend or girlfriend.

TABLE 5: **Warning signs of suicide**[6]

- Talking or joking about suicide
- Increased or heavy use of alcohol and drugs
- Giving away prized possessions
- Reckless risk taking
- Abrupt change in school attendance
- Decline in academic performance
- Inability to concentrate
- Sudden failure to complete assignments
- Changed relationships with classmates
- Increased irritability or aggressiveness
- Mood swings
- Unexpected displays of emotion
- Despairing attitude
- Preoccupation with death and suicide as evidenced in writing, drawings, music
- Disturbed sleep/loss of appetite
- Becoming more or less social than usual
- Loss of interest in important relationships
- Change in appearance and personal care
- Suicide threats (written and/or verbal)
- Statements revealing a desire to die
- Previous suicide attempts
- Depression (crying, sleeplessness, loss of appetite, hopelessness).

If you are concerned that someone is suicidal:

- Ask directly about suicide: Are you thinking of killing yourself? Are you thinking about suicide?
- Discuss suicide openly and frankly
- Show concern and offer support
- Get professional help (e.g. doctor, counsellor)
- Call your local Crisis Line.

Task 5: Initiate crisis counselling and support[7]

Counselling services are beneficial for suicide survivors, including family and friends who are grieving, those who may be traumatized by the suicide, and other youth who may be vulnerable to contagion.

When providing support, varying approaches may be required. A current Canadian report on postvention within schools (Seguin, 2004), suggests that not all students will have the same emotional needs in the aftermath of a suicide.

For example, debriefing may be suitable for those manifesting symptoms of post-traumatic stress symptoms, whereas short-term emotional support and education may be more suitable for those who have heard about the death but had no real connection to the student who died (see Appendix 6).

After a death our first job as a society is to support those left behind. After a suicide death we need to do that in such a way that we don't inadvertently trigger additional deaths. The first step in avoiding contagion is to break the silence around suicide and support the survivors.
Bonny Ball, Suicide Survivor

Counselling services can be coordinated by the relevant members of the suicide postvention coordinating committee. Counselling and support needs might include:

- Initiating follow-up counselling for at-risk youth
- Notifying those affected by the suicide that counsellors are available, and providing information about their location and how to contact them
- Ensuring support is provided to family members, as well as to individuals less directly involved with the deceased, yet negatively impacted by the suicide (e.g. school peers)
- Identifying those individuals who may have trauma issues (see Appendix 6) as a result of the suicide (those at higher risk for a trauma response after a suicide might include individuals who found the body, witnessed the suicide, had a fight with the deceased just prior to the suicide) (Ambrose, 2003)
- Providing additional external resources to local service providers when needs exceed resources.

Youth are often apprehensive about "going for counselling" given the stigma and fear that can sometimes be associated with seeking help. It is important to consider strengthening the supportive role among informal caregivers such as peer helpers, since youth often speak with one another before talking with anyone else. In addition, labeling the support that is offered following a suicide as "support", "care", or "listening", rather than counselling, may increase the likelihood that youth will seek help.

Task 6: Debrief and support professionals

Professionals become suicide survivors when someone they work with dies by suicide. Common helper emotions following the suicide of a client can include guilt, feelings of responsibility, anger, panic, depression, and impatience.[8] Professionals can also benefit from emotional support (see Appendix 8). This support may come through:

- Supervision and consultation
- Stress or trauma counselling
- Psychological debriefing and defusing (see Appendix 5)
- Peer support
- Employee Assistance Programs.

Each agency should ensure that any staff involved with the suicide postvention response receives the support they require. This support is an important stress and trauma management response from an organizational health perspective.

Task 7: Communicate funeral information

Information regarding the funeral should be made available, if this is the wish of the family. Ask the family to identify a key contact person responsible for communicating funeral information. Service providers, including representatives from the SPCC, may have a role in the following:

- Speaking with the bereaved family about their wishes, including cultural practices and rituals, if their clergy or funeral home isn't already taking care of this
- Ensuring that all agencies respect the wishes of the family and, if indicated and appropriate, the wishes of the deceased
- Supporting and communicating the wishes of the family regarding funeral attendance
- Providing ways to "name suicide" in the death notice if the family wishes (see Appendix 4)
- Suggest options regarding "donations to" (e.g. Canadian Association of Suicide Prevention, a local Crisis Centre, a Survivors of Suicide Group).

It is important to:

- Be aware of, and sensitive to, cultural needs and practices regarding a death
- Determine the best way to notify youth about the funeral arrangements

- Arrange travel and supervision for youth's friends attending the funeral or memorial service, when required
- Ensure that young people who plan to attend the funeral are prepared – discuss the purpose of rituals, appropriate etiquette, and other topics as necessary
- Ensure that youth at risk for suicide are supported.

Task 8: Consider remembrance activities

Memorials and remembrance activities are intended to honour the person who died and to help bring closure, hope, and healing to those close to the deceased. However, remembrance activities should be careful not to sensationalize the suicide. Conducting highly-charged, emotional ceremonies and erecting prominent and permanent memorials to remember youth who have killed themselves may inadvertently contribute to the contagion effect among other young people.

When working with the family, clergy, the funeral home and, perhaps, a school representative, to plan remembrance activities:

- Present the facts
- Encourage grieving and show respect for the deceased while avoiding romanticizing the suicide and its cause
- Distinguish between the act and the person
- Reassure family, youth, and other survivors that they are not to blame; "While we can provide care and support ultimately it is the suicidal person who has to reach for life instead of death"[9]
- Embed suicide prevention in the memorial service; for example, mention how others may feel in distress, and the importance of reaching out for help
- Respect cultural norms and the need for community grieving rituals
- Avoid glorifying or sensationalizing the death
- Avoid school memorial assemblies. Large assemblies may encourage contagion
- Avoid permanent memorials (unless this is a standard practice after a student death). Consider initiatives related to suicide prevention that can be dedicated to the young person who died
- Suicide experts (Leenaars & Wenckstern, 1991) and survivors note that school memorials should be consistent with any other youth death.

(See also Chapter 4: Schools and Postvention for guidelines on school-related remembrance activities).

Task 9: Ensure ongoing support for survivors

A death by suicide has a long-term impact on families. Support is often needed not only during the immediate aftermath, but also in the months and years that follow. Ensuring that such services are available and accessible is an important component of a suicide postvention response. Families who have lost a youth to suicide respond in many ways. In the midst of family members' grief and trauma reactions (see Appendix 6) after a suicide loss, they may:[10]

"We only wish in retrospect that we could have done something to stop him from doing this, to stop him from killing himself" (Father of a 14 year-old boy who died by suicide).

- Blame themselves or others for their relative's suicide
- Feel a sense of rejection
- Say that there were no warning signs of suicide, when that may or may not be true
- Have feelings of stigma and/or shame
- Become overwhelmed with feelings of despair, helplessness, and failure
- Feel suicidal themselves
- Fear contagion
- Have very different responses within the family
- Become enraged at their loved ones for "being selfish"
- Experience "posttraumatic growth" (Tedischi & Calhoun, 2004) in their lives (see Appendix 9).

"A suicide kills one person and wounds those who are left behind to mourn" (Grollman & Malikow, 1999, p. xii).

Recovering from the death of a loved one is a process that can be prolonged and complicated when the death is a suicide. The emotional, grief, and possible trauma, recovery processes are both complex and unique in each situation. Postvention services include referral for bereavement counselling, trauma intervention and non-judgemental support for family members (see Appendix 6 & Appendix 7).

Task 10: Facilitate a suicide postvention protocol review meeting

Community partners and members of the Suicide Postvention Coordinating Committee who responded during the aftermath of the youth suicide, come together to review the crisis response and media reporting. This postvention review should take place within two weeks following the crisis and be facilitated by a designated member of the postvention committee. The postvention protocol review (see Checklist 4):

- Provides closure to the postvention response
- Identifies what worked and which areas need improvement (at a later date, consider asking the family of the deceased for feedback about what was helpful to them at the time of their loss)
- Identifies any necessary changes to the response
- Creates the time and place to acknowledge the work done by local professionals and volunteers during the suicide postvention response.

Key points

- When a youth dies by suicide, there is a complex, and at times, conflicting set of needs that require immediate attention.
- In the aftermath of a suicide, these needs guide the crisis intervention tasks necessary for an effective community postvention strategy.
- The SPCC is instrumental in ensuring the tasks are completed.
- In all tasks, compassion for the family and other survivors, as well as respect for their perspective and needs, must be paramount.
- The SPCC members who responded during the aftermath of the youth suicide come together to review the crisis response, including media reporting.

CHECKLIST 2

Suicide postvention tasks

Crisis response

- ☐ Gather the facts
- ☐ Notify the school, other agencies and impacted communities
- ☐ Ensure responsible media coverage

Assessment and support services

- ☐ Identify youth at risk of suicide
- ☐ Initiate crisis counselling
- ☐ Debrief and support professionals

Memorial and remembrance activities

- ☐ Communicate funeral information
- ☐ Consider remembrance activities

Follow-up

- ☐ Ensure ongoing support for suicide survivors
- ☐ Facilitate a suicide postvention protocol review meeting

_____ _____

Signed off
SPCC Chair or Designate

Date

CHECKLIST 3

Responsible media reporting

Did the media

- ☐ Avoid reporting specific details of the method?
- ☐ Avoid a description of the suicide as "unexplainable"?
- ☐ Avoid giving romanticized versions of the reasons for the suicide?
- ☐ Avoid giving simplistic reasons for the suicide?
- ☐ Print the story on an inside page?
- ☐ Print the story below the fold, if it must appear on the first page?
- ☐ Avoid the word "suicide" in the headline?
- ☐ Avoid printing a photo of the person who died by suicide?
- ☐ Report the suicide in a straightforward manner?
- ☐ Mention the negative consequences for survivors of the suicidal behavior?
- ☐ Present alternatives to suicide?
- ☐ Present examples of positive outcomes of people in suicidal crises?
- ☐ Emphasize that there are alternatives to solving seemingly hopeless problems?
- ☐ Provide information on community resources?
- ☐ Include a list of warning signs of suicide?
- ☐ Provide suggestions of what to do and/or where to get help?
- ☐ Use the term "died by suicide" or "killed himself or herself" rather than the terms "completed", "successful", or "committed suicide"?

CHECKLIST 4

Postvention protocol review

- ☐ How well did this suicide postvention strategy guide the actions taken? Was each step taken? If not, why not?
- ☐ Were the actions taken appropriate? If not, what should change?
- ☐ Were there any steps taken that are not currently included in the suicide postvention strategy? Should they be included?
- ☐ What, if any, changes should be made to the suicide postvention strategy?
- ☐ Did the suicide postvention coordinating committee notify relevant service providers in a timely manner?
- ☐ Was the information conveyed to the postvention team (i.e. from the RCMP/police, the coroner, the hospital, etc.) adequate?
- ☐ Was an appropriate person available to answer questions and concerns?
- ☐ Was there a media spokesperson available to guide media coverage?
- ☐ Did the media coverage follow the media guidelines? If not, what media follow-up is needed?
- ☐ Were counselling, support and/or debriefing services forthcoming and available? (for survivors, at-risk youth and professionals, respectively)
- ☐ Were additional financial resources needed? (for example, bringing in additional counsellors to remote communities)
- ☐ How were these funds accessed?
- ☐ Was the contagion effect managed? (i.e. no other youth attempted suicide)

This postvention response revealed the following:

Areas of strength:

Areas for improvement:

_____ _____

Sign-off
SPCC Designate

Date

NOTES

3 FOIPPA

1.2 Health Information Principles

A patient has a right to privacy of personal health information. Such information cannot be disclosed without the patient's authorization.

The Freedom of Information and Protection of Privacy Act enumerates a number of situations in which such information MAY be disclosed without the patient's authorization, including when a person's life is considered to be in danger.

2. Health care providers require access to health data for the provision of care and delivery of services to the individual.

4 As outlined in *Responding to critical incidents: A resource guide for schools,* BC Ministry of Education, (1998). The Guide is available online in a printable version at: www.bced.gov.bc.ca/specialed/rci/ (or equivalent protocol for your geographic area).

5 Schools in other provinces may have varying names for their response teams including tragic events response, traumatic events response, crisis intervention response.

6 Adapted from: *Suicide: What you need to know A Guide for School Personnel* Pamphlet: BC Council *for* Families.

7 For a deeper understanding of grief and trauma after suicide please see Appendix 6 and for further suggestions for supporting survivors of suicide please see Appendix 7.

8 LivingWorks Education, 2004, from ASIST: Applied Suicide Intervention Skills Training

9 SAFER brochure, "Living With Someone Who is Suicidal."

10 This list was compiled from discussions with survivors, reviewing pamphlets including Grief After Suicide, 1993, CMHA; Helping a Suicide Survivor Heal, 1993 and our literature review.

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CHAPTER FOUR

Schools and Postvention

A school is a sub-community within the framework of the broader community. What happens following the sudden loss of a member of the school community is rarely separate from the larger community and the two are best dealt with conjointly (Ambrose, 2003).

Chapter overview

No community postvention response to a youth suicide is complete without taking into consideration school procedures. A strong liaison between schools in the community and the Suicide Postvention Coordinating Committee, including a working familiarity with school procedures following a death by suicide, is essential.

School systems are an integral part of a community. As the majority of young people who die by suicide are part of a school community, the school becomes a natural place for a postvention response. Identifying youth who may be at risk for suicide following the death by suicide of a peer, while responding to the emotional and psychological needs of students, is crucial.

A school's internal resources are the primary means of support following the suicide death of a member of the school community (Mackesy-Amiti et al.,

1996). A postvention response is required not only when a student dies by suicide, but also when parents, teachers, or support staff die by suicide, although the response will vary accordingly (see Checklist 5).

After the suicide of a student

Inform staff and students

- After the staff are briefed, the suicide death should be announced to the students by their teacher, in their regular classroom setting
- The death should be announced privately to those students who are most likely to be deeply affected by the tragedy – siblings and other relatives, close friends, and girlfriends or boyfriends
- A student who is visibly upset following a peer's sudden death by suicide should not be sent home without notifying his or her parents
- Students should be supported to express these feelings with a trusted individual such as a parent, teacher, or school counsellor
- Students (other than family members) should not be dismissed early following a peer's death by suicide; the postvention response should take place within the school.

A balance must be struck that creates opportunities for students to grieve but does not increase suicide risk for other students by glorifying, romanticizing, or sensationalizing suicide (Callahan et al., 1999).

Provide information[11]

- Publicly acknowledge the suicide. This allows mental health, school officials, and others to take steps to reduce possible suicide contagion
- In collaboration with the family when possible, provide factual and timely information about the cause and manner of death. Facts greatly reduce the rumours and innuendoes that often accompany a suicide death
- Talk about depression, self-medication, suicide, and suicide prevention, including reaching out for help
- Talk about the loss and the unknown potential: what the deceased individual might have accomplished in the future
- Openly acknowledge and discuss the emotions and heartache the death has caused
- Make clear to students that there are solutions to problems other than suicide.

Identify at-risk youth

Certain students may be more at risk for contagion than others. School personnel, teachers, counsellors, psychologists, and fellow students are among those who can assist in identifying a student, or other youth, at risk for suicide (see Tables 4 and 5, Chapter 3). The following factors may increase risk for certain individuals in the aftermath of a suicide:

- Past episode of suicidality
- Prevalence of known suicide risk factors such as depression, substance abuse, previous suicide in the family, recent losses, and legal problems
- Previous life experiences and personality factors which could lead an individual to identify with a suicide and increase their susceptibility to imitation.

Protective factors which may lower the risk of imitation or contagion in the aftermath of a suicide include:

- Good emotional health at the time of the loss
- The ability to identify and express feelings
- Access to social support
- Strong family bonds.

There are survivors and professionals who feel that suicide response guidelines are often problematic; for example, discouraging photos of the deceased or the creation of permanent memorials. They believe that school response efforts following a suicide death should be consistent with those responses activated after any kind of death (The Dougy Center, 2000; SurvivorAdvocates Listserve, 2004).

Provide support

- Identify youth who may be at high risk and initiate at least one screening interview with a trained counsellor. Refer for further counselling or other services if needed
- Watch for, and provide extra support to, those youth who might be at greatest risk: Siblings, girlfriend or boyfriend, teammates, and other close friends
- Encourage anyone who is depressed or has been having thoughts of harming themselves to get immediate help
- Remember that some of the youth may already be survivors of suicide (i.e. they may have had a friend or family member die by suicide in the past)
- Have counselling/support services available for all those affected by the death
- Offer information about relevant available professional help, as well as where and how to access it.

Consider remembrance activities

In the school setting the issue arises: How to respect the wishes of grieving family, friends, and others, while balancing the need to reduce possible contagion. Youth or young adults who are at increased risk of suicide may wrongly perceive that they will be remembered or honoured in the same manner as the youth who died by suicide. This belief may increase their risk for suicide or attempted suicide.

The challenge is to facilitate grieving while also remembering and honouring the deceased, without glorifying their death. The school representative on the SPCC can help educate survivors about the risk of contagion and assist in organizing a school memorial activity that is both respectful and considerate of this risk. Guidelines around remembrance activities have been suggested by a number of researchers.[12]

Guidelines for school-related remembrance activities

Memorial services should foster an atmosphere that will help survivors understand, heal, and move forward. Any kind of public communication following a death by suicide has the potential to either increase or decrease the suicide risk of those receiving the communication. Following recommended school-related remembrance activities and avoiding other activities can reduce the risk of imitative suicide.

It is best to avoid:

- Any type of large-scale memorial service or remembrance that takes place at school, especially during school hours, because
  - Students who did not know the deceased may be negatively affected by attending a mandatory or school-wide service
  - Some students may continue to associate that room or hall with the student's suicide.
- Closing the school during the community funeral or memorial service[13]
- Flying flags at half mast, or creating permanent plaques or dedications to the individual such as yearbooks, dances, ball games.

Helpful activities include:

- Encouraging donations to favourite charities of the family of the deceased, suicide prevention efforts, youth psychiatric facilities, or local crisis lines
- Volunteering on suicide hotlines, initiating a peer support group, or hosting a suicide prevention workshop.

After a suicide attempt

School personnel are often faced with integrating a student back into the school setting following a suicide attempt. This can be a difficult time for a student returning to school after a personal suicidal crisis. These students require ongoing support and follow-up by the school counsellor and other professional helpers involved in their care. Confidentiality is extremely important; often rumours and gossip are part of the returning student's experience. A non-judgemental approach from teachers and others, combined with the expectation that the student resume their school attendance and performance (as much as they are able), helps this normalizing and reintegration process.

Consider suicide awareness programming for youth

Following a crisis, there are opportunities for growth and learning. Sometime following a suicide (not in the immediate aftermath) it may be worthwhile to consider offering a suicide awareness program. These programs generally aim to achieve one or more of the following objectives:[14]

- Counteract myths and negative attitudes about suicide, reduce stigma, and encourage vulnerable individuals to seek help
- Increase recognition of suicide risk
- Increase knowledge specific to intervention
- Increase knowledge of helpful resources.

The death of a youth by suicide can be a catalyst for lifting the stigma and taboo which often surrounds talking about this important issue (Grollman & Malikow, 1999). Suicide prevention includes creating opportunities to discuss suicide openly and without judgement. Suicide awareness programs, facilitated by trained professionals or volunteers who are aware of the research regarding such programming, are meaningful vehicles for this important dialogue.

Key points

- The school is part of the community postvention response.
- The school response is a key component of supporting siblings and other youth who were particularly close to the deceased.
- Schools play a significant role in supporting students following the suicide death of a student or staff.
- Efforts to educate students about suicide and mental health/mental illness are effective prevention strategies. A suicide awareness program could be respectfully dedicated to the youth who died by suicide.

CHECKLIST 5

Suggested school guidelines: Postvention procedures[15]

A school postvention policy should include step-by-step procedures covering the following issues:

Short-term (immediate aftermath following a suicide)

- ☐ Who will be the school-based (district-level) person in charge?
- ☐ How will the school mobilize and receive outside help, if necessary?
- ☐ Who will communicate with the bereaved family and the media?
- ☐ How will school support staff handle telephone calls and requests for information from the community?
- ☐ How will information regarding the school's response be communicated to all parents and neighboring schools?
- ☐ How will staff and students be informed of the suicide, and who will do this?

Longer-term (days and weeks following the suicide)

- ☐ How will staff be provided with support for dealing with students' reactions?
- ☐ How will staff and students be informed regarding funeral arrangements?
- ☐ How will the sensational and emotionally-charged climate that surrounds a suicide death in the school community be reduced?
- ☐ How will students at high risk following the suicide be identified and supported?
- ☐ What type of support and counselling services will be provided for peers and school personnel, and how will these be coordinated?

NOTES

11 Adapted with permission from *Frameworks Youth Suicide Prevention Project, Funeral Directors, Postvention Response* (in press).

12 The most current, *After a Suicide*: Recommendations for religious services and other public memorial observances, is found on the web at: www.sprc.org.

13 This gives students the option of whether or not they wish to attend. For some students and staff, staying with their usual routine and supports is the healthiest way to grieve.

14 Adapted from Suicide Awareness Programming for Youth, Nova Scotia Help Line Society.

15 White, J. & Jodoin, N. (2003). *Aboriginal youth: A manual of promising suicide prevention strategies.* (p. 163) Calgary, AB: Centre for Suicide Prevention (slightly adapted with permission from the authors).

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CHAPTER FIVE

Cultural Considerations in Postvention

"Two-thirds of the last generation to attend residential schools has not survived. It is no coincidence that so many fell victim to violence, accidents, addictions and suicide. Today, the children and grandchildren of those who went off to residential schools also live with the same legacy of broken families, broken culture and broken spirit." (Chief Councillor Charlie Cootes, Uchucklesaht First Nation, Port Alberni, BC, May 29th, 1992).

Chapter overview

This chapter explores suicide postvention considerations when working within and across cultures. There is particular emphasis on suicide within Aboriginal communities, since the rate of suicide within this cultural group exceeds any other cultural group within Canada (Kirmayer, 1994).

Role of culture

Culture plays a significant role in any discussions related to suicide. Every culture and religion has beliefs, rituals, expressions, and language related to death, dying, grief, and loss, all of which affect the response to suicide. In the aftermath of suicide, close attention should be paid to the unique cultural meaning of suicide as well as local healing practices for the family, community, and cultural group who have experienced the loss.

Suicide within Aboriginal communities

Aboriginal communities have a higher rate of youth suicide compared to any other culturally identifiable group in the world (Kirmayer, 1994). In Canada, suicide occurs approximately 5-6 times more often amongst First Nations' youth than non-Aboriginal youth. Suicide is the leading cause of death for youth and adults up to age 44 among Aboriginal people. In BC, First Nations youth aged 15-24 have a suicide rate 4.5 times greater than non-Aboriginal youth (Health Canada, 2003, p. 23).

Not all Aboriginal communities are affected by suicide to the same extent. Recent research in British Columbia (Chandler & Lalonde, 1998) has shown that the rate of suicide among Aboriginal youth varies dramatically from one community to another. This research found that more than 90% of Aboriginal youth suicides occur in only 10% of the communities. Some communities have rates as high as 800 times the national average, while more than half of the province's 200 First Nations bands have not experienced a single youth suicide in almost 15 years (Chandler & Lalonde, 2004). What is different about the communities without suicides, and those in which youth suicide occurs in epidemic proportion? According to the findings of Chandler and Lalonde, protective factors appear to include those community characteristics that promote "cultural continuity."

These include:

- Land claims
- Self-government
- Education services
- Police and fire services
- Health services
- Cultural facilities.

Understanding suicide among Aboriginal peoples

To understand the higher rates of suicide and the prevalence of suicidal thoughts among Aboriginal peoples, it is necessary to consider the impact of the following:

- Cultural oppression
- Residential schools
- Stigmatization
- Marginalization
- Racism
- Poverty
- Substance abuse
- Intergenerational trauma, violence, and abuse.

(Royal Commission on Aboriginal Peoples,1995; White & Jodoin, 2003).

Suicide must be looked at within a broad cultural and historical context that understands the role of historical policies of assimilation and practices of colonization, in understanding risks for suicide and other social problems in First Nations communities (Mussell et al., 2004). While it is important to understand the social, historical, and political factors that have contributed to the disproportionately high rates of suicide among Indigenous peoples, it is equally important for service providers to hold a vision for restoring wellness and strengthening Aboriginal communities.

Aboriginal youths' safety, health, and well-being are linked to the quality of interaction not only within the family, but across other areas of influence such as peers, schools, communities, culture, society and the environment (Mussell et al., 2004).

Restoring wellness

Postvention efforts should start with an understanding of what wellness means within the Aboriginal community. "Wellness describes a condition of optimal well-being. Children who enjoy wellness reflect family health. Members of healthy families possess personal purpose, value family membership, seek information, offer assistance, make choices, experience humility, have a sense of humour, believe in an optimistic future, identify with family heritage and possess a relatively secure personal identity" (Mussel et al., 2004, p. 14). Wellness is balancing the physical, emotional, intellectual and spiritual aspects of life (Fraser Valley Aboriginal Wellness Steering Group, 2002).

This is what I have learned from my mother when she was still here on this earth: "Our responsibility, as a caring community is to be there for someone who is in need of care and to help them choose healthy alternatives." Gertie Pierre, Sechelt Indian Band.

Service delivery considerations

In an Aboriginal community the best community resources come from inside the community itself. These include formal helpers such as band counsellors and health care professionals, as well as informal helpers such as elders, spiritual leaders, medicine people, and extended family members. These resources should be identified, developed, and supported on an ongoing basis to build internal capacity specific to suicide postvention needs, while simultaneously serving as community suicide prevention efforts.

It is important to keep the caregivers' and local service providers' emotional health needs in the foreground. Many Aboriginal communities are smaller in size and, in some instances, located in isolated geographic areas. This, combined with community based interventions, means that caregivers are often fulfilling a professional role while also being personally impacted by the traumatic loss itself. Since there are many incidents of trauma, grief, and loss within Aboriginal communities, the cumulative nature of the exposure to traumatic stress for the caregivers is a consideration when developing a suicide postvention protocol (see Appendix 8).

Culturally respectful practices

The following discussion is intended for non-Aboriginal parties who may be going into an Aboriginal community to offer supplementary services in the event of a death by suicide. Outside resources might be considered useful as a way to complement and support the available service providers within the Aboriginal community itself. These resources might include crisis counsellors, psychological stress debriefers, mental health professionals, and others. Non-Aboriginal service providers should consider culturally respectful guidelines (see Table 6) when offering help to an Aboriginal community following a death by suicide.

TABLE 6: **Culturally respectful guidelines**

- Be invited into the community
- Ask the community representative what additional resources would be helpful at this time
- Work in cooperation and collaboration
- Ask the community what resources are available and honour their experience
- Learn the bereavement traditions and healing practices of the community; respect community history and integrity
- Acknowledge the likelihood of accumulated grief, trauma, and loss for Aboriginal community members, including the service providers
- Keep confidentiality in the foreground; honour and respect confidentiality even after a person has died
- During a crisis professionals, other than those immediately affected by the suicide, should provide consultation and debriefing services
- Local community service providers may be grieving the loss of the individual who has died by suicide not only as a professional, but also as a community member or relative. Emotional support is a necessity for these professionals
- There is no "one size fits all" step-by-step response. Service providers are most helpful when they respect local knowledge, culture, wisdom, tradition, and healing practices
- Efforts to develop professional relationships between key service providers should be an ongoing priority. The relationship between service providers both in and outside the impacted community should be established prior to the crisis itself.

Key points

- Service providers are most helpful when they respect local knowledge, culture, wisdom, tradition, and healing practices.
- Aboriginal communities have a higher rate of youth suicide compared to any other culturally identifiable group in the world (Kirmayer, 1994).
- Not all Aboriginal communities are affected by suicide to the same extent.
- In an Aboriginal community, the best community resources come from inside the community itself.

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CHAPTER SIX

Planning for the Future

"Considering there is 'no one size fits all' protocol to be developed, communities must determine the best possible starting point to develop and test suicide postvention protocols" (Calgary Health Region, Suicide Response News and Notes, October 2003).

Chapter overview

This final chapter discusses suicide postvention protocol implementation, including possible measurements of protocol effectiveness. Like all areas of community development, in particular the coordination of community resources, such initiatives take time and ongoing resource allocation to ensure success. It is natural for training needs and educational initiatives to parallel and support the process of postvention protocol development and implementation.

Implementing suicide postvention protocol

As mentioned at the beginning of this workbook, postvention efforts following a suicide most often occur without prior postvention planning or community development. When someone dies by suicide, a community has a choice of doing nothing or trying to do something. With proactive postvention planning, your community can build overall suicide prevention capacity and create a clear sense of direction in the aftermath of a youth suicide.

Since community members, including professionals and non-professionals, come into contact with survivors of suicide during the bereavement process, awareness generated through postvention planning regarding survivors' needs increases the likelihood for a healthy recovery within the broader community following a death by suicide.

Suicide bereavement is unique; it often takes several years for mourning and healing to occur for survivors such as youth and adult family members and close friends. It also takes time for a community to heal after such a loss. The necessary human and financial resources for such follow-up are considerations to discuss during your community's planning discussions.

There are always learning needs and choice points along the way as the community increases its knowledge and procedures to follow in the aftermath of suicide. Youth awareness programs are part of suicide prevention efforts. Agencies and resources that have programs or services for survivors within your jurisdiction are an important part of suicide postvention.

The overall coordination of suicide prevention, intervention, and postvention services helps reduce the stress felt by those in need of help; it also ensures efficiency within the service delivery system itself, which can ease the work load of social service and health care providers.

Resource allocation

Coordination efforts must focus on postvention development and implementation, while making the best use of available fiscal and human resources dedicated to suicide prevention and postvention.

The issue of suicide is too often hidden behind silence and taboo and has only recently been acknowledged as a health priority by the World Health Organization (WHO). Several countries (Canada is not one) have developed national strategies that identify suicide as a priority and designate and coordinate significant resources to research or prevention.[16]

There is a current need for increased investment toward suicide prevention in Canada, including research, training, and the development of helpful suicide prevention, intervention, and postvention resources. Research is also an area requiring financial support and investment.

At the local level, postvention requires fiscal resources to develop and implement a suicide postvention protocol appropriate to your community. Costs include, but are not limited to, meetings of key community and agency representatives (see Chapter 2). Meetings might involve space rental fees, coverage to attend meetings, wages for meeting attendance, photocopying, the development of print resources, the hosting of necessary training events, and other costs related to the ongoing operations of a suicide postvention committee.

Postvention protocol effectiveness

A community should consider their postvention protocol as a dynamic and active model which is regularly discussed (for example, via the Suicide Postvention Coordinating Committee), implemented when necessary, and reviewed for its effectiveness.

There have been various suicide postvention models developed in regions across Canada; however, they are often not measured in terms of effectiveness. The following are possible areas to systematically address in terms of protocol effectiveness[17]:

- Did the protocol result in improved coping skills in survivors?
- Did the protocol lead to a reduction in suicidal behaviour in other youth?
- Did service providers have a sense of direction about what to do after a youth suicide in their community?
- Was there a coordinated postvention response?

Future training needs

As your community's postvention planning develops and evolves, training needs that are directly or indirectly related to suicide postvention may emerge in your community. Training initiatives that broaden the understanding of the complex interaction of biological, social, psychological, and spiritual factors underlying suicide could include topics such as the following:

- Crisis intervention
- Suicide risk assessment
- Identification of resources in the community which provide "continuity of care" after a suicide attempt
- Grief and loss counselling
- Trauma awareness and intervention
- Psychological debriefing; a common model used is the Mitchell model, known as CISD: Critical Incident Stress Debriefing (Mitchell, 1983)
- Training in suicide postvention planning.

Summary

Community development specific to suicide postvention planning, including participation on the SPCC, requires commitment and ongoing vision. As leaders of suicide prevention in your community, you champion overall suicide prevention efforts and help ensure a sustainable postvention protocol.

Key points

- The development of a community suicide postvention protocol requires time, commitment, possible training, and financial resources.
- A community should consider their postvention protocol as a dynamic and active model that is part of their overall suicide prevention efforts.
- Over time, it is valuable to develop a means to measure the effectiveness of a suicide postvention protocol.

NOTES

16 There is currently, however, a proposed "Blueprint for a Canadian National Suicide Prevention Strategy *Summary*" available through CASP: Canadian Association for Suicide Prevention (see www.suicideprevention.ca).

17 Adapted from discussions within Suicide Response News and Notes, October 2003, Volume 3, 10th Edition, Calgary Health Region.

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APPENDIX 1

Glossary of key terms

At-risk individual A person who has been identified as having certain suicide risk factors (e.g. previous suicide attempt) and/or has been exposed to certain suicide risk conditions (e.g. recent suicide of a friend).

Aboriginal Aboriginal people are the descendants of the original inhabitants of North America. The *Constitution Act* recognizes three groups of Aboriginal peoples: Indian, Inuit, and Metis people (BC Provincial Health Officer, 2002).

Bereavement The general state of being that results from having experienced a significant loss. It encompasses a wide range of reactions – emotional, cognitive, spiritual, behavioural, and physical (Skinner Cook & Dworkin, 1992).

Cluster A series of suicides that occur close together in time and space and may involve imitation.

Debriefing Debriefing is an immediate, short-term, often single-session, psychological intervention with two primary intentions: 1) management of psychological distress after trauma, and 2) prevention of the later onset of posttraumatic stress disorder or symptoms such as depression and anxiety among those exposed to trauma.

First Nations First Nations people are often considered members of a First Nation band or tribe. First Nations is not a legally defined term and refers to both Status Indians and Non-Status Indians[18] (BC Provincial Health Officer, 2002).

Grief The set of responses to real, perceived, or anticipated loss. Responses usually include physical, emotional, cognitive, psychological, and spiritual components. Grief refers to the process of regaining equilibrium after a loss.

Intervention Intervention activities include early recognition of suicide risk, direct contact with the individual involved, and referral to an appropriate mental health professional for assessment and care.

Mourning The cultural response to grief. It is the public expression of sharing feelings of grief.

Postvention A range of activities following a youth suicide, designed to provide support to survivors and prevent suicide contagion.

Suicide Death caused by self-inflicted, intentional injury.

Suicide attempt Potentially self-injuring behavior motivated by intent to die, but with a non-fatal outcome.

Suicide contagion The process in which one person's suicide may facilitate suicide by others. Also referred to as copycat suicide or imitative suicide.

Suicide ideation Thoughts of suicide.

Suicide pact Suicides committed simultaneously by two or more individuals who have communicated their suicide intention to others.

Suicide threat A verbal statement or non-verbal action that can be interpreted as communicating that a suicidal act or behavior might occur in the near future.

Suicide survivor An individual who is negatively and/or traumatically impacted by a suicide death.

Trauma A serious injury, wound, or shock to the body and/or mind resulting in major upheaval and possible psychological and behavioural disorders.

Youth "Youth" is being increasingly expanded to include all those under age 24, or even age 30. For the purposes of this document, "youth" refers to those under age 19.

18 Status Indians (sometimes referred to as Registered Indians) are those who are entitled to receive the provisions of the *Indian Act*). Non-Status Indians are those who do not meet the criteria for registration or who have chosen not be registered.

APPENDIX 2

Theoretical framework

Responding to the trauma resulting after a suicide makes use of the following theoretical frameworks:

1. CRISIS INTERVENTION THEORY to provide
   - Support
   - Control
   - Structure

2. TRAUMA THEORY to
   - Normalize
   - Empower

3. GRIEF THEORY to
   - Facilitate natural processes of grief and mourning

Suicide postvention must take into consideration an additional major component:

4. SUICIDE INTERVENTION/PREVENTION THEORY

Suicide intervention and postvention are complex areas that demand not only an understanding of our own attitudes towards trauma, grief, suicide, violence, etc., but also require substantial knowledge and varying levels of skill in applying the knowledge in different situations (Ambrose, 2003).

APPENDIX 3

Responsible media reporting

The effect of media coverage has been documented in many countries worldwide. In 1999 the U.S. Surgeon General's Report on Mental Health concluded that: "Evidence has accumulated that supports the observation that suicide can be facilitated in vulnerable teens by exposure to real or fictional accounts of suicide."

Research has confirmed that there is an increase in suicides following a suicide story in the media (Gould et al., 2003). The increase is proportional to the amount, duration, and prominence of the media coverage. Findings include:

- The suicide of an entertainer or political celebrity is more likely to encourage imitative suicide attempts (contagion)
- Stories on real, not fictional, suicides are more likely to encourage imitation
- The impact of stories about suicide appear to have be greater on teenagers than on adults.

Media guidelines

Media personnel in your community may not be aware of the connection between real or fictionalized accounts of suicide and subsequent increases in suicide behaviour.

There is considerable evidence that there has been a decrease in media-related suicides following the implementation of media guidelines[19]. To discourage imitative or copycat suicides, reports should avoid, or minimize:

- Reporting specific details of the method
- Descriptions of a suicide as unexplainable, e.g., "He had everything going for him."
- Reporting romanticized versions of the reasons for the suicide, e.g., "We want to be together for all eternity."
- Simplistic reasons for the suicide, e.g., "Boy commits suicide because he has to wear braces."[20]

The print media can...

Reduce the contagion effect by:

- Printing the story on the inside page. If the story must appear on first page, print it below the fold
- Avoiding the word "suicide" in the headline
- Avoiding printing a photo of the person who committed suicide.

Encourage prevention of suicide by:

- Presenting alternatives to suicide, such as calling a suicide prevention centre, attending counselling, or reaching out for help
- Mentioning the negative consequences of the suicidal behavior in terms of the pain suffered by survivors, and the loss of the person's potential and years of life
- Whenever possible, presenting examples of positive outcomes following a suicidal crisis
- Providing information on community resources for those who may be suicidal, or who know people who are (e.g. crisis line, child and youth mental health)
- Emphasizing that there are alternatives to solving seemingly hopeless problems.

19 The website of the American Foundation for Suicide Prevention contains information on responsible media reporting including examples of both good and problematic reporting. Link www.afsp.org/education/recommendations/index.html

20 While there may have been a trigger incident, in reality suicide emerges out of a dynamic interaction involving biological, social, psychological and spiritual factors.

AN EXAMPLE

Suicides mobilize Cherry Hill school community

CHERRY HILL — The suicides of two young people last weekend have shaken the township, spurring a community mobilization to deal with these deaths and prevent others.

Since 2001, five high school-age students or recent graduates of Cherry Hill High Schools have committed suicide. All hanged themselves. Last night, hundreds of people — parents with arms slung around children's shoulders, groups of teens hunched close together — attended a community forum on the subject.

The writer goes on to say that:

- The speaker stressed the need to not pressure students to achieve in ways in which they are not capable
- The school superintendent urged parents to treat depression as one would a broken arm or the flu, instead of as a hidden problem
- The father of one of the suicides stressed the need for depressed students to get treatment
- If students have a friend who talks of suicide, they must see to it that a responsible adult is notified, even if that means breaking a confidence.

Misleading

The story implies that:

- Parental pressure to achieve may have caused the students' deaths
- School difficulties are the cause, not the result, of being depressed
- Depression is like the flu or a broken arm when, in fact, depression is not apt to be such a short-lived condition
- The image of "hundreds of parents with their arms slung around their children's shoulders" runs the risk of leading young people to see suicide as a way of getting attention.

Responsible

The story is reported responsibly in that:

- It avoids giving details about individual students in ways that might romanticize or glorify them
- The fact that the students hung themselves is not dramatized in the story's headline
- The father urged depressed students to seek treatment
- A friend's life is more important than breaking his or her confidence
- It is not just parents who can help prevent suicide
- It advises parents to treat depression as an illness.

APPENDIX 4

Death notices and the importance of language

Death notices

Historically, death notices have used terms such as "died suddenly", "died peacefully", or "died sadly", rather than naming suicide as the cause of death. Suicide prevention organizations are rarely named in the donations as part of death notices.

This silence only reinforces the stigma and shame that is so often associated with suicide. The silence serves:

- To increase feelings of shame that so often accompany mental illness and suicide
- To contribute to the general public's not seeing the true number and impact of suicide deaths in our communities
- To prevent the legitimizing of this issue, often leaving it under-funded.

Suggestions from survivors regarding wording in death notices include[21]:

- Died by suicide
- Lost to suicide
- Sadly ended her or his life
- Took her or his own life
- Died from the ravages of depression and suicide ("ravages" doesn't encourage contagion, and is consistent with "died from the ravages of Cancer")

- Donations to, for example: Canadian Association of Suicide Prevention (CASP), Canadian Mental Health Association (CMHA), local crisis centre, local hospital psychiatric unit.

Other related issues raised regarding the wording of death notices include the following:

- Using the phrase "now at peace", or a similar phrase, is probably not a good choice, as some readers may see the phrase as representing a positive or, possibly, desirable state, which could ultimately contribute to the contagion effect
- Some family members may not be ready to be open about the cause of death
- The family may have no knowledge of depression, so cannot name "ravages of depression and suicide."

Compassionate Friends and the American Foundation for Suicide Prevention also recommend using the terms *"died by suicide" or "suicide death"* not only in death notices, but also when referring to suicide in everyday speech or in the media. It is non-judgemental and consistent with the terms used for deaths such as *"died from cancer" or "died of a heart attack."*

One of the keys is shifting the language in death notices from "committed" to "died by." "Committed" increases the stigma associated with suicide, as the word often refers to negative behaviour such as criminal activities. Equally problematic, "successful", or "completed", can connote something desirable or positive. Suggested alternative wording includes:

- Took their own life
- Suicided (using suicide as a verb)
- Died as a result of a self-inflicted injury
- Died by their own hand
- Ended her or his life
- Killed himself or herself.

Similarly, to distinguish a suicide attempt from a suicide, "non-lethal suicide attempt" is preferred to *"incomplete suicide attempt"* or *"unsuccessful suicide attempt."*

Families who have been open and honest about a suicide report that they received a great deal of support from friends and relatives who came forward and disclosed they were also the survivors of a suicide.

Openly disclosing the cause of death allows mental health counsellors and others to initiate postvention activities that may help prevent suicide contagion and reduce the possibility of future suicides.

21 CASP Conference, October, 2004, Bonny Ball and Heather Craig; Canadian Association of Suicide Prevention; SurvivorAdvocates Listserve, Fall, 2004

APPENDIX 5

Psychological debriefing

Rationale for this discussion

The following discussion regarding psychological debriefing is included to serve as both clarification and caution regarding the use of this specific intervention following a death by suicide, especially when offering postvention services to youth. There are many instances in practice where debriefing is used inappropriately and/or with the wrong target audience. In such instances it is possible for debriefing to cause individuals more harm than good.

About psychological debriefing

Debriefing is an immediate, short-term, often single-session, psychological intervention with two primary intentions: 1) management of psychological distress after trauma, and 2) prevention of the later onset of posttraumatic stress disorder or symptoms, such as depression and anxiety, among those exposed to trauma. As such, debriefing is only one element that might be included, when appropriate, within the broader postvention response following a suicide.

Psychological debriefing is a formal type of posttraumatic care. Several models have been developed in the past two decades (van Emmerik et al., 2002, p. 766). Critical incident stress debriefing (CISD), also referred to as the Mitchell model, is a commonly-applied psychological debriefing model. CISD is a specific process based upon core principles of education and crisis intervention; however, it is not the only model of debriefing available.

Psychological debriefing is designed to mitigate the impact of the critical incident and to assist individuals in recovering as quickly as possible from the stress associated with the event (Mitchell, 1983). This intentional process is sometimes used after a suicide to support the normalization of thoughts and feelings that can follow exposure to this type of traumatic incident. Psychological debriefing is not therapy, nor does it deal with the bereavement needs of suicide survivors.

Debriefing can be offered to students, professionals, and others who have been exposed and, potentially, adversely affected or traumatized as a result of the death by suicide. Those at risk for adverse trauma effects can include individuals who found the deceased person (family members, friend) and first responders such as the RCMP/police and coroner, as well as any others who had a sensory exposure to the incident (sight, hearing, smell) related to the traumatic event.

Individuals who are more likely to have trauma issues following a suicide are those persons who may perceive that they played a part in how or why the suicide unfolded (Ambrose, 2003); for example, they recently broke up with the deceased, they gave the person the keys to the car that the victim later drove to their death, or they administered first aid at the scene, and the person died despite their efforts. Such individuals benefit from specific trauma interventions, which may or may not include psychological debriefing.

Cautions regarding psychological debriefing

A Cochrane-based review of the evidence regarding the effectiveness of psychological debriefing has recently been completed (Rose et al, 2004). Although debriefing has commonly been used with children and youth in schools where traumatic incidents have taken place (either on or off site), the effectiveness of debriefing as a trauma intervention is unknown. According to the Cochrane Review (Rose et al., 2004):

1) The effectiveness of debriefing in achieving either of its two main goals remains unknown
2) Single-session debriefing did not reduce psychological distress or prevent the onset of PTSD, and in some cases there was an increase risk of PTSD in those receiving debriefing
3) It is possible for debriefing to create adverse effects in some, given the possibility of vicarious traumatization within the debriefing session itself
4) It is not possible to make recommendations about the use of debriefing in children.

According to these specific review findings, the routine use of single-session debriefing (CISD) cannot be recommended at present. Other sources (Stallard in Wilson & Raphael, 2000; Wraith in Wilson & Raphael, 2000) still offer hints of effectiveness regarding CISD specifically, but admit that major questions remain regarding:

a) The effectiveness of individual and group debriefings
b) The timing of a debriefing and its selection criteria
c) The short and long-term outcomes (benefits or adverse reactions) related to CISD intervention; and
d) The use of debriefing with children and adolescents.

In summary, so little treatment outcome research exists in the current literature that there is little solid evidence to support *or* question the different treatment recommendations in terms of efficacy.

Despite the lack of substantive evidence, psychological interventions are widely viewed as an integral part of a comprehensive response to a critical, or traumatic, event. "The decision to provide debriefing is not necessarily based on findings from empirical research. Reports of satisfaction or perceived helpfulness by participants might be sufficient reasons to continue offering debriefing" (van Emmerik et al., 2002, p. 770). Debriefing is commonly used with children and youth within a group setting to talk about death and other critical life-threatening events (Stallard in Wilson & Raphael, 2000): "the debriefing attempts to meet the individuals' need to understand what has happened and how the critical event has affected them emotionally" (p. 216).

If using debriefing as a means of short-term, immediate, psychological intervention after a suicide, it is important to keep in mind the limitations and cautions being raised in the recent evidence-based reviews. Debriefing should never be the *only* intervention offered, particularly in light of the questions regarding its effectiveness. Short-term interventions with individuals and/or small groups of affected individuals, combined with long-term adjustment and recovery interventions, ongoing trauma interventions, and specific bereavement counselling, are still required to best support survivors and those negatively impacted by suicide.

APPENDIX 6

Grief and trauma after suicide

"The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description" (Redfield Jamison, 1999, p. 24).

Grief after suicide

The death of someone close to us is one of life's most painful events. When the death comes from suicide, survivors, including family and friends, are left coping with a wide range of emotions including sadness, blame, guilt, confusion, anger, and, sometimes, relief, if they have watched a loved one suffer. It takes time to heal grief after such a loss, and each person will grieve in their own way. Adults and children both grieve, and children benefit from having honest information about the death, otherwise they will go through the grieving process again when they learn the truth (Canadian Mental Health Association, 1993).

While grief responses are unique to each individual, there are a number of common themes or phases that characterize the process of grief. Teresa Rando (1984) offers insight into some of these:

1. **Recognize** the loss – acknowledge the death and understand its ramifications.
2. **React** to the separation of the loss – both the primary and resulting secondary losses. Experience the pain; feel, identify, accept and express the myriad emotions encompassed by the term 'grief'.

3. **Recollect** and re-experience the deceased and the relationship. Review and remember realistically – revive and re-experience all the feelings involved, including the negative aspects of the relationship.
4. **Relinquish** attachments to the deceased and the old assumptive world.
5. **Readjust** to move adaptively into the 'new world' *without forgetting the deceased.*
6. **Re-invest** the 'freed up' energy in a new life or identity.

Other frameworks (Worden, 1991) for understanding the tasks of bereavement include:

1. To accept the reality of the loss
2. To experience the pain of grief
3. To adjust to an environment in which the deceased no longer exists
4. To withdraw emotional energy from the relationships with the deceased and reinvest in new relationships.

Growth and healing are never linear; nonetheless, models offer guidance and insight regarding the overall grieving process.

Grief after a loss to suicide can be complicated. Complicated grief and bereavement can occur when a survivor is unable to move through the various tasks of grieving, as noted above. A complicated grief response includes avoidance of grief and chronic, delayed, and inhibited grief responses (Skinner Cook & Dworkin, 1992, p. 10).

In summary, suicide is a death like no other, and those who are left behind to struggle with it must confront a pain like no other. They are left with shock and the unending "what if's" (Jamison, 1999, p. 292). The initial denial that often accompanies death is frequently compounded by a denial of the nature of the death. For example, parents who ultimately accept the loss of a child may continue to deny that the death was a suicide (p. 293). This denial can be compounded due the high level of social stigma that many perceive associated with suicide. Shame and stigma contribute to the complex nature of grief after suicide. Survivors of suicide benefit from ongoing support and opportunities for healing.[22]

Trauma after suicide

In relatively recent years, researchers and mental health practitioners have come to understand the possible traumatic nature of grief after suicide. The historical literature on suicide bereavement rarely mentioned trauma and it is only in the past several years that grief and trauma have been jointly addressed (Figley, 1999; Figley, Bride & Mazza, 1997; Raphael & Martinek, 1997).

Traumatic grief results from the form and context of dying. For example, suicide is sudden, often unexpected, and may be horrific, brutal, and grotesque, involving

22 Please refer to Appendix 7 for information regarding supporting survivors of suicide through the initial phases of the grief process. The longer term bereavement needs and grief counselling considerations and techniques are beyond the scope of this document.

mutilation or extreme pain; this can further compromise a survivor's ability to cope. The nature of suicide death is sometimes more significant than the actual death itself in whether or not a traumatic response results for survivors. It is important to recognize that in traumatic grief, both trauma and grief reactions may occur together (Ambrose, 2000).

Case examples

The following composites illustrate the multidimensional nature of responses following a death by suicide. It is important to understand that, while grief and trauma may each arise from different circumstances, a single event, such as a suicide, can produce both (Ambrose, 2000; Figley,1999). For some suicide survivors, their primary need is for compassion and emotional support related to their sudden loss and resulting grief. Other suicide survivors have been highly traumatized by the suicide and the surrounding circumstances related to the death. These individuals require a therapeutic environment where the goal is to help stabilize anxiety and trauma symptoms, while simultaneously monitoring and assessing for possible suicide risk.

Case example 1: Grief after suicide

Rob, a 17 year-old male, died by suicide. His female friend, Lisa, learned about his death at school the next day. She was understandably upset, filled with questions about why Rob killed himself, and sad that she had not been able to help him. Lisa was tearful and having a hard time concentrating in the hours and days after learning of Rob's death. She wanted to attend his funeral and wrote a letter to him expressing how much she would miss him at school.

Lisa is experiencing a normal grief reaction to this sudden loss, and she would benefit from being able to talk about her feelings and her memories of her friendship with Rob.

Case example 2: Trauma and grief after suicide

John, an 18 year-old male, shot himself in the apartment where he lived with his father. His parents are separated, and John had told his brother Steven, who lives with their mother, of his suicidal thoughts two days prior to his death. Steven came to the apartment for a visit with his brother and found him with a gunshot wound in his head. Steven called 911 but John had been dead for several hours prior to being found. Steven was holding his dead brother in his arms when the police arrived. He was staring blankly, initially unable to respond to questions from the police. His state of shock continued throughout that evening and his distress was high the next day.

Steven is experiencing both grief and trauma as a result of his brother's suicide. Grief, in that he had an emotional bond with his brother and will mourn his death, and trauma, due to finding the deceased and holding him while waiting for the police. Steven had been aware of his brother's thoughts of suicide and was confronted with both the sudden and traumatic nature of John's death. Steven could benefit from a trauma assessment and intervention in addition to the support he will need during his time of grief and loss.

Case example 3: Trauma after suicide

A group of teenagers was attending a house party when one of the young men, Greg, heard screaming coming from a house across the street. He listened to the altercation and was shocked to hear a gunshot. A woman came running from the house screaming for help. Impulsively, Greg ran across the street to offer help. The woman kept pointing inside the house yelling "He killed himself, he killed himself." Greg called "911" on his cell phone and waited with the woman for the police to arrive. He watched for hours as the police and coroner investigated and eventually removed the body from the house. Later that night, Greg lay awake in his bed hearing the sound of the gunshot over and over again. He could not get the sound of the woman's scream out of his mind, or the sound of the police sirens. His heart was pounding as he recalled the night's events.

Greg is experiencing symptoms of trauma (heart pounding, sounds replaying in his mind) and could benefit from a trauma intervention. He will not experience grief over this stranger's death, since he had no emotional connection or prior relationship with the deceased.

Responding to traumatic grief

Trauma effects often have to be dealt with before the grief issues can be addressed (Ambrose, 2000). As Rando (1993) highlights, sometimes grief and traumatic stress are manifested independently; however, there is more often an interplay between them, and both areas must be addressed simultaneously.

Experts in the field of traumatic stress and grief suggest that interventions should be "in waves." Intervention waves may include crisis intervention, intermediate trauma treatments leading to trauma mastery, addressing initial tasks of grief and mourning, and, finally, trauma and loss accommodation (Figley, 1999; Rando, 1998).

Professionals responding in the traumatic aftermath of suicide:

- Must have the knowledge to recognize circumstances that may contribute to traumatic grief through seeking out training in both trauma and bereavement
- Assess for both trauma and grief, keeping in mind they often look similar, especially in the acute phases immediately following the event
- Do a basic trauma assessment including gathering information about the nature of the event, the person's role in the event, the degree of violence and horror, the sense of personal responsibility, and the degree of family and social support
- Should not probe for feelings that may require containment but give permission for them to be expressed (Ambrose, 2000; Ambrose, 1998).

It is important to consider that trauma is frequently an overlay on the grief process and may interfere with grieving and mourning if it is not addressed separately (Saskatchewan Health, 2001).

APPENDIX 7

Supporting survivors of suicide

Understanding the ramifications of death by suicide is important in effectively supporting youth and adult suicide survivors. People exposed to a loved one's suicide can have a heightened risk of suicide themselves. An informed community is better able to recognize and respond to signs of suicide risk in friends and family. Support and care for family members gain additional relevance under these circumstances. With a youth suicide, survivors may include:

- Parents, siblings, and extended family
- Girlfriends or boyfriends, best friends, and special adults such as a coach, teacher, or social worker
- Others who may feel they "should have known" or felt they were "kindred spirits" with the deceased and feel betrayed that the suicidal person didn't reach out to them for support
- Professionals such as school administration, health care professionals, social workers, and others who were, or were perceived to be, "responsible" for the youth and who may face both professional censure and personal trauma
- Others who feel a "like me" link to the person who died by suicide, who have had a suicide in their family, or who have felt suicidal themselves.

The challenge for both youth and adult survivors is in dealing not only with the issues surrounding any traumatic death, but also with the historical stigma and silence, the resulting misinformation, and the isolation, both real and perceived.

There is a variety of ways a community can provide support. Recognizing the unique challenges in grieving the loss of a loved one by suicide is an important first step. Suggestions include[23]:

- Reaching out to draw survivors into the community's normal activities. This deliberate inclusiveness can assist in counteracting the stigma that may accompany a death due to suicide
- Supporting suicide survivors, as one would any survivors, with gestures of kindness
- Talking with survivors about the deceased in an open, sensitive, and supportive manner. Openness will help overcome shame or embarrassment
- Encouraging survivors to seek support with their grieving process from, for example, survivor support groups, hospice bereavement groups, or professional grief counselling
- Remembering that people grieve at their own pace and in their own way.

One survivor, Catherine MacDermott, stated that it was helpful to:

- Learn more about the phenomenon of suicide and why people might choose suicide as an option
- Understand depression and feelings of helplessness and hopelessness
- Have the workplace inform all co-workers of the death by suicide of a worker's family member
- Have a group of family and friends willing to talk openly about the suicide.

Heather Blackwood, who works with the Sunshine Coast Hospice Society, suggests:

- Listen, listen, listen for as long as it takes, without judgement. All loved ones will not grieve in the same way or at the same time or for the same length of time.

Immediate support: An example[24]

Having a trained person available to provide immediate support following the notification of a death by suicide can be very helpful to survivors. New Brunswick has a protocol in place between the suicide prevention team at the Department of Health and Wellness and the coroner's office. The protocol states that in the immediate aftermath of a suicide the coroner can offer to contact the Department of Health and Wellness who will, if the family gives permission and provides contact information, provide the family with immediate emotional support. If the family refuses, there is no further contact.

This service has been well-received by both families and the coroner. The coroner's office appreciates the service, as they know help is available to support the family in the immediate aftermath of suicide. Many families stated that they would not have asked for help; however, they were glad someone called to offer support and to explain the phenomenon of suicide.

23 Adapted from Jordan, J.R. (2001) Is suicide bereavement different? A reassessment of the literature. *Suicide & Life Threatening Behavior*, 31, 91-102.

24 December 2004, Bonny Ball's personal communication with France Daigle, New Brunswick

APPENDIX 8

When a client dies

"I remember standing at Adam's funeral. He was the 13-year-old best friend of my 13-year-old client, Jesse. Adam hung himself in the garage of his family home within a half an hour of Jesse dropping him off on their way home from school together. I felt intense grief over the premature loss of life for Adam and immense worry for the emotional and psychological well being of my young client, Jesse. I felt hypervigilent regarding Jesse's safety in the weeks following Adam's death by suicide." Lynda Monk, social worker

When a client dies by suicide

Professionals are often profoundly affected when one of their clients dies by suicide (Mishara, 1995). In responding to a client's suicide, two important issues should be considered:

- Caregivers are also survivors of a suicide. Care for bereaved caregivers is as important as care for family members and friends
- Sooner or later professional caregivers impacted by suicide will encounter another person at risk. Appreciating the impact of the death of a client by suicide will ensure the effectiveness of future helping interventions (Tanney, 1995).

Some helpers report major disruptions in their professional and personal lives, including posttraumatic stress symptoms. When a client dies by suicide, it is important for the professional to acknowledge the death as a potential traumatic event, due to the risk for primary traumatic stress and/or vicarious trauma, depending on the situation.

Those professionals who are involved with suicide prevention, intervention, and postvention are well-served to be aware of the occupational hazards related to caregiving and helping roles. These costs of caring can include:

- Job stress (Fisher & Abrahamson, 2002)
- Professional burnout (Maslach, 1982)
- Primary traumatic stress (Fisher & Abrahamson, 2002)
- Vicarious trauma/secondary trauma (Stamm, 1995; Pearlman & Saakvitne, 1995)
- Compassion fatigue (Figley, 1995).

Professionals may experience an increase in the following behaviours and attitudes (Mishara, 1995):

- Focus on clues related to suicide potential
- Collegial consultation
- Attention to legal or forensic matters
- Conservative approach to managing clients
- Attention to charting and record-keeping
- Concern with issues of death and dying.

Reflective questions for professionals[25]

- What was your initial reaction to losing your client to death by suicide?
- What was most helpful to you at the time of the suicide?
- What else would have been helpful to you at the time of the suicide?
- What was most helpful in the weeks and months after the suicide?
- What has been helpful to you in your healing?
- How has this experience impacted the way you work with suicidal people?
- What have you learned from this experience?

25 Developed by the American Association of Suicidology, 2001

Supervision and support

A professional who has lost a client to suicide can benefit from receiving social support through their relationship with their supervisor and colleagues. Supervision within the social services often serves two main functions, including an administrative function as well as a social support function. Professionals who have a relationship with their supervisor that is based on trust, support, and mutual respect can call on that supervisory relationship in the aftermath of a client's suicide for emotional support, including discussing the reaction and feelings related to their loss.

Personal and professional self-care

Professionals benefit from actively engaging in self-care practices that allow for work-life balance, self-awareness, and breaks from their caregiving/helping roles. It is very important for professionals who are involved in suicide prevention, including intervention and postvention, to access formal and informal support to mitigate any of the negative affects that might result from exposure to traumatic stress in the line of duty.

APPENDIX 9

Posttraumatic growth

Most people would agree that losing a loved one to suicide is a traumatic life event. Survivors of suicide often speak of the life-changing and devastating nature of suicide loss. Over time, survivors often note another possible emotional and psychological pathway, one which involves making meaning in the wake of tragedy, and new-found personal strength and appreciation for the unpredictability and richness of daily life.

Perhaps such survivor reflections and experiences are best described through understanding the relatively new discussions within psychiatry regarding posttraumatic growth. These discussions note that only a minority of people exposed to traumatic events develop long-standing psychiatric disorders (Tedeschi & Calhoun, 2004) such as posttraumatic stress disorder, anxiety disorders, and depression. That is *not* to say that growth is an inevitable result of trauma but, rather, to explore how personal distress and growth often coexist (Cadell et al., 2003).

Posttraumatic growth can include (Tedeschi & Calhoun, 2004):

- Improved relationships
- Seeing new possibilities for one's life
- A greater appreciation for life
- A greater sense of personal strength
- Spiritual development.

There is a basic paradox within trauma survivors who experience posttraumatic growth, whereby their losses have produced valuable gains. As is the case with many survivors of suicide, traumatic loss can lead to grappling with huge existential questions such as why traumatic events happen, what is the point of life, now that this traumatic event has occurred, and other similar inquiries. The result of such questioning can result in trauma survivors' experiencing life at a deeper level of awareness; hence, personal growth and transformation can result.

As helpers and support people to those grieving a loss from suicide, there are approaches that allow us to help clients process trauma into growth. They include listening without trying to solve, and seeing the value in the client's experience of loss (Calhoun & Tedischi, 1999). This is not to suggest offering trite comments about growth coming from suffering, but rather to listen and support without judgement, over time, so that the client can begin to recognize this paradox themselves in a meaningful way. It is important to note that, while posttraumatic growth is possible, it usually results from coping and struggling with the trauma itself. The focus on the growth should never come at the expense of empathy for the pain and suffering of trauma survivors.

APPENDIX 10

Helpful resources

This appendix has addresses and resources to help the professional gather further information re: suicide and postvention.

American Association of Suicidology
5221 Wisconsin Avenue, NW
Washington, DC 20015
Phone: (202) 237-2280
Fax: (202) 237-2282
www.suicidology.org/

BC Council *for* Families
#204 - 2590 Granville Street
Vancouver, BC V6H 3H1
Tel. 604 660-0675
Fax: 604 732-4813
Toll free Canada/US: 1-800-663-5638
bccf@bccf.bc.ca

- *Leadership through education, training, advocacy and research for the healthy development of families*

  A non-profit, non-governmental organization who, since 1977, has worked on behalf of families, and people who serve families, across the province.

Canadian Association for Suicide Prevention
c/o The Support Network
#301, 11456 Jasper Avenue
Edmonton, AB T5K 0M1
Phone: (780) 482-0198
Fax: (780) 488-1495
casp@suicideprevention.ca
www.thesupportnetwork.com/CASP/main.html
- A list of survivor support groups in Canada is available on the CASP website

Centre for Suicide Prevention
Suite 320, 1202 Centre Street S.E.
Calgary, AB T2G 5A5
Phone: (403) 245-3900
Fax: (403) 245-0299
csp@suicideinfo.ca
www.suicideinfo.ca/

The Compassionate Friends
Toll Free: 1-866-823-0141
Contact: NationalOffice@TCFCanada.net
- An international, non-profit, non-denominational, self-help organization offering friendship, understanding, grief education and HOPE for the future to all families who have experienced the death of a child at any age, from any cause. www.tcfcanada.net/

Hope and Healing: A Practical Guide for Survivors of Suicide
Calgary Health Region
www.calgaryhealthregion.ca/hecomm/mental/Hope_and_%20Healing_%20Booklet.pdf
(BC version in progress)

Living Works Education Inc.
208-1615 10th Avenue SW
Calgary, AB T3C 0J7
Phone: (403) 209-0242
Fax: (403) 209-0259
www.livingworks.net/

On-line survivor support group:
www.journeythroughsuicidegrief.com
To join the group, send an emal to: jude@journeythroughsuicidegrief.com

SAFER Suicide Counselling Agency
#300-2425 Quebec Street,
Vancouver, BC V5T 4L6.
Tel: 604-879-9251
Fax: 604-879-7463

- Short-term therapy for Vancouver and Burnaby residents 13 years or older who are in suicidal crisis or are dealing with someone who is in suicidal crisis. Bereavement counselling and group workshops for individuals and families in any region who are grieving a suicide death.

SurvivorAdvocates Listserve

- A free service of CASP, this on-line chat group enables survivors and health care professionals from across Canada to network and share ideas for a common cause. Membership includes Canadian survivors, researchers, school/community suicide prevention workers, clinicians and other health care professionals, provincial/federal health care staff. To join the Listserve, send an e-mail to SurvivorAdvocates-subscribe@yahoogroups.com.

Suicide Response News and Notes
Calgary Health Region
Suicide Response Coordinator
Catherine.Davis@CalgaryHealthRegion.ca

Youth in BC
www.youthinbc.com/

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