



These Guidelines are donated by Paul Quinnett, Ph.D., President and CEO of the QPR Institute, a suicide prevention organization devoted to saving lives through excellence in public and professional education. QPR stands for Question, Persuade, and Refer, three steps anyone can learn to take to help prevent suicide. As a public health intervention modeled on CPR, QPR has been taught to more than one million people in the US and abroad.

What to do if a Patient Dies by Suicide: Guidelines for Professionals

The following guidelines were developed to aid surviving family members and staff in the event of a patient death by suicide.

Essentially, there are three groups who need assistance following a patient suicide.

- The family
- Other patients (if they were acquainted with the deceased)
- Office staff, colleagues, and yourself

Surviving Family Members

There is no greater anguish or suffering than that brought on by the suicide of a loved one. The pain is even more acute when loved ones believed their family member was receiving treatment and presumed them to be in the care of professionals who should have prevented the tragedy. Therefore, close attention must be paid the needs of the surviving family members.

Clinical experience suggests that close friends and family members are suffering the greatest shock and grief during the first few hours to few days after a suicide. At this time they may not be receptive to telephone calls or visits regarding from you, your staff, or office regarding their need for support, referral or treatment. Clergy, funeral directors, and others typically fill this immediate role before and after the funeral. In some fortunate communities, there may be a survivors-of-suicide outreach service in the community.

Recommendation: Take a moment to learn if there is a survivors-of-suicide support group in your community and note their contact information (click here –AAS link, etc.). These groups can provide important, timely, and critical support service to those loved ones who have lost someone to suicide.

After the funeral, and in approximately two to four weeks following a completed suicide, friends and family members are often receptive to professional aid and assistance.

Recommended steps:

1. The primary care provider should call the family and express condolences. This call should be sincere but brief. Simple, heartfelt language is always best, e.g., “I am sorry for your loss. Please let me know if there is anything I can do.” If this first step seems problematic, consultation with a colleague is advised.

2. Be prepared to offer a referral to a grief support person, organization and/or a survivors-of-suicide group.
3. As a matter of record (to be charted in the deceased's chart), whoever made the original call should remake this call between three and four weeks following the suicide. Two calls are better than one, as it underscores the genuineness of your empathy for their distress.
4. In addition to condolences, it would be appropriate to ask how loved ones are coping with the loss, e.g., "How are you doing?" "How are others doing?". If at all feasible, the family should be offered a no-fee, face-to-face appointment to discuss the aftermath of the tragedy. The appointment may be either with a clinician other than the primary care provider, or the primary care provider, depending upon the collective clinical judgment of the involved staff and their management. This appointment is a time to evaluate the family's need for support services, or to determine if anyone in the family is experiencing suicidal ideation - a frequent occurrence in survivors of suicide.
5. The following considerations are strongly recommended:
 - Do not blame the family for the suicide or in any way imply that they may have had an unseen hand in their family member's death.
 - Do not imply or state that more could have been done. In the event it appears there may have been some negligence, the primary care provider or his or her appointee should not suggest a treatment failure or preventable error occurred. If gross negligence has occurred, it will be determined at a later date, probably through legal action. (Remember, most medical errors do not lead to claims of malpractice, and most claims of malpractice are not due to medical error, but rather to the "perception" that a medical error occurred.
 - Avoid becoming defensive and be prepared for anger that may be directed at you. Anger following a death by suicide is quite common, and should be understood and responded to therapeutically.
 - If the provider dealing with the family feels that a more formal intervention is needed, it is recommended a grief specialist be contacted to provide whatever counseling services may be needed.
 - The primary care provider should only attend a family funeral upon invitation. Confidentiality resides with the deceased. In some jurisdictions, the executor of the estate can only abridge this confidentiality.
 - However badly a care provider may feel about the patient's death, it is important that the family not be exposed to the clinician's pain and grief. The family may then feel obliged to be of help to the clinician, thereby avoiding their own necessary grief work.
 - Because a person has completed a suicide does not give us, as clinicians, permission to divulge harmful or personal clinical details to the family. In a word, it is sometimes better our patients to die with their secrets.
 - Since a completed suicide within a family increases suicide risk in the survivors, it is important to be proactive in our contacts with the family members, and to do everything we reasonably can to remove the curse and taboo of a completed suicide. If possible, surviving family members should be assessed for complicated grief reactions, depressive disorder and suicidal ideation.

Fellow Patients as Survivors

In some treatment programs, a suicide will create "survivors" among other patients. Clearly, this death creates a risk factor for other patients who may already be suicidal. Therefore, staff should be cognizant of this fact and to take all reasonable action to forestall and prevent any "contagion" of suicidal ideation or action on the part of surviving patients as follows:

1. Staff should try to avoid the birth and proliferation of rumors regarding the suicide. This can be done by containing the source of information about the suicide to a single authoritative person, preferably the primary care provider or office supervisor.
2. In a larger service, the Medical Director and CEO should know the details of a completed suicide as soon as possible. If there are special circumstances surrounding the suicide, leadership can address these and proactive steps can be taken to minimize possible survivor problems for other patients or staff.
3. Following a suicide, the primary care provider and involved staff should schedule a meeting as soon as possible to discuss what information will be shared with the family and any others and to debrief the incident.
4. Clinicians whose patients know of a completed suicide should provide for this emotional crisis in their scheduled session, or schedule additional sessions so that this shock/grief can be expressed and dealt with in a therapeutic fashion. A current suicide risk assessment is often indicated.
5. If a patient should be the one who discovers the body or sees the deceased shortly after the suicide, this person may be questioned directly by the police. Depending on the death investigator's interview skills and sensitivity, secondary trauma may occur. Treatment personnel need to provide extensive contact and support in the first few hours or days following the suicide. Permission for additional time, special arrangements for meetings, extra clinical sessions and so forth may be approved. Even a brief, staff memorial service may be appropriate to help get closure on a suicidal death, but should not seal off any questions, anger, grief, reactions, and need to talk.
6. The family should be consulted regarding any desire on the part of other patients or staff to donate money to the family.
7. For previously suicidal or actively suicidal patients, the following steps are indicated, a) increase the number of sessions as desirable and b) investigate suicidal ideation and any exacerbation of risk. Generally, such extra efforts and attention need to be in place for at least 60 days following the death of a patient, and should be reviewed again at six months.
8. Lastly, it is important to return to routine as quickly as possible and be reminded that the structure and usual comings and goings of staff and patients are both comforting and reassuring. Staff members may wish to use their own emotional barometers as a guideline for the interval at which time we are back to "normal routine." Clearly, a completed suicide by a person well known by other patients is hardly "business as usual," and we should never treat it this way.

Staff as Survivors

As clinicians and staff, we are no different than others with respect to being survivors of suicide. We experience many of the same emotions, some of them even more acutely. For our own mental health and well being, we need to be tolerant of each other's needs during these times and to be understanding, kind, and supportive. The following guidelines are suggested:

1. Help your colleagues and yourself. If you are the physician, others may wait for you to open the subject for discussion. The loss of a patient to suicide is never an easy subject to discuss, but avoiding an obvious clinical fact is seldom helpful. Following a completed suicide, staff involved may experience feelings of guilt, or fear that their professional reputation has been damaged. It is important to discuss these feelings. The goal of such discussions should be educational, e.g., "What can we learn from this unfortunate death?" It is also important to discuss this incident with trusted colleagues.
2. Some staff may need a referral to a professional counselor, as they may have lost a relative or close friend to suicide in the past, and the patient's suicide may trigger old and painful memories.
3. You, personally, may need to spend some time with the other clinicians involved in the patient's care, as absence or avoidance of treatment staff may be interpreted as disapproval or disinterest.
4. Any formal fatality review study (if conducted) should be left to a Peer Review Committee and its review procedures. This removal of responsibility for an "official" accounting of the suicidal death from the surviving treatment staff should help reduce some of the acute stress surrounding the incident. Those affected directly will be included in the review process when the facts have been discovered and their input is needed for the final work product.
5. Should you or any staff person begin to experience persistent ideation about the death, intrusive memories about the suicide, guilt, anger, numbing, avoidance or other potentially negative emotional reactions to the loss of a patient through suicide, outside consultation is recommended. Otherwise, it is possible that these post-traumatic emotional states *may impair clinical response and therapeutic judgment when working with other patient's at-risk for suicidal behaviors*. Following a patient death by suicide, we have a personal and professional responsibility to work through these powerful residual emotions and come to a healthy resolution of them.