Riverside Trauma Center Postvention Guidelines

Riverside Trauma Center

A SERVICE OF RIVERSIDE COMMUNITY CARE

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The term postvention was coined by Edwin Shneidman (1972), the founder of contemporary suicidology, to describe planned interventions with those affected by a suicide death that would facilitate the grieving process. Over the last several decades, others have expanded the goals to include stabilizing the environment and reducing the risk of negative behaviors, most notably the risk of contagion (Brock, 2002, 2003; Centers for Disease Control and Prevention (CDC), 1988; Kerr, Brent, McKain & McCommons, 2003; Poland, 2003; Underwood & Dunne-Maxim, 1997).

The postvention guidelines presented here are distinct from many postvention protocols in several important ways. First, the focus of postvention research and writing has been primarily on strategies for offering postvention services in schools. The postvention strategies presented in these guidelines are unique in that they can be used in schools or in other organizations, such as workplaces or community organizations,that have experienced a death. Second, these guidelines include a discussion of how to balance the need for commemoration activities while still addressing the need to reduce the possible contagion effect. Third, these guidelines address the need to provide some trauma response in organizations which have experienced multiple deaths or in situations where someone has witnessed the suicide or death scene. This need has been highlighted by research which has demonstrated increased rates of PTSD in youth up to three years after a friend has completed suicide (Brent et al., 1996).

The following postvention guidelines were originally presented in *Grief After Suicide: Understanding the Consequences and Caring for Survivors*, edited by John Jordan and John McIntosh (see bibliography for complete reference). For a longer, more detailed description of the suicide prevention guidelines and a literature review, please refer to the chapter, "Organizational postvention after suicide death," authored by Lawrence Berkowitz, James McCauley, Donna L. Schuurman, and John R. Jordan. Ordering information is available at: www.routledgementalhealth.com/grief-after-suicide-9780415993555.

Goals of Organizational Postvention

1. At the organizational level, to help restore equilibrium and functioning within the school, agency, community or organization.
2. At the individual and group level, to promote healthy grieving, and commemorate the deceased for all members of the community who have been impacted.
3. At the individual level, to provide comfort to those who are distressed, minimize adverse personal outcomes (depression, PTSD, complicated grief), and reduce the risk of suicide imitation or contagion.
4. At the individual level, to identify those most likely to need support. These are likely to include, but are not limited to, people who were psychologically close to the deceased (e.g., friends and family members), people who were already depressed and possibly suicidal themselves before the death, and those who might psychologically identify with the deceased as being similar in lifestyle, values, or life circumstances. After suicide, it is important to identify members of the community who may have felt responsible for the well-being of the deceased, and by extension, for preventing the suicide. For example, in a school setting, teachers, coaches, and counselors who were closely involved with an adolescent who has died of suicide are at risk. Likewise, in a workplace setting, supervisors and colleagues of a person who takes his or her life may feel particularly guilty and/or ashamed for not preventing the death.

General Guiding Principles for Organizational Postvention

The term "organization" as used here includes institutions such as schools, businesses, places of worship, military units, medical institutions, fraternal groups, and other settings where a group of people have regular interaction with one another and a shared history of relationship with the deceased. What follows is a list of generally accepted guidelines for postvention plans.

1. Avoid oversimplifying the causes of suicide, murder-suicides, or suicide pacts. Emphasize that suicide is not the result of a single factor or event in the life of the deceased (e.g., the breakup of a relationship); rather it is a complex and complicated interplay of events. Also avoid presenting the causes as inexplicable or unavoidable. Emphasize that there are alternatives to suicide when one is feeling distressed or hopeless, and make clear what resources are available for getting help. It can be useful to characterize the act of suicide as a serious mistake in judgment on the part of the deceased, in which their recognition of alternatives and resources for help was impaired by the psychological pain from which they suffered.

2. Emphasize the correlation between depression, mental illness, and suicide, and highlight that help or treatment is available. Reducing the stigma of mental illness enhances the likelihood that people will seek help, particularly if they learn the pathways through which help can be accessed.
3. Avoid romanticizing or glamorizing someone who has died by suicide. That is, do not portray the deceased as a hero or having died a noble or romantic death (as in Romeo and Juliet). Conversely, do not portray the deceased as selfish or worthy of contempt. Emphasize that almost all suicide is associated with psychiatric disorder, and the impairment in judgment that accompanies this disorder.
4. Discourage a focus on the method of the suicide, which is often the subject of gossip and sensationalization. Report the method factually (e.g., he hung himself), but emphasize the important information is that the person mistakenly felt unable to get help for his or her problems, when in fact help was possible.
5. Provide a structure that facilitates ongoing suicide prevention efforts (Gould & Kramer, 2001; Graham, Reser, Scuderi, Zubrick, Smith, & Turley, 2000; Suicide Prevention Resource Center [SPRC], 2008).

What follows is a list of postvention tasks for agencies, schools, organizations, or communities in which a suicide had occurred. It is our recommendation that a postvention plan, based on these tasks, be in place at any organization in preparation for an event like a suicide.

Postvention Tasks

There are several universal tasks found in most effective postvention strategies that can be used in various types of settings including schools, agencies, or workplaces. We recommend these tasks be sequenced as follows:

1. Verification of death and cause.

All responsible postvention efforts begin with verification of the death: who died, when, the circumstances, location, and whether or not the death was a suicide. Most officials – school superintendents, CEOs, community leaders – will be initially swamped with information and rumors from students, parents, colleagues, and the press asking if they have heard that a given person has died. In an age of cell phones, social networking sites, and Twitter, responsible leaders should assume much of the information will be inaccurate and rumors will prevail. No official release of information should be distributed until the circumstances of the death have been confirmed by the appropriate authority: police chief, medical examiner, immediate family member. Even if a family member requests secrecy about the cause of death, it may not be possible to keep the circumstances a secret. In many states the cause of death is public information, though in the United States, federal FERPA and HIPPA laws take precedence. We suggest gently helping the family to think through the "pros and cons" of trying to keep the cause of death a secret, and the difficulty in doing so. If the family still does not want to disclose this information, then the institution must uphold their wishes. However, Hollingsworth (2007, p. 53) notes, "not disclosing the cause of death as a suicide leads to confusion, rumors, speculation, decreases trust among staff and students, puts school supportive staff in the position of not discussing this openly with students, puts other students' parents in a position of not knowing how to support their sons and daughters, and increases the likelihood of contagion."

2. Coordination of external and internal resources.

It is important to quickly mobilize and organize internal and external resources. In a school system, the superintendent or principal should immediately notify his or her crisis response team and plan for an initial meeting within hours or early on the next day. Most crisis teams have written protocols delegating actions and responsibilities in case of sudden traumatic death. Schools with working relationships with local mental health agencies and neighboring school districts and other local resources will often invite these partners to the crisis response meeting. Ideally this will not be the first time school personnel and community programs have met. Although some school systems are inclined to handle a crisis on their own with staff familiar to the students, these local resources can provide valuable consultation for school administrators and teachers who may be unfamiliar with how to handle this devastating loss, and who may themselves be grieving the death of the student. Nearby school systems can send additional counselors to cover students who are in acute grief and the nearby school system may also be able to provide backup to teachers and school staff who might want to attend the wake or funeral. Perhaps the most important reason for utilizing outside resources is to ensure school personnel who are on the frontlines of postvention efforts are themselves being supported throughout the entire postvention effort.

When a death occurs in a business or other organization, it may be more difficult to identify and mobilize resources. A small business might have little experience with the death of a colleague, and death from suicide might complicate any response due to lack of knowledge about suicide and the stigma associated with it. The CEO or his/her designee should contact the Human Resource Director for guidance and to strategize how best to support staff. Mid- to large-size companies typically have contracts with Employee Assistance Programs (EAP) that are usually well trained in managing sudden death or other personnel emergencies. EAPs often are on call as a valuable resource in the aftermath of a suicide death. Local mental health agencies can also provide this assistance to a business or civic association.

A member of the clergy may be another possible resource for an effective postvention plan. Few professionals know more about grief and grief rituals than the clergy, and those who have been trained in suicide postvention and trauma are a potential resource to

support schools and organizations. Unfortunately, many school systems and communities may be wary of crossing the line between church and state and do not use this potential resource. However, we have had good experience working with clergy when they have been trained in crisis response, post-traumatic stress management, or suicide postvention and others have reported similar success (Macy, Behar, Paulson, Delman, Schmid, & Smith, 2004; NAMI-NH, 2010). Local funeral homes may also be an excellent resource for information and are usually willing to answer questions. The funeral director can provide specific information about what will happen during the wake and funeral. For many adolescents, this may be their first funeral, so knowledge about specific details can be extremely helpful: Will the casket be open or closed? Has the family decided on cremation or burial? Who will preside over the funeral? Are there religious rituals that can be explained ahead of time?

3. Dissemination of information.

The most effective strategy for providing known details of the death is a written statement that can be distributed to everyone in the school, agency, organization, or community. It should include factual information about the death and acknowledgement that it was suicide, condolences to family and friends, plans to provide support for those impacted, information about funeral plans if known, or acknowledgement that the information will be provided once known, and any changes in school or work schedule during the upcoming days. It is also strongly advised that an announcement not be read over a public address system. Conducting this conversation in smaller groups (homerooms, work groups, team meetings) gives responders a chance to gauge individual and group reactions. When everyone in the community gets exactly the same information – teachers reading the statement in the classroom; emails to parents or agency employees; press release to local media – rumors will begin to subside.

4. Support for those most impacted by the death.

Close friends, fellow team or club members, colleagues on the same work team, or neighbors in the community may have a particularly hard time and need extra support for a period of time. Those who need support might also include a colleague who recently argued with the deceased or a romantic partner who initiated a breakup. In schools, counselors will frequently follow the schedule of the deceased student. In agencies or workplaces, EAP personnel may want to spend the day being available to the deceased's shift or work group. A neighbor may host a gathering for families on the same block. The emphasis in these activities is on mourning the loss. Although traditionally postvention counselors have tried to minimize discussions about the details and means of the death, trying to divert grieving friends and colleagues away from such discussion may be counterproductive. People struggle to make sense of the question, "Why did my friend/classmate/colleague/neighbor die by suicide?" and they will wrestle with that question for a very long time. Indeed, this question may be the lead-in to a "teachable moment," in which key points can be emphasized in discussions: Suicide is never the result of one thing, but rather the convergence of multiple factors; one of those factors is almost always a psychiatric disorder. Important information to share includes evidence that 90 percent of those who die fromsuicide have an underlying depression, substance abuse problem, anxiety disorder, or other psychiatric issues that contributed to their deaths (Moscicki, 2001).

5. Identification of those at risk and prevention of contagion.

After a suicide death some attention must be devoted to identifying whether close friends or others in the school or organization might be at risk for suicide attempts or other risky behaviors. Those at risk could include individuals having a history of suicidal behavior or depression, a history of tragic loss or suicide in their family, peers who start to identify with the deceased even though the connection was quite remote, and students, coworkers or staff who are likely to have felt responsible for somehow contributing to or preventing the suicide. Generally, in a school someone on the crisis team should keep a master list of the students and staff who are at risk. These individuals may need someone who knows them well to check in with them or their family. Most of those identified will not need an immediate referral or evaluation but may be encouraged to ask for support and asked to identify who can be of most help to them if they are feeling scared, overwhelmed, or depressed.

Identification of those at risk is not a task for schools or colleges only. Some workplaces may have a high percentage of young employees or employees with traumatic histories. There has been little research on the potential for contagion following the suicide death of a co-worker. However, a unique study from Stockholm (Hedström et al., 2008) demonstrated a significant increase in the number of suicide deaths in smaller work settings following the suicide death of a co-worker. Coupled with the finding by Crosby and Sacks (2002) suggesting that about 80% of suicide exposure occurs with the death of an acquaintance, rather than a family member, these studies imply that exposure to suicide is statistically much more likely in the workplace or school setting than through the death of a family member, and support the need to attend to those who may be at risk in work settings as well as educational settings (de Leo & Heller, 2008).

6. Commemoration of the deceased.

Although the original purpose of postvention activity was to facilitate grief (Shneidman, 1972), over the years the focus of postvention activities has shifted to reducing the possibility of contagion. This has sometimes led to misguided efforts to maintain secrecy after a suicide death, blaming or stigmatizing the deceased. Little effort has focused on facilitating healthy grieving as a necessary form of prevention. School, business, and community officials can take the lead in offering public condolences to family and friends, encouraging appropriate commemorative activities, and allowing flexibility in work or class schedules so members of the community

can attend memorial services. Generally our experience has been that in schools, large all-community events during the school or work day, requiring the participation of students or employees, are not ideal. When commemoration activities and funerals are held after school or work hours, participation is voluntary. It is also more likely parents will accompany their children or teenagers to the funeral or wake, a practice that should be encouraged. Supportive postvention activities in the workplace or community do not have to be highly formal events, but might include a casual celebration of the person's life or activities as simple as providing meals, transportation, and other concrete support to the grieving families and peers. For example, in one situation where a loss occurred among staff at a restaurant, staff prepared a special sit-down meal to share together. It is important to be aware of a new type of memorial, especially among high school and college students, the memorialized Facebook page. This page can become a place for friends to visit and post comments to the deceased, but raises the issue of how to respond to posted comments indicating someone is considering suicide.

There is considerable controversy about memorializing a student or colleague who dies of suicide for fear that glorification will lead to contagion. We believe commemoration activities should be the same for any death of a student or colleague, regardless of the cause of death. The CDC (1988) discourages permanent memorials such as planting of trees and placement of benches in a student's memory. As is supported by others in the field (Kerr et al., 2003; Poland, 2003), our experience has been that it is preferable to memorialize those lost to suicide by encouraging and supporting suicide prevention activities of local or national organizations, raising scholarship money through activities or becoming involved in helping other suicide survivors. Encouraging such "mobilizing" activities is also consistent with approaches to helping survivors deal with the potentially traumatic experience of a suicide loss by supporting a sense of agency rather than helplessness (Brymer et al., 2006). When developing policies, it is important to assure consistency of the response, regardless of the type of death. In schools, similar questions arise about how to handle memorials in a yearbook or related publication. Again, the recommendation is to make it consistent with how any other death would be recognized, and to make mention of those attributes and activities about the person that will be remembered, rather than focus on the cause of death.

7. Psychoeducation on grieving, depression, PTSD, and suicide.

The goals of this task are to provide individuals with an understanding of the grieving process, as well as to provide education about signs and symptoms of depression, PTSD, and suicidality. For younger people who may not have experienced a prior loss, understanding that their reactions are normative may be comforting. Regarding education on signs and symptoms of depression and suicidality, the underlying assumption is that we might prevent further suicide deaths by detecting depressive symptoms or suicidal tendencies in others, or help individuals recognize such symptoms in themselves. Appropriate psychoeducation may counter such risks by reinforcing important social messages such as "suicide is a permanent solution to a temporary problem," and by encouraging adaptive coping and problem-solving strategies, such as help-seeking. If, as postulated, familiarity with suicidal behavior as a coping strategy increases the risk of modeling of this behavior (de Leo & Heller, 2008; Insel & Gould, 2008; Rubinstein, 1983), then it is appropriate to provide education about other options for coping with difficulties. We recommend using a curriculum that has been determined to have best practice or evidence-based status (see the SPRC website: www.sprc.org) such as the Signs of Suicide Curriculum for schools ([SOS]; Aseltine & DeMartino, 2004 or Sources of Strength Suicide Prevention Program, Wyman, et. al., 2010).

While few interventions have been developed and tested for providing psychoeducation in a work setting, programs such as the United States Air Force Suicide Prevention program (Knox, Litts, Talcott, Feig, & Caine, 2003) may provide guidance. Similarly, a program such as Question, Persuade, Refer ([QPR]; Wyman et al., 2008) serves as an example of psychoeducation that may be provided in an occupational setting.

At the community level, psychoeducation about suicide and prevention can take place in a wide range of settings, with a goal of educating "gatekeepers" – those in the social network of at-risk persons – who are likely to recognize the warning signs of distress and refer the person for help. The Connect project (formerly called Frameworks) is an evidence-based approach to prevention of youth suicide that targets a wide range of gatekeepers (Baber & Bean, 2009; NAMI-NH, 2010). In our work in Massachusetts, we have provided trainings for community and civic organizations (garden clubs, senior centers, chambers of commerce, etc.), for interfaith clergy groups, and for parent groups. The range of gatekeepers for whom training can potentially be provided is limited only by the creativity of the trainers. For example, in one community the suicide prevention coordinator attempted to gather the town's bartenders for training. While we thought it was a clever idea, unfortunately only one bartender came to the meeting, but it nonetheless demonstrates that non-conventional and "embedded" caregivers may be good targets for psychoeducation about suicide prevention.

8. Screening for depression and suicidality.

Because we know there is a possibility of copycat deaths or contagion, especially following a suicide death among adolescents or young adults, we believe that postvention efforts have a responsibility to screen others for depression or suicidal risk. This imperative is bolstered by the 2007 National Youth Risk Behavior Survey (CDC, 2008) findings indicating that 28% of students met screening indicators for depression, and 14.5% seriously considered suicide. Additionally, case finding is consistent with a public health approach to preventing an illness.

In the case of schools, we use the Brief Screening for Adolescent Depression, which includes two suicide-specific items. This tool is

incorporated into the SOS curriculum (Aseltine & DeMartino, 2004), where students are instructed to self-score and encouraged to self-refer for assistance if they reach criteria for possible depression or suicidality. Other screening tools are available as well, including the TeenScreen, which was developed at the National Center for Mental Health Checkups at Columbia University (Shaffer, Scott, Wilcox, Maslow, Hicks et al., 2004; see www.teenscreen.org for more information). In our work with schools, we include a few additional questions along with the screen and ask students to identify themselves on the screening tool. Any student whose screening meets criteria for possible depression and/or suicidality is seen for an on-site screening by a school adjustment counselor or mental health professional at the school that day. Parents are notified of in-person screenings and recommendations are communicated to the parent/guardian. In schools, our experience has been that approximately 5-7% of students participating in screening are seen for an in-person screening, with a smaller percentage referred for further evaluation or counseling. Equally important as the direct reports of students about their personal status, we have experienced multiple instances where students have used the screening as an opportunity to discuss concerns about a peer or other personal troublesome issues, such as domestic violence. Many students have commented that they find the discussion groups helpful. In one school, 60% of students wrote mostly positive comments, 10% were negative, and 30% were neutral. We recommend the use of participant feedback to shape postvention programs.

Screening for those at risk at a workplace is a more challenging undertaking. With the exception of the military or possibly public safety employment setting, we assume employers would agree that screenings for mental health conditions or suicidality must be voluntary. An online tool, such as that developed by Screening for Mental Health (see www.mentalhealthscreening.org) is an example of an instrument workers may be encouraged to complete, with recommendations to seek assistance dependent upon the screening results. Other screening tools can be found on SPRC's best practice registry (see www.sprc.org). Screenings in the workplace are often conducted by Employee Assistance Programs. Another consideration in the workplace following a suicide death is to ensure managers are trained to recognize warning signs of depression and suicidality. Such action may lead supervisors to refer for help workers who appear to be struggling with depression or other mental health challenges. The company Human Resources Department should be involved in any organized training or referral efforts. Unfortunately, our experience, which coincides with that of others in the field, is that managers are often reluctant to address depression or suicide prevention in the workplace. Perhaps we need to do a better job of highlighting the potential lost productivity that may be associated with workers reacting to the suicide death of a co-worker, and sharing the new evidence of potential for increased deaths when exposed to the suicide death of a co-worker (Hedström et al., 2008). We understand this reluctance as another manifestation of the larger cultural taboo about dealing directly with psychiatric disorder and suicidality.

9. Provision of services in the case of a second or subsequent suicide.

Depending upon the size of the setting or community, a second suicide death in a short period of time or within the same peer group may increase the risk that a cluster is developing within the community. While it is our experience that many communities may wait until a third or fourth suicide to take action, we recommend beginning to form a "community coordinating committee" (CDC, 1988) following a second death. The role of a coordinating committee is to elevate suicide prevention to a community level, and to include a wide range of school, community, and regional or state leaders in the prevention plan. Such a committee should include school officials, public safety, community leaders, local mental health agencies, local media, and clergy, and should be linked to the state or regional coalition for suicide prevention as well as the state's strategic plan for suicide prevention (see for example, Massachusetts Coalition for Suicide Prevention, 2009).

The responsibility of the committee is to develop plans for a response to any future deaths and to begin a plan for prevention in the community. Post Traumatic Stress Management ([PTSM]; Macy et al., 2004) is the model that has been employed in several communities recently in Massachusetts to assist individuals and groups reacting to subsequent suicide deaths. In these communities, a wide range of community members are trained to respond to students, family members, and others. Additionally, coordinated plans and protocols are established for responding to suicidal ideation and threats noted in schools, organizations, young people taken into police custody, mental health centers, etc. In-depth training is provided for local mental health clinicians to improve skills for assessing and managing suicide risk using the best-practice curriculum developed by the American Association of Suicidology (AAS) and the SPRC Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (SPRC, 2008). Additional clinical resources have been provided by state agencies or grants to the schools to assist with implementing prevention services and identifying, triaging, and consulting regarding community members considered to be at elevated risk.

10. Linkage to resources.

An important part of responding to any potentially traumatic event is linking individuals and groups to resources for continued, local support as needed. Ideally, we recommend providing individuals, family members, and the school or workplace with a list of local mental health resources, including contact information for emergency mental health assessment. As noted above, when multiple suicide deaths occur in a given locale, a crucial part of the response includes ensuring that the many local community professionals are collaborating with a single vision and plan. Community coalitions should also be linked to statewide and federal organizations that focus on suicide prevention and postvention.

11. Evaluation and review of lessons learned.

Ongoing feedback should be sought from all involved in the postvention process: students, workers, those involved with implementing the plan, as well as management and local officials, if appropriate. Even if the postvention is a one-time event, plans should include follow-up support and the development of ongoing organizational and community structures to respond in the event of future suicide deaths. Plans should address potentially sensitive milestones like anniversaries or graduation, and those occasions may again be used as opportunities to evaluate and review the process. If the postvention is a larger, ongoing project, involving a planning or organizing committee, the committee should build in periods for review and soliciting feedback from all constituents, and the results of the feedback be built into the ongoing plan.

12. Development of a system-wide prevention plan.

Many school districts, organizations, or communities that have a suicide death will respond to the tragedy determined to do anything they can to prevent further deaths from suicide. They may form a task force or a community coalition and begin looking at strategies for suicide prevention. Excellent resources exist to guide such efforts (see the SPRC, www.sprc.org). There are a few strategies that are common to most of these prevention efforts:

A. Identification and promotion of protective factors. In the case of a community-wide effort, part of the work of a school, worksite, or coalition is to identify and promote factors likely to mitigate further suicide deaths. The following is a list of protective factors associated with "lessened risk for suicide or suicidal behaviors across the lifespan," as identified by the Assessing and Managing Suicide Risk workshop developed jointly by the SPRC and AAS (SPRC, 2008, Resource sheet 5, p. 2):

- Clinical care: effective care for mental and physical health and for substance abuse disorders, positive therapeutic relationships for those having a mental health challenge, ready access to care, and support for help-seeking
- Family and community support: for example, strong connections to family and community, responsibility to children and pets, and support from medical or mental health relationships
- Resilience
- Coping skills
- Frustration tolerance and emotional regulation
- Cultural and religious beliefs that affirm life and discourage suicide.

Some of these protective factors are easier to build and support than others. Workplaces, schools, and communities can all develop policies and practices that promote strong connections with family, workgroup, and community. Schools can include curricula that teach effective coping and problem-solving strategies, and sports and civic organizations can teach or encourage frustration tolerance. The demographics of suicide tell us much about which cultural groups have lower rates of suicide than others (See, e.g., www.sprc.org). Future research into these differences and learning from these groups might help inform our interventions in organizational and community settings.

B. Reduction of means. Reducing access to the methods by which suicide may occur is an essential component of postvention. The Harvard Injury Control Research Center has reviewed dozens of research studies demonstrating that under certain circumstances, decreasing access to lethal means of suicide also decreases the suicide deaths in a given area (see http://www.hsph.harvard.edu/means-matter/). This is particularly true for reducing access to higher lethality means, such as firearms (Marzuk, Leon, Tardiff, Morgan, Stajic, & Mann, 1992). For example, information provided to parents of at-risk peers and students following the suicide death of a peer should include suggestions that families secure or remove weapons from the home. Similarly, families should be encouraged to purge their medicine cabinets (in an environmentally safe manner) of unused medications. Medication prescribed for individuals considered to be at risk should be provided in safe, (small) quantities. Similar precautions should be considered for other means, for example with architectural and physical barriers on bridges and buildings. Balancing this recommendation, however, is the importance of exercising care to not draw excessive attention to a specific method following a suicide death.

The Role of Social Media in Suicide Prevention Efforts

The role of social networking and social media in suicide postvention work is a new and growing area of research and practice. Although some preliminary work is being done using social media for suicide prevention work (see www.emotiontechnology.com for more information about this kind of work), this area is still in its infancy. For example, Google has altered its search algorithm so that when suicide-related search terms are entered, the phone number for the National Suicide Prevention Hotline comes up first, ahead of any search results. Facebook has also implemented steps for reporting a suicide-related post (see http://www.facebook.com/help/?search=report+suicide#!/help/contact.php?show_form=suicidal_content). Even less is known about how to use these sites to continue postvention work in a community, although issues such as commemoration of a person who died by suicide are already present. For example, Facebook pages are often memorialized after a person dies by suicide, raising questions of who is screening the posts for suicidal content and who intervenes when such a post is found. In our experience with youth, we have found it is often

the deceased youth's parents who are monitoring these sites and intervening when necessary. We are currently in the process of determining ways to incorporate social networking issues and opportunities into our postvention practices, and are starting to use focus groups to determine ways to do this in a sensitive and effective manner. We look forward to writing more about these issues soon.

Conclusion

This overview offers guidelines for schools, organizations, or communities to follow after a suicide occurs. The goals, guiding principles, and postvention tasks have been summarized and reviewed here. Special attention has been paid to the importance of balancing the needs for commemorating the deceased and preventing a possible contagion effect, as well as addressing trauma issues which may be present. It is our recommendation that schools, agencies and organizations have a postvention plan in place, following these guidelines, so as to be prepared in the case of an unexpected death.

References

Aseltine, R. H., Jr., & DeMartino, R. (2004). An outcome evaluation of the SOS Suicide Prevention Program. *American Journal of Public Health*, 94, 446-451.

Baber, K., & Bean, G. (2009). Frameworks: A community-based approach to preventing youth suicide. *Journal of Community Psychology*, 37, 684-696.

Brent, D. A., Moritz, G., Bridge, J., Perper, J., & Canobbio, R. (1996). Long-term impact of exposure to suicide: A three-year controlled follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 646-653.

Brymer, M., Jacobs A., Layne C., Pynoos, R., Ruzek J., Steinberg, A., Vernberg, E., & Watson, P. (2006). *Psychological first aid field operations guide (2nd ed.)*. Rockville, MD: National Child Traumatic Stress Network and National Center for PTSD. Available for download at http://www.nctsn.org/content/psychological-first-aid.

Centers for Disease Control. (1988, August 19). CDC recommendations for a community plan for the prevention and containment of suicide clusters. *Morbidity and Mortality Weekly Report*, 37 (Suppl. S-6). Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm.

Centers for Disease Control and Prevention. (2008). Youth Risk Behavior Surveillance-United States, 2007. Surveillance Summaries. *MMWR*, 57 (Whole No. SS-4).

Crosby, A. E., & Sacks, J. J. (2002). Exposure to suicide: Incidence and association with suicidal ideation and behavior: United States, 1994. *Suicide and Life-Threatening Behavior,* 32, 321-328.

de Leo, D., & Heller, T. (2008). Social modeling in the transmission of suicidality. *Crisis: International Journal of Crisis Intervention and Suicide Prevention*, 29, 11-19.

Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior*, 31(Suppl.), 6-31.

Graham, A., Reser, J., Scuderi, C., Zubrick, S., Smith, M., & Turley, B. (2000). Suicide: An Australian Psychological Society discussion paper. *Australian Psychologist*, 35, 1-28.

Jordan, J.R. & McIntosh, J.L. (Eds.). (2010). *Grief after suicide: Understanding the consequences and caring for survivors*. New York: Routledge.

Hedström, P., Ka-Yuet, L., & Nordvik, M. K. (2008). Interaction domains and suicide: A population-based panel study of suicides in Stockholm, 1991-1999. *Social Forces*, 87, 713-740.

Hollingsworth, J. (2007). *Oregon youth suicide prevention. Youth suicide prevention, intervention, & postvention guidelines: A resource for school personnel (2nd revision)* [A modification for Oregon of the May 2002 edition of Y*outh suicide prevention, intervention and postvention guidelines: A resource for school personnel*. Augusta: The Maine Youth Suicide Prevention Program.]. Eugene, OR: Looking Glass Youth and Family Services. Retrieved from http://www.oregon.gov/DHS/ph/ipe/ysp/docs/yspipg.pdf.

Insel, B. J., & Gould, M. S. (2008). Impact of modeling on adolescent suicidal behavior. *Psychiatric Clinics of North America*, 31, 293-316.

Kerr, M. M., Brent, D. A., McKain, B., & McCommons, P. S. (2003). *Postvention Standards Manual: A guide for a school's response in the aftermath of sudden death (fourth ed.)*. Pittsburgh: University of Pittsburgh Medical Center. Retrieved from http://education.alaska.gov/tls/suicide/pdf/postvention.pdf.

Knox, K. L., Litts, D. A., Talcott, G. W., Feig, J. C., & Caine, E. D. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. *British Medical Journal*, 327, 1376-1378.

Macy, R. D., Behar, L., Paulson, R., Delman, J., Schmid, M., & Smith, S. F. (2004). Community- based acute posttraumatic stress management: A description and evaluation of a psychosocial-intervention continuum. *Harvard Review of Psychiatry*, 12, 217-228.

Marzuk, P. M., Leon, A. C., Tardiff, K., Morgan, E. B., Stajic, M., & Mann, J. J. (1992). The effect of access to lethal methods of injury on suicide rates. *Archives of General Psychiatry*, 49, 451-458.

Moscicki, E. K. (2001). Epidemiology of completed and attempted suicide: toward a framework for prevention. *Clinical Neuroscience Research*, 1, 310-323.

National Alliance for Mental Illness, New Hampshire. (2010). *Connect Suicide Prevention Program* (website home). Retrieved February 1, 2010 from http://www.theconnectprogram.org.

Poland, S. (2003). *After a suicide: Answering questions from students*. National Association of School Psychologists Resources website. Retrieved from http://www.naspcenter.org/principals/aftersuicide.html.

Rubinstein, D. H. (1983). Epidemic suicide among Micronesian adolescents. *Social Science and Medicine*, 17, 657-665.

Shaffer, D., Scott, M., Wilcox, H., Maslow, C., Hicks, R., Lucas, C., Garfinkel, R. & Greenwald, G. (2004). The Columbia SuicideScreen: Validity and reliability of a screen for youth suicide and depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(1), 71-79.

Shneidman, E. S. (1972). Foreword. In A. C. Cain (Ed.), *Survivors of suicide* (pp. ix-xi). Springfield, IL: Charles C. Thomas.

Suicide Prevention Resource Center. (2008). *Assessing and managing suicide risk: Core competencies for mental health professionals* [A workshop and program developed by SPRC and the American Association of Suicidology]. Webpage description available at http://www.sprc.org/training-institute/amsr. Retrieved in 2008.

Underwood, M., & Dunne-Maxim, K. (1997). *Managing sudden traumatic loss in the school: New Jersey adolescent suicide prevention project*. Piscataway, NJ: University Behavioral Health Care.

Wyman, P. A., Brown, C. H., Inman, J., Cross, W., Schmeelk-Cone, K., Guo, J., et al. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology*, 76, 104-115.

Wyman, P.A., Brown, C.H., LoMurray, M., Schmeelk-Cone, K, Petrova, M, et. al. (2010). An outcome evaluation of the Sources of Strength Suicide Prevention Program delivered by adolescent peer leaders in high schools. *American Journal of Public Health*, 100, 1653-1661.