

**2016-12-08 After a Suicide-The Zero Suicide Approach to Postvention in Health and Behavioral Healthcare Settings**

Speakers: Julie Goldstein Grumet, Ken Norton, Candace Landmark,  
Eliza Jacob-Dolan, Becky Stoll

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>> JULIE GOLDSTEIN GRUMET: Great. So, again, welcome to everybody. Today's webinar is After a Suicide: The Zero Suicide Approach to Postvention in Health and Behavioral Healthcare Settings. This is one of a series of webinars that the Zero Suicide Program at the Suicide Prevention Resource Center has been able to bring to you.

All of our webinars are archived. This one will be as well. We like to dive into topics that we know the Zero Suicide Toolkit may not have robustly built out yet, things that we know that are incredibly important to the model, but things that we hope that many of you are currently thinking about and hope to provide you with some greater details and some great examples through today's speakers. Today will be similar to every other webinar with some tremendous speakers, people doing really excellent care and excellent work in this space.

I'm Julie Goldstein Grumet. I'm the Director of Health and Behavioral Health Initiatives here at the Suicide Prevention Resource Center and I oversee the Zero Suicide Initiative for SPRC.

For those of you not yet familiar with the SPRC, it's funded by SAMHSA, the Substance Abuse and Mental Health Services Administration. We oversee the Zero Suicide Initiative, the Zero Suicide website, a lot of the training, technical assistance, and support. The SPRC also provides the technical assistance for the Garrett Lee Smith grantees and we support state suicide prevention coordinators. We have many online trainings available and an incredibly robust and comprehensive library of resources all available on our website, SPRC.org. I hope that you'll take a look after today's presentation.

This is our hashtag. We do try to - we will be tweeting throughout today's webinar. We encourage you to join along on Twitter should you like or follow us throughout all of our presentations. We have an incredibly strong community of people

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who often use this hashtag as they're talking about healthcare-related issues. And, again, it's a great learning environment and community.

To give you a very brief overview of what Zero Suicide is. Zero Suicide really builds on the awareness that system-wide approaches have worked in reducing suicide deaths. A few examples of comprehensive approaches from which the Zero Suicide Initiative as it currently stands was built for the United States Air Force and the Henry Ford Health System. Both reduce suicides by about 70 to 75% for those in their care using a comprehensive strategy that I'll describe in a moment. We know that suicide care must be a systematic approach in healthcare systems, rather than the heroic efforts of crisis staff and individual clinicians, as Richard McKeon from SAMHSA has described it. It's been that way for so long.

People are doing tremendous care privately. But what Zero Suicide endorses is the system standing behind each of those individual clinicians, so no matter which door you enter, you will receive safe, competent, confident, comprehensive care. It is very hard for clinicians to do this work while in the absence of a supportive system or without leadership who sees suicide care as a priority. A strong commitment to best practices in suicide care, policies, and training does improve patient safety and support for the clinicians doing this hard work. We know we want to retain clinicians after we've trained them and after they have become competent in providing suicide care.

Some of you may struggle with why do we call it Zero Suicide. I think one way to think about it is reducing suicides to zero is an aspirational goal but reducing suicides generally for those in your care is essential. What other number would be acceptable if not zero? Suicide care, patient safety must be a core responsibility of healthcare, so much so that this was recognized by the Joint Commission in their recent Sentinel Event Alert. The Joint Commission now establishes detection and treatment of all patients regardless of setting as necessary practices. We do have a very comprehensive set of best practices, tools, and a lot more information about the framework at [ZeroSuicide.com](http://ZeroSuicide.com).

This is one way to think about what is the framework for Zero Suicide. It's a framework for providing systematic clinical suicide prevention care. As I said earlier, comprehensive Zero

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Suicide approach could be adopted by an outpatient behavioral healthcare facility or an in-patient hospital or a primary clinic with behavioral health providers on staff. It could be adopted by a state system who disseminates their work to the providers certified through the state. Zero Suicide is about how the healthcare system addresses suicide care. If you look at this box, the outer box really highlights the pieces that need to be in place, a leadership commitment to safety, accountability, and transparency, and a workforce, beyond just those providing clinical care, that everyone is competent, confident, caring, and knows their role in caring for their patients. In the inside box are the components of care, including identifying and assessing people for suicide risk, providing care that directly targets and treats suicidality using effective evidence-based treatments which do exist, and providing contact, engagement, and support during times of transition, especially after acute care. We call this the Suicide Care Management Plan. Much like you would have a care management plan if you had asthma or diabetes, you should know what to expect for your suicide care. The system should strategically know how they plan to care for your risk for suicide and you should be educated on what you can expect. All of this needs to be wrapped in continuous quality improvements. Ideally, you'll collect data at the start, at the launch of your initiative and learn about what you can change continuously.

This was the website I mentioned earlier, ZeroSuicide.com. I encourage you to take a look. We have many resources available for launching your initiative, including an organizational self-study that you can take, worksheets for your workforce or to really think about what data elements you should be taking a look at. We also have a very active Listserv that you can access on that green button where it says get involved. And you can always contact anybody in the Zero Suicide Program at ZeroSuicide@EDC.org. There is our contact information, so please feel free to contact us any time.

For today's webinar, we hope that you'll learn how to explain how a health and behavioral health organization's response to suicide deaths can support improvements in suicide care practices. We will teach you how to describe the role of root cause analysis in a postvention response, and help identify steps that can be taken by organizations to support staff, other patients, and the family following a patient's death by suicide. Postvention is an incredibly important piece of the model, and

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we hope that through today's webinar you'll learn more about how to integrate postvention into the care that you provide and for your staff as well.

We have an excellent lineup of speakers, all of whom have worked very closely with the Zero Suicide Initiative. They've been big advocates and proponents of the Zero Suicide framework. We really admire and respect the work that they do and I'm looking forward to hearing from each of them.

Our first speaker is Ken Norton. Ken is the Executive Director of the New Hampshire chapter of the National Alliance on Mental Illness, NAMI New Hampshire. He led the development of a nationally and internationally recognized program called the Connect Suicide Prevention Program. Many of you may be familiar with it. The Connect Program trains professionals and communities in suicide prevention and response. We invited Ken today because of his extensive experience with postvention in a variety of community settings, including health and behavioral healthcare organizations, and because very early on Ken brought it to our attention that we absolutely have to address postvention very early in the launch and adoption of Zero Suicide. We have to be prepared and think about it at the time that we're rolling out our whole initiative. I really appreciate his efforts in sharing this and helping to guide these efforts. Today will be the first of many resources we develop around postvention. Ken has served on local and national suicide prevention workgroups, including taskforces at the National Action Alliance for Suicide Prevention and the National Suicide Prevention Lifeline Steering Committee.

Thank you so much, Ken, for joining us.

>> KEN NORTON: Thank you for that introduction. Thank you all for joining the call. I'd like to start by simply saying that in taking a comprehensive approach to Zero Suicide, it's really - suicide prevention is the proverbial three-legged stool. If you're not doing prevention, intervention, and postvention, you're not using a comprehensive model. I really want people to think about including that postvention piece as part of your comprehensive suicide prevention efforts. When we talk about postvention, we're really talking about - although the terminology is a little bit off, we're really talking about steps we take before a suicide death to prepare for that death

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and how to go about responding appropriately following a suicide.

Think about suicide as a pebble in the pond. The suicide is the death of that individual. But looking at it from an ecological perspective, those ripples move out and they hit first and sort of foremost the family, but then maybe the school, the workplace, the person's peers, and into their community and society and the world in general. When we look at particularly electronic media and social media, the impact of a suicide death like Robin Williams can be felt around the world within a matter of minutes or even hours. Media is an important component. We'll talk a little bit about that in a minute. Suffice it to say that the training relative to suicide prevention in general is really inadequate. It's a sad fact, presenting all over the country, I ask people, typically master's level clinicians, how many people had a single class in risk assessment, or how many people had a course, and very few - I mean, some people have had a class, very few have had a course, almost no one had postvention training as part of their educational training. It's really important to think about filling in the gaps there and presenting that type of training, making that available for your staff.

What are we doing when we're responding after a suicide death? We really want to think about planning those activities in advance. The goal is really to reduce the risk of contagion. We know that contagion is when we know somebody who dies by suicide, we become at increased risk for suicide. And, certainly, contagion is well documented in news, but it's also seen on college campuses, in tribes, with the military, and sometimes within communities as well. The other goals that we want to think about are really to promote healing and understanding and to promote people who might be at risk to get help or to recognize those people to get help. We really want it to be done as much as possible in an integrated way.

Now this part of - I mean, this slide is really about soft science. Estimates in terms of how many clinicians are impacted by suicide death are really kind of sketchy. Here is some of the data essentially saying that up to half of psychiatrists will lose a client, a quarter of psychologists, 50% of nurses in psychiatric nursing. But, again, these are really not all that reliable, but I think something as a starting point in terms of

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thinking about the impact on a clinician or an organization for a suicide death.

How might a healthcare system be impacted? They might be impacted, or an organization, in a number of ways. It might be a patient who is currently in treatment. It might be a patient who was recently seen in an emergency room. It might be an in-patient suicide death. It might be an outpatient suicide death. It's really important to think about when we're thinking about postvention that there is no us and them. You also need to be prepared for the potential loss of a staff person to suicide death. I've lost four colleagues during my lifetime; two of them were actively involved in crisis suicide prevention work with individuals. That's an important consideration for organizations in thinking about postvention response.

What are the roles that a mental health agency provides following a suicide? Those roles include responses to the family or to the loss survivor, responses to the staff, responses to the community, and response to the media, and perhaps Sentinel Event Reports, and we'll talk a little bit about that, and it may also include response to other clients in certain settings.

What is the impact of suicide death on a healthcare provider? There is some emerging research that shows that it can really rise to the level of posttraumatic response for a clinician, and that would include things like intrusive thoughts, difficulty concentrating, hyperarousal or hypervigilance, isolation, sometimes even dissociative response, and up to a third may experience severe distress for more than a year. I've also found in working with people that it may be career changing. It doesn't typically happen right away. But somewhere in that range between 6 and 18 months, people may choose to leave the profession or take a position that involves less risk assessment or working with vulnerable individuals.

I'd like to read a quote from one clinician's experience. This person says: It was very difficult to cope while helping others cope with the same experience. I had no energy and could not bounce back out of my crying spells and depression. Anxiety was taking over as well. I was getting outpatient therapy myself, but it didn't seem to help me. I felt so alone because I had no other colleagues who had experienced a client's suicide to talk to to validate my reaction; hence, I concluded I must be overreacting. I felt so much guilt and shame for failing these

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parents who trusted us to help their daughter. I felt the worst at about four months after the death as I wasn't getting any better and I was no longer allowed to, quote, take my time, unquote, as administration had first told me. I was being pressured to take new clients. I felt overwhelmed, scared, and helpless. I developed my own suicidal thoughts due to feeling without options to make my life better. I eventually checked myself into in-patient treatment which turned out to be my lifesaver. I think that that gives the sort of depth of impact that a client's suicide can have on an individual clinician.

When we think about postvention planning, we really want to think about how we can coordinate those plans with other organizations and do so in advance so that everybody knows what response they're going to be taking when and if there is a suicide death. Part of that includes the use of protocols. And without protocols, we're often driven by the emotional response. Maybe we knew that person or that person had a particular standing in the community or the organization, and that can be a real challenge when responding when you're grieving or when the organization is grieving. Having protocols really guide people on what to expect. Our NAMI New Hampshire's Connect Program developed specific postvention protocols for key service providers within mental health organizations, but safe leaders, funeral directors, law enforcement, emergency department staff, those kinds of folks. Protocols should include how to confirm the death, how and when you're going to notify clinicians and other staff, how you can assist with a full community deployment plan, what the communication is going to be with the family and who is going to do that. Notification of other clients if, in fact, it was a residential setting or that person was involved in a group. And steps that you might take to adjust the case load are on-call responsibilities for a clinician. You might also consider notifying the Employee Assistance Program or helping clinicians to get set up with some supports.

What are the professional and legal implications? There are many that might be as simple as filling out an incident or a Sentinel Event Report. There might be psychological autopsies. We'll hear more about that later. They should be no blame, no shame when they're done. There might be complaints before professional licensing boards. There might be wrongful death or malpractice suits. I successfully defended a malpractice suit for an individual who was self-destructive, and it was absolutely one of the most difficult times in my career. There

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may be other things, systemic recommendations that an organization wants to consider to make it a learning experience which is really congruent with a Zero Suicide approach.

What about the family's perception of clinicians? Up to 40% report that clinicians had contacted them, and almost half believe that the clinician was withholding information from them. Seventy-five percent who weren't contacted report that they tried to contact the clinician. What we absolutely know is the clinicians who were seen as grieving and who answered questions were less likely to be sued.

What about attending the service and other professional concerns, the wake or the funeral? Do you contact the family? Does the organization send the family flowers? If you attend the service, will you be welcomed, or would that be considered a breach of confidentiality or perhaps even an affront to that family? And who is being served by your presence? Are you doing it for yourself? Are you doing it for the family? If you're in a rural area, might some people assume that your presence at that service indicates that this person was involved in treatment? There are a lot of ethical considerations you need to take when thinking about that part of a postvention response. One of the positive things to think about is a lot of emerging research showing that there is posttraumatic growth that can occur from a very difficult situation, and that can happen both at the personal and professional level following a suicide death.

The Connect Program is NAMI New Hampshire's program. It's an example of a - I'm sorry, I think I missed one slide here. I'm going to go back. No, I guess it's not there. The Connect Program is an example of a comprehensive program, and it really works to do an environmental scan of the community and organize a planning process, looking at what that response is going to be for that mental health organization often as the lead within the community but also recognizing that sometimes that organization can be deeply impacted by the suicide death if that had been somebody that they were in treatment with. Looking at having protocols to follow in terms of what that postvention response is going to be and what that interface is going to be with key community stakeholders.

Key points to remember if a suicide occurs, and that's that we really all grieve differently. And we want to really stress that importance of self care skills and asking for help and



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watching out for who is not doing well and taking any threat of suicide seriously, helping other people to understand how to prevent contagion, and to think about - we often think about postvention in the immediate sort of timeframe, what happens after 24 hours, what happens after 48 hours, what happens after 72 hours, but we really want to look at it at the long term, and that includes from an organizational perspective, how is it impacting on the individuals or on the organization, what about anniversary dates. It's really important to think about as part of that piece what are you doing to take care of your staff, what supports are you providing them, who needs those supports, how will you check in with them, a few days later, a week later, a couple of weeks later, a month or two later, and how can that, as that process moves along and maybe some of those sentinel events or psychological reports move along, that can be a real key to thinking about what that postvention response should be.

>> JULIE GOLDSTEIN GRUMET: Thank you so much, Ken. I think you've raised so many of the issues that come to us frequently through phone calls and emails, and also what you've really highlighted is the need for discussing this in advance. You don't want to wait until an adverse event to say now what are we going to do. These are the kinds of things that you want to discuss in advance. Think about policies, training your staff, making sure everybody is very comfortable. Thank you so much for that very helpful and meaningful presentation.

We want to pause for a moment and let the audience type into the chat box things that maybe were the most meaningful or poignant to you about this presentation, or is there a key takeaway that was sort of a light bulb moment for you. I do want people to know that we are noting questions that are coming in during presentations, and we'll have time after all of the presenters speak for Q&A. We are just going to take those questions and hold onto them towards the end of today's webinar.

I see several people typing in. Somebody said: Whether your presence at a funeral is serving others or serving yourself, how would it be received, and what a good thing to think about in advance. Some people are surprised at the intensity of how this might impact caregivers. The funeral service seems to have really stood out for a few people and what you should plan for, whether or not you should go and the role that you would play if you're there.

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>> KEN NORTON: That funeral service piece is one of those kind of gray areas where it really very much depends on the situation and perhaps on the individual client and/or the organization, but it's important to consider those things in advance and have some maybe sort of key questions or key protocols that you're going to use in thinking about what that organizational response is going to be.

>> JULIE GOLDSTEIN GRUMET: Thanks for pointing that out, Ken. And I see somebody, John Jordan, wrote in: But we also want to make sure that the American Association of Suicidology has a clinician survivor taskforce available at their website Suicidology.org. It's a great resource for clinician survivors. And so, please, if you know of other resources, the chat box is a great place to share them. We'll be sending this out. As I said, we'll be continuing to build resources on the Zero Suicide website.

I see a couple of other people talking about scared to think of their colleagues as at risk for suicide and what a sad event to lose a colleague. Your story, the example you shared about the clinician who ultimately ended up receiving in-patient care really seems to have touched a lot of people and really drives home the fact that we can't do this work in a vacuum. We are all doing very difficult work and entitled to have these emotions. And we should be given the permission to have the emotions to do this difficult work, but sometimes that's difficult when this is a job. But for most of us, this is far more than just a job. It's a passion and commitment. I'm glad that we have some additional resources to share with you to make this job something that you can excel at, feel comfortable at, and continue to provide good care to the patients with whom you work.

I'm going to move us on. For another moment while I am introducing our next speaker, I'm going to let the chat continue while I introduce my next speaker. A few other people are still typing, and I don't want to take away from that, but I want people to take a look at some of these resources. I'm going to introduce, though, in the meantime, Candace Landmark. She's the Executive Director of Access Crisis and Acute Behavioral Health Services for Community Health Network in Indianapolis, Indiana. She has 30 years plus of clinical and administrative experience in behavioral health. She's a faculty member at Indiana University and facilitates behavioral health clinical training

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for their nursing program. She joined the Zero Suicide Institute as faculty and really has done an excellent job of sharing the framework that Community Health Network has developed with other organizations that are launching their initiative. She's an incredible speaker, very passionate, and really helpful to organizations getting started. Candace is speaking with us today about her organization's experience with incident reviews and other policies that they've created to support their staff after a client death by suicide.

Candace, thank you so much for joining us today.

>> CANDACE LANDMARK: Thank you. And thank you, everyone, for joining. I do see a few people in the audience that I have worked with, actually. And some of the discussion points that I'll be making today, if you have any questions, feel free to ask. I am thrilled to represent Community Health Network in discussion today about how we look at the aftermath of suicide events. We rolled out our Zero Suicide Initiative a couple of years ago. So we are doing a lot of work and find that the root cause analysis that I'll be discussing today, and many of you might be very familiar with the process, how important it is to help us reduce and prevent these unfortunate incidents.

One of the challenges that we typically have in our organizations is we want to make sure that we have the mindset to present a just culture. This quote seems very pertinent in that it is said that the single greatest impediment to error prevention in the medical industry is that we do punish people for making mistakes. To understand failure, we really don't want to try to figure out where people have screwed up in the process. We don't want to find out - we don't want to ask ourselves why didn't they notice what we find to be important now. Rather, we want to figure out why did it make sense for them to do what they did when they did it. For us to help reconstruct that event so that we can help reduce these incidents from occurring in the future.

This is a comprehensive approach to event prevention. This is that Swiss cheese model that we've probably already seen that has, as you can see, the holes in it. What we want to do is we want to prevent the errors by detecting the system weaknesses and correct and find the root causes of the events. There are multiple barriers that are designed to help us actually get to these errors.

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In talking about the root cause analysis, what this is, it's a structured problem-solving technique that results in one or more corrective actions to prevent recurrence of an event. The goal of a root cause analysis is to find a root solution. I won't really be getting into this today, but there are oftentimes where an event does not meet the conditions of a root cause analysis, and we'll get to that, and we would be directed by our team to do what's called an ACA, or an apparent cause analysis, and that's a bit more of a limited investigation of an event. It's really considered sometimes to be a precursor or a near event, near miss event. The goal of this is to remediate conditions that are averse to quality and support future trending and monitoring of facts - efforts, pardon me.

At a high level, an RCA, an event occurs, and we want to stabilize that first. We want to consider the need in our organization for the use of the RISE team. The RISE piece stands for Resiliency in Stressful Events. That is a team of people across our organization, and not necessarily all in behavioral health, that have been very specifically trained in responding in traumatic events. They can show up as a team. They can show up individually. They meet the needs of whatever that event was. Our first and foremost consideration is to take care of our staff that were involved in an event such as a suicide of one of our patients, one of our employees, anything like that. We can use them for many other events. We're pretty proud of this team. We've had a lot of questions asked about how it works. They've been very well received, and they respond quite often. We have a process set up of how they're contacted and how they respond and that kind of thing. They're available seven days a week, 24 hours a day.

We want to notify our risk department of the event and we will do an initial investigation. We'll develop an SBAR document for our advisors for root cause analysis. And those advisors, they'll do a huddle. Our lead analyst will complete an investigation. We develop events in a causal factor chart. This RCA process is a three-meeting model which I'll show you a little bit more in a couple of slides from now. We meet with an executive sponsor to prepare them for their responsibilities. I've served in that role on several occasions. There is very specific training for that. I'll explain a little bit more about that role in a couple of minutes. And then, ultimately, we will

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identify the root causes and the significant proximate causes that require action planning.

When the event occurs, again, we want to stabilize that situation. As I mentioned, we'd want to notify our team of support that can come to the scene if needed. We want to sit down with our risk manager and discuss the event and make sure that our appropriate site leadership is notified. Our incident reporting system is referred to as MIDAS, and so we would enter that event in our reporting system, and then our risk manager, who I believe is on this call, will investigate and develop an SBAR and we'll take this to our root cause analysis advisor team. For those of you who may not be familiar with the SBAR, it's a very concise document that includes the situation, the background, the assessment, the recommendation, and any requests for the RCA advisors in this document. Keep in mind, our risk person has already done some investigation and will have some idea of maybe a recommendation to them.

Our RCA advisors meet, they huddle, and they meet very, very soon after the event is known. We don't wait. We get involved very, very quickly. And then they will go by a series of criteria that will classify our event and it will tell us whether it's a serious versus a precursor or a near miss and they'll determine the level of analysis we do; as I mentioned, the RCA, the ACA. We have not talked about barrier analysis, but that's another type of deep dive that we can do when we have an event and there are some classifications of that as well. Our disclosure discussion happens within 24 hours, and our goal ultimately is to get to the root cause within 45 days of the event. We're very intentional about that. Additional decisions that are made by our huddle are who will be our executive sponsor and the lead analyst on this particular process. We also want to continue to identify any additional support needed to any of our team that we may not have touched initially or continue to give support to the team as needed. What we don't want to do in that huddle is we don't want to fix the problem because it's too soon and it's not the right group. We don't want to get into too much detail or jump to any conclusion. Again, we want to always trust the process.

This is an algorithm that sort of looks at the decision-making for safety events. It kind of tells you when there is an answer to a question, yes, such as if there is a deviation from the expected practice or standard of care. If there is, we want

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to ask ourselves did the deviation reach the patient. If that answer is yes, we then ask ourselves did the deviation cause moderate to severe harm or death. If that is yes, then automatically, as you can see, it leads us to the serious safety event which would take us to the root cause analysis. And then there is some other decision-making as you can see there.

Joint Commission defines sentinel events as a patient safety event that reaches a patient, results in death, permanent harm, or severe temporary harm. I've noted here for suicide, we look at the suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department.

Moving to the investigation of our RCA process, we do a very extensive review of records, literature, equipment. That includes the patient records, any assignments to the staff who may have taken care of the patient. We look at any equipment that may have been involved that we have control over in that event. We are very intentional about literature review or consultation with experts are expected with each RCA. As part of the investigation, we conduct interviews with everyone who had some involvement, whether it's limited to the most involved person. We want to make sure that we are very specific in how we explain the process to the folks who were involved. We want to make sure, again, that we're providing this just culture and making sure they understand it is about that process and not the person. This is a very tough time. Typically, when we've had a suicide event and people have touched the patient, they're already feeling very badly, so we have to be very, very careful how we approach these interviews. We want to be very - the folks who do our interviews are very, very trained in making sure that they make that staff feel very, very comfortable.

So then, early on, we want to meet with the executive sponsor. We want to make sure that the executive sponsor understands the event, understands some of the details about the event, and typically that's a senior leader in our organization. They're ultimately going to be responsible for managing the process and the root solution and implementation of the actions. They also serve as what I would refer to as a barrier buster. If there are some action items that we seem to not be able to solve or have some issues getting to that, they would refer to the

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executive sponsor and that executive sponsor would help move them through it.

The RCA, as I said earlier, is a three-meeting model. And as you can see, we've outlined here in this chart the three meetings, typically what happens in those meetings, and sometimes that first meeting can be really long because we are very intentional about every piece of detail that that event has. Any time that we have touched that patient no matter where it is, there is an incredibly intense review and a timeline is established. We go through each and every - and I have been a part of several particularly suicide events that we have taken a lot more time doing this than we do getting to the other pieces and parts because this really helps you get there. This is what the three-meeting model is. You ultimately want to get in your third meeting, you want to get to that consensus on what the root cause or causes are, and you want to begin to action plan this root cause or causes. You want to test for the comprehensiveness of the root cause. You want to continue to ask why, why, why, why, why, why. And, really, when you stop asking is when you know that the actions to prevent recurrence that you've identified, they don't change. You continue to say yes, this is what we need to do. And I can tell you that in our circumstances, we do that very well. We ask why, why, why all the time.

When we get to what we believe to be is a root cause, we ask ourselves these criteria. Is it a proven cause and effect relationship? If it's corrected - if corrected, will the recurrence be prevented? Is it under our control to prevent, and can we do it cost-effectively? And then we want to move to corrective actions to prevent the recurrence. At a minimum, we're going to address each root cause, which include actions to address other causal factors. We definitely want to beware of fixing world hunger. Sometimes we try to get a little bigger than we have the ability to do and we really want to stick to what we know that we can fix. We try to have a single person responsible for each action and we set very, very clear due dates for each action step. We do check steps after we've identified the action plan, and the executive sponsor works with the lead analyst and they make sure that this stays on track. Again, we have 45 days from beginning to end to complete this process.

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This is a slide on testing the strength of the solution. And then, ultimately, we want to develop a spread and a sustained plan. The executive sponsor really helps with this. It's part of the action planning. The stakeholder team wants to discuss and decide the transportability of the root cause and the action planning. We want to find out does this problem exist other places. Is there information that needs to be shared and how? Some actions do apply across our organizations and some don't. And, again, the executive sponsor helps determine the extent of that spread and sustained plan.

And that's all I have today.

>> JULIE GOLDSTEIN GRUMET: Candace, thank you so much. I think it's such a robust protocol that you have that really helps ensure that this is done well, meaningfully, in a way that you can actually learn from and improve the care that you're providing. I think it's clear to our audience why we selected today's presenters. They are a wealth of information.

And so we just wanted to take a moment to reflect on what Candace just shared with us. And what was most meaningful or poignant to you about what she shared? What might be a key takeaway for you? Jackie Christmas said I like the concept of an executive sponsor to move things along, right, assigning the responsibility to one person. People like the structure to the root cause analysis, remove the subjectivity from the process.

>> CANDACE LANDMARK: Amira-sponsored training. I want to reinforce that, that here we don't just assign someone. Once you have been identified as someone who can be an executive sponsor, you are given training on how to help move through that process.

>> JULIE GOLDSTEIN GRUMET: Candace, that speaks so well to all of the components of Zero Suicide. Nothing is assumed, that by putting a protocol into place or by naming somebody as part of a team, they understand their role and what they should be doing. I think that's probably one of the areas of a gap across all of our healthcare. We assume if somebody is licensed, therefore they know how to provide quality suicide care. Perhaps you have somebody in leadership serving as the executive sponsor and you guys have really taken this really thoughtful approach to say now we're going to train them what their role as executive sponsor is. What a great example for the rest of us to follow.



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>> CANDACE LANDMARK: Thank you.

>> JULIE GOLDSTEIN GRUMET: A few other questions came in. Questions that have come in we're going to throw into the chat box to take at the end of today's presentation. A couple of people have asked about who is on the huddle team and the RISE team. I think we're going to hold off on that for now and we'll take that - we should have about ten minutes for Q&A at the end. I will say I know the RISE team is something very interesting to people. We are looking at several resources to be able to share with you. We will share - somebody asked previously about a gold standard protocol. We will be able to share that with you. It is already available on the Zero Suicide website. And I think some information about the RISE program. We're going to look to put some material together, a little bit about Community Health Network's RISE program because that, I think, has been a highly effective resource and we want to make sure that people know how you did that and who comprised on that team. We'll give you a couple of minutes later in the Q&A to talk more about that. Yeah. Thank you, Candace. Somebody asked if we recorded and will replay this webinar. All of our webinars are archived, so this one will be archived and available on the ZeroSuicide.com website within the next few days. What I see from a lot of the chats, there are a lot of questions. Some key takeaways are we need more information about postvention but that your presentation today really highlighted a lot of thoughts for our audience so that their wheels are turning and they really want to go home and do this great work that you've already started. I do see a lot of questions. We do track all of these questions and try to integrate them into resources that we develop. And, yes, the slides will be available as part of today's webinar when we archive that.

I want to thank Candace for a tremendous presentation. I assure you that all of our speakers and faculty continue to be available by reaching out to ZeroSuicide@EDC.org. We can continue to access the expertise that we have available to us, as well as using the Zero Suicide Listserv which you can access on the homepage of the ZeroSuicide.com website. I have never worked among a community this generous with its resources and its time and its expertise. There are about 1,000 people currently on the Zero Suicide website who are survivors, who are researchers, who are practitioners, state leaders, all trying to do this really good work in the systems in which they work, so

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willing to share their expertise and their resources. If we don't get to your question today, please go ahead and post that to the Zero Suicide Listserv. We've had amazing conversations come up on that Listserv and I think it's been a real guiding force in a lot of the work people are doing, so please continue to use that.

I am going to turn this over now. I want to thank Candace for an excellent presentation. People clearly are very excited about trying to implement what Community Health Network has already so successfully implemented. I'm going to turn this over to Eliza Jacob-Dolan. Eliza is the clinical director of Riverside Community Care's Newton Youth Outreach Program in Boston, Massachusetts. She has over 25 years of experience serving and advocating for youth and families through various community mental health programs that they offer. She is a member of Riverside's trauma team and leads postvention response efforts following a suicide or other traumatic events throughout the state. Eliza has incredibly kindly volunteered to share her own story of being a clinician survivor of a patient's death by suicide. I so appreciate her willingness to talk to us today. I know that Ken shared a really poignant story earlier. Eliza has joined us to also share her story so that hopefully we can learn from that and continue to revise how we do the work and how we care for the excellent practitioners doing this work.

Thank you, again, Eliza.

>> ELIZA JACOB-DOLAN: You are welcome, Julie. Hello to all of you out there. My name is Eliza Jacob-Dolan and I'm a licensed independent clinical social worker. I've worked in community mental health settings for the past 25 years, like Julie said. My focus in treatment is I've always been what I call a worker bee, that I am doing home-based or outreach services with adolescents and families and that is my passion and what I continue to do as well as very part time as the clinical director of these two small programs through Riverside Community Care.

>> JULIE GOLDSTEIN GRUMET: Thank you. And, Eliza, again, this is just an opportunity. We're just going to talk a little bit more informally. We don't have a formal presentation planned. We just wanted people to hear a little bit more about your story. And, again, I just want to say so much about how we appreciate your willingness to share your lived experience as a clinician

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who has lost a patient to suicide. Your perspective, insight, willingness, and bravery to share your story is invaluable so that others can learn.

>> ELIZA JACOB-DOLAN: Thanks. It was about three years ago, two or three years ago, that I had a client die by suicide. I had been seeing this young adolescent for only about - we had probably four sessions together. She was referred to our program through the school and with collaboration with her mom. I found out about her death - I got a call one evening at home from my supervisor. I'm very boundary. I thought, okay, they're calling me, what's it about, what are you bothering me about, what paperwork didn't I do, what is going on. She shared the news that my client had died by suicide. It was absolutely shocking because that day I had had an incredible, I thought, of really great session with her where we were drawing and I was pointing out the hopeful pieces in her drawing and we really had a good exchange. It was shocking, to say the least, and really absolutely confusing. Yeah. Yes. Julie, where do you want me to go from there? How do I keep going?

>> JULIE GOLDSTEIN GRUMET: No. That's okay. I think many of the feelings that you're describing are similar to Ken's story earlier in the presentation about what it feels like.

>> ELIZA JACOB-DOLAN: Right. Some of that - right. When I was listening to Ken, it was - and what my supervisor offered me, which - so the next day when I came in, it was the focus on the self care. He reiterated over and over that I was responsible for asking for help and just that they would move at my pace. He talked about that I would notice that my concentration was off, that I had fuzzy mind and that that was okay, and not to judge myself and not to, as I would find myself crying as I'm filling up my gas tank, just to notice that I'm crying as I'm filling up my gas tank and not to judge myself and to notice that I couldn't remember what I had just been doing ten minutes ago, that I was feeling like I wanted to isolate but knowing that that was not going to be helpful, so to invite my friends in and to invite my family to care for me and to let people do that because as a clinician, I am a caregiver, so a shift in roles for me.

Some of the concretes that I can remember were drink lots of water, Eliza, go for walks and get your body moving, notice that your sleep is going to be messed up and that can interfere with

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everything, and you could not have changed this. This was not my fault. The amount of times that that was said to me when I would raise it, and it was only said to me when I would raise it, I should have known, look, I would go over my last session with people, with different colleagues who were so supportive. The support came mainly from people being present to me and listening to my story and they were lacking in judgment and overflowing in empathy and affirming. I had been known as someone that could do the outreach work, especially with adolescents, because I could hold the risk, I wasn't a quick reactor. And so questioning was my style all wrong. When Ken was talking about - Julie, when Ken brought up the part about changing careers, I had those questions of, okay, I'm not good at this anymore. I've been good at this for however many years, but I'm not good at it anymore. I continued to have a lot of my supervisor being available to me as much as I needed him to be and offering me space, space to process. He has incredible knowledge about postvention and that was a gift in that way.

>> JULIE GOLDSTEIN GRUMET: Yeah. You've described that he really was - you were very fortunate to have him as a supervisor because of his incredible knowledge and compassion. You were doing the trauma work yourself, you were doing crisis intervention work in the state, and I'm sure you knew all this had you been the person to need to see that and educate others. But in the moment, it was you and how helpful it was that people were very concrete and reminding you of the same principles that we might forget to allow ourselves to remember in the moment.

>> ELIZA JACOB-DOLAN: Right. To be on the other, you know, to sit in the other chair, the power differential was just so different, and to be cared for that way was and still is - it's exposing, right, because my professional and personal got all combined in a way that I wasn't comfortable with but I didn't have a choice. Riverside Community Care did a beautiful job of normalizing that and not - I don't know - just normalizing that. Where we ended up, one of the - at the time of my client's death by suicide, our team was in transition. So I wasn't the clinical director. There was another woman there and I was a see for service worker. There were four other full-time workers who were either - one had just resigned, two were on a maternity leave. There was just no one working the program. When I asked for time off, they were like, yeah, sorry, you need to keep working. That was very difficult to do and, as I look back on it, very helpful because I realized my resilience, I realized that I was

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competent, that I could find focus and I could continue to do my job, which was very helpful.

About maybe six months after, I'm not even sure about the time, but it was less than a year after, our team had been - we had hired some people, some people were back from leave, and we ran a coping group which is a postvention tool, Julie, that is - how do they describe it - a guided discussion. During the process of it, it is probably around nine questions or something like that and you go through in a circle manner taking turns talking about how did you hear about the event, the traumatic event, where did you feel it in your body because so much of the trauma response is that the body holds the score, where did you feel it in your body, what did you wish. If something didn't happen, what did you wish would have happened or what could you have changed? At that point, I realized that I had some resentment and anger towards the team, that there wasn't a team, first of all, and that people weren't - the agency didn't respond as if it was someone else who had had a loss. I didn't get the flowers. I didn't get on the meal train. I didn't get the card. It was still taboo in a way, though we talk about it not being. That was an a-ha moment to me during that and I was really glad I had that process to be able to figure out that that was a piece of what I was still carrying with me from it.

>> JULIE GOLDSTEIN GRUMET: And how remarkable for you that you were able to recognize that, and the organization was able to hear it. Right? I think it was so -

>> ELIZA JACOB-DOLAN: Right. Absolutely. Oh, no. Yes. That they have those tools. It had been such a safe or a - it's hard to say affirming, but a safe process, I guess. It's not one that I would ever say like in my career I want this, but I don't know that there is another way or that I have large regrets or sores about following it because I'm able to stay with the same agency. I'm continuing to practice with the same population. You're right. The ending of the coping group is the self care model. As a group, you share with people how you're going to do something for self care, if it's yoga classes, meditation, walks, eating, inviting someone to join you for something, and then the group holds you accountable and checks in with each other. At that point, the group really changed because we all were a part of this. It affected all of us and not just me, so I wasn't - I wasn't the holder of all of the trauma anymore. It

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was the group had experienced it on different levels and we were able to share our healing together.

>> JULIE GOLDSTEIN GRUMET: It was really sort of an organizational coping group. It wasn't Eliza's coping group.

>> ELIZA JACOB-DOLAN: Right. No. It was our team. It was the team's coping group. Yes.

>> JULIE GOLDSTEIN GRUMET: This was a group then that met over how many months?

>> ELIZA JACOB-DOLAN: This group is a - it was a one-time coping group meeting. Right? And you can - someone comes in and leads that group for us. But the group as a team are clinicians that that's the team that I'm now the clinical director of. There are 12 of us that do the outreach work to families and adolescents. Does that make sense?

>> JULIE GOLDSTEIN GRUMET: M-hmm.

>> ELIZA JACOB-DOLAN: We're the -

>> JULIE GOLDSTEIN GRUMET: No, go ahead.

>> ELIZA JACOB-DOLAN: Go ahead. The coping group was a one-time event that's about an hour and a half to two hours, right, and the members of the coping group are the members, a lot of them are still the members of the team that I'm still a part of.

>> JULIE GOLDSTEIN GRUMET: And do they hold quarterly - does your organization hold quarterly coping groups, or do they only bring them up in the aftermath of an event, or when it's sort of apparent that somebody is struggling? Who gets to launch a coping group?

>> ELIZA JACOB-DOLAN: Anyone can. At any time, you can request to have someone run a coping group for you because of a traumatic event that this group of people - that this group of people have gone through. I just was a co-leader in a coping group. I wasn't a participant, but I was a co-leader in one the other night for board members who had had a death, right, a recent death of a board member. It was that group processing their loss. They are run through our Riverside Trauma Center for - anyone can request them. The Trauma Center helps people decide

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for the postvention what groups to gather together. If it's a student who has died in the school, then they're going to pick the group that is the really good friends as one coping group and then another group is going to be the friends of the sisters maybe or a third group is going to be the teachers of that student who have taught. There can be many different ones around one loss.

>> JULIE GOLDSTEIN GRUMET: And so how was the experience of participating in a coping group helpful to you?

>> ELIZA JACOB-DOLAN: It was helpful to me because I got to - I was asked to think about - with a distance from the event, right, so I have time, I'm not as reactive to the event, so I have time to think about where is the trauma still sitting with me, where in my body am I still feeling it. I kept feeling it in my gut. For me, what it was, it was like a fire in my belly because I was angry. I was angry that - one of the ways that I wanted to be treated was to have people acknowledge it in the formal ways that we acknowledge a loss, if that makes sense. Go ahead.

>> JULIE GOLDSTEIN GRUMET: And what about any sort of, you know, you were talking again that you could handle working with adolescents because you were always able to kind of manage a certain degree of risk, you were a very trusted colleagues. How do you think participation in the coping group maybe helped you around some perceived stigma you felt about yourself or the others might have felt towards you?

>> ELIZA JACOB-DOLAN: Right. I think that, for myself, it was an affirming place to be able to say what everyone else had been saying to me, but it was me saying it to people instead, what my colleagues and my supervisors had been saying of, Eliza, you didn't do anything wrong; Eliza, you didn't have that much control; Eliza, if you would have asked this question or that question, the what-ifs. I was able to say in the coping group I remember hearing this and I was shocked, and I did the best that I could do. Yes. That's where it was very helpful to me. And as I continue to practice, it's the same - for me, it's the same of I have lived experiences. Right? When I became a mother, I changed as a clinician because I had a new lens. Right? As a survivor of suicide, I have a new lens. I have a new lens when I supervise people who are carrying risk and using assessment tools and putting that out as like one of our priority teaching

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moments when we take on our interns each year. It just has come right up into the forefront and has stayed there for us.

>> JULIE GOLDSTEIN GRUMET: And how do you feel like perhaps your organization changed as a result of running a coping group? You really turned a lens and used a strategy on your own staff that you hadn't - that you'd been using externally to support others. Were there any next steps identified or changes you noticed among the dynamic of the team or the culture from running a coping group for somebody who is part of the staff?

>> ELIZA JACOB-DOLAN: I can't speak specifically because I don't - Julie, I don't know the specifics of the bigger Riverside. But what I've heard is that it was acknowledged, that there are, as Candace was talking about, how do you organize yourself to be able to respond as an agency. Because we have the Trauma Center as part of our whole agency, we are privileged in that they can respond to crisis that we have. And so I think as a larger agency, it was giving priority to that and recognizing that we need to somehow recognize the need for that care in that process within our own house as well as the houses outside of us.

>> JULIE GOLDSTEIN GRUMET: What are some steps that you would recommend for organizations to take to support a clinician after a patient's suicide?

>> ELIZA JACOB-DOLAN: Excuse me?

>> JULIE GOLDSTEIN GRUMET: What would be some steps or actions you think that organizations should take then to support clinicians after a patient's suicide?

>> ELIZA JACOB-DOLAN: Oh. I think it's very important to time and the support and the - how do you say this? How do I say this, Julie? I'm thinking of the piece when Ken said, you know, that the clinician felt like they should be over it in four months or whatever. It's that continual - that remembering that this person has been through and is in the process of an incredible trauma and having your trauma-informed lens as a supervisor and as a manager on and on forever because this is the reaction that you're going to get, this clinician has changed. I would like the managers in agencies to be equipped with that and to not be afraid of that but to feel competent in



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terms of holding those of us that are asked to hold this risk with our clients. Is that making sense?

>> JULIE GOLDSTEIN GRUMET: No, it makes perfect sense that we have to remember the same skills, compassion, time, and space that we give our clients, we have to be able to give one another.

>> ELIZA JACOB-DOLAN: Right. Yeah. And on a biweekly paycheck. It doesn't end. The anniversary times are huge, even if the clinician isn't recognizing it because they're moving on. It will come up in some way. It comes up with the headaches. It comes up with I'm just feeling really low. What's going on? Having the supporters being well informed.

>> JULIE GOLDSTEIN GRUMET: Eliza, you've created a great picture of how your organization really helped you after this loss and the experience that you went through. I really appreciate your bravery and sensitivity and sharing with us so that others can know from, you know, it's hopefully something that nobody else will have to go through. But in the event that it does, it's so important to know how we can support people in our organization, not just in our communities but our colleagues who might be struggling after a suicide loss. We really have to think about it. Thank you for sharing so honestly what helped you so that maybe we can help others who are working with us should this happen in the future.

>> ELIZA JACOB-DOLAN: Thank you for making this a safe place to do that.

>> JULIE GOLDSTEIN GRUMET: Yeah. Thank you so much for sharing with us today.

>> ELIZA JACOB-DOLAN: You're welcome.

>> JULIE GOLDSTEIN GRUMET: We have a moment just to kind of hear what people are thinking based about what Eliza was able to share. I imagine many of you have been in the position having to support a colleague or perhaps it's even something very frightening to think about. I can imagine what do you do. Eliza really gave us some practical steps about things that were helpful and not so helpful. There are a lot of comments, Eliza, about your bravery and for validating and sharing your story. I think, if nothing else, the fact that you were able to come

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forward and talk about this so that others can learn is so very appreciated. Thank you so much.

>> ELIZA JACOB-DOLAN: You are welcome.

>> JULIE GOLDSTEIN GRUMET: Maybe, as we were talking about earlier, being able to share some additional resources if there is a template for the coping group that was run or a website where we can access more information. We'd be happy to share that with today's audience. A couple of people talked about it's a good reminder of just what it takes to really be a provider in the field and the toll it can take on being a provider when tragedy occurs. Very powerful feedback. Thank you so much for your honesty. I think it sounds like the coping group is new to several people. Maybe people have used it, but they haven't necessarily turned it inward to their own staff. It sounds like this is a good opportunity for people to think about another resource should they be in this position.

I'm going to turn it over now. I want to, again, thank you, Eliza, so much for sharing. I know it's been hard to share your experience and you were very kind to share it with us. I hope you see that reflected from today's comments everybody who really has an opportunity to learn from that. Again, I'm really glad that you were able to join us today.

>> ELIZA JACOB-DOLAN: You are welcome.

>> JULIE GOLDSTEIN GRUMET: Yeah. Thank you. And our discussant now is Becky Stoll. We invited Becky just to kind of think about she is part of Centerstone. She's the Vice President of Crisis and Disaster Management Services at Centerstone where she has 20 years of behavioral health experience as a licensed clinical social worker. Becky is very active in the National Action Alliance and she serves as a faculty of the Zero Suicide Institute. We've invited her here because Centerstone has really been a leader in thinking about the policies and practices across many of the different components of Zero Suicide, but around postvention in particular. We just wanted to give her a moment or two to reflect on what she heard and maybe she can highlight any important themes that she heard running across all three presentations.

Thank you, Becky, for joining us.

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>> BECKY STOLL: Thank you, Julie. Hello from very, very chilly Nashville, Tennessee. If you can believe it, it's very cold here today. It was fascinating to listen to the other speakers and hear some of the information because we live in that world and we're doing that same kind of look internally when we have an unfortunate event around a suicide death of someone in our care. I think the little nuggets I pulled out for myself that I really would just want to highlight and focus and hopefully all of us can hone in on is that we kind of have three buckets of people that we need to pay attention to after an event. I thought Ken and Candace did amazing jobs talking about our staff. And so when we have clinicians and even support staff who sometimes know these patients who may die by suicide in our care, that we're doing the best we can to take care of them and help them keep a career hopefully that they love and that they're passionate about.

I know internally here at our agency, we developed peer support teams for those kinds of events. We have a manual that we developed that goes along with that, and then we have a team of clinicians who are kind of trained as peer supporters. Any time we have an event, not only do we do some of the things that are similar to what Candace was talking about, but also making sure that this peer support team can be activated. And it is clinicians who have been through that event, just like Eliza had, so they can talk to them about that event. But we also have other patients who oftentimes have been in groups or see each other in the lobby or know each other from different ways and we also want to make sure we're tending to the needs of patients who might be impacted by a suicide death of someone in care. We always make sure that we're doing that.

The third group, I think, that we just have to be mindful and to tend to are the surviving loved ones of the person who has died by suicide. I think that one becomes a little bit stickier than the other two. It's, in my experience, not simpler to provide services to staff and other patients, but the process is a little bit easier. When it comes to surviving loved ones, including family members, we often have to look at some of the legal ramifications. We wrote probably a couple of years ago a document that kind of outlined what our processes were going to be around that. The one around surviving family members is the most complicated because sometimes legal ramifications around inadvertently disclosing someone's protected information, even in death, can be complicated. I just think we all have to be

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very, very mindful of releases of information and do those go to the grave with someone. We just have to make sure in some of the ways that we would like to be caring and comforting and supportive to family members. Sometimes we have felt like we can't do some of the things we need to do because we don't know if the family knew the patient was in care. Some of our areas are rural. Often staff see these obituaries or we have a family member call in and talk about someone who has died by suicide and you want to take cakes and casseroles and do all those kinds of things and go to the funeral and send flowers, but always having to be mindful can we do that. Was the patient talking to their family about their care? Do we have the authorization to do that? When we do, there are lots of nice things that can be written into policies around reaching out to the family telephonically. We offer them free face-to-face appointments to come in so we can try to start putting those postvention pillars in place and hope we can prevent some of the suicides that might trickle down as a result of that. I really just encourage folks across the country to tap in whatever legal counsel you have to ask in your state what are the restrictions around confidentiality, whether you have releases or don't have releases in terms of speaking with someone's family member who has deceased. You definitely want to make sure you're not breaking that person's confidentiality.

And then we have a few guidelines around the considerations you really need to make when dealing with a family member. Often, they are blaming themselves, not wanting to imply or state that there is more that could have been done or that they missed something. I think Ken was talking about not becoming across as defensive or angry or standoffish in terms of how we're interacting with those folks. And so on the Zero Suicide website, I think we have that document and I think the peer support documents that we have. Glad for folks to see those. If they have questions about that, just let us know.

>> JULIE GOLDSTEIN GRUMET: Thanks, Becky. A lot of Centerstone's resources are some of our guiding documents on the website. We have several of our faculty on as speakers and on today's call. I think really what we're hearing is the need for thinking about all of this in advance. This postvention and what you're going to do in the event of an adverse event really needs to be discussed by your team with clear policies and training in place, compassion for your own team when this does happen, and recognizing that that's a long process and how can you best

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support your team through this rather than a one-time event. Even as Eliza was saying, it could be the anniversary of the patient's death. That is a time when you need to come back around to the clinician and, again, provide support and opportunity for discussing how they're doing. I really want to thank all of today's presenters for giving us a really well-rounded perspective on how best to do postvention within organizations.

A few questions came in. I'm going to start specifically with Candace. People were asking a little bit more about the RISE team and who is part of the RISE team, if you could speak for a moment about that.

>> CANDACE LANDMARK: Sure. I'm not the subject matter expert on how that team was trained - developed and trained, but what I can tell you is that the roles that make up a RISE team for us is multidisciplinary. There are physicians, there are nurses, there are therapists, just an array of people that are not all in the behavioral health arena. Mostly, they're people that have volunteered because they have a commitment and a passion for this work and they want to give back in some way. Once those people are identified, they are sent to a very specific training to be able to do this work. I am not a part of that team at this time. I do have a desire to do that in the future. I hope that I've answered the question. If not, please feel free to ask again.

>> JULIE GOLDSTEIN GRUMET: Well, we also work so closely with Community Health Network. We can get some more information out to the audience.

>> CANDACE LANDMARK: Absolutely.

>> JULIE GOLDSTEIN GRUMET: Yeah. We've always appreciated your partnership with us.

>> CANDACE LANDMARK: Thank you.

>> JULIE GOLDSTEIN GRUMET: Yeah. Ken, you were starting to speak some about providers attending funeral services. Somebody had asked are there any studies or outcomes about providers who do attend funeral services? I'm not sure if what the person was asking are is that hard for the provider or just, statistically speaking, if most providers attend funeral services. But I think

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if you can speak for a moment broadly about what tends to happen if a provider attends the funeral. Is that in the best interest of the family?

>> KEN NORTON: Sure. There are no studies that I'm aware of. I think sort of jumping back one second, the kind of legal standard has always been, if you ask an attorney, they would say that you shouldn't have any contact with the family, and yet there is that human response piece. In terms of that boundary relative to confidentiality, this is a great thing where informed consent becomes very important in dealing with your clients in advance. Who else from the family knows that this person is in treatment with you? What information might you share and when might you share that information? It doesn't mean you're going to give really detailed or confidential information. But in the event of something like this, like a client death, if you have any contact with the family, is that a breach of confidentiality? If you're showing up at the funeral service, is that a breach? Again, particularly if it's in a rural area. And, again, that human side that families deeply appreciate any contact, even if it's often not able to get into the level of detail or answer the questions that they would like. You certainly should be clear before you're sharing any detailed information what the legal ramifications of that are because, as was said, confidentiality doesn't necessarily end at death.

>> JULIE GOLDSTEIN GRUMET: Right. Is there information specifically on the Connect website about things to consider, some of the things that you talked about today about whether or not to attend the funeral, whether or not to send flowers, how to access some legal support to think about what the law is in your state?

>> KEN NORTON: There is not any specific information there, although there will be. At AAS, I am doing a pre-conference on ethical considerations for suicide and we do get into some of that there. As I mentioned, it's really more, you know, it's kind of a gray area. I think it's things that people need to consider and talk about in terms of what questions they're going to ask or what steps they're going to take to come to a decision about that depending on - I mean, if there is a release of information, for instance, with the next of kin, there might be a very different reaction than if the next of kin had no knowledge that the person was in treatment.

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>> JULIE GOLDSTEIN GRUMET: Right. Thanks for pointing that out. And thanks for bringing up another excellent conference. The American Association of Suicidology Conference is in Phoenix this year in April. I know Ken and his team will be presenting about postvention. Our team at Zero Suicide also has a pre-conference about doing the Zero Suicide Framework. There is a lot of excellent information at that conference, so consider joining it.

I want to thank all of our presenters for joining us today for an excellent webinar, very informative about an area of the Zero Suicide Framework that I know we often get asked about. People are looking for resources. They want to do it right, carefully, thoughtfully, and so I really appreciate what you've brought to today's conversation, a vast amount of new resources and ways to look at this. The solution is never one simple answer, and we know that, but we have an incredible group of people currently doing this work. As I said, please reach out to the Zero Suicide Listserv for additional questions. Please visit [ZeroSuicide.com](http://ZeroSuicide.com). We're constantly updating the website. And feel free to reach out to us via this email or phone number at any time with additional questions. I hope everybody has a wonderful afternoon. I want to thank you all for joining us. Have a wonderful holiday season. Take care.