A Postvention Guide for Organizations After a Client Dies by Suicide

A client's death by suicide is among the most challenging events a behavioral health organization may face.[1,2] Beyond the profound emotional impact on clinicians and staff, organizations must navigate clinical, operational, legal, and administrative responsibilities while maintaining care for other clients. A clear postvention plan helps organizations respond promptly, compassionately, and consistently by clarifying roles, supporting affected clinicians and teams, protecting continuity of care, and creating opportunities for organizational learning.

Remember, suicide can occur even when a person has received appropriate care.

Core Elements of an Organizational Postvention Plan

1. **Response Leadership**

   The organization should identify who will lead the response and who is responsible for each major task. Clear roles reduce confusion and help ensure that emotional, clinical, legal, and operational needs are addressed promptly.

   The plan should identify:

   - Postvention response lead
   - Treating clinician support lead
   - Legal/risk management contact
   - Communication lead
   - Continuity-of-care lead
   - Staff support lead
   - Lived-experience advisory lead, if available
   - Family/community contact lead
   - Review and learning lead

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2. **Confirmation and Communication**

   Rumors and incomplete information are common in the immediate aftermath of a client's death by suicide. Organizations should confirm the death with reliable sources before communicating broadly, and communication should be accurate, compassionate, coordinated, and privacy-protective. Sample communications can be found in A Manager's Guide to Suicide Postvention in the Workplace.

   The plan should clarify:

   - Who confirms the death
   - Who is notified first
   - What information can be shared (with family permission)
   - Who communicates with leadership, staff, family, other clients, and external partners
   - How rumors, incomplete information, or social media reports will be handled

3. **Confidentiality, Documentation, and Legal Guidance**

   A client's death by suicide may involve sensitive issues related to protected health information, clinical records, reporting, liability, and contact with family members or others. Additionally, records related to substance use treatment may also be governed by 42 CFR Part 2; organizations should consult their privacy officer or counsel before disclosure.

   If the client was a minor, additional privacy and disclosure considerations may apply. Organizations should seek privacy and/or legal guidance before sharing treatment information with parents, guardians, or other family members, as rules may vary based on state law, minor consent provisions, substance use treatment protections, prior preferences, and who is legally authorized to act after death. Decisions should not be left to the treating clinician alone.

4. **Continuity of Care and Support for Other Clients**

   Organizations should plan how care will continue for other clients while supporting the treating clinician and any affected treatment programs.[3] In group, residential, inpatient, school-based, or intensive treatment settings, communication should be factual, non-sensational, privacy-protective, and supportive.[3]

Workload and coverage needs will vary based on organization size, staffing, client population, setting, and the affected clinician's role. Because there is no single standard that fits all settings, organizations should establish a plan that outlines how coverage will be handled and how support and resources will be made available to staff. At minimum, plans should consider same-day coverage for urgent clinical responsibilities, protected time for documentation and consultation, temporary schedule adjustments, and follow-up reassessment of workload needs.

The plan should clarify:

- Who will determine workload or schedule adjustments
- Who will cover urgent clinical needs
- What same-day coverage, protected time, or temporary schedule changes are available
- When workload coverage needs to be reassessed
- Which clients may be affected by the death
- How to communicate with affected clients while protecting privacy; avoiding method of death details; and discouraging blame, speculation, or scapegoating
- Whether additional outreach, support, or risk assessment is needed for other clients, especially those who:
    - Had a close relationship with the person who died or participated in a shared treatment setting
    - Are already at elevated suicide risk
    - May have learned graphic or inaccurate information through social media

5. Clinician and Staff Support

A client's death by suicide may be experienced as both a personal loss and a professional crisis.[1,2] Organizations should normalize clinicians' reactions and provide proactive support that extends beyond the first days or weeks.[2] Distress may recur later. Events such as a case review, complaint, deposition, court proceeding, memorial or funeral, death anniversary, or suicide death or attempt by another client can reactivate grief, self-doubt, or traumatic stress.

Support should not be dependent on the clinician asking for help. Organizations should also consider the impact a client's death by suicide can have on the broader care team, including trainees, clinical and administrative staff, peer-support specialists, interpreters, contractors or shared-care providers, and supervisors who may also be grieving.

The plan should include:

- Immediate supervisor or leadership outreach
- Emotional support and practical assistance
- Help with documentation, communication, and coverage
- Clinical consultation or supervision
- Peer support from trusted colleagues
- Temporary workload flexibility or protected time, with follow-up as needed
- Employee assistance program (EAP) information, therapy referrals, or other mental health resources
- Follow-up check-ins over time

6. Family and Community Contact

Communication with the family members and loved ones of the client who died by suicide should be compassionate, coordinated, and consistent with confidentiality requirements and legal guidance.[4] A condolence call should not become a defense of the care provided or a detailed discussion of treatment; questions about records or treatment information should be directed to the organization's privacy officer, health information management, or legal process.

The plan should clarify:

- Who may contact family members or loved ones
- What information can and cannot be shared
- How condolences may be expressed
- How requests for clinical information or records will be handled
- Whether staff may attend funerals or memorials, including any approval process or time-off arrangements
- How to respond if contacted by family, attorneys, media, or community members

7. Review, Learning, and Plan Revision

After the immediate crisis has passed, the organization should conduct a structured review focused on learning, not blame.[5] A systems-focused review helps organizations strengthen policies, training, communication, supervision, documentation, and continuity-of-care procedures.

The review should consider:

- Were roles and responsibilities clear?
- Was the treating clinician supported?
- Were confidentiality and legal procedures followed?
- Was communication timely, compassionate, and coordinated?
- Was continuity of care maintained?
- Were other clients and staff adequately supported?
- What gaps or barriers emerged?
- What changes are needed to policies, training, supervision, documentation, or communication procedures?

Additional Considerations if the Client Was a Minor

If the client who died was a minor, postvention planning may require additional coordination with parents or guardians, schools, pediatric providers, child-serving systems, and other community partners. Family contact, consent and disclosure, media or community exposure, and support for peers may be more complex. Organizations should consider whether affected youth require proactive outreach, suicide risk reassessment, or updates to safety and treatment plans.

Additional Frameworks and Resources

Developing a postvention plan can be complex, but organizations do not need to start from scratch. Established frameworks and resources can help guide planning, clarify roles, and strengthen organizational response after a suicide death. Resources to consider include:

- **After a Suicide: Postvention Toolkit for Workplaces**: American Foundation for Suicide Prevention toolkit assists workplaces in responding to a suicide.
- **A Manager's Guide to Suicide Postvention in the Workplace**: Practical guidance from the Carson J. Spencer Foundation for managers and leaders supporting staff after a suicide.

- **The Impact of Suicide on Professional Caregivers: A Guide for Managers and Supervisors**: NYS Office of Mental Health's Suicide Prevention Center guide offering suicide prevention and postvention resources for behavioral health systems.
- **Postvention**: Postvention resources from Zero Suicide, a systems-level framework for safer suicide care that includes postvention planning and organizational policies.

References

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