

Special Interest Group on Postvention: *Newsletter.*

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COLLABORATIVE EFFORT PRODUCES MANAGER'S GUIDE TO HELP WORKPLACES WITH THE AFTERMATH OF SUICIDE

See guide at: [http://carsonjspencer.org/
ManagersGuidebook.pdf](http://carsonjspencer.org/ManagersGuidebook.pdf)

Denver, CO – In the U.S., the majority of people who take their lives are working-aged people, and yet workplaces are often unprepared to deal with this crisis. Today the American Association of Suicidology (AAS) and the National Action Alliance for Suicide Prevention (Action Alliance) announce the launch of a collaborative publication, in partnership with Crisis Care Network (CCN), and the Carson J Spencer Foundation entitled *A Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of Suicide*.

For every suicide death, an estimated minimum of six people are affected, resulting in approximately six million American "survivors of suicide" in the last 25 years. The creation of the guide came as a logical step for the collaborators. "The demographics of suicide inform us that the working-age individual, in particular working-age male, is most at risk for suicide," explained Dr. Alan Berman, Executive Director for the AAS. "A sizeable proportion of these deaths by suicide occur on the worksite, or otherwise affect the worksite, pointing to an increased need for postvention in the working population. These guidelines are most important for systems of employment, in the worst case possibility that such a tragedy occurs."

The guide provides clear steps for postvention, giving leadership a sense of how to immediately respond to the traumatic event, have a plan in the short-term for recovery, and consider long-term strategies for helping employees cope down the line. Dr. Sally Spencer-Thomas, CEO & Co-Founder of the Carson J Spencer Foundation, explained: "We collaborated to create succinct procedures with checklists and flow charts to be a go-to guide for people dealing with the crisis of suicide. Our goal is to help to reduce the impact of the suicide event by offering a blueprint to handling these challenging situations. The guidebook allows for immediate access to clear steps to take for moving forward, and helps workplaces plan to move from a solely reactive position on these issues into policy development and trainings."

"In many postvention responses we saw business leaders forced to operate well outside of their training and expertise, grappling with unanswered and unanswerable questions," said Bob VandePol, President of CCN. "When there is a death by suicide, all eyes turn to leadership and people take their cues based upon how leadership responds. It's also true that people under the influence of traumatic stress look to leadership and make assumptions about their own personal worth within the company, so there is tremendous power in a calm, compassionate presence by management during this time."

The collaborators worked to create a set of guidelines that are useful across varied types of workplaces, and they expect a range of individuals within these organizations and companies to find the information immediately helpful. “This guide can be useful to managers at all levels—from the CEO of a large business to a front-line supervisor of a small organization,” asserted Action Alliance Executive Secretary, Dr. David Litts. The Action Alliance played a key role in bringing these groups together to develop this resource.

To download your own copy of these guidelines and to review others, please go to <http://carsonjspencer.org/ManagersGuidebook.pdf>.

American Association of Suicidology

Founded in 1968, **AAS** is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS leads the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

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National Action Alliance for Suicide Prevention

The National Action Alliance for Suicide Prevention, a public-private coalition, works to advance the *National Strategy for Suicide Prevention* by championing suicide prevention as a national priority, catalyzing efforts to implement high priority objectives of the *National Strategy*, and cultivating the resources needed to sustain progress. Launched in 2010 by Health and Human Services Secretary Kathleen Sebelius and former Defense Secretary Robert Gates, the Action Alliance envisions a nation free from the tragic event of suicide. For more information, see www.actionallianceforsuicideprevention.org.

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The Carson J Spencer Foundation (www.CarsonJSpencer.org) is a Colorado nonprofit, established in 2005. We envision a world where leaders and communities are committed to sustaining a passion for living. We sustain a passion for living by Delivering innovative and effective suicide prevention programs for working-aged people.

Coaching young leaders to develop social enterprises for mental health promotion and suicide prevention.

Supporting people bereaved by suicide.

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Crisis Care Network

Founded in 1997, Crisis Care Network (CCN) is the EAP industry’s premier provider of Critical Incident Response for the workplace. CCN helps individuals and organizations return to work, life, and productivity following critical incidents. We mitigate the human and financial costs of workplace tragedy such as workers' compensation claims, low morale, employee attrition, and litigation. CCN has established the nation's largest network of master’s- and doctoral-level clinicians trained as Critical Incident Response Specialists, responding more than 1,000 times per month to workplace incidents for EAP’s, insurers, and employers in communities throughout the United States and Canada.

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Support for Suicide Bereaved

The Scottish government suicide prevention initiative Choose Life, has launched two new support tools. A new publication called Supporting People Bereaved by Suicide is a practice guide for organisations that respond to suicide, including both first responders and those involved in longer term support. More questions than answers, which was developed in collaboration with Cruse Bereavement Care Scotland, serves as a complimentary training course.

For further information go to; <http://www.chooselife.net/uploads/documents/67-SupportingPeopleBereavedBySuicide.pdf> .

The statement below was developed by a working group at the meeting of the International Work Group on Death, Dying and Bereavement in Victoria, British Columbia on April 28 – May 3, 2013. You have full permission to translate the document into other languages, and to distribute it via websites, blogs, the media, and other venues. It is our intention that the message be shared widely..

When does a broken heart become a mental disorder?

Rarely, if ever.

But don't tell that to the American Psychiatric Association, which has just released its fifth version of the *Diagnostic and Statistical Manual of Mental Disorders*. The *DSM* is a catalogue of mental disorders, hundreds of them, each trailing a listing of symptoms. The manual informs selection of a diagnosis, which is required by U.S. insurance companies for reimbursement for mental health care.

There's a major change in the newest version, *DSM-5*, with serious implications for the millions of people who are coping with the death of a child, spouse, parent, friend, or other loved one.

But first, a quick glimpse at the history of this publication, often referred to as the bible of psychiatry. The very first edition, published in 1952, didn't even refer to grief, considering it an accepted and normal reaction to the death of a loved one. The third edition added an exclusion statement under Major Depressive Disorder, referred to as the "bereavement exclusion." Under this exclusion, a diagnosis of Major Depressive Disorder could not be made for a full year after a death. They recognized that normal and common reactions to the death of a loved one could look like symptoms of depressive disorder, for example, sadness, disturbed sleep, lack of concentration, changes in eating, and loss of interest in things that were once pleasurable.

In 1994 the 4th version of the *DSM* reduced the bereavement exclusion to two months after a death, and this new version removes the bereavement exclusion completely, meaning in effect that anyone can receive a diagnosis of Major Depressive Disorder two weeks after the death of a child, parent, spouse, friend, or anyone.

Why does this matter? For at least three reasons:

First, normal reactions to the death of a loved one will be easily misclassified as the mental disorder depression. Grief is not the same experience as major depressive disorder. It is not an illness to be treated or cured. It is a healthy response to a painful reality that one's world is forever altered, and will never be the same. Absorbing this loss, and adapting to all the changes it unleashes, has its own unique course for every person, and will not be stilled or stopped by quick fixes or simple solutions. Death is a life-altering event, but grief is not a pathological condition.

Second, antidepressants are commonly and frequently prescribed. There is a strong likelihood that newly bereaved people will qualify for a diagnosis of Major Depressive Disorder just two weeks after a death even though their reactions are normal. Antidepressants have not been shown to be helpful with grief-related depressive symptoms, and there is accumulating evidence of long-term negative effects of being on antidepressants. We need to ask why psychiatry is pathologizing grief and therefore making inappropriate pharmacological treatment easier. And we should not overlook the self-interest of pharmaceutical companies who see a new and substantial market for antidepressants, currently a multi-billion dollar industry.

Third, about 80% of prescriptions for antidepressants are written by primary care physicians, not psychiatrists. We have the expectation that physicians, as well as psychologists, social workers, and clergy, to whom many of us turn for help after losses of all kinds, have professional training, solid research backing, and supervised experience to guide them. Some do, but in fact, a

considerable majority of practitioners with these degrees have no professional training at all in responding to the bereaved.

The caution here? Be wary of physicians or other medical professionals who rush to prescribe anti-depressants to address your grief.

Here's a better prescription: Mourn the death of your loved one in your own way. There is no prescribed formula. You may cry; you may not. Your reactions will be shaped by many things: the relationship you had with the deceased, your personality style, and the support or lack of support you receive from others. Push aside those who tell you to move on, that every cloud has a silver lining. What one person finds comforting might not work for another. Find friends and family who understand, and with whom you can share your experience. If they won't listen or help, or if their help is not enough, search for support groups through your local hospital, hospice or community organizations. Don't be afraid to seek professional help, but if you do, ask about the person's training, qualifications, and experience with grief, loss, and bereavement.

We grieve as deeply as we love. We can get off track with love, and we can respond to our grief in ways that aren't healthy, or don't serve us well. But let's not make love, or grief, a mental disorder.

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This document was written by a group of concerned professionals in response to the release of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*.

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Suicide among Health Care Professionals: Outcomes of the Suicide Support and Information System, Ireland

Background

In 2008, the HSE's National Office for Suicide Prevention commissioned the National Suicide Research Foundation (NSRF) to develop and pilot a Suicide Support and Information System (SSIS). The SSIS is innovative as it was developed to prevent suicide by facilitating access to support for the bereaved while at the same time obtaining information about risk factors associated with suicide and deaths classified as open verdicts, which is in line with key priorities of *Reach Out*, the Irish National Strategy for Action on Suicide Prevention (2005-2014) (HSE, 2005) and *Vision for Change* (Government Report, 2006).

Key objectives of the SSIS are to:

- 1) Improve provision of support to the bereaved,
- 2) Better define the incidence and pattern of suicide in Ireland,
- 3) Identify and better understand the causes of suicide,
- 4) Identify and improve the response to contagion and clusters of suicide,
- 5) Reliably identify individuals who present for medical treatment due to self-harm and who subsequently die by suicide

Between September 2008 and December 2012, the SSIS was implemented successfully in close collaboration with Coroners in Cork City and County, Ireland. Information on confirmed cases of suicide and undetermined deaths was obtained after conclusion of the coroners' inquest. Bereaved family members received information on suitable support services and were referred to quality assured bereavement support services if required. Relevant information on factors associated with the death and the deceased were obtained in an appropriately sensitive and confidential manner from sources including coroners, the family and health care professionals, especially GPs who had been in contact with the deceased.

Recent evidence from the SSIS shows a relatively high proportion (4.3%) of health care professionals among the 301 recorded deaths by suicide in Cork City and County. Among the health care professionals who took their lives, women were overrepresented and the mean age at time of death was 37 years. The most frequently reported occupation was in the area of nursing (general and psychiatric nursing). In most cases, direct or indirect signs were given about suicidal thoughts to people in the environment prior to suicide, and in most cases there was evidence of depression, the majority of whom were in contact with services. Taking into account that these numbers only apply to Cork City and County, the expected number of suicides among health care professionals at national level would be considerably higher.

These findings underline the importance of increased awareness among health care professionals about depression and suicidal behaviour, and optimised supervision and professional support for people working in health care professions, especially when there are indications of mental health problems. These outcomes also underline the need to improve regulations for counsellors and psychotherapists working with people suffering from mental health problems.

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Voices that Inspired a Nation to Action

The United States National Strategy for Suicide Prevention (NSSP) defines postvention as the “response and care for individuals affected in the aftermath of a suicide attempt or suicide death.” In many places around the world, postvention is seen as a clinical support service for people who have lost a loved one to suicide. Such support helps individuals heal and helps prevent additional suicides by addressing the needs of a vulnerable group. But those who have lost friends, family members, or loved ones to suicide should not be viewed merely as individuals in need of clinical support, but also as allies who can add their voice to the cause of suicide prevention. The experience of the United States is a testament to the power of the active engagement of those bereaved by suicide.

In the late 1990s, I worked for a member of the U.S. Senate (the upper house of our national legislature). His name is Senator Harry Reid. While helping him prepare for a hearing on mental health and the elderly, I discovered that the state he represented, Nevada, had the highest rate of suicide in the nation. This also marked the moment when I became aware that suicide was a leading cause of death in the United States as well as in many nations around the world.

At the hearing, my boss revealed that he had lost his father to suicide many years earlier. This was the first time he had publicly shared this fact. After the hearing, we heard from individuals from all over the country who were touched by suicide. They acknowledged the senator’s loss and asked him to help lift the veil of secrecy that surrounded suicide and put suicide prevention on the public policy agenda.

Many people who had lost loved ones to suicide came to our nation’s capital to meet with the Senator and other elected representatives. Two of these people were Jerry and Elsie Weyrauch, who had lost their daughter Terri to suicide. The Weyrauchs founded the Suicide Prevention Action Network (SPAN USA), which was dedicated to building the political will to address the problem of suicide. They were aware that the United Nations report *The Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies* called for countries to create national suicide prevention strategies and coordinating bodies to oversee the implementation of these strategies.

The Weyrauchs and others who had lost loved ones to suicide collected thousands of signatures on petitions calling on the U.S. Congress to do the following: to pass legislation ending the discrimination between treatment for mental and physical health concerns, and to create a national strategy for suicide prevention. Once each year, they sorted the petitions by state and congressional district and traveled to Washington to deliver the petitions to members of Congress. They gave a voice and a face to the statistics about suicide and inspired the nation to respond.

Our legislators were asked to introduce and support resolutions affirming that suicide is a national problem and that our nation needed a national strategy for suicide prevention. These resolutions passed in 1997. At about the same time, Dr. David Satcher became Surgeon General. The Surgeon General’s job is to advance the health of the people of the United States and advise the president and the secretary of health and human services on health policy. In 1999, Dr. Satcher put suicide prevention and mental health on the national agenda by issuing *The Surgeon General’s Call to Action to Prevent Suicide*.

In 2001 the *National Strategy for Suicide Prevention: Goals and Objectives for Action (NSSP)* was published. In 2004, thanks to the courageous efforts of another U.S. Senator, Gordon Smith from Oregon, legislation was signed into law that helped states, tribal nations, and colleges create youth suicide prevention and early intervention programs.

In 2010 the United States created the National Action Alliance for Suicide Prevention to oversee the implementation of the NSSP, champion suicide prevention as a national priority, and cultivate the resources needed to make and sustain progress. In 2012 the NSSP was revised. That revision includes a goal (Goal 10) to “Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.”

People who have lost friends and loved ones to suicide were the catalysts that led to the first NSSP; the creation of the Action Alliance for Suicide Prevention; and the elevation of postvention to the position it now holds in the field of suicide prevention in our country. The efforts of those bereaved by suicide who have lost a family member, loved one, or friend to suicide remind us how important it is to ensure all voices of those affected by the tragedy of suicide are included in the effort to create a truly national and truly comprehensive movement to prevent suicide. The voices and stories of those touched by suicide loss have inspired this nation to action.

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