



Collaborating to Heal Addiction and Mental health in Primary care (CHAMP) Resources to Develop Clinic Support Plan after a Patient Death Due to Suicide or Overdose

Overview

- Losing a patient to suicide or overdose is a dreaded potential consequence of psychiatric illness.
- Fortunately, in most clinical settings such patient losses rarely occur, but their rarity also means that few people feel confident and comfortable dealing with either the practical matters or the emotional impact associated with these occurrences.
- This document provides resources and guidance for clinics faced with the need to respond to the loss of a patient including a plan to complete immediate responsibilities, to provide resources for provider emotional responses and to create opportunities for greater levels of personal and professional growth and development.
- These resources are intended only as general guidelines and can be modified as appropriate for the individual situation.

Attend to Immediate Responsibilities

It is helpful to have a clear protocol of next steps after the death of a patient due to suicide or overdose, as providers often experience shock and distress after the immediate news of the loss of a patient.

1. Create a list of people that need to be notified in case of a patient death. Below are some people to consider:
 - Medical Director/ Chief of Service
 - **Risk management**
 - **Family members:** Disclosures of protected health information about the deceased patient are still limited by the HIPAA privacy regulations and ethical and legal requirements for confidentiality remain in place. Only discuss protected health information of which the family has knowledge. You may need to inform family members that your disclosures are limited by State and Federal privacy laws. Strategize a good way to provide the family support and information without breaking privacy, perhaps by designating one staff person who has some knowledge of the case and is aware of these issues (it might also require some coordination with risk management)
 - **Clinic Staff**
 - **Other patients** Disclosures of protected health information about the deceased patient are still limited by the HIPAA privacy regulations; A general guideline is to disclose only information that has been available through third-party and/or, public sources
2. Administrative case review – Following an adverse outcome, administrative and clinical leaders will routinely review the circumstances of the event for medical-legal and quality assurance purposes. If this is not the case in your setting, your admin team perhaps needs to seek guidance on the efficacy of this approach. This administrative case review differs from a suicide case review conference, whose primary goals are related to educational/emotional support.

Access support for emotional experiences of providers

After an initial response of shock and disbelief, common emotional responses to patient suicide include grief, guilt, anger, betrayal, sadness, self-doubt and sometimes relief. Levels of distress in the clinician survivor are sometimes comparable to distress in clinical populations of bereaved individuals seeking treatment after the death of a relative. Potential sources of support:

- **Informal peer support**
- **Senior Clinician/Mentor Discussion and Reflection Literature review** – Many provider survivors have written case reports describing their experience with patient suicide and overdose. Reviewing these reports may decrease the sense of isolation that follows patient suicide.
- **Employee Assistance Programs/Personal psychotherapy** – Individual psychotherapy may be helpful to providers/staff in dealing with emotional responses to a patient Sudden death by suicide/Overdose

Suicide/Overdose Case Review

Following the suicide death of a patient, a suicide/overdose case review allows for an examination of the circumstances surrounding the death – including the suicide risk factors, protective factors for suicide and treatment interventions – as well as an opportunity to express emotions related to the case. While it is never clear whether any specific action or inaction played a causal role in patient suicide, case review fosters professional responsibility by allowing the clinician to learn from the negative outcome in a way that may benefit future patients. That said, an ill-timed case review or a case review conducted with a blaming tone can be harmful to clinicians. To avoid these harmful effects, a case review should be conducted after some resolution of initial negative emotional experiences (especially grief and guilt) and with the acknowledgement of the uncertainty and challenge involved in predicting and preventing suicidal behavior.

1. **Setting of a case review** – A suicide/overdose case review may take place in any professional setting that fulfills the educational function of the process. For cases involving a treatment team, this may be in a staff conference or larger morbidity and mortality conference, which should be approved by the Leadership and will need to ensure that appropriate institutional confidentiality requirements are observed.
2. **Components of a case review** – For educational purposes, a case review should consist of the following components:
 - General circumstances of the case – treatment setting, presenting symptoms, events leading up to the suicide.
 - Risk factors for suicide/overdose
 - Protective factors for suicide/overdose
 - Assessment of suicide risk/overdose
 - Treatment interventions for suicide/overdose
 - Other interventions that may have been implemented to modify risk or protective factors.

Professional Growth and Responsibility

Following an experience with patient suicide, providers may benefit from modifying their professional practices and engaging in altruistic activities to help others prepare for or cope with this experience. If a provider engages in these activities ensure they are following appropriate confidentiality and HIPAA guidelines.

1. **Suicide risk assessment and documentation** – Clinicians should review their suicide risk assessment and documentation practices. Documentation should include a review of relevant risk factors, assessment of suicide risk, interventions to modify suicide risk and justification for the level of care (justification for not initiating higher levels of intervention).

2. Altruistic activities

- Public sharing of experiences
- Researching common experiences related to losing a client and Organizing educational activities related to patient suicide/overdose
- Publishing literature
- Reaching out to other provider survivors

Additional Resources:

Administrative:

- Suicide: Psychological autopsy, a research tool for prevention. <https://www.ncbi.nlm.nih.gov/books/NBK7126/>
- Sung J. Sample Agency Practices. https://www.sprc.org/sites/default/files/resource-program/Sample_Agency_Practices.pdf
- Kaye MS, Soreff SM. The psychiatrist's role, responses and responsibilities when a patient commits suicide. American Journal of Psychiatry 1991; 148(6):739-43. <https://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.148.6.739>
- Cotton PG, Drake RE Jr, Whitaker A, Potter J. Dealing with suicide on a psychiatric inpatient unit. Hospital and Community Psychiatry 1983; 34(1):55-9. <https://pubmed.ncbi.nlm.nih.gov/6826151/>
- Supporting Providers After Drug Overdose Death. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6436101/>
- Jane G. Tillman. When a patient dies by suicide. <https://www.aamc.org/news-insights/when-patient-dies-suicide>
- Guidelines to Assist Clinical Staff after the Suicide of a Patient. https://www.iasp.info/pdf/postvention/guidelines_to_assist_clinical_staff_after_suicide_patient_grad.pdf
- Sample Agency Practices https://www.sprc.org/sites/default/files/resource-program/Sample_Agency_Practices.pdf
- When a Patient Dies by Suicide https://www.rcpsych.ac.uk/docs/default-source/members/supporting-you/if-a-patient-dies-by-suicide/when-a-patient-dies-by-suicide-a-resource-for-psychiatrists-2020.pdf?sfvrsn=10e72fdc_2
- Post-Vention Guide https://omh.ny.gov/omhweb/suicide_prevention/omh_postventionguide.pdf
- Washington state Overdose resources <https://stopoverdose.org/>

For Providers:

- Gitlin MJ. A psychiatrist's reaction to a patient's suicide. Am J Psychiatry 1999; 156:1630-1634. <https://pubmed.ncbi.nlm.nih.gov/10518176/>
- Kolodny S, Binder RL, Bronstein AA, Friend RL. The working through of patients' suicides by four therapists. Suicide and Life-Threatening Behavior 1979; 9(1):33-46. <https://pubmed.ncbi.nlm.nih.gov/432906/>
- Reeves G. Terminal mental illness: resident experience of patient suicide. Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry 2003; 31(3):429-41. <https://pubmed.ncbi.nlm.nih.gov/14535611/>