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Responding to a suicide death: The role of first responders

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ABSTRACT

Effective response by first responders in the immediate aftermath of a suicide death can play a critical role in reducing risk and promoting healing for family, friends, and the larger community by helping people who are newly bereaved to cope with the immediate crisis, created by the death. They also can lay the foundation for the difficult journey of mourning and healing that must follow. Stressing the importance of a comprehensive and coordinated community response to suicide, this article addresses the principles and practices that are called for in the Guidelines by highlighting four distinct first responder communities: law enforcement and emergency medical services; medical examiners; funeral professionals; and clergy and faith leaders. For each of these groups, the interrelated functions they serve after a suicide are described, and clear suggestions for improvement of these functions in the service of better assisting suicide loss survivors, as well as the broader community, are discussed.

The critical role first responders plays in effective postvention response cannot be overstated. In laying out the basic tenets for “*Responding to Grief Trauma and Distress After a Suicide: U.S. National Guidelines*” (hereafter referred to as the Guidelines), the authors noted:

The vision that guided the Task Force in its work is of a world where communities and organizations provide everyone who is exposed to a suicide access to effective services and support immediately—and for as long as necessary—to decrease their risk of suicide, to strengthen their mental health, and to help them cope with grief. (Survivors of Suicide Loss Task Force, 2015, p. 1)

One of the key components of the Guidelines is that it takes a comprehensive look at postvention response and moves beyond the traditional thinking that postvention is only directed toward the immediate family. Toward that end, this article will explore the critical role of first responders during the first hours and days following a suicide.

Research tells us that the factors leading to a suicide death are complex, yet the media often portrays causes in simplistic terms. If they are known at all, the answers about why someone took their life are much more complicated than the simple explanations offered in the media. Even in the case of “copycat” suicides, although the method and/or the place may be the same, the aspects and influences that led that person to take

their life are likely quite different from the preceding death. Despite the uniqueness and complexity of each particular suicide, one commonality to be found in all suicide deaths is the involvement of first responders in responding to the death.

We will go beyond the traditional definition of first responders and include those key professions likely to have direct contact with loss survivors in the first 72 hr or so following a death. In addition to emergency medical services (EMS) and law enforcement, we also include medical examiners or coroners, funeral directors, and faith leaders.

How first responders respond to a suicide death is of critical importance:

Professionals who are likely to have early contact with the bereaved (police officers, coroners or medical examiners, emergency department personnel, faith leaders, funeral directors, etc.) can have a significant impact, for better or for worse, on the newly bereaved. They can be supportive and compassionate, providing comfort, needed information, and linkage to other resources. Or they can be detached, impersonal, or even hostile to loss survivors, focusing only on the technical requirements of their job rather than on helping the human beings they serve and ameliorating the shock and tragedy of suicide. (Survivors of Suicide Loss Task Force, 2015, p. 29)

Lack of training and best practice protocols combined with a lack of understanding of the impact

of suicide on loss survivors and, particularly, the potential for increased risk are all major contributors to a poor response. The first responder's own personal experience and comfort level with suicide will also likely have an impact on their response.

A story can best illustrate this. In 2003, the author embarked on a statewide project in New Hampshire to develop best practice protocols to promote an integrated and effective community postvention response to suicide death which became the foundation for NAMI New Hampshire's Connect[®] Suicide Prevention and Postvention Program. Looking at the critical and immediate role of funeral directors following a suicide death, the author scheduled meetings with two funeral directors to get their input on best practice protocols for their profession when responding to a suicide death. One of the most significant barriers New Hampshire faced at the time, particularly for youth suicide deaths, was how to deploy a postvention response if the family refused to acknowledge that the death was a suicide. Often law enforcement and other officials would not disclose or confirm that it was a suicide in an attempt to protect those families.

The first funeral director visited was in Concord, the state capital. He was very receptive to what we were doing, and talked openly about suicide death in his own family and among other people he had known. When the author posed the challenge to him about getting families to publicly acknowledge the death was a suicide, he thought for a moment and said "I don't think I've ever had a family that wanted it kept a secret." After driving 20 miles north to the rural community of about 3,000 people where the author resides, he met with another funeral director who was visibly uncomfortable with the whole topic and didn't understand the purpose of the meeting or what the project was attempting to do. When faced with the same question about how to help families be willing to admit the death was a suicide, he looked quizzically and said "I don't think I've ever had a family who wanted anyone to know it was a suicide." This confirmed the importance of the work we were undertaking and particularly the key role that the attitudes of funeral directors and faith leaders play as first responders in providing comfort, care, and guidance to a family after a suicide death. It also highlights one of the overarching goals of the Guidelines, "The bereaved deserve a consistent response and first responders who are well trained, knowledgeable, and compassionate in their approach to new survivors" (Survivors of Suicide Loss Task Force, 2015, p. 29).

In this article, we will look at the specific roles of first responders in responding to suicide deaths and hear directly from a few of them about their best practices

and the importance of the Guidelines in informing their response to reducing risk and promoting healing after a suicide death.

Law enforcement and EMS

Almost all suicide deaths involve a death scene and subsequent response by some combination of law enforcement, EMS, coroners or medical examiners, and funeral directors. Most also involve formal notification to the family and/or ongoing contact with the coroner or medical examiner until the point that an official determination has been made as to the cause and method of death as well as the issuance of a formal death certificate. Many loss survivors and/or families will also turn to faith leaders for comfort, support, and for conducting a funeral or memorial service.

The death scene poses challenges and opportunities for first responders and loss survivors. Although 58% of suicide deaths occur in a home or residence, many also occur in public settings including parks or wilderness areas (Centers for Disease Control and Prevention, National Center for Health Statistics, 2015). Some deaths in residential settings occur when someone else is present in the home and, in some circumstances, in the unwitting presence of another person. Another difficult scenario is when a family member or housemate returns home to find the body of their loved one. In public settings, there may likely be witnesses who may or may not have had a relationship to the decedent. These situations all greatly increase the likelihood of lasting trauma for those involved. New Hampshire developed information about witness trauma and a card which first responders can disseminate to individuals who have witnessed or come upon a suicide death scene (NAMI New Hampshire, n.d.-a).

For first responders responding to a call for assistance for a possible suicide, the first decision involves determining whether any first aid can be rendered or whether a pronouncement of death is required. Localities handle this differently in terms of who is authorized to make an official determination. In almost all jurisdictions, unattended or untimely deaths almost always require securing the scene, so a proper investigation can be conducted. The investigative aspect of a suicide death can set up immediate tension or conflict between first responders and family or loved ones who are present and who may be asked to temporarily leave the room or home. For the EMS, law enforcement, and medical examiners or coroners called to the scene, this is just another day at work and another death. But for the family members and loved ones this is a nightmare they may never have imagined, or a horror they

have feared for some time—but either way, an event and a scene they never will forget. One family member described returning home and seeing police cruisers and an ambulance in front of their house. Parking across the street and trembling with dread and fear, they saw and heard first responders standing outside their home visibly laughing and joking with each other—just moments before being informed of their loved one’s suicide. It is a painful memory they still carry many years later. Others talk about being prevented from entering their home and/or having a few minutes with their loved one’s body because it was considered a “crime scene.” Many loss survivors relive the trauma of being left to clean up the aftermath of the death. More than once, the author has heard from suicide loss survivors who were callously handed the firearm that their loved one had used to take their life.

Often it is EMS who are first to respond to the scene. They work closely with law enforcement personnel who typically are responsible for contacting the medical examiner or coroner. Once a death determination has been made, EMS often leaves the scene. However, by staying, they can play an important role in comforting the family while law enforcement and the medical examiner conduct the death investigation. Here is an example of how one EMS currently responds to a suicide provided by Vicki Blanchard, BS, NRP, I/C, Clinical Systems Coordinator, New Hampshire Bureau of Emergency Medical Services.

Though it is hard to generalize a response to the Guidelines, there are commonalities that are worth mentioning. Consistent with the recommendations of the Guidelines, we have concluded that EMS providers need more training and guidance on how to care for the loss survivors at the scene of a death. At this time the resources we have available for training are limited and I feel the Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines will be a great asset for the EMS community and our education development team as we create this training. EMS providers are sensitive to the survivor’s feelings and, depending on the community, many times know the victim. Although we don’t have a specific protocol to that effect, we encourage EMS to remain on the scene of a suicide call to provide support to and assist with finding resources for the victim’s family.

EMS works hand in hand with the police almost every day and therefore has a relationship to enable crime scene protection. In addition to the police, usually the Medical Examiner’s Office is called to death scenes and they will leave the family two pamphlets: one the Office of Medical Examiner’s Frequently Asked Questions (New Hampshire Department of Justice Office of the Attorney General, *n.d.*) and the other is NAMI

New Hampshire’s (2012) Grief Support after Sudden Traumatic Loss.

In the wake of the heroin epidemic, we have begun to recognize difficulties with compassion fatigue and the mental health of our EMS providers, and are actively researching ways to assist our providers in maintaining their own mental health. We do have the State’s Critical Incident Stress Debriefing group which many EMS agencies utilize; however, not all use it because they have internal systems for dealing with stress. As with developing training for helping family and survivors on the scene of a suicide, the Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines will provide us with another resource as we continue to work on this subject. (V. Blanchard, personal communication, June 16, 2016)

Law enforcement also plays an essential role in responding to a suicide death at the scene and/or through the death notification process. They must treat the area of the death as a crime scene. Keeping the family/loved ones away from the body and the investigation can be a challenge. Depending on the circumstances and condition of the body, they may feel they are doing the loved ones a kindness, but the family may feel differently. Similarly, law enforcement may take possession of a suicide note as part of their investigative process. If there is a suicide note, the family should be informed and every effort made to provide the note or a copy to them as soon as possible. If the note is harsh, angry, or blaming, law enforcement may take the additional step of preparing the family and recommending that they have a counselor, faith leader, or other supportive person with them when they read it. The Guidelines point out the importance of the “practical assistance” (Survivors of Suicide Loss Task Force, 2015, p. 22) with which the loss survivors will need. One often overlooked area specifically mentioned in the Guidelines is cleaning and restoration of the death scene (Survivors of Suicide Loss Task Force, 2015). Law enforcement or funeral directors may assist with this, though truly it is not their responsibility. Depending on local custom or traditions, faith communities or even community members may assist as well. Regardless of this, law enforcement and/or funeral directors should ensure that some steps are taken to prepare the family, connect them with a cleaning service, and/or support them through this process. Law enforcement sometimes is responsible for returning personal effects of the deceased. This can be a difficult process for loss survivors, and sensitivity to this process is encouraged and especially so if the personal effects include the firearm, or other means which the person used to take their life. Law enforcement is typically tasked with notifying the

immediate next of kin following the death. Best practice protocols for law enforcement death notification are readily available. However, additional care should be taken with a suicide death regarding the self-blame, regret, and/or rejection that family/loved ones often feel and to offer reassurance that the causes of suicide are complex and no one is to blame for the death. An excellent free online training for law enforcement for death notification is called “We Regret To Inform You” developed by the FBI and Penn State University (Federal Bureau of Investigation, 2015).

Medical examiners

Medical examiners and coroners are frequently overlooked as first responders. Yet their role is critical, both from an investigative standpoint as well as for the interface they have with family at the scene and in the days following the death when a determination is pending. When it was first established by SAMHSA, the Suicide Prevention Research Center held regional conferences around the country where each state was invited to bring a small team of people. New Hampshire decided to include an assistant deputy medical examiner from our medical examiner’s office. On the return trip, the assistant deputy medical examiner disclosed that before attending she really had no idea why we wanted her to come to a suicide prevention conference. After several days at the conference, she clearly understood that postvention is prevention and how an effective and comprehensive response to suicide can reduce the risk of contagion and promote healing for those bereaved by suicide. She realized that coroners and medical examiners were not just investigating death scenes, but they also play an important role in suicide prevention efforts. This connection between response after a suicide death and prevention is articulated throughout the Guidelines, including a specific reference to the National Suicide Prevention Strategy (NSSP). The 2012 NSSP declares “helping those who have been bereaved by suicide is a direct form of suicide prevention with a population known to be at risk” (U.S. Department of Health and Human Services (HHS) Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). While New Hampshire had always benefited from a positive working relationship with our medical examiner’s office, the relationship became even stronger as a result of the assistant deputy medical examiner making the connection between postvention response and prevention.

As a result of her attendance at the conference and a closer working relationship with the medical examiner’s

office, NAMI NH’s Connect[®] Suicide Prevention Program was invited to help train the assistant deputy medical examiners who do death investigations at the scene. At the training, data regarding increased risk for suicide for those who have lost a loved one to suicide was reviewed, which, in turn, helped to improve the participants’ understanding and response to suicide loss survivors. The training also presented findings from suicide deaths in New Hampshire, including areas where data were lacking. Through this process, the assistant deputy medical examiners saw firsthand how the information they collected was used, how it helped inform future intervention and prevention strategies, and where data gaps served as a barrier to effective response. This resulted in the assistant deputy medical examiners being much more thorough in their reports and the information they collected at the scene.

Recognizing that the medical examiner’s office is the sole link to every suicide death and their next of kin in our state, several organizations, including the Department of Health and Human Services Bureau of Behavioral Health, the New Hampshire Youth Suicide Prevention Assembly, NAMI NH, and loss survivors collaborated with the medical examiner to send a packet of information to the next of kin for every suicide death in the state. Originally started as a pilot program for youth, it was expanded to all ages and includes a letter cosigned by a survivor of suicide loss and our chief medical examiner. The packet contains information on the unique aspects of grief and loss for suicide loss survivors as well as resources, support group, listings and other information. The contents of the New Hampshire’s survivor resource packet can be downloaded at the Connect[®] Program website (NAMI New Hampshire, n.d.-b). In reviewing the Guidelines, Dr. Thomas Andrew, New Hampshire’s Chief Medical Examiner, described the role of medical examiners in responding to suicide as follows:

Among the cadre of professionals responding to a suicide is typically a representative of the medical examiner or coroner’s office. Depending on the specific jurisdiction, that individual may be a trained death investigator, the coroner or medical examiner him or herself, or a law enforcement officer working collaboratively with the coroner or medical examiner’s office. Regardless of the “who,” the essential element in this particular first responder’s effective and compassionate interaction with survivors is the “how.” While confronting death is a daily occurrence for these professionals, they must never lose focus on the fact that exposure to such a death for survivors, whether or not they were the specific individual to discover their loved one, has the potential to produce an emotional crisis requiring an organized mental health response. This requires

not only sensitivity to the loss experienced by the survivor and all that entails in gathering crucial information from an individual at what may well be the worst moment in their entire life, but also requires the reassuring knowledge that can be passed on to survivors that their agency will soon follow up with information to connect them to other supports and resources.

While it is acknowledged that setting the proper tone of sensitivity, competence, and reassurance is more innate than teachable, medical examiner and coroner's offices are well advised to thoroughly steep their investigative agents in these concepts as part of not only their basic training, but their ongoing in-service training and continuing education. In fact, a long-standing requirement for certification by the American Board of Medicolegal Investigators has been that those seeking certification must demonstrate proficiency in assisting the family. In specific, candidates must offer the decedent's family information regarding available community and professional resources. It cannot simply be assumed that some other unnamed person or agency will open this door for survivors. Just as the forensic autopsy begins at the scene, so, in fact, does the community response.

Training for investigators must be followed up by an organized response by their parent agency. The New Hampshire Office of Chief Medical Examiner specifically launched a program in 2004 in which a packet of resource material is mailed to the next of kin within two weeks of a suicide. The packet contents and a link are described above. While certainly not unique to New Hampshire, programs such as this help address the immediate postvention needs of survivors and informs them of community and mental health resources that can shepherd survivors through this life-changing event.

Medical examiners and coroners also play a valuable role in the surveillance, research and evaluation arm of suicide prevention as a natural outgrowth of their public health mission. Information meticulously collected at the scene and in the aftermath of a suicide by way of review of clinical or other records not only serves its base function in assisting in the investigation of an individual death, but collated data regarding suicide in a given jurisdiction over time has the potential to effectively inform and direct prevention efforts. The medical examiner or coroner's office is uniquely positioned to fashion a comprehensive framework of events from pre-suicide to suicide to post suicide in a majority of such episodes. Simply investigating the immediate circumstances, examining the body and issuing a death certificate is not merely an inadequate response—it is a disservice to survivors and the community at large. The Latin inscription over the door of the Office of Chief Medical Examiner in New York City applies equally to every medicolegal jurisdiction. It reads, “Hic locus est ubi mors gaudet succurrere

vitae,” and is typically translated, “This is the place where death delights to serve the living.” The mission of the medical examiner or coroner is to make these words ring true for those left behind after sudden, unexpected or violent death. It begins with their response to the scene and continues through the collaborative work with other disciplines for more effective prevention. (T. Andrew, personal communication, June 24, 2016)

Funeral professionals

As the investigation at the scene progresses, one of the key decisions which will be made is whether the body will be taken by the medical examiner or coroner for an autopsy. This is a legal decision in which the family typically has no say and may find upsetting. Law enforcement and the medical examiner can play a key role by explaining the legal process, time frames, and who will be in touch with them. This is the point when funeral directors typically become involved. Law enforcement, medical examiners, or EMS, if they are still on the scene, should assist the family with selecting a funeral service if they are not already connected with one. If the body will be autopsied, the funeral service will usually be tasked with transporting. If no autopsy will be performed, the funeral director will bring the body to the local funeral home or to a crematorium depending on the wishes of the family.

In reacting to the Guidelines, Funeral Director and Author Eric Daniels of Melbourne, Florida, had this to say about the role of funeral directors as first responders to suicide death.

Death by suicide is always sudden and tragic, and often unexpected. The majority of suicides that I have responded to were where a family knew there were some troubling circumstances in the person's life, but that they never thought the circumstances were so dire that the person would consider death by suicide. Other deaths by suicide are totally unexpected, and the survivors have an additional psychological step (such as being in a “total fog”) besides having to cope with the normal stages of grief.

The funeral director is often the second to be in communication with the survivors after the police. It is therefore very important that the funeral director be as sensitive as possible when speaking to the family. He must always keep in his mind that this is not natural, and that it is a sudden and life altering event for the survivors. The most important thing that a funeral director must possess during this time, besides compassion (which he or she should always possess), is projecting confidence to the family that from the time he or she takes their loved one into their care, everything

will be done professionally, confidentially, and with the utmost dignity and respect. The family must not get a feeling of being ostracized at any time. Also, it is perfectly acceptable for the director to be human and even show compassion with a hug, if the family is open to it, and needing a loving response.

During subsequent meetings with the family, it should be suggested that the life that was lived, not only be memorialized, but celebrated. Of course, this will be the family's decision, but we must remember that there were a number of years lived by this person, and a number of lives touched by this person. It should not be about how the person died, but how they lived. It is of vital importance that the funeral director asks the family if they wish to share the manner of death with the public. This does not mean to suggest that the public know the cause of death, but only the manner (accident, natural, or suicide). Many families do not want others to suffer the same fate, and so they want to expose the epidemic of suicide so that there is awareness. The funeral director must always take the family's orders, although it is okay to make suggestions to celebrate the life that was lived rather than the death that was tragic.

Finally, the funeral director should avail himself to the family at any time in the future, and be available, even if the family just needs to talk. Resources should be given to all families so that they know they are not forgotten by the funeral director once the funeral is over. Enduring relationships is a very important value for funeral directors, especially in a situation where death by suicide has occurred. A handwritten, sincere letter to the family shows the family that they are not just a number, but that they meant something to many people, including the funeral director. The funeral director should be compassionate, confident, kind, and ready to suggest how to celebrate a life rather than just memorializing a death. (E.M. Daniels, personal communication, June 12, 2016)

Clergy and faith leaders

Depending on the beliefs, traditions, and wishes of the family, they may or may not choose to contact a faith leader. For families who are actively involved or connected with a faith community, it will likely be one of the first calls they make and the faith leader may respond to the scene or family before the funeral director and/or while law enforcement and medical examiners are still there. For other families, the decision to involve a faith leader may be a point of friction and disagreement which the family faces. Sometimes different faith traditions exist, even between immediate family members. Or there may be differing opinions between family members about what the deceased would have

preferred. While many religious traditions have evolved in their thinking/approach to suicide death, some still consider it a sin, and this may also influence the decision about contacting a faith leader. Funeral directors can often provide guidance to the family on faith leaders who will be supportive following a suicide death.

When faith leaders are involved they often have dual responsibilities. Their primary responsibility is to the family, but if the family and/or decedent were involved in a faith community, they also have a role in assisting their faith community to make sense of the death, to grieve, and, hopefully, provide support to the family. This is an important part of the healing process, as many families report feeling isolated, alone, and unsupported after a suicide death, or as some families have stated, "the casserole dishes never came ..." As with other first responders, training and education about suicide play an important role in the ability of faith leaders to respond effectively to a suicide death. Additionally, for faith leaders, they have the opportunity to communicate and educate their faith community about suicide and a supportive response prior to a suicide death.

In responding to the Guidelines and the role of faith leaders as first responders, Reverend Laura Biddle, of Newburyport MA, who is also a Grief Counselor, offered the following thoughts:

The need for spiritual healing begins the moment there is a suicide. Faith leaders and spiritual healers serve the bereaved by practicing awareness of and sensitivity to religious language, avoiding language that shames or traumatizes. Tending to the spiritual needs of family, friends, and the broader community encourages immediate healing after suicide.

Here are six ways to begin spiritual healing after suicide:

1. The faith leader/clergy has explored and examined their own personal feelings and religious beliefs regarding suicide through self-discovery, training, and honesty.
2. The leader shows up as soon as possible to be present with family, friends, and first responders. Listening with compassion to the story and the emotions will offer a glimmer of light in the midst of profound darkness.
3. Meet with the family about the funeral. Ask questions that have to do with the life of the one who has died and the hopes for the funeral. If at all possible, guide this conversation toward a willingness to use the word "suicide" at the funeral.
4. The suicide funeral is a unique opportunity to begin healing on a large scale. The funeral is an opportunity

- to destigmatize people's "reaction" to death by suicide, create a compassionate community, and begin prevention work.
5. Bereavement support after the funeral is vitally important to the work of healing and prevention. Peer support groups can be a great aspect of spiritual healing if they have strong leadership. Faith leaders and clergy have access to numbers of people who are bereaved by suicide. If trust in a leader has been established, a support group can be extremely effective.
 6. Self-care and collaboration with other healers are essential. (L. Biddle, personal communication, June 20, 2016)

Self-care and training for all first responders

This latter point is a key consideration for all first responders and is emphasized as a recommendation in the Guidelines. "First responders themselves—and others exposed to suicide—may need assistance with their own grief and trauma reactions that result from their work experience" (Survivors of Suicide Loss Task Force, 2015, p. 22). First responders are frequently exposed to highly traumatic events including suicide, and there is some evidence that first responders are themselves at higher risk of post-traumatic stress disorder, depression, and suicide. "Comprehensive statistics are hard to come by, but it is neither a new phenomenon nor much of a secret: A lot of fire, EMS and law providers kill themselves" (Erich, 2014). As a means of addressing this, it is imperative that a comprehensive postvention response includes check-ins and support for first responders. As referenced in the EMS section above, some localities have set up their own peer support programs and/or critical incident stress debriefing programs. It is also important to note that in rural communities, it is highly likely that the first responders personally knew the decedent and/or their family, which adds an additional complexity to their role as first responders as well as their own need to grieve and to practice good self-care.

Providing first responders with appropriate training is essential for improving postvention response. This is called for in Goal 4 of the Guidelines. "Create the infrastructure and delivery systems for training a wide array of service providers in suicide bereavement support and treatment and in minimizing the adverse effects of exposure to a suicide" (Survivors of Suicide Loss Task Force, 2015, p. 33). Objective 4.2 goes a step further and indicates that these trainings should be customized for specific community providers and goes on to specifically identify the first responders discussed in this article.

Taking a broader look at loss survivors and the role of first responders is essential. When the author advocated with the U.S. Army Suicide Prevention Program Chief to develop a comprehensive postvention response, the program chief responded by saying "I understand; we need to do more for the family after a suicide death." The author responded by saying yes, but you also need to prepare the military police who are responding to the scene, the casualty notification officer who will do the death notification with the family, the commanding officer who will feel personally responsible for the death, the Chaplain who will minister to the family and loss survivors and conduct the memorial service, the public information officer who will message to the media, the decedent's combat buddies, and so on.

This is the absolute core of the Guidelines—that all suicide prevention efforts need to have a planned, comprehensive, and integrated postvention response (in particular, please see Goals 1, 5, 7, 8, and 9):

The Survivors of Suicide Loss Task Force unequivocally believes that a comprehensive and systematic postvention response on behalf of the people exposed to a suicide fatality must be a core element of all suicide prevention planning and implementation efforts by communities, states, tribes, and the nation as a whole. (Survivors of Suicide Loss Task Force, 2015, p. 20)

The Guidelines further state:

The time to develop a coordinated response to an event such as suicide is before it happens, so that key leaders in the group will be trained and feel prepared to respond in a way that is helpful and reassuring to everyone affected by the death. (Survivors of Suicide Loss Task Force, 2015, p. 25)

NAMI New Hampshire's Connect[®] Suicide Prevention Program

One program that has this essential component of an integrated community response to suicide is NAMI New Hampshire's Connect[®] Suicide Prevention Program. The Connect[®] Program is designated as a national best practice program in suicide prevention and postvention. The postvention program within Connect was based in part on the recognition that community and institutional response to suicide, if it was not ignored entirely, were often unplanned, fragmented, and poorly executed. Working at the grassroots level, focus groups were established with first responders and other key stakeholders to develop best practice protocols for each key service provider in a postvention response. Using vignettes based on real-life scenarios, they were tested to insure sensitivity to the needs of

survivors, effective communication, and a timely, coordinated, and integrated response. The protocols were then each converted to separate trainings for law enforcement, EMS, medical examiners/coroners, funeral directors, faith leaders, emergency departments, mental health providers, etc. Specific training was also developed to prepare communities (however, a community is defined including a town, school/campus, military base, social service organization, workplace, tribal/first nation, or county/region) and institutions to develop their own postvention response plans. Working at the community level and across first responders and provider groups creates a shared language, better understanding of roles and responsibilities, and results in increased trust and a more integrated response which promotes healing and reduces risk for those impacted by a suicide death. Successful implementation in other states, tribal nations, and countries has been achieved through the use of this framework, and carefully applying and adapting it to the specific culture, norms, and context of a particular community, region, or host organization.

Another example of an excellent postvention response program is the LOSS team model (Local Outreach to Suicide Survivors (Campbell, n.d.). LOSS teams work closely with first responders through an active postvention model developed by Frank Campbell, Ph.D., LCSW, C.T (Campbell, Cataldie, McIntosh, & Millet, 2004). The teams consist of a mental health professional and a suicide loss survivor who are called to the scene of a suicide by the coroner or law enforcement to provide immediate support to friends and loved one who are at the scene. In addition to providing immediate comfort to loss survivors, the LOSS team model has been found to be effective at reducing the amount of time it takes loss survivors to seek help through peer supports or professional counseling (Cerel & Campbell, 2008).

Role of the media

One final consideration is the role media play in reporting on suicide. Though they will not be involved in covering most suicide deaths, the media will likely cover suicides which occur in public, and/or suicide deaths of high profile community members and youth. Members of the media will likely interface directly with first responders including law enforcement, EMS, or medical examiners/coroners, or they may try to directly access their records/reports. Research demonstrates that *how* media report on suicide can contribute to increased risk of suicide contagion (Gould & Lake, 2013) or, conversely, can reduce risk and increase the likelihood that people at risk will seek help (Schonfeld, 2014). Best

practices for reporting on suicide are well documented and can be found at www.reportingonsuicide.org. Postvention training for first responders should include familiarizing them with these recommendations to prepare them for how to most effectively respond to media requests following a suicide death.

Summary and conclusion

The immediate hours after a suicide death offer a critical opportunity for reducing risk of contagion and for promoting healing. As the Guidelines indicate, first responders are by definition at the forefront of providing an effective response. For the purpose of postvention response to a suicide, it is important to broaden the usual law enforcement, and EMS definition of first responders to also include medical examiners/coroners, funeral directors, and faith leaders. All are likely to have contact with immediate family and friends within 72 hr of the death and have the opportunity to frame and influence a response without blame or shame. Despite the important roles they play, most first responders have had no formal training in postvention and, subsequently, are often not familiar with best practices for an effective response. The Guidelines stress the importance of establishing protocols and providing training for first responders. Training will not only increase their understanding about best practices and the importance of their roles but can also increase their sensitivity to the needs of immediate family and the broader community after of a suicide death, providing them with shared concepts and language necessary for an integrated and effective response. Responding to a suicide can also impact first responders who themselves may be at higher risk for depression, trauma, and suicide, making it essential that a postvention response includes caring for the caregivers. As first responders are often sought out by the media following public and/or high profile suicide deaths, training them how to safely message about suicide, consistent with the media recommendations, is a critical component to effective prevention efforts. Comprehensive suicide prevention must include postvention planning and training and first responders are a key group to engage in this effort. NAMI New Hampshire's Connect[®] Suicide Prevention Program is an excellent example of a comprehensive, community-based postvention program including community preparedness, best practice protocols, and training.

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