

AFTER A SUICIDE

A Toolkit for Pharmacy Residency Programs



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This document was developed by the following ASHP workgroup:

Lillian A. Agyei, MPH

Project Manager, Well-Being Ambassador Program

Bayli J. Larson, PharmD, MS, BCPS

Strategic Initiatives Associate

Anna Legreid Dopp, PharmD, CPHQ

Senior Director, Clinical Guidelines and Quality Improvement, Center on Medication Safety and Quality

Karly M. Low, PharmD

Director, Member Relations, New Practitioners Forum

Rachael A. McGarry, MS

Director, Member Engagement

Much appreciation for the following individuals who reviewed the document and provided feedback:

Marshall E. Cates, PharmD, BCPP, FASHP, FCCP, FALSHP

Professor and Chair, McWhorter School of Pharmacy, Samford University

Katrina L. Derry, Pharm.D., BCCCP, BCPS

Pharmacist Specialist, Medication Use Policy; Residency Program Director, PGY2 Critical Care Pharmacy, UC San Diego Health

Jonathan P. Lacro, PharmD, BCPS, BCPP

Director, Pharmacy Education and Training; Residency Program Director – PGY1 Pharmacy; Residency Program Director – PGY2 Psychiatric Pharmacy, VA San Diego Healthcare System

Marjorie Shaw Phillips, MS, RPh, FASHP, CIP

Clinical Research Pharmacist and Pharmacy Manager, Clinical Research and Residency Programs, AU Medical Center Pharmacy Department, Augusta University Health; Clinical Professor of Pharmacy Practice WOS, University of Georgia College of Pharmacy; IRB Chair, Augusta University and Augusta University Health

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Foundation
for Suicide
Prevention**

After A Suicide: A Toolkit for Schools, created by the American Foundation for Suicide Prevention/Suicide Prevention Resource Center Workgroup: Joanne L. Harpel, JD, MPhil; Peggy West, PhD, MSW; Gayle Jaffe, MSW, MPH; Donna Amundson, LCSW

After a Suicide: A Toolkit for Medical Schools, amended by the Mayo Clinic Workgroup: Liselotte Dyrbye, M.D.; Christine Moutier, M.D.; Alexandra Wolanskyj-Spinner, M.D., FACP; Sidney Zisook, M.D.

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At a Glance

In the event of a suicide within a pharmacy residency program, it is critical to have a plan of action already in place. This toolkit gives you a foundation for doing so. First and foremost, we encourage you to assemble a **Crisis Response Team** (pg. 7), and we have provided a suggested **Crisis Response Communication Plan** (pg. 8).

This toolkit also serves as a practical handbook to consult at the time of a suicide. You will find guidance and step-by-step lists on how best to go about:

- **Getting the Facts First** (pg. 9)
- **Informing the Emergency Contact Person/Family** (pg. 10)
- **Sharing the News** (pg. 13)
- **Helping Residents, Preceptors, and Staff Cope** (pg. 19)
- **Working with the Community** (pg. 21)
- **Memorialization** (pg. 22)

You will also find within the **Appendix** (pg. 28) immediately usable advice and checklists including a **Checklist for After a Suicide** (pg. 29), **Crisis Response Team Planning Template** (pg. 31), **Tips for Talking about Suicide** (pg. 34); **Sample Scripts to be Used in Face-to-Face Communication** (pg. 37); **Sample Email Death Notifications** (pg. 40); a **Memorial Service Planning Checklist** (pg. 43); a **Sample Media Statement** (pg. 44); and **Key Messages for the Media Spokesperson** (pg. 45).

It is our hope that you will read through this toolkit before an event takes place. Whether or not you do so, this handbook can serve as a useful guide in the immediate aftermath of a suicide.

In this document, the phrase **residency program is used in the most inclusive sense to mean all post-graduate pharmacy training programs, including PGY1 residencies, PGY2 residencies, and fellowship training programs. The term **program** may also be used interchangeably to mean the same.*

The term **resident is used in the most inclusive sense to mean residents and fellows.*

The term **program leadership is used in the most inclusive sense to mean the residency program director (RPD) and individuals the RPD has delegated authority to conduct the residency program.*

The term **institution is used to mean the employer or primary practice site of the deceased resident or fellow.*

Introduction

The death of a pharmacy resident by suicide is devastating, shocking, and stressful for all involved. It can feel different than the death of a patient and may be more like that of a family member or close friend. There are also aspects of suicide loss that can be traumatizing for many.

Being aware of the experiences common to suicide loss can help:

- **Prevent contagion**
- **Allow the pharmacy residency community (as well as others affected or impacted) to grieve and feel supported**
- **Raise awareness of the mental health needs of the community**
- **Engage in suicide prevention efforts at a later stage**

It is also important to remember that the resident is a colleague or hospital employee. While pharmacists may have experience dealing with patient deaths, managing the aftermath of a resident's death by suicide requires a different set of responsibilities. Thankfully, this is not an everyday experience – but this means residency programs are often uncertain about how to respond and need reliable information, practical tips and tools, and guidance readily available.

Experts in post-graduate pharmacy education and training, resident well-being and resilience, and suicide have collaborated to make this toolkit. The intent is to help residency programs in the aftermath of a resident death by suicide respond in a compassionate and coordinated way using a systematic approach. The toolkit contains consensus recommendations endorsed by the American Foundation for Suicide Prevention (AFSP). The toolkit's practical tips are modeled after the gold standard resource *After a Suicide: A Toolkit for Schools*¹ co-developed by AFSP and the Suicide Prevention Resource Center. Additional resources are provided in the Appendix. Key considerations, general guidelines for action, dos and don'ts, templates, and sample materials are provided on strategies for notification of the event and support of the community. This toolkit may serve as a guide for the development of a local action plan.

It is important to have procedures in place that approach all deaths in a similar fashion. Processes for notifications, bringing residents together as a community, and creating memorials should be the same when responding to the death of a resident who dies by suicide, by car accident or from any other cause. This approach minimizes stigma and reduces the risk of suicide contagion.

Proactively Developing a Suicide Response Plan

Ideally, the residency program (or the larger institution) will develop a suicide response plan before a suicide occurs. Program leadership can connect with their institution's Human Resources division for existing policies, procedures, and resources. If a protocol for responding to the death of a trainee is already in place, steps should be taken to ensure the protocol specifically addresses suicide. Suicide death should be addressed in a similar manner as other types of death. However, there are some unique aspects of suicide loss that require consideration. Having a plan in place will facilitate a coordinated response by a team of individuals who can support each other. Development and endorsement of such a plan should involve key stakeholders, such as the Chief Pharmacy Officer (CPO) or other pharmacy department leadership, residency program leadership (e.g., residency program directors and delegated staff), preceptors, Staff Mental Health Service or Employee Assistance Program personnel, communication office, human resources, legal, and law enforcement.

The plan should include details about:

- Ensuring the emergency contact list is updated yearly
- Reinforcing the importance of timely arrival and notification of absences during orientation
- Addressing a missing resident
- Confirming death of a resident and how to do so
- Developing a Crisis Response Team
- Communicating with emergency contact/family
- Notifying residents and staff
- Determining who needs to know what (program of deceased resident vs. greater interdisciplinary team)
- Creating templates for face-to-face, phone, and written notifications
- Planning a memorial service
- Managing media inquiries
- Managing social media
- Supporting the well-being of residents, program leadership, preceptors, other staff, Crisis Response Team members, and the deceased resident's family members and/or significant other
- Conducting post-mortem reviews, psychological autopsies, and root cause analyses

Once developed, the plan should be widely disseminated to program leadership and office personnel. Awareness of the plan should also be part of all appropriate staff orientations, and the plan should be easily locatable after-hours and on weekends by key personnel, such as the program leadership and other pharmacy leadership.

Crisis Response Team

A Crisis Response Team serves an important role following any critical incident, including the loss of a resident to suicide. The team carries out the critical aspects of crisis management in the aftermath of suicide loss: communication, support of the community, and prevention of contagion.

Selecting the team leader and members can be accomplished in a number of ways, but the team should include several key individuals such as: CPO and pharmacy department leadership, program leadership, preceptors, other interdisciplinary team staff, representatives from human resources, legal and communications/public relations, and mental health professionals. The team leader needs to ensure the checklist is carried out.

In some instances, the program leadership may be best suited to lead the team, and in other instances, it may make more sense for a psychologist/psychiatrist or other key staff to lead or co-lead the effort.

It is strongly recommended that the residency program director (RPD) and staff/administrators/preceptors closest to the event seek counseling, both in the immediate aftermath of the event and several months later. There are many ripple effects of suicide tragedies, and many of those ripples come back to affect such staff/administrators/preceptors. They too need support, yet may be reticent to seek it.

Crisis Response Team members will likely need to meet twice a day, every day for the first week: a morning meeting to report in and then an end-of-the-day/evening meeting to determine detailed plans for the following day. A template to help you develop an action plan for your Crisis Response Team is available in [Appendix B](#).

Crisis Response Communication Plan

Once the death has been confirmed by the institution, a coordinated crisis response should be implemented to manage the situation, provide opportunities for grief support, help residents, program leadership, staff, and preceptors cope with their feelings, and minimize the risk of suicide contagion. (See [Crisis Response Team](#), pg. 7)

First, a Crisis Response Team should be identified. This team should coordinate communication across the residency program, associated institutions, and others. Keeping a list of individuals who need to be informed and a plan for who will speak to each individual along with notes of when these activities are completed is useful (see [Appendix C](#) for example), as the manner and time of these notifications will vary. In-person notifications should be done whenever possible by respected authorities who know as much as is known about what has happened, so that they can answer questions and best convey institutional concern, involvement, gravitas, and assurances. One approach and a list of potential individuals with whom to communicate is shown below.

Timing is key. Residents should not hear about the event in the press or from social media before having heard about it from the program leadership. Furthermore, what is said publicly may be limited to some degree by the family's wishes. It is important to distinguish what might be said in a public meeting versus a meeting with institutional leadership. It may also be prudent to maintain confidentiality of the information until others have been notified.

Communication Plan

Immediately in Person or Virtually (by Phone or Video Conferencing)

- Institutional leadership (President/CEO and CPO), pharmacy department leadership, program leadership, human resources personnel, resident mental health/employee assistance personnel, and deceased resident's emergency contact/family.

Same Day in Person or Virtually (by Phone or Video Conferencing in Select Instances)

- Residents and others who were close to the deceased resident — including significant others or close friends, residents in the same training program as the deceased resident, preceptors or other residents working directly with the deceased resident at the time of death, patients receiving longitudinal, primary care from the deceased resident at the time of death, legal, communications/public relations, institutional leadership team at other hospital campuses (as applicable), leaders of resident wellness programming (as applicable), other interdisciplinary staff (as applicable).

Within 24–48 Hours by Email (video conferencing may be used if preferred)

- Residents and preceptors in other training programs at the institution, mentors/advisors, leaders within local pharmacy community, dean of students at the deceased resident's school/college of pharmacy, program leadership at other local institutions (as applicable), other key local, state, and national organizations in which the resident was involved (if known).

The first people to notify are those who need to know while formal announcements are prepared and residents are notified (see [Sharing the News](#), pg. 13). A suggested communication checklist can be found in [Appendix C](#).

Get the Facts First

In the event of a possible death of a resident, it is imperative to obtain accurate facts. Obtaining as much information as possible helps alleviate speculation and rumors that can fuel emotional turmoil within a residency program. Sometimes the family learns of the suicide first and informs someone at the institution, such as the RPD; in other cases, the death of a resident comes to light after the resident does not report for duty or after a phone call from local authorities, emergency department personnel, or others (e.g., the deceased resident's roommate or close friend). Depending on the situation, facts may be obtained or clarified by contacting the coroner, medical examiner's office, or local law enforcement.

The cause of death (i.e., suicide) should not be disseminated without first speaking with the family about their preferences. Full discussion of this can be found in [Sharing the News](#) (pg. 13) and [Appendix F](#).

Missing Resident

A resident not showing up for work may be a serious problem or a simple mistake. Because many residents do not have a land line phone, or in some situations a pager, we are dependent on a charged cell phone for contact.

Residency programs should have a process in place for how and when to deal with a resident who does not arrive when expected (see below for a suggested strategy).

Stepwise Approach to Finding a Missing Resident

- Contact the resident using their preferred method of contact: by phone (via text or voice call) or by email
- If there is no response, next options include:
 - » Calling resident's emergency contact/family
 - » Contacting local police or hospital security to request a welfare check

Informing the Emergency Contact/Family

Individuals within the residency program may be the first to know a resident has been declared deceased. In such a situation the Crisis Response Team leader or a delegate (e.g., RPD) should contact the emergency contact person immediately. Every resident should have emergency contact information on file (phone numbers, email address, and names of parents, spouse/partner, or other emergency contact person such as a roommate). Such information should be updated yearly. Please review the section titled: **Get the Facts First** (pg. 9) for guidance on how to proceed.

In other situations, the police may know first and will have their own protocol for notifying the next of kin. If the resident was brought to the emergency room, the physician who declares the individual deceased would likely make the call. In situations where another individual has disclosed the death of a resident, it is still important that the Crisis Response Team leader or a designated individual from the institution call the emergency contact.

Before calling the emergency contact, it is helpful to obtain as much information as is currently available (see **Get the Facts First**, pg. 9) as well as information about what, if anything, has already been conveyed to the emergency contact/family (e.g., by police, emergency department physician). This initial call should focus on condolences and extending support.

First, find out with whom you are speaking. If the emergency contact is not the resident's family member, ask if there is a family member with whom you should speak. Then, ask what the institution can do to assist and discuss the family's preference regarding what information is provided to residents and others at the institution. The emergency contact/family member may ask what happened. Sometimes it is not clear early on if the death was by suicide or was accidental. Starting with questions about what they have heard or what they understand about what happened may be helpful. Be careful to stick to the known facts and avoid any conjecture. Ask if they have thought about funeral arrangements and if residents and others from the institution can attend. Some families wish for the funeral to be private.

Although difficult, it is vital to discuss what information can be relayed to residents and others at the institution. If the death is determined to be a suicide and the family does not want it disclosed, the emergency contact should be informed that it would be helpful for fellow residents to know the cause of death. It is important to tell the emergency contact that residents and others at the institution are deeply affected by the passing of their loved one and would benefit from an honest disclosure of cause of death. Disclosing that the resident died by suicide (1) enables peers, preceptors, program leadership, and support staff to fully process and grieve the death of the resident, (2) learn more about suicide and its causes, and (3) take an important step to keep residents safe and avoid more tragedy. Given the stigma of suicide being even higher in various minority groups, a chaplain might be able to help family give permission to disclose the cause of death. That said, it should be kept in mind that the family may be in a state of shock immediately following the death and may not be ready to accept suicide as the cause of death. It is advisable not to push too hard, with the understanding that acceptance may arise within 24–48 hours.

End the conversation by providing information about how the emergency contact can reach a singular, designated contact person at the institution (typically the caller) if questions arise following the initial call. If the institution's designated contact person is not the individual making the initial call, be sure that is clearly conveyed to the emergency contact. Also, let the emergency contact know to expect a follow-up phone call within a few days. At that time, the caller should ask about travel plans and relay that information to the Crisis Response Team so that members can meet with the family in person after they arrive. Suggested topics to cover with the emergency contact can be found below (see **Topics to Cover with the Emergency Contact/Family**, pg. 11). It may be relevant

to inform the emergency contact/family of anticipated media attention surrounding the death of their loved one. Although suicides happen every day all over the world, the death of a resident may draw unwanted media attention; the caller can help prepare the emergency contact for this potential experience.

ADDRESSING FAMILY AND THE COMMUNITY

Postvention efforts need to take into consideration the backgrounds and cultures of everyone affected by a suicide, including the family, residency program, institution, and greater community. Backgrounds and culture may significantly affect the way people view and respond to suicide and death.

It's important to be mindful that the extent to which people are able to talk about suicide varies. In some cultures, suicide is still viewed as a moral failing. Therefore, it is important to be sensitive to the beliefs and customs of the deceased resident's family and community (e.g., rituals, funerals, etc.) and how the family and community respond to the death. It is also important to exhibit and use appropriate behavior and language, as well as to understand any potential perceptions related to individuals outside of the family or community intervening to provide support.

Topics to Cover with the Emergency Contact/Family

First Call (within 24 hours)

- Introduce yourself, identify your role at the institution, and verify with whom you are speaking
- Continue conversation:
"I am calling you because we have learned of some serious news concerning [NAME OF RESIDENT]. Here at [NAME OF INSTITUTION] we may not have complete information, but I want to talk with you about what we do know so far and learn what you may know as well."
- Ask what information they have received thus far and gather any other knowledge or thoughts they may have; be careful not to confuse this person's conjecture with fact
- Relay only what you know to be facts concerning the resident's death
- Offer to meet and provide condolences; ask if there is any assistance the institution can provide to the emergency contact and/or family
- Ask permission to speak with fellow residents and other appropriate people about the cause of death
- Consider suggesting a vigil; in some cases, there is a strong wish on the part of residents to do this — the family can be included per their wishes
- Inquire about funeral arrangements and release of home address for condolence notes
 - Can the institution help? Are residents/others welcome to attend? May flowers or condolence cards be sent? If so, where? (Note: the residency program may want to collect condolence notes and send to the family in one package)
 - If this information is unavailable, consider asking again on future call
- Consider mentioning the potential for media attention (the family is not obligated to take interviews and can refer media to the institution's communications team if preferred)
- Provide contact information for the investigating officer
- Identify/confirm who the family spokesperson is for ongoing communication and verify how best to contact this person moving forward; share how that person can best contact the caller/institution's designated contact (daytime/evening/weekend phone number(s), email(s), etc.)
- Commit to calling again the next day

Second Call (at 24–48 hours)

- ☐ Gauge willingness to share funeral plans and release of address for condolence notes (if not provided during prior call)
- ☐ Share desire for on-campus memorial service and acceptable venue (if appropriate/applicable)
- ☐ Ask about travel plans so Crisis Response Team members can meet with the family in person
- ☐ Share possible assistance the institution can provide:
 - ☐ Finding local accommodations
 - ☐ Collecting deceased resident's belongings before the family's arrival
 - ☐ Packing up and shipping belongings (if the death occurred inside the resident's housing, it will likely be sealed by police during their investigation and unavailable)
- ☐ Discuss possibility of the institution placing an obituary
- ☐ Provide assistance with administrative or human resource issues (insurance, final paycheck)
- ☐ Provide resources for suicide loss survivors ([AFSP.ORG/LOSS](https://www.afsp.org/loss))

Subsequent Call (up to several weeks later)

- ☐ Coordinate with family and human relations regarding found items (e.g., pagers, electronics)

Sharing the News

Following the notification of key personnel and the emergency contact, a plan must be developed and implemented for how to notify fellow residents as well as relevant staff of the deceased resident. What to say and how to say it varies by the group being informed along with the family's wishes.

It is important to follow guidelines on safe messaging about suicide in any communication about suicide. Do not use the outdated phrase committed suicide as it is considered offensive to some. Rather, select more neutral and compassionate words to use such as *died by suicide*, *took her life*, or *killed himself*. While it is particularly important to avoid idealizing the person and glorifying suicide, talking about suicide does not increase a person's risk for dying by suicide. Discuss the person in a balanced manner and do not be afraid to include the struggles that were known, especially in individual conversations about the death.

It is critically important for steps to be taken to ensure that suicide contagion risk is minimized to every extent possible. Contagion risk is heightened when a vulnerable individual is exposed to sensationalized or graphic communication about the suicide or when the deceased's manner of death or life is portrayed in an idealized manner.² The risk of suicide contagion is mitigated by including support and mental health resources in several communications and ensuring that every communication following the death is vetted with the following do's and don'ts in mind:

DO	DON'T
Avoid Contagion	
<p>In written communications, acknowledge the tragic loss to suicide of a member of the residency program (and call it a suicide if the emergency contact person has given permission), but do not include the method of suicide in written communications.</p> <p>During in-person meetings, it is fine to mention the method of suicide; however, avoid dwelling on the manner of death during in-person conversations (e.g., "He took his life by hanging. We probably won't ever fully know all of the factors that led to his suicide, but we recognize that there must have been overwhelming pain/struggle, and we grieve his loss").</p>	<p>Don't include graphic or detailed descriptions of the suicide method, location, or circumstances surrounding the death.</p> <p>Don't highlight pictures of the location or sensationalized media accounts.</p> <p>Even during in-person meetings, avoid providing more detail than the general method (e.g., "died by overdose, hanging, took his life using a firearm"). Going beyond this into more detail is not advisable especially in writing or group settings.</p>
Choose Language Appropriately (Don't Glorify the Act of Suicide)	
<p>Talk about the person in a balanced manner. Avoid idealizing the person and only extolling virtues.</p> <p>Do not be afraid to include the struggles that were known, especially during conversations.</p>	<p>Try to avoid describing the deceased resident only in terms of his/her strengths. This paints a picture of suicide being an option/solution or presents a confusing picture when the person's apparent struggles aren't mentioned or alluded to.</p>

DO	DON'T
Encourage Help-Seeking	
<p>Always include the list of resources and the after-hours numbers that anyone can call 24/7. Include the 988 Suicide & Crisis Lifeline (call/text 988 or chat 988LIFELINE.ORG) and the Crisis Text Line (text TALK to 741-741).</p>	<p>Don't portray suicide as a reasonable solution to the person's problems.</p>
Give Accurate Information About Suicide	
<p>Explain that suicide is a complicated outcome of several health and life stressors that converge at one moment in a person's life to increase risk. Mention the fact that mental health is a real part of life, dynamic and changing like other aspects of health. Reinforce that we all face challenges and can support one another. Explain that along with risk factors, there are known protective factors that mitigate risk for suicide. Emphasize the institution's stance on help-seeking as a sign of strength and a way to show the most proactive, mature level of professionalism. Mention the fact that there have been times when all good leaders have sought support or healthcare to the good of their personal health/well-being, as well as for the betterment of their professional work.</p>	<p>Don't portray suicide as the result of one problem, event, or issue.</p>

Notification should occur as soon as possible, ideally the same day as the death or before work starts in the morning. If there are residents who were very close to the deceased who are known to the institution (significant others, close friends), they should be notified first and separately from the others. Members from the Crisis Response Team should connect regularly with these people over the next few weeks.

Although it is permissible to disclose that a resident has died, the cause of death should not be disclosed unless approved by the emergency contact/family. In situations where the family does not want the cause of death shared with other residents, it is still important to acknowledge the death and immediately follow up with a statement (verbally and/or in writing) about the supportive mental health resources that are available to residents. If the cause of death has not been confirmed and there is an ongoing investigation, members of the Crisis Response Team should state that the cause of death is still to be determined and additional information will be forthcoming. Suggested processes as well as both oral and written scripts to help convey this information are provided on the next page and in [Appendix E](#) and [Appendix F](#).

NOTIFYING RESIDENTS IN THE SAME TRAINING PROGRAM AS THE DECEASED RESIDENT

- Ideally, notification should occur in-person on the same day as the death or before work starts the following morning. Practically, this can be difficult, especially if the institution has multiple campuses and clinical sites. Attempts should be made, however, to communicate the news in-person simultaneously to all residents who may have known the deceased resident. The remainder of residents at the institution should be notified following initial outreach to those closest to the deceased resident; this should occur within 24–48 hours by email or video conferencing depending on preference.
- Whenever possible, limit groups to no more than 20 to deliver the news. This is recommended to encourage honest dialogue and to avoid group escalation in anxiety, which is more likely in a large group setting. If not possible, office staff should secure a room large enough to hold everyone receiving the news in person.
- Office staff should contact every resident telling them of an emergency mandatory meeting. Residents should be reached by phone, email, or text with instruction to attend the meeting regarding “sad news”. Residents who are off should be called and asked to come in to attend the meeting. In the event a resident is unable to attend the in person meeting, video conferencing can be used to share the news.
- Program leadership, program support staff, pharmacy department personnel, preceptors, and members of the Crisis Response Team should also attend this meeting.
- It can be helpful to have mental health professionals, chaplain services, and employee assistance counselors available at the meeting when possible.
- In situations of multiple institutional campuses, efforts should be undertaken to bring residents at external sites/campuses together to be informed at the same time as residents on the main campus. During these site-based discussions, local site directors and mental health personnel should facilitate the discussion. In these cases, the Crisis Response Team should identify a staff point of contact at each site to coordinate this initial meeting and to identify any residents who seem vulnerable and may need further monitoring or additional support. While in person meetings remain ideal, video conferencing may be used as needed.
- During the meeting, members of the Crisis Response Team should introduce themselves (if not known to the residents) and other guests. Tips for how to talk about suicide and avoid contagion are provided in [Sharing the News](#) (pg. 13) and sample scripts to relay information in person about the death can be found in [Appendix E](#). Share accurate information about the death of the resident, as permitted by the emergency contact/family.
- If the emergency contact/family refuses to allow disclosure related to the manner of death, the Crisis Response Team can state:

“The family/emergency contact person has requested that information about the cause of death not be shared at this time.”
- The Crisis Response Team can take the opportunity to talk with residents about suicide in general terms and state:

“We know there has been a lot of talk about whether this was a suicide death. Since the subject of suicide has been raised, we want to take this opportunity to give you accurate information about suicide in general, ways to prevent it, and how to get help if you or someone you know is feeling depressed, struggling, or may be suicidal.”
- Allow residents to express their grief and identify those who may need additional support and resources. It is often expected that residents and others would/should “process” their feelings after being notified; however, it is important to stress that it is normal to have intense feelings, memories, and thoughts that may catch them off

guard. Let them know these feelings should lessen over time and encourage anyone who is feeling distressed and thinks talking would be helpful to access support resources. Explain that everyone's grief response is different — some residents will need time off and others may find solace in working. Commit to providing coverage or changing schedules as needed.

- Remind all residents of the importance of seeking help if they are experiencing difficulty as well as the process in place for accessing care:
 - » Encourage residents to debrief/process their experience of losing a peer. Provide a list of individuals, such as preceptors, who are available to residents, and to whom the residents can reach out to talk about the loss/debrief. This is not mental health treatment, but rather supportive debriefing with an advisor/mentor. Consider providing cell phone numbers of Crisis Response Team leaders and/or other staff and encourage residents to call these individuals 24/7 for support as needed. (Reminding residents of the support available to them should be done in-person during meetings as well as via emails.)
 - » Clinical treatment may be indicated for anxiety, sleep and mood problems, and prevention of a depressive episode (e.g., in a resident with a history of recurrent depressive episodes). Explain how residents can access treatment, if indicated.
 - » Provide a list of institutional and community-based mental health providers for debriefing and clinical treatment options.
- Address barriers to engaging in self-care:
 - » Explain the process for taking time off and how program leadership will help arrange coverage. Emphasize that over the course of training, everything evens out, it is vital to take needed time to prioritize one's mental health, and colleagues are happy to provide coverage as needed.
 - » Remind residents that program leadership will not know who is receiving mental health care. Consider having people in the audience speak about their own experience with seeking mental health care or stating that many people who have never sought mental health services find speaking with a trained mental health professional at times like these to be very helpful.
 - » Some residents may have heard that seeking mental health services may have negative ramifications on licensure. It is important to remind them that medical diagnoses and care are protected under HIPAA and that unaddressed mental health problems are much more likely to negatively impact safe practice or pharmacy licensure than appropriate help-seeking behaviors.
- Remind residents if they have struggled with depression themselves or are actively getting mental health care, they may want to check in with their therapist or psychiatrist.
- Inform residents of a clear mechanism to help identify anyone they are concerned about (e.g., to whom to bring that information if concerned), including the video produced by the AFSP ([YOUTUBE.COM/WATCH?V=I9GRXF9QEBA](https://www.youtube.com/watch?v=I9GRXF9QEBA))
- Share information about suicide bereavement groups in the community — [AFSP.ORG/SUPPORTGROUPS](https://www.afsp.org/supportgroups) has a list of over 800 nation-wide suicide loss support groups.
- Ask if residents know of anyone (outside of the residency program or institution) who may need to be notified or sent resources. For example, the resident may have had a significant other in the local area who is not known to the emergency contact/family but whom friends of the deceased know.
- Talk about the importance of coming together as a community and supporting each other in times like these.
- As applicable, inform residents about the funeral and the process for requesting time off to attend.

Residents may also experience guilt about not recognizing the signs of distress and suicide risk in another resident. As pharmacists, residents tend to see themselves as sensitive to others and not having “noticed” the signs of distress can induce guilt. It is important to remind everyone that residents often feel the need to appear strong as part of their identity as healthcare practitioners and may cloak their feelings of anxiety, worry, feeling overwhelmed or trapped, or other psychiatric symptoms. This makes it difficult to identify those in distress so they can receive assistance and makes the person feel more isolated, as no one knows how they really feel. Remind residents that hindsight is 20/20; as with all health outcomes, while many suicides can be prevented, not all can.

Take the opportunity to highlight the importance of reaching out and the complexity of suicide — it has multiple “causes” in every instance; we often do not know all of the physical, emotional or life stressors/past experiences with which the person was contending. (For tips on how to talk about suicide, see the [Sharing the News](#) (pg. 13) and [Appendix D](#).) While it’s important to learn the warning signs, remember that everyone saw the resident in different contexts at different times. Therefore, each person likely had minimal data points to fill in the fuller picture of the multiple converging risk factors before death.

There are likely to be people in the group who are more deeply affected by the death. It may be difficult to meet their needs during the initial meeting. It might be helpful to allow for a separate time for those who wish to discuss the event in more detail, particularly if the reporting is to a larger group. For example, members of the Crisis Response Team could offer to spend an additional 30 minutes with anyone who wants to talk further about the death. It’s best to provide several options for dialogue, including one to two people outside the residency program, since privacy is very important to some trainees and staff.

A second meeting with the residents may also be wise to encourage them to think about how they would like to remember their peer. Ideas include writing a personal note to the family, participating in or attending the memorial service, or doing something kind for another person. Other reflective activities such as writing, poetry reading, or an art project can also be very helpful. These can be done individually or as a group. It is important to acknowledge the residents’ need to express their feelings while helping them identify appropriate ways to do so.

At the end of the meeting, the Crisis Response Team should gather to (1) review the day’s challenges, (2) debrief and share experiences and concerns, (3) consider strategies for people who may need additional support, (4) remind each other of the importance of self-care, and (5) plan for next steps and follow up. This might also be a good time to write an email to residents and key program staff about resources that were verbally shared during the meeting as well as any next steps.

Immediately after this meeting it is critical to inform preceptors and staff assigned to the services with affected residents and institutional leadership about the death and the fact that residents have just been informed. These people may have known the resident and may also be affected by news of the death. It is also important that these people understand that some residents may be distraught when they return to practice.

Residents in the same program who did not attend the in-person meeting should be informed as soon as possible, preferably by telephone or video conferencing rather than email.

Written Communication with Others

Next, an email announcement should be sent to residents in other training programs at the institution, leaders within local pharmacy community, and the dean of students at the deceased resident’s school/college of pharmacy, and program leadership at other local institutions. Such communication should be sent within 24–48 hours and should include neutral and compassionate language (i.e. died by suicide, etc.) as appropriate. A follow-up email can be sent later with details regarding the obituary, address of emergency contact person, and if applicable, funeral/memorial service information. Sample email scripts can be found in [Appendix F](#). A similar approach should be used for cases of death by any cause.

For RPDs and pharmacy leaders at other institutions/hospitals in the surrounding geographical area —particularly where residents from different training programs have rotations together, a thoughtful approach to whether an announcement should be made must be considered. On the one hand, if residents from different training programs have learned about the death, it can be helpful for leaders to gather them together to provide factual information and similar messages about the importance of well-being, support being available, and help seeking being a sign of strength. However, if most residents have not become aware, this type of messaging can create unnecessary anxiety. It is recommended for the RPD and/or members of the Crisis Response Team to start by meeting with program directors to determine the level of knowledge among the nearby residents and to gauge the tone and level of concern the community is experiencing.

Supporting and Helping Residents Cope

In the aftermath of a suicide, residents may feel emotionally overwhelmed, which can disrupt patient care, learning, and overall performance. Most residents have mastered basic skills to control their emotions, but these skills can be challenged in the setting of a suicide. For some residents, it will be their first experience of death of someone they personally know, let alone by suicide.

Residents are likely to recognize complex feelings. The death of a resident, under any circumstances, triggers an acute grief response, which may be intensely painful but is generally self-limiting. There are no prescribed ways of going through grief and everyone goes through it on their own terms, with uniquely individualized experiences, symptoms, trajectories and time courses. For some, grief is hardly noticeable; while for others, it can be devastating — both physically and emotionally. The physical indicators of distress (such as stomach upset, restlessness, and insomnia) and the emotional expressions of grief (often compared to an emotional tsunami — occurring in waves and ripping apart a person's sense of meaning and belonging) tend to peak within days to weeks to months until they become less intense and less frequent. For most bereaved people, grief provides an opportunity to say goodbye, pay respects, feel the pain, and hopefully mourn in the comfort and support of friends, relatives, and neighbors. There is no situation where the old adage, “a trouble shared is a trouble halved” is more true.

Overall, the mourning process is the way bereaved people come to grips with their loss and ultimately transition to a life in which the deceased peer is not forgotten, but rather resides in a comfortable place in the bereaved person's heart and memories. Grief after especially sudden and unanticipated losses, such as after a death by suicide, often has the added dimension of psychological trauma with symptoms such as hypervigilance, avoidant behaviors, intrusive memories, numbness, sleep disruption, or changes in mood. These symptoms should lessen in intensity over time (days to weeks usually); if they do not lessen or if they are at a level of severity that interrupts the resident's functioning, the resident should be encouraged to seek mental health care.

It may be helpful to reach out to residents to help them process their emotions and better identify those who may need additional support. Mental health professionals can meet with small groups of residents to help them express feelings and discuss safe coping strategies. Residents can be encouraged to use relaxation or mindfulness skills as a way to cope with intense emotions related to the event. Residents may also seek validation and permission from program leadership to engage in activities that will help them feel better, take their mind off the stressful situation, and seek help. Participating in rituals, such as attending the funeral or memorial service, may help residents resume their daily lives and responsibilities.

Pay attention to residents who are having particular difficulty, including those who may have struggled previously or who begin to show signs of deteriorating health/well-being (e.g., tardiness, sick days, short temper, trouble managing workload, or any persistent changes from baseline behavior patterns). Encourage them to talk with counselors, the chaplain, and other appropriate personnel.

The one-year anniversary of the death or other significant dates (such as the deceased's birthday) may stir up emotions and can be an upsetting time for residents. Remember that while residents may be desensitized to death in general and may react to patient death differently, the death of a peer, particularly by suicide, can evoke strong emotions. It is helpful to anticipate this, particularly for those residents close to the deceased or who are exposed to other deaths or challenges soon after the loss.

The loss of a resident also has practical consequences on schedules and work flow, particularly in the residency class that has lost their colleague. Consider solutions such as providing increased extender coverage for that year.

Supporting and Helping Preceptors and Staff Cope

Although staff (including those from other disciplines within the care team) will have known the resident to varying degrees, the experience may still have a powerful personal impact. Taking the time to offer support in the aftermath of a traumatic event is important.

Some staff will have had very close ties to the deceased. For those who struggle with their own baseline mental health issues, the death of a resident with whom they had a close relationship can be triggering. Healthcare practitioners may also feel guilty about not recognizing the signs of distress and suicide risk in a resident. Additionally, preceptors may blame themselves for their perceived role in contributing to the situation (e.g., via workload demands, negative evaluations, etc.). It is important to remind everyone that residents often feel the need to appear strong as part of their professional identity and may likely cloak their feelings of anxiety, worry, and other psychiatric symptoms in order to carry out their job functions. This makes it difficult to identify those in distress so they can receive assistance and makes people feel more isolated, as no one knows how they really feel. The reasons that someone dies by suicide are not simple and are related to mental anguish that gets in the way of the person thinking clearly. Remind staff that hindsight is 20/20; as with all health outcomes, while many suicides can be prevented, not all can.

Some staff who are deeply touched by the experience may need to discuss with their immediate supervisor whether they can take the rest of the day off and how to handle the immediate workload. These people may also be directed to Employee Assistance Program personnel or other in-house experts.

In situations of longitudinal experiences, other clinical staff may also be impacted. In an effort to communicate support to this broader network of the hospital/clinical community, make sure key leaders such as chief physician and chief nursing officers are made aware. (See [Appendix F](#) for template emails).

Staff should be reminded that:

- Self-care is an important part of professionalism and is critical in caring for others; residents learn from watching others model solid self-care practices. Unattended feelings and mental health needs can lead to poor communication skills
- If you see something, say something (i.e., speak with the resident or contact the program leadership if you notice changes in a resident's behavior, irritability, etc.)
- Build relationships with residents
- Residents are working extremely hard — remember to acknowledge that and thank them
- Mindfully share your own experiences — it is important for residents to know that many of the difficulties are a part of training

Ideally, steps should be taken so that one person, such as the RPD, does not repeatedly have to tell the story of the resident's death. Using a Crisis Response Team, as previously described, helps ease the burden.

Staff and members of the Crisis Response Team should have debriefing meetings with in-house experts. Reaching out to these individuals two to eight weeks after the event is also a useful way to support their well-being and ongoing bereavement. Many find speaking with a therapist or counselor tremendously helpful as well.

Working with the Community

It may become necessary in the aftermath of a suicide to communicate with community partners such as the coroner/medical examiner and police.

If warranted, the coroner or medical examiner is the best starting point for confirming that the death has been declared a suicide. (In some cases, it may also be necessary to contact the police department to verify the information). However, given how quickly news and rumors spread (including through media coverage, email, texting, and social media), institutions may not be able to wait for a final determination before they need to begin communicating with residents and staff. There may also be cases in which there is disagreement between the authorities and the family regarding the cause of death. For example, the death may have been declared a probable suicide, but the family believes it to have been an accident or possible homicide. Or the death may have been declared a suicide, but the family does not want this communicated, perhaps due to stigma, respect for their loved one's privacy, fear of risking contagion, or because they simply do not (yet) believe or accept that it was suicide.

Institutions have a responsibility to balance the need to be truthful with the community while remaining sensitive to the family. As mentioned above, this is an opportunity to educate the community (including potentially vulnerable residents) about the causes and complexity of suicide and to identify available mental health resources, without divulging the cause of death if the family does not offer its permission. Communication scripts can be found in [Appendix E](#) and [Appendix F](#).

The police will likely be an important source of information about the death, particularly if there is an ongoing investigation (for example, if it has not yet been determined whether the death was suicide or homicide).

The Crisis Response Team will need to be in close communication with the police to determine (a) what they can and cannot say to the community so as not to interfere with the investigation and (b) whether there are certain residents who must be interviewed by the police before the Crisis Response Team can debrief or counsel them in any way. In situations where law enforcement must speak with residents to help determine the cause of death, a member of the Crisis Response Team may offer to accompany the resident for this discussion and notify institutional legal counsel.

Memorialization

Communities often want to memorialize an individual who has died. It can be a challenge to balance meeting the needs of distraught residents and staff while preserving the day-to-day activities of taking care

of patients and learning. **It is very important to treat all resident deaths with the same basic approach, while giving special consideration to contagion risk and the unique aspects of suicide loss.** The approach for responding to the death of a resident from a car accident or cancer should be basically the same as for a resident who dies by suicide. This approach, particularly not remaining silent in the face of a suicide, minimizes stigma and reduces the risk of suicide contagion. In the case of suicide, it is very important not to inadvertently glamorize or romanticize the deceased resident or the death. It is best to emphasize the link between suicide and underlying mental health problems (such as depression, anxiety, and burnout). These conditions can cause substantial psychological pain while not being apparent to others.

The first step is to discuss with the emergency contact/family if they approve of a memorial service or remembrance event, and if so, what an acceptable venue would be. Particular religious beliefs may make a chaplain service inappropriate, for example.

A memorial service planning checklist can be found in [Appendix F](#).

- In choosing a location, it is best that the memorial service not be held in regular meeting rooms; doing so could inextricably connect the space to the death, making it difficult for residents and staff to return there for regular learning.
- The location should not be the place of death.
- It is also best if services are held outside of regular hours. Involving family and the resident's close friends in planning the memorial can be helpful.
- It is important to provide an opportunity for residents to be heard. It will be valuable to remind all who will be speaking at the memorial about the importance of emphasizing the connection between suicide and underlying mental health issues and not romanticizing the death in any way.
- When announcing the memorial, include details regarding what to expect as well as policies for attending memorials and funerals, arranging coverage for clinical assignments, and other relevant details.
- Consider the timing of the service for particular faith traditions.
- Mental health professionals should attend the memorial and be available to provide support.
- Attendees should be requested, if possible, to turn off their phones, pagers, and other electronic devices as a sign of respect to their deceased colleague; being able to truly focus for this brief span of time means a great deal to those most intimately affected by the loss. For those on call, they should try to have a colleague cover for them for 2–3 hours, if possible.

Sometimes there is a desire to establish a permanent memorial (e.g., planting a tree, installing a bench or plaque, establishing a scholarship). Although such memorials may not increase risk of contagion, they can be upsetting reminders to bereaved residents and staff. Careful consideration should be given to whether a permanent memorial is warranted, and this should only be done if this is protocol for other resident deaths. If possible, permanent memorials should be located away from common areas of work and learning. It is also important to remember that once a permanent memorial is set up, it establishes a precedent that can be difficult to sustain over time. Sometimes families choose to set up a memorial scholarship fund in honor of their loved one; these can be handled on a case-by-case basis. Memorial funds are almost always positive since they take some time to set up and therefore are not likely to lead to contagion.

Other approaches for memorialization include:

- Holding a day of community service or creating an institutional-based community service program in honor of the deceased
- Putting together a team to participate in an awareness or fundraising event sponsored by one of the national mental health or suicide prevention organizations (e.g., [OUTOFTHE DARKNESS.ORG](https://www.outofthedarkness.org)) or holding a local fundraising event to support a local crisis hotline or other suicide prevention program
- Sponsoring a mental health awareness day
- Purchasing books on mental health for the local library
- Working with the administration to develop and implement a curriculum focused on effective problem-solving or other pro-mental health activities such as mindfulness
- Volunteering at a community crisis hotline
- Raising funds to help the family defray their funeral expenses
- Making a book available in a common space for several weeks in which residents and staff can write messages to the family, share memories of the deceased, or offer condolences; the book can then be presented to the family on behalf of the community

Online Memorial Pages and Social Media

Online memorial pages and message boards have become common practice in the aftermath of a death. At times, residency programs/institutions may choose (with the permission and support of the deceased resident's family) to establish a memorial page on its website or a social networking site. As with all memorialization following a suicide death, such pages should take care not to glamorize the death in ways that may lead other at-risk residents to identify with the person who died. It is therefore vital that memorial pages utilize safe messaging, include resources, be monitored, and be time-limited.

It is recommended that online memorial pages remain active for up to 30 to 60 days after the death, at which time they should be taken down and replaced with a statement acknowledging the caring and supportive messages that had been posted and encouraging residents who wish to further honor their friend to consider other approaches.

If the deceased resident's friends create a memorial page of their own, it is important that the Crisis Response Team communicate with the friends to ensure that the page includes safe messaging and accurate information³. An example of recommended language for a friends and family memorial page could include: "The best way to honor your loved one is to seek help if you or someone you know is struggling." When possible, memorial pages should also contain information about where a person in a suicidal crisis can get help (e.g., call or text 988 to access the 988 Suicide & Crisis Lifeline or text TALK to 741-741 to access the Crisis Text Line). Members of the Crisis Response Team should also join any resident-initiated memorial pages so that they can monitor and respond as appropriate.

Social media should be monitored for several weeks following the death. A member of the Crisis Response Team who is adept at social media can watch for distressed posts by other residents as well as posts that get into graphic details about suicide, pictures of the location of death, or memes that make suicide seem like a positive outcome (e.g. meme with picture from the movie Aladdin with the text "Genie, you're free" that unfortunately went viral after Robin Williams's death). Posts that increase risk of contagion should be taken down.

Media and the Press

A member of the Crisis Response Team should be assigned to media relations. A media statement should be prepared (see [Appendix H](#) for example) and a designated media spokesperson identified. Identifying key messages for the media spokesperson can be helpful (see [Appendix I](#) for example). Typically, only authorized staff or institutional communication personnel should speak with the media. It may be best to advise residents and staff to avoid interviews with the media. The media can also be provided guidance on how best to report on suicide to minimize risk of suicide contagion ([AFSP.ORG/REPORTING](https://www.afsp.org/reporting)).

Moving Forward

Promoting the well-being of residents and all members of the institution requires a long-term, sustained effort. Continuing to improve the learning environment and support for trainee wellness must occur beyond the acute phase after a suicide. A few months following the suicide, the institution should consider implementing:

- Mental health and suicide awareness programs to educate residents and staff about the symptoms of depression and the causes of suicidal behavior
- Programs to educate residents and staff about mental health and the risk of suicide among healthcare practitioners, particularly pharmacists
- A suicide prevention program that utilizes an educational campaign directed at all levels of the institution and specific mechanisms for help seeking to be safe and encouraged⁴
- A readily available listing of suicide prevention resources, including:
 - » Best Practices Registry for Suicide Prevention (available at [SPRC.ORG](https://www.sprc.org)): A database of such programs that have been determined by expert peer review to reflect best practices for suicide prevention
 - » National Registry of Evidence-Based Programs and Practices, maintained by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services (available at [SAMHSA.GOV](https://www.samhsa.gov)): While few of the programs are specific to suicide prevention, this database includes mental health interventions that have been scientifically tested
- Some institutions may also wish to take collective action to address the problem of suicide, such as by participating as a team in an awareness or fundraising event to support a national suicide prevention organization or local community mental health center

Death of a resident by suicide poses a significant emotional challenge. A comprehensive and stepwise approach to help the community grieve should be developed and tailored to the institution. Although one hopes to never face this difficult loss, preparation can ease the anguish and optimize the outcomes for the institution and community at large.

Additional Resources

Resources to Support Pharmacist and Clinician Well-Being

- [WELLBEING.ASHP.ORG](https://www.ashp.org/wellbeing)
- **ASHP MENTAL HEALTH SUPPORT CERTIFICATE** (20.5 CE hours including Introduction to Mental Health and Suicide Prevention – 1.75 hours; Suicide Screening and Assessment – 3.75 hours; Strategies to Reduce Suicide Risk – 2 hours; Pharmacist Integration of Mental Health Disorders and Suicide Prevention Across Practice Settings – 1.5 hours)
- **ASHP WELLBEING AND RESILIENCE PROFESSIONAL CERTIFICATE**
- National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. [HTTPS://DOI.ORG/10.17226/25521](https://doi.org/10.17226/25521).
- National Academies of Medicine Resource Compendium for Health Care Worker Well-Being [HTTPS://NAM.EDU/COMPENDIUM-OF-KEY-RESOURCES-FOR-IMPROVING-CLINICIAN-WELL-BEING/](https://nam.edu/compendium-of-key-resources-for-improving-clinician-well-being/)
- [STEPSFORWARD.ORG/MODULES/PHYSICIAN-WELLNESS](https://stepsforward.org/modules/physician-wellness) (American Medical Association)
- **SUICIDE AWARENESS AND REFERRAL FOR PHARMACY PROFESSIONALS** (Washington State Pharmacy Association)

Mental Health and Behavioral Health Resources

- The **AMERICAN FOUNDATION FOR SUICIDE PREVENTION (AFSP)** is a voluntary health organization that gives those affected by suicide a nationwide community empowered by research, education and advocacy to take action against this leading cause of death. With local programs and events in all 50 states, AFSP's chapters are at the forefront of suicide prevention. Visit [AFSP.ORG/CHAPTERS](https://afsp.org/chapters) to find a local chapter in your community or explore other suicide prevention resources at [AFSP.ORG/RESOURCES](https://afsp.org/resources).
- Use the Behavioral Health Treatment Services Locator to find confidential and anonymous information about treatment services for substance use, addiction, and/or mental health problems: [FINDTREATMENT.GOV](https://findtreatment.gov)
- Call the 24/7 National Helpline at 1-800-662-HELP (4357) for treatment referral and information
- Visit [MHANATIONAL.ORG/FINDING-HELP](https://mhanational.org/finding-help) to find mental health resources and support services
- Contact your Employee Assistance Program (EAP) or other employee-supported mental health resources to learn more about assistance you can receive for crisis response
- Identify local grief and trauma-informed counselors in your area

Crisis Resources

- **988 Suicide & Crisis Lifeline**
[988LIFELINE.ORG](https://988lifeline.org)
Call or text 988 or chat [988LIFELINE.ORG](https://988lifeline.org) for free and confidential support 24/7
- **Crisis Text Line**
[CRISISTEXTLINE.ORG](https://crisistextline.org)
Text “TALK” to 741-741 for free and confidential support 24/7
- Find out if your community has a mobile crisis unit. Know the contact information for your local hospital emergency department, psychiatric hospital, or walk-in clinic.

Suicide Prevention Information

- Suicide Risk Factors and Warning Signs: [AFSP.ORG/SIGNS](https://afsp.org/signs)

Loss and Healing Resources

You are not alone. AFSP offers programs and resources to support you on your healing journey.

- Visit [AFSP.ORG/IVE-LOST-SOMEONE](https://afsp.org/ive-lost-someone)
- Find a support group: [AFSP.ORG/FIND-A-SUPPORT-GROUP](https://afsp.org/find-a-support-group)

Resources for the Media

- Safe Messaging: [SUICIDEPREVENTIONMESSAGING.ORG](https://suicidepreventionmessaging.org)
- Reporting Guidelines, Recommendations for Reporting on Suicide: [AFSP.ORG/SAFEREPORTING](https://afsp.org/safereporting)



Appendix: Crisis Response Tools

Appendix A:

Checklist for After a Suicide

The following timeline and checklist* has been customized for the pharmacy workforce and postgraduate pharmacy residency and fellowship training programs by ASHP.

DAY 1*

- Activate the **Crisis Response Team** (pg. 7); if not already in place, develop one using the provided tips (pg. 6) and template (**Appendix B**)
- Conduct immediate notifications (see **Crisis Response Communication Plan**, pg. 8)
- Initiate contact with the deceased resident's emergency contact/family
- Make a plan for notifying residents who were close to the deceased resident; significant others or close friends should be notified first, separate from other residents
- Hold meeting(s) with residents; check in daily with program leadership and preceptors — they are on the frontline and may know who is struggling
- Commit to providing coverage or changing schedules as needed and consider cancelling nonessential work duties (i.e. presentations, and journal clubs) for a designated period of time (i.e. 1-2 days, 1 week)
- Ensure that mental health services are available 24/7 for at least the first two weeks for anyone impacted
- Debrief with Crisis Response Team (do so on a daily basis for at least the first week or longer as needed)

DAY 2

- Coordinate remaining announcements (see **Crisis Response Communication Plan**, pg. 7)
- Identify and check in individually with any at-risk residents (e.g., residents in the same program, close friends, roommates/housemates, potential romantic partners [current and former if known], residents already receiving mental health care)
- Hold multiple open-hours sessions for mental health professionals to debrief with residents — this will also help identify at-risk residents
- Have mental health professionals available for residents to drop in and see as needed throughout the day
- Attend to the well-being of program leadership, preceptors, and staff by promoting access to one-on-one counseling and coordinating larger group meetings facilitated by an expert to debrief on the loss and its impact
- Check in with deceased resident's emergency contact/family regarding funeral arrangements, next steps, and plans to meet
- Let residents, program leadership, preceptors, and other staff know about funeral arrangements and address for condolence cards and social media site, per family's preferences
- Debrief with Crisis Response Team

DAY 3-4

- Encourage informal gatherings of residents outside of scheduled or on-call hours
- Assess resident well-being and provide assistance and support as able/needed (e.g., meals, transportation, lighter workloads, etc.); ask preceptors and mentors to check in with advisees

- Return to regularly scheduled activities
- Debrief with Crisis Response Team

WEEK 1

- Continue to check in with residents and those working closely with them (program leadership, preceptors)
- Debrief with Crisis Response Team; team should continue to meet on a routine basis to monitor community well-being and to carry out the communication plan and other needed actions

WEEK 2

- Draft and distribute a statement that recognizes that it is still early in grieving process and reinforces the continued availability of mental health services, caring for each other, and the availability of program leadership and preceptors to speak with residents, etc.
- Check in with deceased resident's family regarding any human resource issues (benefits, final paycheck, returning of electronic devices, etc.) and memorial service
- Plan and hold memorial service
- Ask preceptors to check in with advisees or mentees, plan group dinners, etc.
- Provide suicide loss resources to the community/appropriate individuals ([AFSP.ORG/AFTERALOSS](https://www.afsp.org/afteraloss))
- Debrief with the Crisis Response Team

WEEK 3-4

- Consider scheduling another session to debrief with residents
- Continue to check in with residents, program leadership, preceptors, and pharmacy staff about how to best continue providing support and identify who may need additional help
- Monitor resident coping and absences as well as impact on schedules and workflow
- Debrief with the Crisis Response Team — focus on next steps

BEYOND THE FIRST MONTH

- Hold memorial service if not done already
- Consider monthly process groups with mental health professional
- Attend to resident well-being issues
- Develop a departmental resident well-being plan (if not already in place) and engage institutional leadership to develop a longitudinal plan for monitoring and addressing resident well-being and burnout
- Develop an institutional and resident program suicide prevention plan (if not already in place) that takes the long view on how the institution plans to address factors that lead to stress, burnout, and suicide risk

**The timeline above should be modified to best meet the needs of the residency program or institution. This information is provided as a suggestion to illustrate suggested components and timeline to help a grieving community heal.*

Appendix B:

Crisis Response Team Planning Template

Use the following template as you develop your action plan for your Crisis Response Team.

Team Leader: _____

Team Member	Tasks from Checklist	Date Completed

Appendix C:

Suggested Internal Communication List

	Who?	When?	Notes/Completed
Phase 1: Immediate Notification In Person or Virtually (by Phone or Video Conferencing)			
Chief pharmacy officer (CPO) and/or director of pharmacy (DOP)			
Institutional leadership (president/CEO)			
Residency program leadership			
Crisis Response Team members			
Employee mental health service personnel			
Deceased resident's emergency contact/family			
Phase 2: Same Day Notification In Person or Virtually (by Phone or Video Conferencing)			
Deceased resident's fellow residents (starting with those who had a close, personal relationship with deceased resident such as significant others or close friends if known))			
Residents in the same training program as the deceased resident			
Preceptors working directly with the deceased resident at the time of death			
Other institutional staff (i.e., Legal/Risk Management, Communications/Public Relations, leaders of resident wellness programming, select hospital staff such as those within the pharmacy department and/or those who on interdisciplinary clinical team)			
Institutional leadership team at other hospital campuses (as applicable)			
Residency program leadership at other campuses (as applicable)			

	Who?	When?	Notes/Completed
Phase 3: Notification Within 24–48 Hours by Email (video conferencing may be used if preferred)			
Program leadership, preceptors, and residents in other training programs at the institution			
Mentors/Advisors (if known)			
Dean of students at the deceased resident's school/college of pharmacy			
Residents in other training programs at the institution			
Leadership at other local institutions (i.e., program leadership at other local institutions as applicable)			
Pharmacy leadership in local community or at state/national level (e.g., key local, state, and national organizations in which the resident was involved if known)			

Appendix D:

Tips for Talking about Suicide

Give Accurate Information about Suicide	Say
<p>Suicide is a complicated behavior. It is not caused by a single event.</p> <p>Research is very clear that in most cases, underlying mental health conditions like depression, substance abuse, bipolar disorder, post-traumatic stress disorder, or psychosis (and often comorbid occurrence of more than one) were present and active leading up to a suicide. Mental health conditions affect brain functioning, impacting cognition, problem solving, and the way people feel. Having a mental health problem is actually very common and is nothing to be ashamed of, and help is available.</p> <p>Talking about suicide in a calm, straightforward manner does not increase risk of residents.</p>	<p>“The cause of [NAME]’s death was suicide. Suicide most often occurs when several life and health factors converge leading to overwhelming mental and/or physical pain, anguish, and hopelessness.”</p> <p>“There are treatments to help people with mental health struggles who are at risk for suicide or having suicidal thoughts.”</p> <p>“Since 90% of people who die by suicide have a mental health condition at the time of their death, it is likely that [NAME] suffered from a mental health problem that affected [his/her] feelings, thoughts, and ability to think clearly and solve problems in a better way.”</p> <p>“Mental health problems are not something to be ashamed of — they are a type of health issue like any other kind, and there are effective treatments to help manage them and alleviate the distress.”</p>
Address Blaming and Scapegoating	Say
<p>It is common to try to answer the question “why?” after a suicide death. Sometimes this turns into blaming others for the death.</p>	<p>“The reasons that someone dies by suicide are not simple and are related to mental anguish that gets in the way of the person thinking clearly. Blaming others — or blaming the person who died — does not acknowledge the reality that the person was battling a kind of intense suffering that is difficult for many of us to relate to during normal health.”</p>
Do Not Focus on the Method or Graphic Details	Say
<p>Talking in graphic detail about the method can create images that are upsetting and can increase the risk of imitative behavior by vulnerable people.</p> <p>If asked, it is fine to give basic facts about the method, but don’t give graphic details or talk at length about it. The focus should not be on how someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, etc.</p>	<p>“It is tragic that [NAME] died by hanging. Let’s talk about how [NAME]’s death has affected you and ways for you to handle it.”</p> <p>“How can we figure out the best ways to deal with our loss and grief?”</p>

Address Anger	Say
Accept expressions of anger at the deceased and explain that these feelings are normal.	“It is not uncommon to feel angry. These feelings are normal and it doesn’t mean that you didn’t care about [NAME]. You can be angry at someone’s behavior and still care deeply about that person.”
Address Feelings of Responsibility and Guilt	Say
<p>Reassure those who feel responsible (e.g., due to workload demands, low evaluations scores, etc.) or think they could have done something to save the deceased. Many pharmacists have exceedingly high expectations of themselves, and they may feel that they should have detected signs of suicide risk. The reality is that many cloak their internal distress (to their detriment) so that it can be challenging for even the closest people in their lives to observe the change in their mental state.</p> <p>This highlights the importance of asking and caring when you notice even subtle changes in others’ usual way of behaving and approaching problems.</p>	<p>“[NAME] was a colleague, a friend, and not your patient. No one has the ability to predict imminent suicide. We do know that talk saves lives. If your gut instinct tells you something is different about a fellow resident’s behavior, just engage in a conversation with them, and if you are still concerned, encourage them to seek help and consider letting [NAME OF APPROPRIATE LOCAL PERSON] know.”</p> <p>“This death is not your fault. This is an outcome we all would have wanted to prevent, and no one action, conversation or interaction is what caused this.”</p> <p>“We can’t always predict someone else’s behavior. Especially when many of us are able to hide distress.”</p>
Promote Help-Seeking	Say
<p>Advise residents to seek help from a trusted mentor or mental health professional if they or a friend are feeling depressed.</p> <p>Communicate that we don’t need to wait for a crisis — early help seeking is a sign of strength. If residents have thoughts of self-harm, encourage them to call or text 988 to connect with the 988 Suicide & Crisis Lifeline, text TALK to the Crisis Text Line at 741-741, go to the emergency room, or call 911.</p>	<p>“We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried or depressed or had thoughts of suicide?”</p> <p>“There are effective treatments to help people who have mental health struggles or substance use problems. Suicide is never the right answer.”</p> <p>“This is an important time for all in our community to support and look out for one another. If you are concerned about a friend or colleague, you need to be sure to tell someone.”</p> <p>“Whether you get help from recommended resources or others, the important thing is to get help when you need it.”</p>

Encourage Hard Conversations	Say
<p>People have been conditioned to be afraid of conversations about suicide. However, talking about suicide does not increase a person's risk for dying by suicide. Although these conversations are difficult and may feel intrusive, they are very important, especially if you observe behaviors or signs that worry you.</p>	<p>"I've noticed [INSERT CONCERNING BEHAVIOR]. I'd like to understand more about what you're going through. Can you tell me more?"</p> <p>"Sometimes when people are going through what you're going through, they find themselves in unimaginable pain. Thoughts like, 'I wish I could go to bed and not wake up in the morning' enter their mind because their pain has exceeded their ability to cope. Do you ever feel like that?"</p> <p>"Sometimes when emotional pain is so intense, people think about suicide. I'm wondering how many times suicide might have crossed your mind, even if just fleeting in nature."</p>

Appendix E:

Sample Scripts for Face-to-Face or Virtual Communication

Death Ruled a Suicide

It is with great sadness that I have to tell you that one of our residents, **[NAME]**, has died by suicide. All of us want you to know that we are here to help you in any way we can. (Provide a few moments for acute reactions of residents, which may include gasps, loud crying etc. as some residents may react very strongly to the news.)

A suicide death presents us with many questions that we may not be able to answer right away. Rumors may begin to circulate, and we ask that you not spread rumors you may hear. We'll do our best to give you accurate information as it becomes known to us.

Suicide is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness.

Sometimes these risk factors are not identified or noticed; in other cases, a person will show obvious changes or warning signs. One thing is certain: there is support and treatments that can help. Even when crisis occurs, suicide isn't the solution.

Each of us will react to **[NAME]**'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known **[NAME]** very well and may not be as affected, while others may experience a great deal of sadness whether you knew him/her well or not. Some of you may find you're having difficulty concentrating, and others may find that diving into your work is a good distraction.

We have mental health professionals available to help us with this sad loss and to enable us to understand more about suicide. If you'd like to talk to a counselor, these are the contacts. **[INSERT CONTACTS HERE]**

Sometimes when we are confronted by the death of a colleague, we feel responsible. We wonder if there was "something that we missed." First, remember, that **[NAME]** was a colleague, a friend, and that was not your patient. No one has the ability to predict imminent suicide. We do know that talk saves lives. If your gut instinct tells you something is different about a fellow resident's behavior, just engage in a caring conversation and listen to their thoughts; if you are concerned, encourage them to seek help and consider letting **[NAME OF APPROPRIATE LOCAL PERSON]** know. This video produced in association with the AFSP provides some real life examples of how to broach this topic. [YOUTUBE.COM/WATCH?V=I9GRXF9QEBA](https://www.youtube.com/watch?v=I9GRXF9QEBA)

This is a time to take a moment to be together, to remember **[NAME]** in our grief, and to support one another. Please remember that we are all here for you.

Cause of Death is Unconfirmed

It is with great sadness that I have to tell you that one of our residents, **[NAME]**, has died. All of us want you to know that we are here to help you in any way we can. (Provide a few moments for acute reactions of residents, which may include gasps, loud crying etc. as some residents may react very strongly to the news.)

The cause of death has not yet been determined by the authorities. We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask you only share information known to be factual since inaccurate information can be hurtful to those coping with this loss. Please also be mindful of the use of social media in discussing this event. We'll do our best to give you accurate information as it becomes known to us.

Each of us will react to [NAME]'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known [NAME] very well and may not be as affected, while others may experience a great deal of sadness whether you knew him/her or not. All types of emotions are common following the loss of someone you know — sadness, confusion, guilt, anger, numbness. Some of you may find you're having difficulty concentrating, and others may find that diving into your work is a good distraction.

We have counselors available to help our community deal with this sad loss and to enable us to understand more about suicide. If you'd like to talk to a counselor, just let us know.

Sometimes when we are confronted by the death of a colleague, we feel responsible. We wonder if there was "something that we missed." First, remember, that [NAME] was a colleague, a friend, and that was not your patient. No one has the ability to predict death. We do know that talk saves lives. If your gut instinct tells you something is different about a fellow resident's behavior, have a conversation with them. If you are concerned, encourage them to seek help and consider letting [NAME OF APPROPRIATE LOCAL PERSON] know.

This is a time to take a moment to be together, to remember [NAME] in our grief, and to support one another. Please remember that we are all here for you.

Cause of Death May Not be Disclosed

It is with great sadness that I have to tell you that one of our residents, [NAME], has died. All of us want you to know that we are here to help you in any way we can. (Provide a few moments for acute reactions of residents, which may include gasps, loud crying etc. as some residents may react very strongly to the news.)

The family has requested that information about the cause of death not be shared at this time.

We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask that you only share information known to be factual since inaccurate information can be hurtful to those coping with this loss. We'll do our best to give you accurate information as it becomes known to us.

Since the subject has been raised, we do want to take this opportunity to remind you that suicide, when it does occur, is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness.

Sometimes these risk factors are not identified or noticed; in other cases a person with a disorder will show obvious changes or warning signs. One thing is certain: there are treatments that can help. Suicide should never be an option.

Each of us will react to [NAME]'s death in our own way, and we need to be respectful of each other. Feeling sad, upset, confused, angry, or numb are normal responses to loss. Some of you may not have known [NAME] very well and may not be as affected, while others may experience a great deal of sadness whether you knew him/her or not. Some of you may find you're having difficulty concentrating, and others may find that diving into your work is a good distraction. We have counselors available to help us deal with this sad loss. If you'd like to talk to a counselor, just let us know.

Sometimes when we are confronted by the death of a colleague, we feel responsible. We wonder if there was “something that we missed.” First, remember, that [NAME] was a colleague, a friend, and that [NAME] was not your patient. No one has the ability to predict death. We do know that talk saves lives. If your gut instinct tells you something is different about a fellow resident’s behavior, have a conversation and listen to them, and if you are concerned encourage them to seek help and consider letting [NAME OF APPROPRIATE LOCAL PERSON] know. This video produced in association with the AFSP provides some real life examples of how to broach this topic: [YOUTUBE.COM/WATCH?V=I9GRXF9QEBA](https://www.youtube.com/watch?v=I9GRXF9QEBA).

This is a time to take a moment to be together, to remember [NAME] in our grief, and to support one another. Please remember that we are all here for you.

Appendix F:

Sample Email Death Notifications

Sample Email Death Notifications for On-Site Residents, Preceptors, and Staff

To be sent by email with subject “Sad News”.

An email announcement should be sent to members of the surrounding pharmacy community (e.g., institutional leadership and pharmacy staff at the deceased resident’s program), the deceased resident’s preceptors and mentors, preceptors in the local community (as applicable). A follow-up email can be sent later with details regarding the obituary, address of emergency contact person (if released, see above) and funeral/memorial service information (if applicable). Remember that the same approach should be used in other types of death.

Death Ruled a Suicide

I am writing with great sadness to inform you that one of our pharmacy residents, [NAME], has died. Dr. [NAME] was a post-graduate [YEAR 1 RESIDENT/YEAR 2 RESIDENT] in the [TRAINING PROGRAM] at [HOSPITAL]. [HE/SHE] was a graduate of [COLLEGE OF PHARMACY] in [YEAR]. Our thoughts and sympathies are with [HIS/HER] family and friends and the Department of Pharmacy at [HOSPITAL].

All available residents were given the news of the death today. The cause of death was suicide. We want to take this opportunity to remind our community that suicide is a very complicated act. It is usually the culmination of several health and life factors that converge in a person’s life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and physical pain, anguish, and hopelessness. Sometimes these risk factors and warning signs are not identified or noticed; other times, a person who is struggling will show more obvious symptoms or signs.

Resources for support and mental health care are listed below. We encourage any community members to seek the help they need. It is a time to come together, to grieve, and to support each other.

(As applicable depending on emergency contact person preference) Information about a remembrance service will be shared as it becomes available.)

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[CRISIS RESPONSE TEAM LEADER OR RPD]

Cause of Death is Unconfirmed

I am writing with great sadness to inform you that one of our pharmacy residents, [NAME], has died. Dr. [NAME] was a post-graduate [YEAR 1 RESIDENT/YEAR 2 RESIDENT] in the [TRAINING PROGRAM] at [HOSPITAL]. [HE/SHE] was a graduate of [COLLEGE OF PHARMACY] in [YEAR]. Our thoughts and sympathies are with [HIS/HER] family and friends and the Department of Pharmacy at [HOSPITAL].

All available residents were given the news of the death today. The cause of death has not yet been determined by the authorities. We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask you to respond to any speculations as to the cause of death with a reminder that this is not yet clear. We'll do our best to give you accurate information as it becomes known to us.

Since the subject has been raised, we want to take this opportunity to remind our community that suicide, when it does occur, is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors are not identified or noticed; other times, a person who is struggling will show more obvious symptoms or signs.

Resources for support and mental health care are listed below. We encourage any community members to seek the help they need. It is a time to come together, to grieve, and to support each other.

(As applicable depending on emergency contact person preference) Information about a remembrance service will be shared as it becomes available.)

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[CRISIS RESPONSE TEAM LEADER OR RPD]

Cause of Death May Not be Disclosed

I am writing with great sadness to inform you that one of our pharmacy residents, [NAME], has died. Dr. [NAME] was a post-graduate [YEAR 1 RESIDENT/YEAR 2 RESIDENT] in the [TRAINING PROGRAM] at [HOSPITAL]. [HE/SHE] was a graduate of [COLLEGE OF PHARMACY] in [YEAR]. Our thoughts and sympathies are with [HIS/HER] family and friends and the Department of Pharmacy at [HOSPITAL].

All available residents were given the news of the death today. The family has requested that information about the cause of death not be shared at this time. We are aware that there has been speculation that this may have been a suicide. Since the subject has been raised, we want to take this opportunity to remind our community that suicide, when it does occur, is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors are not identified or noticed; other times, a person who is struggling will show more obvious symptoms or signs.

Resources for support and mental health care are listed below. We encourage any community members to seek the help they need. It is a time to come together, to grieve, and to support each other.

(As applicable depending on emergency contact person preference) Information about a remembrance service will be shared as it becomes available.)

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[CRISIS RESPONSE TEAM LEADER OR RPD]

Sample Email Death Notification for Pharmacy Leadership, Residency Program Directors, and Preceptors in Other Rotational Sites

Refer to the emails above in addressing whether the cause of death is known and if the family wishes it to be shared. The email to the rest of the training programs should come from the RPD.

I am writing with great sadness to inform you that one of our pharmacy residents, [NAME], has died. Dr. [NAME] was a post-graduate [YEAR 1 RESIDENT/YEAR 2 RESIDENT] in the [TRAINING PROGRAM] at [HOSPITAL]. [HE/SHE] was a graduate of [COLLEGE OF PHARMACY] in [YEAR]. Our thoughts and sympathies are with [HIS/HER] family and friends and the pharmacy residency community.

All available residents were given the news of the death today. The cause of death was suicide. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors and warning signs are not identified or noticed; other times, a person who is struggling will show obvious symptoms or signs.

Please speak with your residents about this sad news and the supports which are available to them. Consider if you have any student pharmacists rotating at your institution or residents who may be at risk and reach out to them individually. Please notify me of any concerning behavior by a trainee.

Resources for support and mental health care are listed below. We encourage any community members to seek the help they need. It is a time to come together, to grieve, and to support each other. [INSERT CONTACTS HERE]

(As applicable depending on emergency contact person preference) Information about a remembrance service will be shared as it becomes available.

Please do not hesitate to contact me at with any questions or concerns.

Sincerely,

[RPD]

[CONTACT INFORMATION]

Appendix G:

Memorial Service Planning Checklist

In consultation with the family, the following details may be considered:

	Who?	When?	Notes/Completed
Name and date of remembrance			
Location			
Order flowers			
Obtain a sign-in book for family to keep			
Framed picture of resident to place on easel			
Furniture needs			
How many chairs are needed			
Tables to display pictures and belongings			
Coat racks			
Tissues			
Basket to collect cards			
Catering and room reserved			
Organization: How will the program run?			
Will there be a master of ceremonies?			
Will any preceptors or staff speak?			
Which resident(s) will speak? Open microphone?			
Does the family want/feel comfortable speaking?			
Music and/or slideshow			
What music will be playing when guests arrive? Are residents/staff able to play piano at opening, during service, and after?			
Will a slide show be put together to run with pictures while people are arriving or as part of the memorial?			
Video — Does the family want it videotaped?			
What audiovisual equipment is needed?			
Program: Who will design program for memorial?			
Support: Will counselors be on hand to support guests?			

Appendix H:

Sample Media Statement

It may be necessary to proactively or upon request provide a statement to local media outlets. Such statements will likely need to be reviewed by the institution's communication and legal team. In some states, there may be a state law regarding discussing cause of death. A sample script is below:

We were informed by the coroner's office that a [AGE] year-old pharmacy resident at [LOCATION] has died. The cause of death was suicide.

OR

We were informed by the coroner's office that [NAME], a [AGE] year-old pharmacy resident at [LOCATION] has died unexpectedly. Dr. [NAME] was a post-graduate [YEAR 1 RESIDENT/YEAR 2 RESIDENT/FELLOW] in the [TRAINING PROGRAM] at [HOSPITAL]. [NAME] was a graduate of [COLLEGE] in [YEAR] and [COLLEGE OF PHARMACY] in [YEAR].

Our thoughts and support go out to [HIS/HER] family and friends at this difficult time.

Trained crisis counselors will be available to meet with residents, faculty, and staff starting tomorrow and continuing over the next few weeks as needed.

*Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can increase the risk of suicide contagion ("copycat" suicides), particularly among youth. Media are strongly encouraged to refer to the document *Reporting on Suicide: Recommendations for the Media*, which is available at afsp.org/media.*

Media Contact

NAME:

TITLE:

INSTITUTION:

PHONE:

EMAIL ADDRESS:

Appendix I:

Key Messages for Media Spokesperson

For use when fielding media inquiries.

Suicide/Mental Illness

- Suicide is one of our nation's leading, yet preventable, causes of death
- As a leading cause of death in the United States, we must invest in research and prevention at a level commensurate with suicide's toll on our nation
- The risk of suicide increases when several health factors and life stressors converge at the same time in a person's life
- Multiple risk factors and protective factors interact in a dynamic way over time, affecting a person's risk for suicide; this means there are ways to decrease a person's risk, once you learn which modifiable risk factors are pertinent in a particular person's life (getting depression treated and well managed, limiting use of alcohol, particularly during times of crisis, developing healthy boundaries in relationships, limiting exposure to toxic people, developing healthy self-expectations and accepting imperfection as a part of life, etc.)
- We are learning how to connect the dots and notice warning signs, to detect when people are at increased risk — suicide is generally preventable
- Depression and other mental health problems are the leading risk factors for suicide
- Depression is among the most treatable of all mood disorders; more than three-fourths of people with depression respond positively to treatment
- The best way to prevent suicide is through early detection, diagnosis, and vigorous treatment of depression and other mental health conditions, including substance use problems

Residency Program/Hospital Response Messages

- We are saddened by the death of one of our residents. Our hearts, thoughts, and prayers go out to **[HIS/HER]** family and friends, and the entire community.
- We will be offering grief counseling for residents and staff starting on **[DATE]** through **[DATE]**

Residency Program/Hospital Response to Media

- Media are strongly encouraged to refer to the document Reporting on Suicide: Recommendations for the Media, which is available at [AFSP.ORG/MEDIA](https://www.afsp.org/media)
- Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion ("copycat" suicides)
- Media coverage that details the location and manner of suicide with photos or video increases risk of contagion

- Media should avoid oversimplifying the cause of suicide (e.g., don't say "resident took his/her own life after breakup with significant other"); this gives people a simplistic understanding of a very complicated issue, and doesn't allow for learning about the many risk factors that can be points for intervention
- Instead, remind the public that more than 90% of people who die by suicide have an underlying mental health condition such as depression, and that mental health can be managed and optimized like any other aspect of health
- Media should include links to or information about helpful resources such as local mental health resources, such as the 988 Suicide & Crisis Lifeline (call/text 988 or chat [988LIFELINE.ORG](https://988lifeline.org)) and the Crisis Text Line (text TALK to 741-741)

Glossary

Anxiety: an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure; people with anxiety disorders usually have recurring intrusive thoughts or concerns, may avoid certain situations out of worry, and may also have physical symptoms such as sweating, trembling, dizziness, or a rapid heartbeat

At-Risk: a person who is (or is believed to be) thinking about suicide or prone to suicidal behavior (also *suicide risk*)

Bipolar Disorder: a mental health condition characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes

Burnout: a syndrome characterized by high emotional exhaustion, high depersonalization (e.g., cynicism), and a low sense of personal accomplishment

Conjecture: an opinion or inference formed on the basis of incomplete information without proof or sufficient evidence

Community: a group of people residing in the same locality or sharing common interests, attitudes, and values

Comorbid: the co-occurrence of two or more disorders in an individual

Coping: the use of cognitive and behavioral strategies to manage the demands of a situation that are considered to be taxing or exceeding one's resources or to reduce the negative emotions and conflict caused by stress

Coping Strategies: an action, series of actions, or thought process used in meeting a stressful or unpleasant situation or in modifying one's reaction to such a situation; coping strategies typically involve a conscious and direct approach to problems (in contrast to defense mechanisms)

Crisis: a situation (e.g., a traumatic change such as a death by suicide) that produces significant cognitive or emotional stress in those involved and can reduce the information-processing capacities of those affected

Crisis Management: the organization and mobilization of resources to overcome the difficulties presented by a sudden and unexpected threat or event, such as a death by suicide

Crisis Response: the range of advance planning and actions taken to address disasters, crises, critical incidents, and tragic events (including a death by suicide) to reduce or mitigate further harm or distress to those affected

Crisis Response Communication Plan: a set of steps to take when a crisis (such as a death by suicide) first emerges, including guidance for managing the situation, communicating about the crisis, providing opportunities for grief support, helping those affected cope with their feelings, and minimizing the risk of suicide contagion

Crisis Response Team: a group of individuals trained to implement the critical aspects of crisis management in the aftermath of a traumatic incident such as a death by suicide, including communication, support of the community, and prevention of contagion

Depression: a negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, despair, pessimism, and despondency, that lasts more than days and interferes with the activities of daily life; depression can cause various physical and cognitive symptoms or social changes such as pain, weight loss or gain, sleeping pattern disruptions, lack of energy or motivation, difficulty concentrating or making decisions, and/or withdrawal from social activities

Disorder: see *Mental Health Condition*

Distress: a negative emotional state or stress response that results from being overwhelmed by demands, losses, or perceived threats; the specific quality of the emotion may be unspecified or unidentifiable

Emotional Turmoil: a negative mental state involving feelings of panic, confusion and agitation

Grief: the anguish experienced after significant loss, usually the death of a beloved person, that is distinguished from bereavement and mourning; grief may or may not be given public expression and often includes physiological distress, separation anxiety, confusion, yearning, obsessive dwelling on the past, and apprehension about the future; grief may also take the form of regret for something lost, remorse for something done/not done, or sorrow for a mishap

Grief Support: resources (e.g., support groups, publications, etc.) to help survivors of suicide loss

Intervention: a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing medications for mood disorders or strengthening social support in a community)

Mental Health: the capacity of an individual to establish constructive relationships with others and the environment in ways that promote subjective well-being and foster optimal development and use of mental abilities (cognitive, affective and relational) to cope with the ordinary demands and stresses of life

Mental Health Condition: any condition characterized by cognitive and emotional disturbances, abnormal behaviors, impaired functioning, or any combination of these; such disorders cannot be accounted for solely by environmental circumstances and may involve physiological, genetic, chemical, social, and other factors (also *disorder*)

Mental Health Problem: diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met (also *mental health issue*; *mental health struggle*)

Mental Health Professional: a healthcare practitioner who is certified to provide mental health services for the purpose of improving an individual's mental health or to treat mental health problems either independently or as part of a treatment team (also *mental health personnel*; *mental health provider*)

Mental Health Services: any interventions—assessment, diagnosis, treatment, or counseling—offered in private, public, inpatient, or outpatient settings for the maintenance or enhancement of mental health or the treatment of mental or behavioral disorders in individual and group contexts

Method (of suicide): action or technique which results in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping)

Post-Traumatic stress disorder (PTSD): a disorder that may result when an individual lives through or witnesses an event in which he or she believes that there is a threat to life or physical integrity and safety and experiences fear, terror, or helplessness; symptoms are characterized by (a) reexperiencing the trauma in painful recollections, flashbacks, or recurrent dreams or nightmares; (b) avoidance of activities or places that recall the traumatic event, as well as diminished responsiveness (emotional anesthesia or numbing), with disinterest in significant activities and with feelings of detachment and estrangement from others; and (c) chronic physiological arousal, leading to such symptoms as an exaggerated startle response, disturbed sleep, difficulty in concentrating or remembering, and guilt about surviving the trauma when others did not

Postvention: a strategy or approach that is implemented after a crisis or traumatic event has occurred

Prevention: a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors

Psychosis: a mental health condition involving significant disconnection from reality and characterized by serious impairments or disruptions in the most fundamental higher brain functions—perception, cognition and cognitive processing, and emotions or affect—as manifested in behavioral phenomena, such as delusions, hallucinations, and significantly disorganized speech

Resilience: the ability of an individual, organization, community, or system to withstand, adapt, recover, rebound, or grow from adversity, stress, or trauma

Risk Factor: a factor that makes it more likely that an individual will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment

Safe Messaging (about suicide): the conscious avoidance of potentially harmful language when sharing information about suicide

Self-care: the practice of taking action to preserve or improve one's own health that can be managed without the assistance of others

Self-harm: the various methods by which individuals injure themselves, such as self-cutting, self-battering, taking overdoses or exhibiting deliberate recklessness

Stigma: negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency. A stigma implies social disapproval and can lead unfairly to discrimination against and exclusion of the individual

Stress: the physiological or psychological response to internal or external stressors that influence how people feel and behave; it may be manifested by palpitations, sweating, dry mouth, shortness of breath, fidgeting, accelerated speech, augmentation of negative emotions (if already being experienced), and longer duration of stress fatigue

Substance Abuse: A maladaptive pattern of compulsive substance use marked by recurrent significant social, occupational, legal, or interpersonal adverse consequences, such as repeated absences from work or school, arrests, and marital difficulties

Suicidal Behavior: a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide

Suicidal Crisis: a situation in which suicide is threatened or attempted

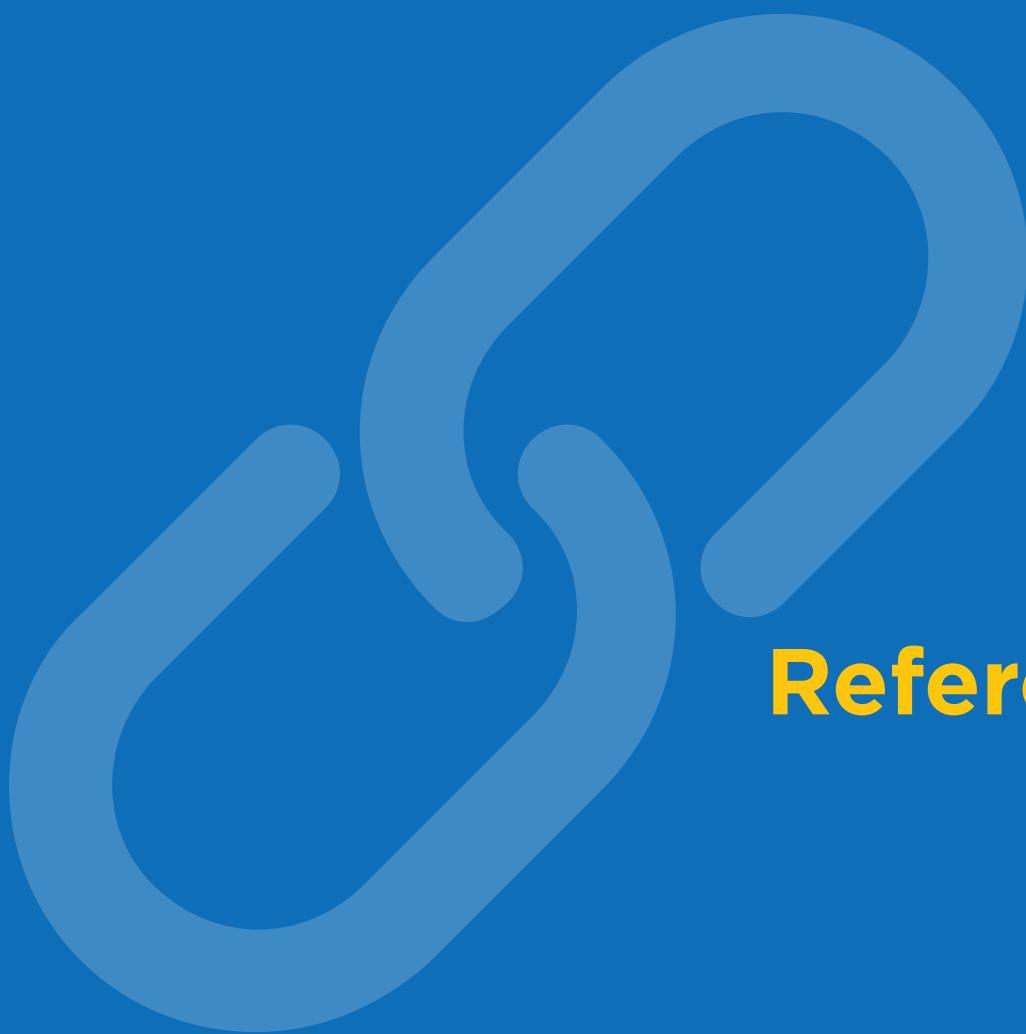
Suicidal Thoughts/Ideation: self-reported thoughts of engaging in suicide-related behavior

Suicide: death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death

Suicide Contagion: a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts

Suicide Risk: see *At-Risk*

Well-Being: a state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook, or good quality of life; professional well-being includes being satisfied with one's job, finding meaning in work, feeling engaged at work, having a high-quality working life, and finding professional fulfillment in work



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