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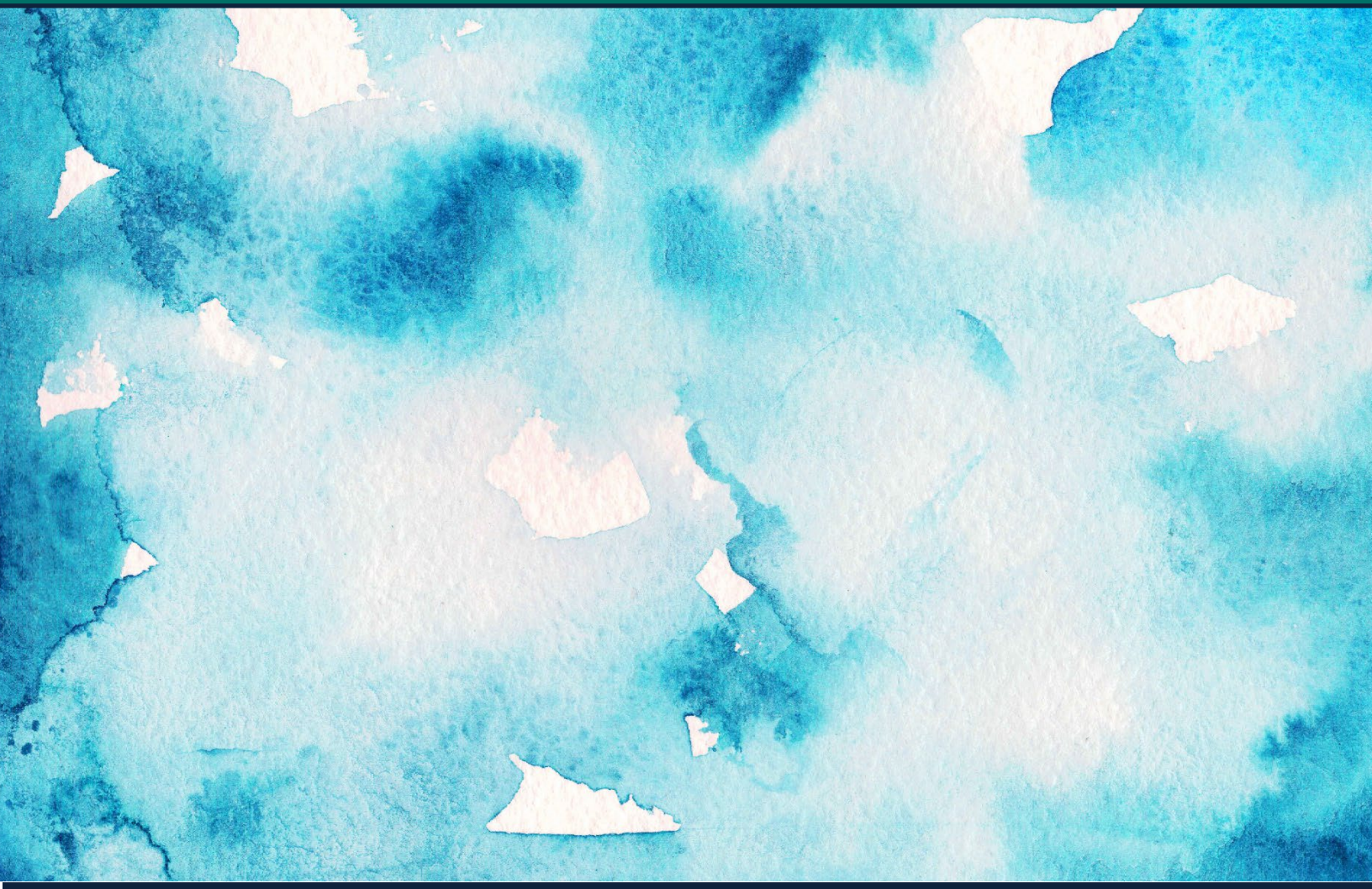

Suicide Review Teams

Guiding Principles & Best Practices

Suicide Review Teams

Released July 2023

Guiding Principles & Best Practices

Purpose

The purpose of this reference manual is to establish and standardize the best practices and guiding principles for local suicide review teams (SRT). This guidebook was developed with input from multiple suicide review teams, representative of a diverse set of communities across Wisconsin in winter 2023.

Acknowledgements

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Overview

What is a suicide review team?

A suicide review team is a group of local multi-disciplinary organizational representatives who come together to discuss risk factors and circumstances surrounding a death by suicide in order to recommend local prevention strategies. Suicide review is intended to be a "deep dive" of a suicide case, using all available data and information to understand the factors that preceded the death by suicide.

Purpose: To improve our understanding of how and why a person dies by suicide, to develop recommendations to improve our response to suicide deaths and develop prevention initiatives to take action to improve the health and safety of our community.

Goal: To explore missed opportunities for intervention and enhance the community's ability to respond to prevent future suicide deaths.

Suicide Review Team Objectives

- Identify and evaluate the prevalence of risk factors for suicides.
- Promote collaboration between community agencies.
- Educate the public, policy makers, and budget authorities about fatalities involving suicides.
- Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being of those considering suicide in your community.
- Develop and disseminate an annual report describing any trends, risk factors, or patterns of suicide deaths, along with any recommendations for changes in law, policy, or practice that will prevent future deaths by suicide.

Establishing a Suicide Review Team

The process to establish a suicide review team can vary across communities and agencies. Individuals deciding whether to establish a suicide review team should consider the following steps to determine readiness and ability to create and sustain a review team. In-depth information on meeting mechanics will be described within the next section.

- **Step 1: Questions to answer before the first meeting:**
  - Who will be the chairperson? What will their duties be? (i.e., create reports, gather and input data, put agenda together, lead the meeting, take minutes, or will these duties be divided among team members?)

- What date and time will the review team meet? How often will the team meet (monthly, bimonthly, quarterly)? How long will the meetings be? How will the meetings be documented?
- Where will the meeting be held? Will it be held in-person or virtually? Will it be at the same place each time or will the location be rotated? Will refreshments, snacks, or lunch be provided? Who should be invited to the meeting? Will you have team members RSVP to the meeting? For on-line registration, consider using a free online form builder like www.jotform.com or www.eventbrite.com. You can post the link in a meeting reminder e-mail.
- How many cases will be reviewed at each meeting? Which suicides do you want to review? Where will you find cases? What ages will be covered?
- Do you have a confidentiality agreement? Will legal counsel need to review and approve it?
- How long will the process of obtaining agreements of confidentiality process take?

- **STEP 2:** Where can information be gathered to prepare case summaries for the review?
  - Autopsy, toxicology report, death certificates, and scene investigation (from the medical examiner's office)
  - Obituary (if available)—found in the local paper or from www.legacy.com
  - Criminal record reports—utilize local inmate search through Sheriff's Department or State database (WI CCAP)
  - Social media (Facebook, Twitter, Instagram, etc.). This may provide some insight into the thought process of the decedent at time of death
  - Case summary to include:
    - Demographic information – Name, date of birth, age, date of death, gender, race
    - Cause of death—determined by the Medical Examiner or Coroner's office
    - Manner of death—determined by the Medical Examiner or Coroner's office
    - Treatment by first responders or emergency room
    - Date death was pronounced

Potential Team Members

Core Members:

- Medical Examiner/ Coroner's office
- Law enforcement
- EMS/Fire department
- County Human Services
- Hospital system(s)
- District Attorney's Office
- Department of Corrections
- Social workers
- Public or tribal health department
- Community agencies
- Mental health professionals
- Individuals with lived experience
- Tribal leader
- Suicide prevention advocates

Ad Hoc Members

Dependent on who has additional information on decedent.

- Schools/Colleges
- Clergy
- Crisis response
- Pharmacist/toxicologist
- Pain management clinician
- Housing authority
- Community resource specialists

        - Biopsychosocial history of decedent
            - Medical history
            - Social history
            - Criminal history
        - Autopsy report – includes final diagnoses and toxicology screen (if available)
- **STEP 3:** What does the agenda include for the review meeting?
    - Introductions, updates and information sharing with review team members
    - Review confidentiality guidelines and expectations
    - Discussion of current suicide statistics and trends in the review team jurisdiction
    - Review cases based on how often meetings take place and for what length of time
    - Team debrief or self-care activity
    - Next meeting date, time, and location
- **STEP 4:** What information will be documented at and after the review?
    - Sign in sheet
    - Confidentiality agreements
    - Answer these three questions as you conduct your review:
        - **Why suicide? Why this method? Why now?**
        - What steps could have been taken or where were the touch points that may have prevented this death?
        - What prevention recommendations can we make? Do we have enough information to make recommendations? If not, what information is still needed and from whom?
    - Document your findings from the review. *See data entry on page 22.*
    - Decide which database will best suit your community's needs for tracking findings and recommendations. *See Using SRT Review Information for Prevention, page 25.*
    - De-identify all information, maintain confidentiality, and keep the chosen database password protected and limit access.

Team Member Responsibilities

Before agreeing to be a part of the suicide review team, each member should consider the responsibilities and time commitment required. Teams may choose to formalize these responsibilities within a member letter of commitment, memorandum of understanding, or similar document. It also may be beneficial to review these periodically and make changes as the team grows or new members join to ensure participation is mutually beneficial.

Responsibilities of Core & Ad Hoc Members

- Treat the decedent with dignity, including the use of suicide safe language (e.g., "die by suicide" versus "commit suicide"). *For additional information, see Appendix page 47.*
- Engage in any virtual communication (e.g. via email) when necessary
- Maintain up-to-date confidentiality agreements and memoranda of understanding
- Contribute relevant information about the decedent from agency records, as permitted
- Serve as a liaison to the organization or colleagues in the field
- Provide definitions of professional terminology to increase knowledge and skills of review team members
- Interpret and explain agency procedures and policies
- Explain the legal responsibilities or limitations of member's profession as it pertains to suicide and suicide prevention strategies and interventions
- Support and promote recommendations created by the team that are relevant to you or your organization

Responsibilities of Coordinator/Facilitator

- Research and learn about facilitation best practices including leading in-person and virtual meetings
- Ensure the team operates according to the guidelines adopted by the team by setting clear expectations for yourself and team members, including:
    - Attend each meeting if the decedent interacted with your agency
    - Be respectful of the decedent
    - Maintain confidentiality
    - Come prepared with information to share at each meeting

- Prepare for meeting
    - Schedule and set agenda for meetings
    - Send meeting notices
    - Send cases to be reviewed and meeting agenda with time to collect data (e.g. 1-2 weeks prior, or as agreed upon by members)
    - Prepare PowerPoint or other method to move through agenda
- Lead meetings and preserve professional decorum
    - Outline the process of the meeting
    - Maintain accurate and relevant goals for the review team
    - Ensure all attendees sign or adhere to the confidentiality agreement
    - Identify members who will take notes and track prevention recommendations
- Ensure identified tasks or next steps are completed after the review meeting
    - Ensure the case report is entered into the chosen database in a timely manner (e.g., within one month of the review, or as required by a funding or reporting agency)
    - Share recommendations made to team members and track progress towards goals. *See Using SRT Review Information for Prevention section, page 25.*

Case Review Selection

Selecting cases for suicide review meetings will depend on a couple of factors.

However, your team chooses to select cases, it is important to provide your review team members with an opportunity to review these cases prior to the suicide review meeting. This allows members the chance to familiarize themselves with the details of each case, and to come to the meeting prepared with additional information or questions. Based on existing review teams, below are two of the most common factors that influence how cases are selected.

Access to Cases

First, depending on the level of involvement of the local Medical Examiner/Coroner office, teams may not have access to data on every suicide that occurs in the community. This may be part of the recommendations or initial action plan when establishing a review team.

Second, particularly in smaller communities, suicides may be an uncommon event, and therefore there are few cases to select for review each year. In this case, your team may choose to review every suicide that occurs in your community and meet on an ad-hoc basis as suicides occur versus maintaining a regular schedule.

In larger communities, it may not be possible to review every suicide that occurs. In this situation, case selection could occur in a couple of ways. Your team could select to review the most recent suicides that have occurred, or you may choose to wait to review suicides until all the relevant information is available to the team (e.g., toxicology data, which can take several weeks to be finalized).

Thematic Review

Another approach to consider is reviewing cases that illustrate a theme to maximize resources around potential prevention strategies. An example of this thematic approach to suicide review is grouping cases in which the decedents were experiencing legal issues preceding their death by suicide. By selecting this theme, review team members may identify prevention recommendations specific to the criminal justice system as a result of the conversations that take place in the meeting. Additionally, invites can be sent to specific partners who may not be currently engaged in the review team but can contribute their expertise to the process.

Meeting Process

Once a suicide review team has been determined to be possible and desired in a community leadership needs to identify the process in which the meetings will held, including before, during, and after the event.

Creating a Case List

As previously noted, case selection will depend on suicides that occur in the community, but it is strongly recommended to wait to review cases until all relevant information is available. Toxicology, for example, is often a key piece of information that is helpful to suicide review, but toxicology results can take several weeks to be finalized. Additionally, certain death investigations may take longer time to complete. Review team facilitators should check with law enforcement partners, district attorney, and/or the medical examiner/coroner's office to ensure that death investigation has been completed prior to placing the descendent an upcoming agenda.

Based on previous experience, a good rule of thumb is to hold 30 to 45 minutes per case, so review teams can plan accordingly based on the amount of time scheduled for each meeting. This is generally enough time to present the available data on the case and discuss the circumstances of the case, as well as to propose new and review previously identified prevention recommendations. Depending on the other items on the agenda and the time allowed for the meeting, most teams review one to two cases per meeting.

Scheduling Meetings

Frequency of review teams will depend on how prevalent suicides are in the community, as well as the availability of review team members. Larger communities with a higher prevalence of suicide may choose to meet more frequently to review as many cases as possible. Smaller communities with one or two suicides per year may choose to meet only as needed. Capacity to actively participate in review team meetings by also impact meeting frequency and contribute to what date/times work best for most. Be mindful that stakeholders may be involved in several types of fatality reviews, such as child death or overdose fatality review teams, consider scheduling suicide review meetings to precede, follow, or alternate with the other fatality review meetings could help increase participation.

Another consideration related to scheduling meetings is to schedule at a time when members are more likely to have a natural break after the meeting, such as at the end of the day or leading up to traditional lunch breaks. Suicide review can be a mentally and emotionally taxing task, by being intention when the meetings are scheduled this can help ensure that team members have an opportunity to take a break and process the meeting before moving on to their next task. Review teams can also include time for a debrief or self-care activity within the meeting agenda. *See the Self-Care & SRT Debrief section, page 28.*

Maintaining Confidentiality & Agreements

Confidentiality is critical for death review teams. Wisconsin State Statutes allow for suicide reviews to remain confidential and be exempt from open meeting law, but steps need to be taken before, during, and after the review meetings.

Public statements may be made in the form of a recommendation without any identifying information that may reveal about whom it is speaking. Respect for the decedent and their families while sharing historical context and circumstances contributes to the review process.

Obtaining a confidentiality agreement from all members can be done in a variety of ways. For example, at the beginning of each meeting, a confidentiality statement can be read or shown to all present. All members should provide agreement in whatever means is appropriate for the meeting setting (e.g., if a meeting is held in person, members can indicate agreement by raising their hand, and if a meeting is held virtually, members can indicate agreement by noting it in the chat or upon registering for the event).

The purpose of suicide review is to conduct a thorough review of suicides in Milwaukee to better understand the circumstances and risk factors and to take actionable steps to prevent future deaths.

The Right of Confidentiality will be respected by team members participating in the review process. Each agency representative is responsible for maintaining the confidentiality of the information shared and discussed as required by Wisconsin Law. In addition, each team member and invited guest is expected to comply with his or her professional ethics and refrain from sharing information outside of the suicide review process/meeting.
Team reviews are closed to the public and confidential information cannot be lawfully discussed unless the public is excluded. The disclosure of confidential information is permitted only to the extent allowed and or required by law and professional responsibilities.

As a Milwaukee Suicide Review Commission team member, I agree that I will not disclose or disseminate confidential information to which I gained access as a part of the case review process. I understand that I may be subject to civil or criminal penalties if I improperly release information obtained during the review process.
Dated February 15, 2023, the individuals who sign their names and agencies in the Zoom chat box agree to abide by the terms of this confidentiality agreement.

Example of confidentiality agreement shown to members during virtual meeting, provided by the Milwaukee Suicide Review Commission.

If applicable, a memorandum of understanding (MOU) could be developed to outline specific requirements for the review team and its members. A MOU is created to promote and protect public health and safety and allows review of data and facts available for a suicide death.

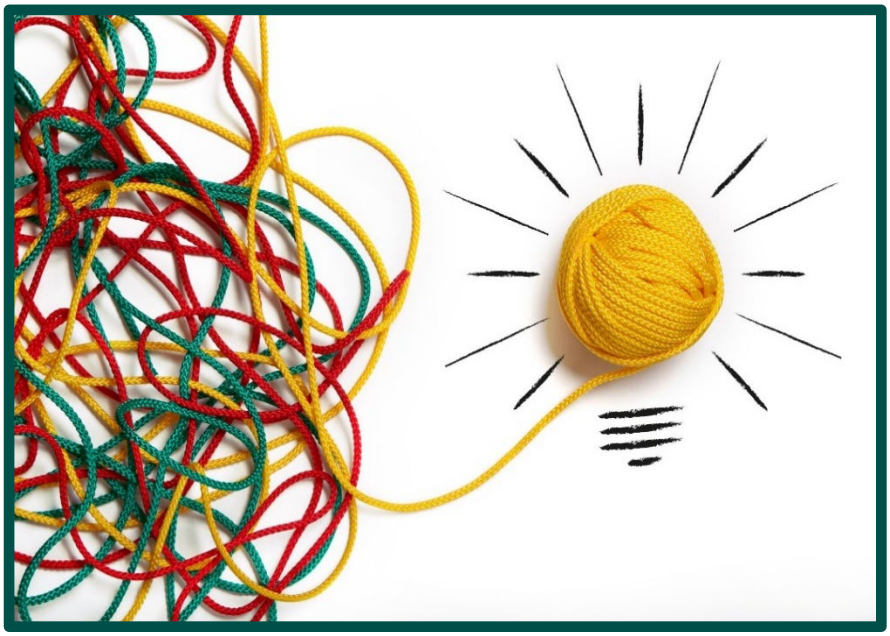
A MOU may include the following:

- Objectives of the group
  - Strengthen resources
  - Improve community understanding
  - Identify policy changes
  - Reduce stigma
  - Produce recommendations
  - Other objectives as appropriate
- Team members
  - Provide the facilitator with an updated roster every year of who is attending
- Confidentiality
  - All members agree to maintaining confidentiality in meetings
  - Maintain the understanding that no information should leave the meeting space
  - Understanding that each agency has their own confidentiality requirements that may prohibit them from sharing information, but as of 2/14/2023, there is legislation being introduced that will permit data sharing across agencies for the purpose of suicide review
- Termination of the agreement
  - Written notice 30 days prior to the suicide review team facilitator
- Authorized signatures
  - This agreement is made this DAY of MONTH, YEAR, between ORGANIZATION and members of the Suicide review team.
  - Section for a signature, title, date and email of an authorized signee and any other designees from the organization.

See Appendix for an example of a MOU on page 36-41.

Review Process

Suicide is a biopsychosocial health issue, and suicide review should follow a biopsychosocial format (Rodríguez-Otero, J. E. et al., 2022). That is, review teams should consider the **biological (physical), psychological, and social factors** that were present in the life of the decedent. It may be helpful to break the case review down into the following parts:



Physical Factors

Examples:

-Disability

-Chronic illnesses or pain

-Additional biological stressors

Psychological Factors

Examples:

-Mental health issues

-Substance misuse

-Previous suicidal behavior

Social Factors

Examples:

-School relationships

-Employment

-Legal issues

-Discrimination

By breaking down a suicide review in this manner is helpful to not only ensure that all facets of the case are considered, but to also consider prevention opportunities related to physical health, psychological health, and social functioning. Obtaining and discussing as much information prior, during, and following each review team meeting with this lens will help determine appropriate and comprehensive recommendations.

Information Gathering & Sharing

In preparing for a suicide review, teams will want to collect as much available data as possible that encompasses all of the biopsychosocial risk factors of the decedent(s). The Medical Examiner or Coroner's case report may be the initial, and sometimes only, information available for review, underscoring the importance of establishing that organizational relationship. However, there is a substantial amount of information that can be obtained via an internet search on platforms such as those listed to the right.

Potential Internet Sources to Add to Case Details

- Obituaries and tribute walls
- News articles
- GoFundMe's
- Court case information (if publicly available in your state)
- Social media profiles
  - Facebook
  - Instagram
  - Twitter
  - YouTube
  - LinkedIn
  - Tik Tok
  - Blogs (e.g., Tumblr)
  - Reddit

Tips for searching for publicly available data:

- If using a search engine, searching for the decedent's name as it is written on their death certificate may not yield results. If the decedent has a common name or if location services are turned off on the web browser, results may include an excessive number of pages and unrelated information. To avoid this, type in the full name and city and/or state of death to narrow down search results.
- If publicly available, search through the friends or followers/following on the decedent's social media profiles and look out for individuals with the same last name. Scanning through pictures and mentions/tags can also help to fill in knowledge gaps. Sometimes friends and family member profiles can reveal just as much, if not more, information of the decedent.
- If teams can find one social media profile but are struggling to find profiles on other platforms, try searching the username of the found profile on the other sites. For example, if you know a decedent uses the username @JDoe23 on Instagram, try searching for that username on Twitter. Similarly, friends and family members may use similar usernames across multiple platforms.

Obituaries

When searching for the decedent(s) background using a search engine, the obituary is likely to be one of the first results. Online obituaries may only contain funeral information and basic information (e.g., dates of birth and death), other times it can unveil much more including hobbies, experiences, and important relationships. Family members and friends may contribute public eulogies for the online obituary or tribute page for all to read. This information can be beneficial in painting a more complete picture of the decedent(s).

Other Sites

Other links that may appear in a search include news articles, GoFundMe pages, company or business websites, and other similar pages. News articles and GoFundMe's can give information on anything in that individual's life that may have been important or potentially traumatic. For example, the Milwaukee County Suicide Review Commission has found:

1) A news article describing a previous house fire during the winter holidays.
2) A GoFundMe set up by the family after the decedent's death indicative of financial struggles and other recent stressors.
3) A letter posted by an organization that connects prison inmates with pen pals in which the decedent spoke extensively about their physical and mental health struggles and previous suicide attempts.

In each of these circumstances, valuable information was shared with the group that otherwise would have been unknown and not factored into the decedent's background.

Social Media

Most social media platforms do not allow access to profiles or search engines if you are not logged into an account. For this reason, suicide review teams should be careful when conducting this search as to not like or otherwise make yourself known on anyone's accounts, especially if you view family members' or other loved ones' profiles as well.

It is recommended to search the name of the decedent in each platform's engine as social media profiles do not always come up in a general Internet search. Social media profiles can be powerful sources of information because of the anonymity and vulnerability people sometimes feel they have on these platforms. Evidence of suicidality may be evident in posts, messages, or comments prior to death.

Other pieces of information that may be extracted from a social media profile include:

1) Personal, local, or global events that may have been causing the decedent distress before their death.
2) Any increase or decrease in regular social media activity leading up to their death.

3) The type of language and rhetoric family members or friends were using with the decedent prior to their death.
4) Posts following their death (e.g., tribute posts).

Examples of information the Milwaukee County Suicide Review Commission have previously discovered via social media profiles include a tribute post from the decedent in honor of someone they had lost some time before their death, a sudden halt in social media activity in the months leading up to their death, and posts detailing mental health and their struggle with suicidal ideation over a long period of time.

Court Case Information

In Wisconsin, information on any person with records of criminal or civil charges or lawsuits in the state can be accessed by the public through an online search tool. This system, called the Consolidated Court Automation Programs (CCAP), is often the most valuable source of publicly available data. Information relating to the psychological or social factors in a decedent's life can be found within this or a similar system.

Examples of the information available on CCAP that may contribute to stressors or be points where interventions may have been missed include:

- History of or current eviction status
- History of or current divorce status
- Issuance of restraining order(s)
- Pending or history of criminal charges, such as an operating while intoxicated (OWI) violation, assault or domestic violence charge, or theft
- Court order to surrender firearms

YOUR MENTAL HEALTH MATTERS

An important thing to remember when mining for publicly available data is to pay attention to your own mental health. Especially when searching social media profiles, you are likely to come across pictures and videos of the decedent.

For some people, this may bring attention to the gravity of the situation. It is sometimes easier to forget the fact we are reviewing cases of real people when reading an investigative report; having a face and potentially voice to the name can be a stark reminder of that fact.

Know that it is normal to not have an emotional reaction when reading an initial report but have a multitude of feelings when faced with the image of the decedent (or vice versa).

Health Care Information

It is important to work with health care system partners to determine the feasibility of obtaining this information. Recruitment of review team members who have access and permissions to legally access medical records can be incredibly valuable to the overall process. Information on previous emergency department (ED) visits, psychiatry or psychology appointments, prescription history, and other health history that can be extracted from medical records. While some medical information can sometimes be obtained by the medical examiner, this information is not readily available or sought out.

Next of Kin (NOK) Interview Data

The NOK interview can provide an in-depth look into how the decedent lived, their social supports, and stressors and circumstances leading up to death by suicide. Information gathered in the NOK interview provides the suicide review team a greater understanding of the decedent's life experiences and an ability to identify non-traditional touchpoints or other systems the decedent interacted with outside of those represented on the suicide death review team. When merged with other data collected, the NOK interview helps to provide a more robust picture of the decedent's personal life.

For a complete guide on conducting next of kin interviews, please see Next of Kin Interviews: A Practitioner's Guide to Implementation, as listed within references on *page 35*. This guide has historically been used by opioid fatality review teams but can be applicable to suicide review teams. Additionally, it may be beneficial for team members who plan to conduct NOK interviews to complete psychological autopsy training, as noted on page 22.

Specific considerations for suicide specific NOK interviews follow:

WHY conduct a Next of Kin (NOK) interview:
Every decedent was a person with hopes, dreams, fears, family and friends. The NOK interview focuses on the decedent as a human being and presents a perspective different than agency records. The NOK interview deepens the understanding of life factors leading up to the suicide death. At times, the NOK interview sheds light on the decedents life that is in direct contrast to agency records, inviting deeper thought and inquiry.

The information from the NOK interview is used to create community specific suicide prevention recommendations to prevent future deaths by suicide. By exposing unmet community needs and systems gaps that may have contributed to a suicide death, opportunities and strategies can be developed to improve the quality and effectiveness of services and systems.

WHY survivors of suicide loss participate in the NOK interview:

Often family and/or friends find a sense of purpose in participating in a NOK interview as a way to honor their loved one by helping identify missed opportunities for prevention or intervention. Survivors of suicide loss are at an increased risk of dying by suicide, so ensuring they have resources and support to navigate the grieving journey is suicide prevention. Participating in a NOK interview gives survivors the opportunity to talk about the decedent in a way they may not feel comfortable doing with family or friends.

It is important to understand that family or friends may not want to "reopen the wounds" of losing a loved one by participating in a NOK interview. Being able to explain the NOK interview process,

WHO IS NEXT OF KIN?

Primary

- Significant other (e.g., spouse, partner)
- Parents or primary caregiver
- Roommate
- Siblings
- Children (at least 18 years old)
- Employer
- Teacher
- Close friend

Secondary

- Relatives (e.g., aunt, uncle, grandparent)
- Co-workers
- School staff
- Peers
- Friends

confidentiality, how that information is used and stored may help a family member or friend feel more confident/comfortable about participating in the NOK interview process.

WHO should conduct the NOK interview:

The type of professional who conducts a NOK interview varies from team to team and is often based on community resources and organizational capacity. Because Medical Examiner/Coroner will establish a relationship with the survivors of suicide loss, sometimes it is most natural for them to conduct the NOK interview as a part of their death investigation, however capacity is a common issue. If this is the case, it can be helpful to have the Medical Examiner/Coroner introduce the next of kin interview process to family during the death investigation, which eliminates

> Having law enforcement conduct next of kin interviews is not recommended. Suicide is often referred to as an act that is "committed", like a crime. By having law enforcement conduct the NOK interview, this may further perpetuate stigma.

a cold call introduction by another professional. In some communities, members of public health, suicide prevention organizations, or mental health professionals conduct the NOK interview.

Interviewer Skills

The professional conducting the NOK interview should have training and skills in crisis management and intervention, including assessment and navigating intense situations as well as providing critical support. They should also be familiar with trauma treatment, bereavement counseling/resources, mental health, as well as the suicide death review process and goals.

Other skills that are important for the professional conducting a NOK interview include: active listening, ability to read and respond to body language and non-verbal cues, having the ability to navigate difficult conversations and topics, detail oriented,

TIMING OF NOK INTERVIEW

Some teams rely on the recommendation of the Coroner/Medical Examiner to determine when the next of kin might be ready/willing to participate in the NOK interview based on their experience at the scene.

The American Association of Suicidology recommends conducting interviews between 6-12 months after the death.

Other considerations include:

- Decedent's date of birth
- Decedent's date of death

Avoiding birth date and death date anniversaries is recommended.

strong written and verbal skills, practices and prioritizes self-care and the effects of second-hand trauma, culturally competent and humility pertaining to diverse perspectives, and an ability to encourage open conversation and communicates clearly.

HOW should NOK interviews be conducted:

Considerations for how a NOK interview should be conducted, including contacting the next of kin, preparing for the interview, conducting the interview, and presenting findings can be found later in this manual. *See the Next of Kin Interviews: A Practitioner's Guide to Implementation document found within the reference section on page 34*.

WHAT type of information is collected:

When considering what information is collected, it is recommended that review teams build the assessment based on the biopsychosocial factors that may have contributed to the individual's suicidality. *See the Suicide Investigative Form Example in the Appendix on pages 38-39.* Additionally a fillable pdf form is available for download at https://www.mcw.edu/departments/comprehensive-injury-center/divisions/division-of-suicide-prevention.

Meeting Process Example: Marathon County

Each team may be different when doing a review. Do not be afraid to do something other than what is outlined here. Touchpoints are points in a person's life that they may have had contact with another agency or person in their life that could have provided them the support they needed.

In Marathon County, meetings proceed as follows:

- Decedent information
  - Name
  - Date of birth
  - Date of death
  - Incident address
  - Race and sex
  - Method used
  - Jurisdiction of law enforcement
- Police findings
  - The 911 caller information
  - Findings at the scene
  - Interview with witness or people at the scene
  - Previous contact with law enforcement
- Medical examiner
  - Next of Kin interview
  - Toxicology report
  - Historical context
  - Autopsy findings
  - Other relevant information
- Emergency Medical Services (if called)
  - Response to call
  - Previous contact
  - Other relevant information
- Crisis interactions & Corporation counsel
  - Mental health holds
  - Crisis admissions
  - Previous contact
- Corrections and District Attorney
  - Historical context
  - Diversion programs &/or Prosecutions
  - Previous history of jail incarceration
- Mental Health & Treatment providers
  - Medical history
  - Treatment history-mental health/illness
  - Trauma
  - Medications
  - Hospitalizations

Meeting Process Example cont.

- Other contributors
  - Schools
  - Pharmacy
  - Clergy
  - Veterans Affairs
  - Community services providers
  - Department of Social Services
  - Prevention Community
  - Other
- Another option for touchpoints is as follows:
  - At the scene
    - Medical Examiner
    - Police
    - Emergency medical services (EMS)
  - Next of Kin interviews
    - Familial context
  - Historical context
    - Medical services
    - Police/corrections
    - Schools
    - Mental health and medical providers

Discussion

The American Association of Suicidology has promoted a framework for conducting psychological autopsies, which may be helpful for discussing cases as part of suicide review team meetings. This framework is centered around using data from suicide cases to answer three questions: **"Why suicide?" "Why now?" and "Why this method?"** Using these three questions to guide the discussion of data presented through the suicide review process can be a helpful way to consider all aspects of the case. The "Why suicide?" question can help initiate a discussion about the specific biopsychosocial stressors and factors that the decedent was experiencing that contributed to and/or preceded the suicide. Many individuals experience the same stressors and life factors but do not go on to die by suicide – the "Why suicide?" question helps to tease apart those experiences that specifically contributed to the suicide. The "Why now?" question facilitates a discussion around the acute stressors that the decedent encountered that immediately preceded the suicide event. This question also helps distinguish between those factors that were chronic stressors in the lives of decedents and how those chronic stressors were impacted by more immediate factors. Finally, the "Why this method?" question facilitates discussion around lethal means and therefore can contribute to better understanding how lethal means safety may have contributed to the prevention of this suicide.

Psychological Autopsy

Psychological autopsy is a best practice postmortem data collection process to help determine factors that may have contributed to an individual's death. It can be a valuable tool in suicide research and prevention efforts.

Although not necessary, suicide review team members may be interested in obtaining psychological autopsy certification. More information can be found at https://suicidology.org/pact/.

Data Entry

One benefit of data entry is that it enables the monitoring of data and trends over time to determine if new or emerging issues are contributing to suicide in your area, allowing your team to be more proactive. Additionally, contributing data to a state-level database allows information across counties to be aggregated together to provide a deeper understanding of suicide at the state level. Given the fact that much of the state-level data available is delayed and is limited in terms of context and contributing circumstances, suicide review teams have a deeper, more real-time picture of suicide in our state.

Given the richness of information learned through the local suicide review process, it is recommended that teams develop a method of gathering and storing data that is discovered through the suicide review process. In Wisconsin, review teams utilize a REDCap database that is a means to securely store information gathered during a suicide review. Each team coordinator can request a login to begin entering data that will only be accessible to approved members of the perspective team. In some instances, a state review team coordinator can view all data in

aggregate form, with all personal information removed to protect confidentiality. Currently, the REDCap database follows the format of the *Suicide Investigation Form* found at https://www.mcw.edu/departments/comprehensive-injury-center/divisions/division-of-suicide-prevention.

What if there is not enough information?

The amount and type of information available following a suicide death investigation is varied, and in some cases, there is very little information to draw upon for the suicide review. Suicide review teams have a few options in this scenario:

1. The team can choose to not review this case, particularly if there are several other cases that can be reviewed.
2. The team can hold the review with the information that is available and ask members to search for additional information that can be revisited at a future meeting.
3. If allowed, the team coordinator can attempt to contact next of kin to conduct an interview to gain more information about the decedent and share new information at a future scheduled review.
4. Finally, teams may also prepare more cases (e.g., gather information, prepare slides) than the pre-determined number that can be reviewed at each meeting. For example, the suicide review team in Eau Claire typically plans to review three cases at every meeting but prepares five cases in the event there is limited information on any one case. This still allows enough cases for the review and utilizes the reserved time for team members.

It is also important to remember that even with minimal information, sometimes the process of suicide review can highlight potential prevention recommendations, additional partners to bring to the table, and/or areas for capacity building to support future reviews. It is not required to derive recommendations from each case - but with each review, the team will learn more about suicide overall in the community.

Conducting a Joint Review

Joint reviews involve a meeting of different types of fatality review teams (e.g., overdose fatality review and suicide review, child death review and suicide review) to review a particular case or a set of cases that crosses over multiple teams. There are a number of benefits to consider in conducting a joint review meeting with other fatality review teams, including sharing resources, information, increasing engagement, reducing demand for meetings, and leveraging expertise that aligns with the goals of each individual team.

Gathering fatality review teams together invites different areas of expertise together to conduct a deep dive into these cases, which may enhance the quality and adoption of prevention recommendations. Additionally, reviewing the crossover cases together can help ensure that fatality prevention does not occur in silos and that the social determinants of health that may have contributed to the death are addressed.

When conducting a joint review, it is important to keep a couple of things in mind. First, the teams should work together to schedule the meeting at a time when the maximum number of team members can attend. Also, issues around confidentiality should be discussed – it is critical to understand how each team manages confidentiality and privacy of decedent information, and to arrive at an agreement for how confidentiality will be maintained during the joint review. This may involve gathering affirmations of commitment to maintain confidentiality from team members on paper or virtually prior to undertaking the review itself. Finally, developing concrete action items or next steps with responsible parties and specific timelines is critical to ensuring that the rich conversation that occurs during a joint review meeting is translated into recommendations for prevention. *For an example of a shared review agreement refer to the Appendix, pages 36-41.*

Using SRT Review Information for Prevention

From the case selection throughout the review process, SRT's should develop recommendations for prevention that are based on best practices, tracked, and evaluated prior to reporting back to the review team, key stakeholders, and the community. These recommendations should be documented, tracked, and reported upon to the commission and community. SRTs can be supported by having clear roles and expectations including securing an experienced facilitation, a dedicated notetaker, and engaging the prevention community in identifying recommendations.

Once the recommendations have been documented with responsible parties identified, additional resources necessary to complete the task, and a realistic timeline for completion, updates can be part of the regular meeting agenda. If possible, individuals or parties responsible for completing work on the recommendation, any possible resources, and date for follow up should be noted and shared with all members at the end of the meeting. One of the tools to support thorough recommendation planning is the creation of SMART(IE) objectives, which ensure more precise tracking towards desired outcomes.

Tracking Recommendations & Outcomes

Tracking recommendations and outcomes is beneficial for multiples reasons. First, it ensures that actionable steps are taken towards suicide prevention efforts. This is not only beneficial for outcomes, but also provides the suicide review team members with positive motivation to continue to participate and engage in the process, when they can see the impacts made.

As review teams evolve some may find it beneficial to create two documents to track internal and external recommendations for both prevention strategies and process improvements. The internal document can be useful to document updates on a continual basis, as well as to provide

an area to track specific case follow-up or recommendations on existing processes. This document may provide more personal information which could be linked back to the decedent(s), so it is important to ensure it is for internal use only. While the external document would include an overview of each recommendation, including those responsible, progress, and a timeline for updates to be shared at a future review team meeting. This external document could also serve as an opportunity to summarize the meeting discussion, to keep those that were unable to attend up to date and can be used to build the agenda for the next meeting. *An example of these different tracking methods can be found in the Appendix section, pages 44-45.*

Tracking outcomes provide review teams opportunities to document progress towards goals, analyze and evaluate recommendations, and ensure best practices are adhered to. Organizing the recommendations within a conceptual framework, such as those listed below, enables teams to quickly identify points of intervention, as well as gaps and areas of need. The following are not meant to be exhaustive or prescriptive but intended to serve as examples for review teams to consider.

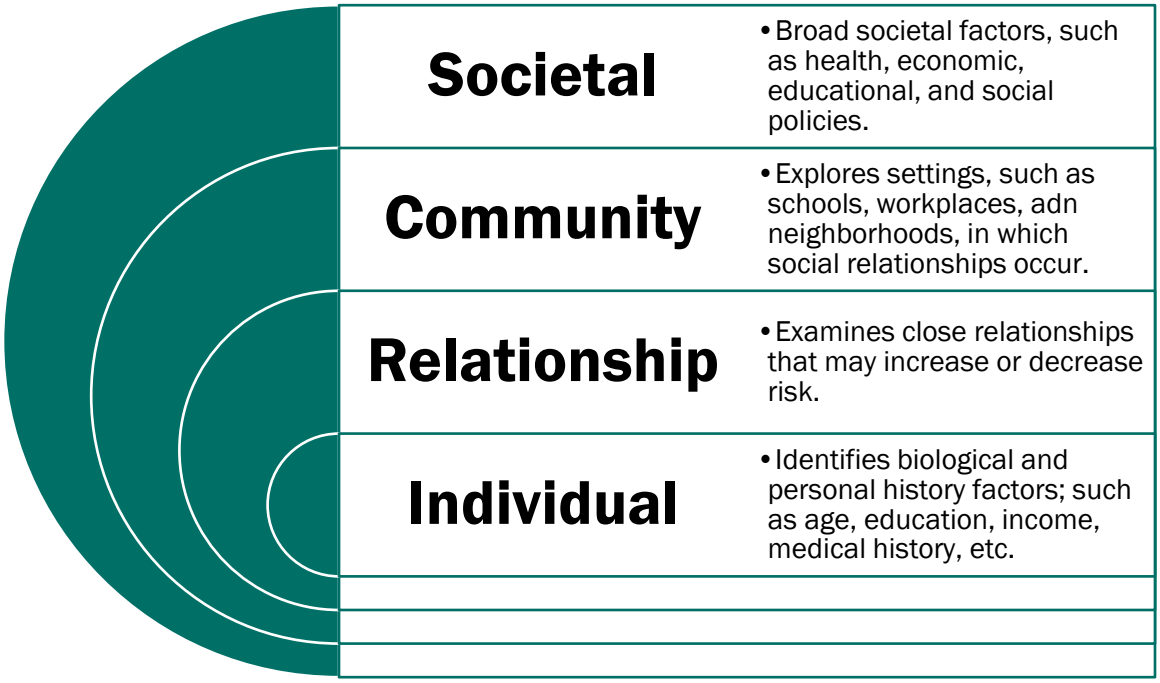
Haddon's Matrix

	Host	*Agent*	*Physical Environment*	*Social Environment*
Pre-event				
Event				
Post-event				

The Haddon's Matrix has been used widely in injury prevention research and programming to address a variety of injuries (Runyan, 1998). The matrix identifies factors across the epidemiological triad (Li, 2022) at the individual level, means of injury, and physical and social environment across different phases of injury and pairs these factors with the three levels of prevention (primary/pre-event, secondary/event, and tertiary/post-event). Haddon's Matrix uniquely fits the circumstances of suicide and addresses the discussion of biopsychosocial factors when a suicide occurs (Li, 2022; Beautrais & Larkin, 2013). *An example of recommendations positioned with Haddon's Matrix from the Milwaukee Suicide Review Commission, found in the Appendix on page 46.*

Social Ecological Model

Used to consider multiple levels of factors that impact an individual's health, the social ecological model can help determine strategic prevention efforts across a variety of health outcomes, including violence prevention. Factors at the individual, relationship, community, and societal levels independently and in relationship to each other influence the risk of an individual for a particular health outcome. Prevention efforts that address multiple factors within each level have the potential to create sustainable change.



Adapted from Centers for Disease Control social-ecological model for violence prevention (CDC, 2002)

In summary, it is strongly encouraged that all prevention recommendations be systematically tracked and analyzed by all members of the suicide review team. This action will help to highlight areas consistently being addressed through case reviews, identify similar recommendations being proposed, spotlight the need to put concerted effort - possibly from multiple stakeholders and sectors - to address an area of need. This process can also identify opportunities for new partnerships, tease out new prevention strategies, along with documenting successful efforts and outcomes.

Self-Care & SRT Debriefing

Secondary traumatic stress, often called compassion fatigue, is the emotional duress that results when an individual hears about the firsthand trauma experiences of another (Pearlman & McKay, 2008). Without the practice of self-care, this is one of the biggest concerns for members of local death review teams. Attending suicide team meetings can be hard on one's emotions and well-being. Resilience may vary based on the case details, relationships, or what is happening in the members' life at any time. Some members have experienced more reviews and are not as affected as others may be, but that does not mean these members' self-care is less important.

So, what does this mean? Self-care means taking the time to do things that will help you achieve optimal health – including reducing stress and improving all eight dimensions of wellness, including physical health and emotional health.

Wellness Wheel

Image from https://www.clarion.edu/student-life/health-fitness-and-wellness/office-of-health-promotions/wellness-wheel.html.

Vicarious Trauma

According to Pearlman & McKay (2008), vicarious trauma "is the process of change that happens because you care about other people, who have been hurt, and feel committed or responsible to help them. Over time this process can lead to changes in your psychological, physical, and spiritual well-being (p. 5)."

Signs & Symptoms

The following are a small example of possible signs and symptoms of vicarious trauma. This list is not exhaustive and not intended to be used for diagnosis. For further information, please see the cited resource. If you are concerned about yourself or someone close to you, please seek professional care.

- Changes in worldview or frame of reference
- Physical or psychological symptoms:
  - Hyperarousal
  - Repeated thoughts or images regarding traumatic events
  - Feeling numb
  - Increased sensitivity to violence
- Behavior & Relationship Changes
  - Difficulty setting boundaries
  - Feeling disconnected
  - General social withdrawal

Addressing Vicarious Trauma

Individually and as a team, develop pre-, during, and post care routines to disrupt difficult feelings. Develop a list of strategies one can turn to when needed and consider:

- Preferred physical, social, or creative activity
- Plan "off-task" time after meeting
- Seeking professional support individually or as part of team meeting
- Identifying triggers and initial signs or symptoms

While debrief or self-care activities may wrap up or ground review team meetings, intentionally easing into a meeting by doing introductions, ice breakers, announcements, and reviewing ground rules can help members leave the stress that was brought with them at the door, allowing them to ease into the case review. For additional guidance on addressing vicarious trauma as part of a review team, please see Guidance for CDR and FIMR Teams on Addressing Vicarious Trauma by the National Center for Fatality Review and Prevention, *listed within Refences on page 35*.

Example Icebreaker Questions

Icebreakers in the form of simple questions (that do not require much thought) can have many benefits, including help lighten the mood, find commonalities, and build trust with members who may not work regularly with each other. Consider having a few "go-to" questions that could be used during any season taking into consideration the diverse backgrounds and experiences your team members may draw upon. Below are a few easy and creative examples but are not meant to be exhaustive. Have fun with it, and don't forget to include them on your slideshow and/or agenda!

What are you most looking forward to this spring/summer/fall/winter?

Share the thing that made you laugh the hardest this past week.

What is a trip or activity that you are looking forward to this year?

What is the last TV show or movie you watched that you liked?

Last book you read?

If you were going to be famous, what would you be famous for?

Go to karaoke song?

You could only eat one meal for the rest of your life. What is it?

What was your favorite or worst class in school, why?

Examples of Self-Care

At the conclusion of the review team meeting, facilitators or other team members can lead an optional group meditation, debrief, or other grounding activity for interested attendees. This can be in the form of deep breathing, sharing a funny or inspirational video, guided imagery, journaling, or reporting on what is one thing that they are going to do for themselves later that day. Facilitators can also get in the practice of distributing or providing team members with examples of self-care in case they are not familiar with it or need a gentle reminder of its importance.

Facilitators should also prioritize self-care. Speaking and directing a review team meeting can be very draining, both physically and emotionally. Taking a long lunch break, doing a self-care activity, and spending time talking to a coworker generally about the meeting can help decompress, prevent burn out, and reduce the effects of compassion fatigue.

Examples of Self-Care Activities

It may be beneficial to include options to engage all 5 senses.

Going on a walk

Reading a book

Snowboarding/skiing

Watching a comfort tv show

Getting a massage

Going on a date with a partner

Listening to favorite music

Playing with a pet

Baking a cake/cookies

Drinking tea or favorite drink

Put on favorite smelling lotion

Example of grounding technique that could be used as part of team or individually.

Final Thoughts

Suicide is a leading cause of death in our state, but suicide can be prevented. Suicide review teams play an integral role in understanding the many complex factors preceding suicides, in identifying and implementing prevention recommendations, in building the community's awareness and capacity around the issue of suicide. The multidisciplinary composition of suicide review teams allows for a broader understanding of suicide in the community, maximizes existing resources, and facilitates important partnerships and conversations that can be leveraged to support best practice prevention strategies. This guidebook is intended to assist suicide review teams in conducting this important work in local communities. Afterall, the more communities work together to prevent suicide, the more lives that will be saved.

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Appendix

Example of *Memorandum of Understanding for Suicide Review Teams* courtesy of Winnebago County Adult Suicide Death Review Team.

Interagency Agreement

Winnebago County Adult Suicide Death Review Team

As of the current date, July 26, 2022, the agencies on the attached addendum* have been invited to engage in this cooperative agreement.

WHEREAS, the parties are vested with the authority to promote and protect the public health and safety and to provide services which will improve the well-being of individuals and their families.

WHEREAS, the parties agree that they are mutually served by the establishment of multi-agency, multi-professional adult suicide review, and the outcomes of the reviews will be the identification of preventable deaths by suicide and recommendations for interventions and prevention strategies.

WHEREAS, the objectives of an adult suicide review team are agreed to be:

1. Accurate identification and uniform reporting of the cause, manner, and relevant circumstances of every suicide death with special emphasis on those features that relate to potential preventability.
2. Improved communication and coordination of agency responses to deaths by suicide in the investigation and delivery of services.
3. Design and implementation of cooperative, standardized guidelines for the investigation of suicide deaths.
4. Identification of needed changes in legislation, policy and practices, and expanded efforts in community health and safety to decrease preventable deaths

WHEREAS, the parties agree that all members signing this agreement are essential to an effective review.

WHEREAS, the parties agree that the review process requires case specific sharing of records, and that confidentiality is inherent in many of the involved reports so that there will be clear measures taken to protect confidentiality, and no case review will occur without all present abiding by the confidentiality agreement.

NOW THEREFORE, it is agreed that all team members and others present at a review will sign a confidentiality agreement which prohibits any unauthorized dissemination of information beyond the purpose of the review process. The review team will not create any files with case specific identifying data. Case identification will only be utilized to enlist inter-agency cooperation in the investigation, delivery of services, and development of prevention initiatives. It is further understood that there may be an individual case which requires that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on the agency's clear connection with the issue at hand. It is further understood that a participating agency may use information obtained at the review in accordance with the mandated responsibilities of that agency. It is also understood that team review data may be entered into the Centers for Disease Control and Prevention National Violent Death Reporting System and submitted to the Medical College of Wisconsin REDCap, where it will be maintained for the purpose of establishing a database for the adult suicide review to identify trends for prevention recommendations.

By signing this document, each party of the Winnebago County Adult Suicide Review Team, agrees they have read, understood, and agreed to the aforementioned terms and conditions.

Signature: _____ Date: _____

Print Name: _____

Title: _____

Agency Name: _____

* Winnebago County Health Department, as facilitator of the Adult Suicide Review process, will maintain a copy of this signed agreement form and a current list of all parties who have signed the agreement.

Example of *Confidentiality Agreement* for Suicide Review Teams courtesy of Marathon County Adult Suicide Death Review Team.

CONFIDENTIALITY AGREEMENT

Insert Meeting Date

The purpose of the Suicide Death Review Team is to conduct a thorough review of all preventable suicide deaths in Marathon County to better understand how and why an individual dies by suicide and to take action to prevent other deaths.

To assure a coordinated response that fully addresses all systemic concerns surrounding suicide deaths, all relevant data should be shared and reviewed by the team, as permitted by law, including historical information concerning the decedent, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure by law.

Wisconsin state statutes allow for suicide death reviews to remain confidential and can be exempt from the open meeting law. In no case will any team member disclose any information regarding team discussion outside of the meeting other than pursuant to the mandated agency responsibilities of that individual. Failure to observe this procedure may violate various confidentiality statutes that contain penalty. Public statements about the general purpose of the overdose death review process may be made, as long as they are not identified with any specific case.

Thereby, the undersigned individuals agree to abide by the terms of this confidentiality policy.

Name	**Agency**

Example of *Interagency Agreement* courtesy of the Marathon County Review Teams.

Marathon County Review Teams

Interagency Agreement

I. Purpose

This Interagency Agreement (hereinafter "Agreement") is made amongst multi-agency and multi-professional team members vested with the authority to promote and protect public health and safety and to provide services which will improve the wellbeing of children and their families in Marathon County.

The parties to this Agreement recognize that they are mutually served by the establishment of one or more multi-agency, multi-professional review teams, including an Overdose Fatality Review Team, a Suicide Death Review Team, a Drug Endangered Children Review Team and a Child Death Review Team (collectively "Review Teams"). These teams will review data and facts available for specific fatalities or endangered individuals in Marathon County. The review of this information is aimed to identify preventable deaths, to develop recommendations for interventions, and to define relevant prevention strategies.

II. Objectives

The objectives of Marathon County's Review Teams are as follows:

1. Accurate identification and uniform reporting of the cause, manner, and relevant circumstances of reviewed fatalities with special emphasis on those features that relate to potential preventability.
2. Improved communication and coordination of agency responses to fatalities in the investigation and delivery of services.
3. Design and implementation of cooperative, standardized guidelines for the investigation of certain categories of fatalities.
4. Identification of needed changes in legislation, policy, and practices, and expanded efforts to prevent reviewed fatalities.

III. Team Members

It is recognized by all parties to this Interagency Agreement that each member may have information essential to an effective review of a particular case. In order to maintain an effective and responsive review team, members will be required to provide to the Marathon County Medical Examiner a primary contact for the agency and written notice if that primary contact changes.

The authorized signee from a particular member agency may permit other individuals from his or her agency to participate in case reviews. Such participants shall be required to keep all exchanged information confidential as required by law and as set forth herein. The signee from a particular member agency is not required to participate directly in the review or in receipt of review information.

IV. Confidentiality

The parties agree that the review process requires case-specific sharing of records, and that confidentiality is inherent in many of the involved reports. The parties further recognize that certain participating agencies are bound by laws, regulations, rules, ordinances, or other confidentiality requirements that may be applicable to a particular set of facts in a given case. All attendees of review meetings agree that there will

be clear measures taken to protect confidentiality, and that no case review will occur without all participants executing a confidentiality agreement to emphasize protection of the exchanged information.

All persons participating in a review discussion will be required to execute a confidentiality agreement. No confidential information shared at a case review may be redistributed by any participating person for any reason. Case identification will only be utilized to enlist inter-agency cooperation in the investigation, delivery of services, and development of prevention initiatives. The parties shall abide by all applicable federal, state, and local laws, rules, regulations, and standards with respect to maintaining the confidentiality of medical records and the release of patient information, including the securing of required consents as needed.

The parties recognize that each team member is subject to his or her own rules of confidentiality, ethical requirements, and other prohibitions that may prevent the sharing of certain information at certain times. Each team member is charged with complying with his or her applicable rules of confidentiality and with deciding when or how to participate with a given case review. Medical records and protected health information will not be re-released by any participating party without appropriately signed releases of information or court order, as applicable or required.

There may be an individual case which requires that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on the agency's clear connection with the issue at hand. A participating agency may use information obtained at the review in accordance with the mandated responsibilities of that agency as required by law.

Team review data may be entered into the OFR REDCap database, CDR state database, and SDR state database, where it will be maintained for the purpose of establishing a state central registry for prevention death data. The registry will include standardized data from death review teams throughout Wisconsin. The data entered into this database shall be standardized or in aggregate form and shall not reveal personally identifiable information.

V. Liability

Nothing in this Agreement shall impose on any participating agency, or on any Review Team as a whole, any liability for a breach of any law, regulation, rule, or ordinance, including those applicable to confidential information, committed by another participating agency member. Each participating agency shall retain liability for any such breach.

VI. Term, Termination, and Amendment of Agreement

This Agreement shall remain in effect until the dissolution of Marathon County's Review Teams as determined by the Marathon County Medical Examiner. Additionally, any participating agency may terminate their involvement in this Interagency Agreement by submitting in writing to the Marathon County Medical Examiner the agency's intention to terminate and the effective date of the termination.

This Agreement may be amended only by execution of a written amendment agreed upon in writing by each participating agency.

VII. Effective Date and Execution

This Agreement shall be effective as of the date of the first signature of a participating agency. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. Delivery of an executed signature page of this

Agreement by facsimile, email, or other customary means of electronic transmission shall be deemed to have the same legal effect as delivery of a manually executed counterpart thereof.

VIII. No Partnership

This Agreement shall not create or be construed to create in any respect a partnership or other business association between the participating agencies.

IX. Entire Agreement

This document constitutes the entire Interagency Agreement between the participating agencies and supersedes all prior agreements relative to Marathon County Review Teams.

X. Applicable Review Teams

The undersigned agency hereby indicates participation in the following Marathon County Review Teams:

☐ Child Death Review Team ☐ Overdose Fatality Review Team ☐ Suicide Death Review Team

☐ Drug Endangered Children Team

XI. Authorized Signatures

This cooperative agreement is made this day of , 2023, between (agency name), and members of the Marathon County Review Teams.

Authorized Signee (Print) Title Email

_____

Signature

Example of *Suicide Review Investigation Form* courtesy of Marathon County Adult Suicide Review Team.

Suicide Investigation Questions

History	
Was a note present?	Social media comments/posts?
History of mental health: __ Depression __ Anxiety __ Bipolar Disorder __ Personality Disorder __ Schizophrenia __ Other __ Post-Traumatic Stress Disorder (non-military)	History of chronic alcohol abuse?
History of illicit drug abuse?	History of prescription drug abuse?
Previous *inpatient* mental health treatment? Dates & Facility	Previous ***outpatient*** mental health treatment? Dates & Provider
Seen by a health care provider in last 30 days? Dates, Provider & Facility	Would the suicide be classified as impulsive?
Previous suicide attempt? __ Within last 6 months __ Within last 2 years __ Over 2 years ago __ Unknown time frame __ No previous attempt	Previous verbalization/suicide threat?
Family history of suicide?	Recent death in the family?
History of childhood trauma? __ physical abuse/neglect __ sexual abuse __ Emotional abuse/neglect __ Parent treated violently __ Parental separation or divorce __ Incarcerated household member __ Substance misuse within home	History of intimate partner violence? __ Physical abuse __ Emotional abuse __ Sexual abuse __ Financial abuse

Social	
Is acute alcohol intoxication a factor?	Is acute illicit drug intoxication a factor?
Is acute prescription drug intoxication a factor?	Recent loss of interest in life, sex, activities, personal hygiene, or change in daily routine?
Was this a significant date?	Interpersonal problems?
Recent change in relationship status?	Sexual orientation issues?
Job, financial problems?	Eviction or loss of home?
Peer problems/bullying?	School problems?
Criminal or legal problems?	Recent argument or physical fight?
Veteran status: __ Never enrolled __ Active Duty __ Reserve/Guard __ Prior Service __ Previous Deployment	Duty related issues: __ Military Sexual Trauma __ Post-Traumatic Stress Disorder (service induced) __ Combat/service injury __ Traumatic Brain Injury

Example of *Meeting Agenda & Recommendation Tracker* courtesy of Milwaukee County Suicide Review Commission.

Meeting Summary

Date

Meeting Key Take Aways

- Used to summarize main discussion points from meeting that is de-identified

Meeting Key Actions

Action	Responsible Individuals	Potential Resources	Date of Follow Up

Previous Action Updates

*Will be provided during **Date** meeting*

Action	Responsible Individuals	Date Initiated	Previous Progress
Insert previous action items that will be reviewed during meeting			

Recommendations & Actions

Completed

Recommendation	Theme	Outcome
List all completed actions/recommendations		

In Progress

Theme: (Can separate recommendations into themes)

Recommendation	Individuals Responsible	Date Initiated	Progress

Example of *Recommendations Across Haddon Matrix* courtesy of Milwaukee Suicide Review Commission.

	Individual	Means	Physical Environment	Social Environment
Pre-Event	Completed • Outreach to FB group of transportation workers to determine need for suicide prevention materials • Peer support for LGBTQ+ individuals No Progress • Education & coping skills related to relationships/break ups for youth & caregivers • Determine feasibility for school district policy to provide SW/counseling services 1x w/o parent permission • Determine health systems outreach to patients who miss appointments • Provide information on signs of suicide risk & how to respond to families of ind. dealing w/ terminal illness	Completed • Provide National Suicide Lifeline information for nitrate poisoning searches No Progress • Determine health systems current practice/feasibility to conduct firearm access screening in primary care	Ongoing • Conduct study examining association between evictions and suicide within county No Progress • Determine health systems current practice/feasibility to conduct suicide risk assessment for all visits (trauma, ED, primary)	Completed • Obtain info on local university current suicide prevention programming Ongoing • Outreach to BIPOC communities to address stigma No Progress • Investigate screenings outside of healthcare (e.g. schools) • Improve risk assessment practices to include family members • Education/training for employers/orgs relating to suicide risk, refer to services, and provide resources to ind. losing job/suspension
	No Progress • Evaluation of trauma psych added to tertiary process/hospital policy	Completed • Develop Hoan Bridge Suicide Prevention mobilization team No Progress • Discuss possibility of increased patrolling on the Hoan Bridge to deter suicidal behavior	Completed • Literature drops at locations that serve unhoused individuals • Determine health systems current practice/feasibility to embed MH workers in primary care	
Event				
			No Progress • Policy analysis of step-down services from CH-51 WI vs. other states	No Progress • Exchange of info for local agencies, including first responders, schools, etc.
Post-Event	Completed • Determine feasibility of LOSS team model Ongoing • Outreach to ind. after suicide (incl. those who were aware of risk & tried to help) • Compile bereavement resources for loss survivors (provide to funeral homes, families, ind., etc.) • Use standardized suicide investigation form @ med. examiner (include veteran status) No Progress • Gather stakeholders interested in postvention • Examine current practices for providing support to providers after loss of patient	No Progress • Means reporting, especially identifying owner of firearm	No Progress • Examine feasibility of suicide postvention clinic w/in trauma quality of life clinic	Completed • Initiate committee w/ hospital systems to do sentinel event Ongoing • Conduct psychological autopsies for ind. who survived previous attempt No Progress • Determine feasibility of communication loop between systems (healthcare, schools, medical examiner, etc.)

Safe Language, adapted from Talk Suicide Canada.