Making Connections: LOSS Team and other Active Postvention Models

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The literature estimates an average of at least six survivors per suicide (Andriessen, 2009), approximately 200,000 new survivors each year in the U.S. with a wide variety of relationships—at least 45—to the deceased beyond those of immediate family, including co-workers, friends, distant relatives, community members, and acquaintances (Campbell, 2011). The effect of suicide on loved ones, termed suicide survivors, is agonizing and perhaps best illustrated by numerous studies demonstrating that survivors are often at increased risk for suicide—between 2 and 10 times that of the general population (e.g., Runeson & Åsberg, 2003). Sadly, it is estimated that only one in four survivors seeks help after a suicide (Dyregov, 2002; Provini, Everett, & Pfeffer, 2000). This deadly cycle is why Shneidman (1972, summarized in Aguirre & Slater, 2010) suggested that “postvention, i.e., activities that come after the suicide to alleviate its impact on survivors, serves the dual purpose of assisting survivors through the grief process and preventing suicide for future generations” (p. 529).

**What is Active Postvention and Why is it Needed?**

Postvention while essential, is complex. A main complexity is how best to link survivors to postvention services, especially grief support services such as the suicide survivor support group which is the most commonly available and suggested form of postventive grief support (Cerel, Padgett, Conwell, & Reed, 2009). Strategies to link survivors with grief support services are: the passive postvention model (PPM) and the active postvention model (APM) (Campbell, 1997). With the PPM, identifying available services is the survivors responsibility, resulting in estimated averages ranging from 97 days (Cerel & Campbell, 2008) to 4.5 years (Campbell & Cataldie, 2003; Campbell, Cataldie, McIntosh, & Millet, 2004) for survivors to find services.
The less common APM involves active outreach to newly bereaved suicide survivors, usually through volunteers who are suicide survivors themselves. The goals of outreach are to connect the newly bereaved with other survivors who have experienced a loss to suicide, normalize what they are experiencing, educate them on what they will experience, and provide them with resources for help including self-help books and a list of grief support services in the area—preferably a suicide support group. This outreach begins with an initial visit but usually involves several follow-up visits. It is important here to stress that the goal of the APM is not to provide counseling or therapy to the newly bereaved. The APM has three variations: outreach to survivors at the scene of the death, delayed outreach to survivors, and a combination of these two activities. Research on the APM indicates that it results in an estimated elapsed time of just over a month (39 to 48 days), about half that of the PPM (Campbell & Cataldie, 2003; Campbell et al., 2004; Cerel & Campbell, 2008).

**What Are the Variations of Active Postvention Programming?**

**Outreach to Survivors at the Scene of the Death**

The concept of active postvention at the scene of the death was originated by Frank Campbell (1997) in Baton Rouge, Louisiana with the first LOSS Team—Local Outreach to Suicide Survivors Team. Campbell’s LOSS Team concept is currently being implemented in communities in the United States, Australia, Canada, New Zealand, Northern Ireland, Singapore, and Tasmania among others. The LOSS Team, in its original conception, “places a new first responder at the scene of suicides while the body is still present” (Campbell & Cataldie, 2003, p. 36); this person is usually a suicide survivor who has been trained to handle the intricacies of intervening during this difficult time for the new survivor. The survivor first responder fills a role that...
traditional first responders (e.g., police, coroner or medical examiner, fire department, emergency medical service providers) may neither be trained nor have the time to fulfill.

(Aguirre & Slater, 2010, p. 535)

The LOSS Team learns of the death through a variety of mechanisms depending on the community; variations of notification include the coroner or medical examiner, police department (or other law enforcement unit), or chaplains affiliated with the police department.

**Delayed Outreach to Survivors**

In implementing Campbell’s (1997) LOSS Team concept, some communities have found that outreach at the scene of the death is not always feasible. These communities have implemented other strategies. One such strategy involves a mentoring program between a senior survivor and the newly bereaved survivor. In this example, when the organization learns of a new suicide, they ask the newly bereaved if they are interested in speaking with another survivor. If so, they identify a senior survivor with the same loss, e.g. a mother who lost her son to suicide, and ask that survivor to contact the new survivor. The two then proceed in a mentoring relationship with the goal being to help the newly bereaved survivor connect with grief support services.

**Combination of At the Scene of Death and Delayed Outreach**

Another strategy is that when a suicide occurs, the responding police department (PD) decides if it is appropriate for LOSS Team to be at the scene of the death. If it is not appropriate to go to the scene, the police department asks permission from the survivors present to share contact information with the LOSS Team; the team then contacts the survivors as soon as possible through phone or email to arrange a meeting. The LOSS Team, whether meeting the survivors at the scene of the death or later, engages in follow-up with the bereaved.
How to start a LOSS Team or other Active Postvention

There are several key phases to starting a LOSS Team or other Active Postvention; heretofore referred to as LT/AP. These include: assessing the community, developing the outreach process, mobilizing resources, and ongoing evaluation.

Assessing the Community

In beginning a LT/AP, it is paramount that the community can sustain such a venture (See Figure 1 for key questions to ask). Firstly, a LT/AP is ill-advised if a community does not have grief support services to which the newly bereaved survivors can be referred. The goal is to help the newly bereaved understand the need for grief support services and educate and refer. Secondly, there must be community support, especially from the grief support services since they will experience growth and need to plan for such expansion. Thirdly, and perhaps most salient, the LT/AP will need a home. Is there an agency that can house such a venture? Existing LOSS Teams/AP are typically housed in suicide and crisis centers or other mental health agencies where suicide survivor services are already offered though starting a non-profit is an option.

Developing the Process for Outreach

As previously noted, LT/AP may involve contact with the newly bereaved survivors at the scene of the death, delayed or some combination thereof with follow-up visits thereafter. Development of the process must be collaborative with the agency housing LT/AP, those who will staff it (volunteers and some LT/AP programs have at least one paid person who coordinates the activities), and the organizations that will refer newly bereaved survivors to the LT/AP. Once it is decided that a community can sustain a LT/AP (see Assessing the Community section), a next step should be contacting possible organizations that would be in a position to refer the newly bereaved. These include the coroner/medical examiner, police department and/or police
department chaplaincy program, sheriff’s department, fire department, and emergency medical
service. Which organization provides the referrals will largely depend upon the individual
communities. The first LOSS Team in Baton Rouge, Louisiana relies upon the coroner to notify
the LOSS Team of suicides in the community. Others in the U.S. rely upon police and sheriff
departments. Once possible organizations are identified and meetings arranged, it is important to
present the LT/AP concept in terms of “Here’s how we can help you” and present the different
LT/AP variations (i.e. at the scene of death, delayed, and combination). Each community will
have different policies and procedures for these organizations that will need to be adhered to for
LT/AP to work. It is best to let the potential referring organizations guide the process
development since without these organizations’ help with referring, a LT/AP will not be feasible.

Once a referring agency has helped LT/AP outline a process for learning of new suicides,
the LT/AP needs to decide other procedures. A few questions to consider: 1) How many people
will meet with the newly bereaved?—most existing LT/AP programs work in teams of two; 2)
Who will be present?—some LT/AP programs prefer two survivors while others use pairs of one
survivor and one mental health professional; 3) How will the team members arrive at the meeting
location?—will they travel to the location together in one vehicle or meet there?; 4) What does
the team want to accomplish with the newly bereaved survivor during the visit?—in addition to
being with the newly bereaved in solidarity, this may also include interfacing with police and
other first responders, calling friends and family of the newly bereaved\(^1\), arranging clean up of
the scene, and calling employers, schools, etc.; 5) Once at the meeting location, what will the
team members leave for the newly bereaved?—many existing teams leave at a minimum a
community resource brochure and a business card while others also leave reading materials (See

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\(^1\) Often, family and friends of the newly bereaved don’t know what to say; this is a good opportunity to guide them
in terms of what a new survivor needs and how they can help.
Figure 1 for examples); 6) When will the LT/AP members contact the survivors again?; and 7) How often will the team follow-up with the survivors?

Figure 1. 

**Examples of Resources LT/AP programs give to Survivors**

- Pamphlet listing local support groups and counselors
- *Touched by Suicide* by Michael F. Myers and Carla Fine for adults.
- The *SOS Handbook* by Jeffrey Jackson (available through the American Foundation for Suicide Prevention: [http://www.suicidology.org](http://www.suicidology.org)).
- Other ideas for resources: *Dying to be Free* by Beverley Cobain and Jean Larch.

**Mobilizing Resources**

Once the community is found to be ready for a LT/AP, the next steps are recruiting and training volunteers, securing funding, developing the process for outreach, and raising awareness. A main strategy for populating the LT/AP is to recruit seasoned survivors through existing suicide survivor support services. For example, facilitators of survivor support groups often keep a database of survivors who have attended and can initiate a connection between the newly formed LT/AP and these potential members. Once a list of potential members is developed, it is recommended that those interested be trained. Frank Campbell, the originator of the concept, provides training to communities and information can be found at [http://www.lossteam.com/](http://www.lossteam.com/). In recruiting, it is important to have a screening process in place to ensure LT/AP membership will not put a survivor at risk for undue harm. Providing training first is an important step as it raises the potential team members’ awareness of what they might experience. Once they have been trained, those still interested in serving on the team can be interviewed individually for screening. Typical issues to cover during screening include questions about the potential volunteer’s experience with suicide, how the experience was...
handled by the potential volunteer and others involved (including family, friends, law enforcement, church, etc.), what sources of support were accessed, and how the potential volunteer takes care of him or herself during stressful situations

**Funding**

Though in most implementations of LT/AP, the outreach is performed by volunteers, expenses are still associated with the program and thus funding is an issue. Expenses include training of LT/AP members, a dedicated phone line or answering service for the LT/AP to field calls notifying them of a new suicide; creation and purchase of materials including publicity items such as business cards and brochures; resources to be given to the newly bereaved (See Figure 1 for examples); and some LT/AP programs also have a paid person who coordinates programming. The typical grants nonprofits seek for programming are wonderful sources for funding. However, another option that may be very fruitful depending on the community’s awareness and commitment is a 5K run. For example, the LOSS Team of Tarrant County raised over $73,000 in its first year to fund the program through a 5K run planned during suicide prevention week (September 10).

**Raising Awareness**

Once the team has been trained, funding secured, and the process for outreach decided, while the LT/AP begins its operation, it is important to alert the community of its existence. This serves two main purposes: 1) keeping a steady stream of volunteers to staff the team; and 2) assisting with referrals. Despite well-intentioned plans for learning of each suicide in a community, there are other suicide deaths that will not be reported. For example, a newly bereaved survivor who needs LT/AP outreach may not receive it if their loved one died in

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2 More information on screening is covered by Dr. Campbell in his training and work with LOSS Teams as they form.
location outside of the LT/AP’s coverage area. But, if there is community awareness of the
program, perhaps a referral wills till be made. Many LT/AP programs do periodic presentations
to organizations serving the community such as mental health agencies, hospitals, and other
social service organizations.

**Ongoing Evaluation**

Ongoing evaluation is essential to developing and sustaining any social service program.
Funding agencies, more so now than ever, require proof of effectiveness in both reports of how
given funds were used and in requests for funding. Elements of a strong evaluation plan include:
a) a system for tracking contacts with families and b) a mechanism for acquiring feedback from
survivors served. For a tracking system, important elements to capture include a) how the
survivor was referred to LT/AP; b) date of the suicide and relationship of the survivor to the
deceased; c) date of each contact\(^3\) with the survivor; d) mode of contact, e.g. phone, face-to-
face\(^1\), at scene of death, email; e) who made the contact\(^4\); f) what resources the survivor has been
given (Figure 1); and g) when the survivor accessed grief support services and which services
were accessed. The elements listed are easily captured during follow-up contacts. However, the
mechanism for acquiring feedback from survivors served regarding overall satisfaction with the
LT/AP should be planned with care. In the first few months after the loss, survivors might be
burdened by an evaluation form or survey. Suggestions include a phone call or survey a year
after the loss. LT/AP programs should keep all correspondence with survivors as they will
occasionally express gratitude and describe how they were helped in emails and other
communications.

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\(^3\) In evaluation of Tarrant County’s LOSS Team, it was found that face-to-face is the newly bereaved survivor’s
preferred method of communication including on-scene and multiple follow-up contacts with LOSS Team.
Survivors emphasized that on-scene was not enough; follow-up visits were essential.

\(^4\) Whenever possible, it is important that the team member(s) who made the initial contact with the survivor be the
consistent contact for that survivor so as to ensure continuity of care.
Conclusion

Establishing a LT/AP requires considerable preliminary work. However, the work is fulfilling and essential in the care of survivors. Essential to the process are: 1) involvement of survivors—they know what they need and are tremendous resources; and 2) involvement of the community—LT/AP programs are community initiatives and need to be tailored to the individual communities they serve. The information given here is a guide to get a program started but by no means is it a cookie-cutter recipe. Each program will have its own nuances based on its home community. Dr. Frank Campbell (http://www.lossteam.com/) is a great resource for additional information regarding starting a LT/AP. Also, when a community begins the process, he will help them connect with other LT/AP programs to learn, share resources and experiences, and become part of a network of active postvention programs.

Checklist for Starting a LOSS Team or other Active Postvention (LT/AP)

I. Assess the community
   A. Is there a network of services to which a LT/AP can refer the newly bereaved?
   B. Is there support within the community for such a program? E.g., mental health providers, survivor of suicide groups, suicide prevention programs
   C. Is there an agency or organization able and willing to house the LT/AP? E.g., crisis center, mental health organization?

II. Develop the Process for Outreach
   A. How will the LT/AP learn of new suicides? E.g., law enforcement, coroner/medical examiner, other source?
   B. How many people will meet with the newly bereaved and who are they? E.g. most existing LT/AP programs work in teams of two survivors or survivor/mental health professional combinations
   C. How will the team members arrive at the meeting location?
   D. What does the team want to accomplish with the newly bereaved during the visit?
   E. What will the team members leave for the newly bereaved? (See Figure 1 for examples)
   F. When will the LT/AP members contact the survivors again and how often will the team follow-up with the survivors?

III. Mobilize Resources
   A. Recruit, train (through Dr. Frank Campbell: http://www.lossteam.com), and screen volunteers
   B. Secure funding sources
   C. Raise awareness in the community

IV. Develop and implement an ongoing evaluation plan including tracking of
   A. Elapsed time between learning of the suicide and accessing grief support services;
   B. Which services were used; and
   C. How LT/AP may improve outreach.
References


