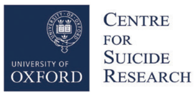
If a patient dies by suicide:

A resource for Mental Health Professionals



About this guide

This guide was developed after conducting surveys of mental health professionals who had experienced the death of a patient by suicide. The first of these surveys (Gibbons et al 2019) was conducted amongst psychiatrists and the second (Croft et al 2022) amongst mental health professionals from all other disciplines, including unqualified support staff. It was also informed by a review of the research literature, focus groups with mental health clinicians and from the personal experiences of the authors and those they have worked with over the years. The guide is aimed at all mental health professionals, including trainees and unqualified staff. Its purpose is to provide information about a difficult topic that those in mental health often avoid discussing, to reduce a sense of isolation, and to help clinicians cope at what is likely to be a very difficult time. Quotes from mental health professionals who have experienced the death by suicide of patients and who contributed to the surveys are used to illustrate professionals' experiences.

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Some facts about suicide

Most individuals who die by suicide in the UK are not in contact with mental health services at the time of their deaths. Around a quarter have been in contact with psychiatric services at the time of their deaths or in the 12 months previously. Prediction of suicide is notoriously difficult, with most patients who die by suicide having been assessed as at low risk at their final service contact, even when this has occurred shortly before death. There are, however, times of particular risk, including the two-week period following discharge from psychiatric inpatient care and also the first few weeks following a hospital presentation for self-harm. While there is evidence that strategies to prevent suicide at the general population level can be effective, and psychiatric services probably prevent numerous suicides (although this is more difficult to demonstrate), identification of patients who are at greater risk than others is extremely difficult. The unpredictability of suicide is one of the factors that makes such deaths in patients under the care of mental health services so challenging for all those involved.

Emotional responses reported by mental health professionals following deaths of patients by suicide

Most clinicians working in mental health services will experience the death of a patient by suicide at some point in their career. For many it will occur more than once. A significant number will be exposed to a patient suicide whilst in training. The loss of a life is very significant and those deaths occurring in a professional context are no different. Each clinician responds to a patient's death differently; however for the majority the aftermath can be very distressing and may be the most psychologically difficult experience encountered in their professional life.

Some respondents in our surveys reported coping relatively well following a patient's death; however for most there were significant effects on their emotional wellbeing, their functioning at work, and their personal lives. Many reported experiencing a wide range of intense emotions. Some suffered severe distress. For most, these feelings passed within a few

weeks, but for others the impact continued for a long time and some thought they had met the criteria for clinical depression or other mental health conditions, whether they sought help or not.

The feelings reported included:

- Sadness
- Anxiety
- Guilt
- Shame
- Anger
- Fear
- Paranoia

Some professionals also reported:

- Feeling responsible for the death
- Fear that they had made a mistake that had contributed to the death
- Feeling blamed or fearing that they would be blamed by others for the death

Feelings of responsibility, fear and self-doubt are frequently reported after the death of a patient by suicide. These thoughts and feelings are often not rational but can feel very real at the time. Suicide is complex and multifactorial. The psychological pathways involved in someone deciding to take their life are

poorly understood. Therefore, suicide may leave uncertainty, which can result in a clinician assuming an unjustified level of responsibility, often at great personal cost.

The following are quotes from mental health professionals in the surveys who shared their emotional responses after the death of a patient by suicide.

"Like being deeply wounded...the feeling of something good having been destroyed...guilt, sadness, shock, injustice..."
Psychiatrist

"Overwhelming sense of guilt and personal responsibility. Grief. Tearfulness. Reduced appetite. Difficulty sleeping. Difficulty Concentrating. It knocked my confidence in keeping my patients safe."
Nurse

"My initial emotions were of shock. I then became very upset and found that I would cry very easily over the next couple of weeks. I began to question my ability as a nurse and lost confidence. I also questioned what others would think of me."
Nurse

Research has shown that some clinicians experience serious grief reactions in response to the death of a patient by suicide. In one study, 53% of clinicians reported stress levels in the weeks following a suicide comparable to those found in studies of people seeking treatment after the death of a parent (Chemtob 1988). This might be unexpected; some people in the surveys were taken aback by the extent of their grief.

"I was confused by how much I felt this loss, even though the relationship had been a professional/therapeutic relationship and not a personal one."
Psychologist

It is common for clinicians to ruminate over patient contact and treatment provided, often questioning whether something was missed or more could have been done.

"Questioning decisions and actions made by myself and others at the time and subsequently afterwards."
Social Worker

The effect of a patient death by suicide on clinicians can be influenced by similarities between the patient's features, or the event itself, and the clinician's other personal or professional experiences and relationships. Such 'personal resonances' (Wolfart 2011) can sometimes exacerbate the clinician's distress, especially if they are intense. However, they might also provide insight into the impact of such deaths on others.

"Remembering the interview over and over, trying to search for things I had missed. Remembering his face...made me remember previous traumatic events."
Psychologist

Feedback from clinicians suggest particularly high levels of pain associated with the death by suicide of a child or young person. Some respondents said it led them to reflect on their own circumstances and become more protective of their own families.

"I became more anxious about my own child's welfare."
Nurse

"It left me with the need to nurture and value my own family, friendships and loved ones more"
Nurse

Almost all of professionals who responded to the surveys said that initially their experience of the death had a detrimental effect on their clinical practice.

"It made work far more stressful for me as I became fearful about all my other patients and found it hard to trust my own judgement or risk assessment."
Occupational Therapist

Understandably, because of the nature of these feelings, some clinicians reported withdrawing from their colleagues, fearing their negative judgement. However, isolation can make these feelings worse rather than better. It is important to remember that you are not alone. Clinicians who completed the surveys indicated that talking to colleagues or managers, including those who had been through similar circumstances, was immensely helpful.

"It helped to know that some of my colleagues had been through it, I was not the only one to feel the shame and guilt."
Psychiatrist

As time went on some reported more self-awareness and acceptance of the possibility of suicide.

“It made me be more direct when assessing suicide risk in clients, and not shy away from those ‘difficult’ questions.”
Occupational Therapist

Some respondents had reflected on their role and profession as a result of the suicide and expressed conviction that professionals should allow themselves to accept limitations and challenge insurmountable expectations.

"It is a very frightening world where one professional group is given an impossible task and then censured by society (and themselves) for failing to achieve it.’
Psychiatrist

“I feel that it's so important to protect ourselves and colleagues from the emotional and psychological vitriol we are exposed to. We need to be sensitive but not take on everything thrown at us. ... We don't need to be self-sacrificing. Supervision and staff support are key in this.”
Psychiatrist

A significant proportion of those responding to the surveys had considered a career change or had actually changed their career path as a result.

“It made me overly cautious as a clinician. It made me want to leave mental health...It definitely makes me question what can really be done to help someone once they have reached a point, and it makes me question sometimes why am I doing this job.”
Occupational Therapist

Conveying information about the death and providing managerial support

If you are someone who manages or supervises other staff, you may find yourself in the position of having to inform them about a death of a patient by suicide and also of offering support. How this news is imparted is very important because it can influence the emotional impact of the death.

"I worked closely with this patient but only found out they had died by accident - I was really shocked that there was no mechanism for informing all staff that a patient had died."
Nurse

It is important to consider all staff members who have been involved in the patient's care, however peripherally, and to ensure as far as possible that everyone is informed in a timely manner. Remember that some staff who have been involved in looking after the patient may have recently left the Team (e.g. students or trainees on placements). It is also important to think about the non-clinical staff who have been involved in the patient's care, such as those who work in administration or domestic jobs. These employees may be particularly vulnerable to being affected by the death because they have not had the training or experience that many clinicians have, and they too may have had a close relationship with the person who has died.

"As I was part of an external company, I didn't feel that I was given any support by the staff at the hospital. They didn't see me as a colleague or member of staff so didn't offer any support or even ask me how I was."
Advocate

The results of the surveys suggested that most clinicians valued support from their manager or supervisor. They found it helpful to have someone in their workplace to turn to both for emotional assistance and to guide them through the practical tasks that may be required of them following the death, such as enquiries and inquests.

"Conversation with my manager was helpful, she was empathetic and supportive. She helped me to complete Trust paperwork."
Psychologist

Even if you do not provide this support personally, it is important that you are aware of what your organisation offers and can signpost staff to these resources.

There is no ideal support that suits everyone. Clinicians vary in what they want and need. They do value knowing that support is available and having choices about whether and when they can access it.

Staff who responded to our surveys commented that it was unhelpful to be expected to carry on as normal and for others to assume that they would be feeling better soon after the

death. Some benefitted from time off work. It is helpful to check in from time to time with those who were involved in the care of a patient to see whether they need further support.

"When the case was brought up recently I didn't realise how strongly it would still affect me now."
Social Worker

How to look after yourself

It is to be expected that the death of a patient by suicide will have some impact on you. This impact can vary, from clinician to clinician, and between one death and another. It is important to recognise that you are likely to do things a bit differently in the period after the death for your own health and wellbeing. The following strategies may be helpful:

The first few days

There are often many demands on clinicians in the immediate aftermath of a patient's death by suicide. You are likely to have urgent duties to carry out as well as your normal ones. You will be better able to perform these tasks if you pay attention to your own welfare.

Connect with the people around you

Withdrawing from others, at work and at home, puts you at risk of increasing your sense of isolation and will give you more time to ruminate in an unhelpful manner. Evidence about support after traumatic events indicates that those who fare best tend to be those who are able to connect with their natural support systems, such as family, friends, colleagues and communities. Talk to members of your family that you trust, or friends, colleagues or a mentor who can accompany you emotionally and offer you support. You are not breaking confidentiality when you talk about your feelings. Many clinicians find it helpful to talk confidentially to a colleague

who has been through similar experiences, or other clinicians involved in caring for the patient who has died.

Soothe yourself

It helps to know what enables you to relax and to make sure you do it. Be kind to yourself. Self-criticism and impatience won't help you feel better. Treat yourself as you would treat a good friend or your patients. Try to have patience regarding your own difficulties. Some people might like to use relaxation, mindfulness or gentle exercise as healthy coping mechanisms.

Look after your emotional health

Expressing emotions is a normal part of processing distressing experiences. You may observe that you feel tearful, easily upset and impatient with your partner or family. You may have experiences similar to a grief reaction. Consider if these emotions interfere with your ability to carry out your clinical duties. Some clinicians have reported that it was helpful to read articles, papers or books related to suicide and other clinicians' experiences in similar situations. These include a paper by a psychiatrist named Gitlin (1999) that recounted his emotional experience following the suicide of one of his patients, and a book called 'Working in the Dark' by Campbell and Hale (2017) who theorise about the nature of suicide and why it can leave such distress in those that survive, including clinicians. (These resources are referenced at the end of this booklet).

Look after your physical health

Have some structure to your day (particularly if you need time off work to recover), including activity and rest times. Sleep,

eat regular meals, stay hydrated, keep physically active. Do not drink alcohol excessively, 'self-medicate' or 'overdo it' (sport, work, other activities). Keeping a healthy day-to-day routine will help reduce tiredness and emotional exhaustion.

Seek help

Many people will want to assist you and help you find alternative support and resources. A lot of the clinicians in the surveys found talking to colleagues beneficial. The main thing is to ask people. You should not feel obliged to discuss what has happened, but avoiding doing so can sometimes be unhelpful. Some workplaces will offer formal or informal debriefing following a patient's death, for individuals or teams. Going for a walk with a friend, or some similar activity, might be an invaluable distraction if you are feeling preoccupied and unable to stop thinking about the death. Some professionals also noticed the benefits of talking to a therapist, in a safe and confidential setting.

Consider making temporary adjustments to your working patterns.

Most clinicians in the surveys reported they continued working, perhaps finding it useful to maintain regular structure through work where support from colleagues could be more easily accessed. However, it may be helpful taking some time away from work to recover and you should consider if a temporary adjustment to your clinical duties is desirable. A referral to Occupational Health might help put necessary measures in place if you need ongoing adjustment to your work pattern to support your recovery and to deliver safe patient care.

"I think I would have benefitted from taking a week off and although managers did tell me I could, I felt I shouldn't. If it was a form of leave other than sick leave I might have felt it was more acceptable to take the time I needed."
Occupational Therapist

The medium and longer term

Individuals recover at their own pace and this is influenced by many factors. If you are still having difficulties several weeks

or months on, or begin to have difficulty at a later stage, this is not unusual and not something to just struggle on with. You may benefit from some additional support. There are many options for accessing support, but the first step is to recognise that you might need this and to let someone else know.

Signs that this may apply to you can include the following:

- Frequent intrusive thoughts or images of the events around the suicide
- Nightmares and disturbed sleep
- Being more irritable, tearful or anxious
- Avoiding people or situations that remind you of the suicide
- Avoiding situations where you may need to make difficult clinical decisions
- Taking longer than usual over work tasks, doubting your judgement or having difficulty concentrating
- Persistent low mood
- Poor motivation
- Avoiding social contact
- Thinking about leaving mental health services altogether

Many clinicians find it difficult to admit they are in emotional difficulty. Concerns about confidentiality and not understanding the support structures available are key obstacles to seeking help. You may find it easier to speak to someone outside your workplace initially. This may be a friend or relative, although your GP or a therapist may also be a good starting point.

Other sources of help suggested by the clinicians in the surveys are listed towards the end of this booklet.

Seeking formal professional help

Some clinicians experience significant mental health difficulties following a patient's death by suicide, including depression, anxiety or features of PTSD. Remember that counselling or therapy is an option if you need to speak to an external professional. Some Occupational Health departments offer this support, or you can access national helplines, help from your professional body, NHS or private therapy (see the section on resources at the back of this booklet).

Team support

Unless you are in private practice working alone, you will be a part of a larger team. If you know that a colleague has been affected by suicide, and appears to be distant or behaving differently, ask them how they are and provide them with information about support they can access. Share this booklet with them. It is important to remember that less experienced members of the team and support staff affected by patient suicide may not be aware of the impact of patient suicide on themselves and team members. They may be puzzled by behavioural changes of colleagues affected by suicide, such as withdrawal or engaging with patients and colleagues differently. Discuss the suicide and its impact in your staff support groups, even if you were not directly involved in the care of the patient. Team dynamics and the manner in which members of a team interact with one another will be affected when one or more of your colleagues have been involved in loss of a patient to suicide.

What might prepare for the experience of a death of a patient by suicide

Training

The following are different opportunities to learn about what to expect:

- **Mental health and medical indemnity organisations** run workshops on internal investigations, legal processes and have articles about how to write a statement to the coroner or prepare for an inquest.
- **Other clinicians** are often willing to share their experience at academic meetings or training sessions. It is very worthwhile making use of such opportunities.

If one of your colleagues has been involved in the care of a patient who died by suicide, it may be informative for you (and a way of helping) to shadow them when they present their statement to the coroner at the inquest. In this way you can learn about the process when not directly involved.

- **Learn about local processes** It is very helpful to find out about how your organisation responds to a death by suicide, and to get involved in these processes, before you experience them yourself. Leading a serious incident investigation or shadowing an investigator following the death of a patient can be a good way of learning about the processes. This can include attending or observing the panel or group where recent serious incidents reports are reviewed prior to submission to the relevant NHS commissioner.

"I think that a training on coroners' courts' would be helpful for clinicians to attend routinely as it will make it a little less daunting - maybe a visit to the actual court at a time when they are not highly emotional."
Social Worker

Conferences

There are national and regional conferences focused on suicide, suicide prevention and the effects of suicide on those bereaved including mental health professionals.

Literature

Reading good quality professional articles on the topic can be helpful. A few key references are included at the end of this booklet.

The formal processes following death of a patient by suicide

After a suicide a number of legal and investigative processes take place. These can be stressful, particularly if you are not familiar with them.

"The subsequent inquest, investigation and complaints by family also really affected me, I had to take time off sick as I wasn't able to function at work."
Social Worker

The police

As part of the initial investigation, the police and coroner have to gather information about the person who has died. If they have left a note or message, the police or coroner's office may need to take it away. The police need to make sure that no-one else was involved in the person's death.

The Inquest and the Coroner

In England and Wales, sudden and unexplained deaths are reported to the coroner, who is an independent judicial officer (usually a lawyer or a doctor). A coroner must hold an inquest if it was not possible to find the cause of death from the post-mortem examination, if the death is found to be unnatural (suicide is considered an unnatural death), occurred in prison, police custody or in hospital. The main inquest hearing should

normally take place within six months from the death being reported. However, some cases are more complex and the wait can be considerably longer, in some cases years. In a death that may be suicide the coroner generally requests a post-mortem. If the post-mortem examination can establish the cause of death, a coroner may decide the investigation is complete or that further investigation is unnecessary.

The inquest is not a trial and its role is **not to apportion blame**. The role of the inquest is to discover the facts about:

- Who has died
- How they died
- When and where the death happened with the aim of giving a verdict so that the death can be officially registered.

There are occasions where a death is internally investigated by a Mental Health Organisation before the inquest and is identified as a probable suicide, only to find out after coronial investigation that the death occurred in a different way and/or receives a verdict other than suicide. The role of such investigations is to identify if and how care can be improved. This is explored further below (see Internal investigations within the Trust).

Common inquest verdicts include:

- **Suicide.** These verdicts used to be based on the coroner being sure a person intended to take their own life. However, since 2018 this has changed to a probabilistic verdict, i.e. based on a coroner assessing the probable likelihood of suicide.

- **Natural Causes**
- **Open (death due to undetermined cause)**
  When the cause of death cannot be confirmed, and doubt remains as to how the death occurred.
- **Accidental**
  Unless suicidal intention is clearly indicated in the narrative, the death is often classified by the Office for National Statistics as 'accidental'.
- **Misadventure**
  Almost the same as accidental but where the person died as a result of actions by themselves or others that went wrong or had unintended consequences.
- **Narrative**
  Where the coroner feels the other conclusions are not right for these circumstances and sets out his or her understanding of the facts. Narrative verdicts have become increasingly common.

The conclusion of the coroner can come as a surprise. Some people believe very strongly that the person who has died took their own life, and are then confused or distressed when the verdict is 'open' or 'accidental'. A narrative verdict may feel inconclusive.

Being a witness at an inquest

If you were directly involved in the patient's care, it is possible that the coroner will request a statement from you via your employer's legal department. The coroner may also ask you to attend the inquest as a witness. Families sometimes have

their own legal representative at the inquest, so that they have someone who can guide them through the process, give them advice and ask questions.

It can feel daunting if you are called to attend an inquest. Respondents in the surveys often found the prospect of being a witness, and writing a statement, anxiety provoking. However, your organisation's legal department will usually act as your link with the coroner, and they will provide advice about your statement to the coroner and support for the preparation for the inquest. Your role is to state the facts. Sometimes the guilt that clinicians feel after a death results in them behaving in a defensive manner or unreasonably taking responsibility for the death. This is unhelpful to the coronal process. Without meaning to, they put themselves in the spotlight and make it harder for the coroner to assess the reality of the situation. Survey respondents indicated that the support from the legal team was generally beneficial.

Information to include in witness statements are:

- The patient's demographic characteristics, including their name, date of birth and address
- Your qualifications
- How you became involved in the patient's care
- A timeline of the patient's care, mental state and progress while they were being treated by you and your team
- A brief summary of your statement at the end and condolences to the family

As well as the Trust legal team, if you have professional indemnity insurance, that organisation can provide you with advice about your statement once it has been fully anonymised. You may find it useful to read previous statements to the coroner from colleagues who have been in your position in the past, particularly if this is the first time that you have been required to write a statement. Attending an inquest where you are not involved helps to familiarise yourself with the process.

"I was helped with my caseload to allow me plenty of time to write the coroner's report and plenty of support in doing this. When I took a day off for stress following the funeral and coroner's inquest this was not questioned ...service manager and other staff at the time attended the Coroner's inquest with me. Trust Solicitor was very empathic and sensitive."
Occupational Therapist

Sometimes during the inquest the coroner can become concerned about an aspect of care provided to the person who has died. In this case they may make a Prevention of Future Deaths report. The organisation must respond within 56 days, stating what action it has taken over the area of concern. These reports are sent to the Chief Coroner and published electronically.

There are clear guides to the inquest process. See: https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide and also St Johns Smith (2009) (referenced at the end of this booklet).

The processes in Scotland

In Scotland there is no system of coronal inquests as there is in England, Wales, and Northern Ireland. Accidental, unexpected, unexplained, sudden, or suspicious deaths are investigated privately for the local Crown Office and Procurator Fiscal Service by a lawyer called the Procurator Fiscal. The Procurator Fiscal will investigate the cause and circumstances and will then decide whether there is a need for a Fatal Accident Enquiry.

A Fatal Accident Enquiry (FAI) is a public enquiry into the circumstances of a death when it is thought to have occurred as a result of an accident, whilst a person was working or when a person was in legal custody. It is not used when a death is thought to be suicide, unless the death occurred in custody. The FAI is held in the Sheriff Court. At the end of an FAI, a Sheriff makes a determination which will set out:

- where and when the death occurred
- the cause of death
- any precautions by which the death might have been avoided
- any aspects of systems that caused or contributed to the death.

An FAI cannot make any findings of fault or blame against individuals.

The Scottish Association for Mental Health have produced a very thoughtful and helpful booklet for those bereaved called 'After a Suicide'. The link for download is available at the end of this booklet.

Internal investigations within the Trust

There will be an internal investigation within the Trust, sometimes called a Serious Untoward Incident (SUI) Review, or similar.

- This investigation is not to find out about, or comment on, the cause of the death; this is the coroner's role.
- It is an opportunity to look at the pathway of care provided to the patient and whether anything can be learned from an examination of this. The aim is to identify, both good practice and areas for development, and make recommendations that can improve future care of other patients.
- These processes are about rational fact-based organisational learning and not for providing emotional support for the clinicians involved.

A member of the mental health service's team investigating the SUI makes contact with the family and asks for their views to be added to the investigation.

Clinicians' experiences of the formal processes

The formal enquiry processes ensuing from the suicide of a patient can be experienced as challenging, particularly if a clinician feels vulnerable.

The surveys indicated that clinicians can find inquests and internal investigations helpful or unhelpful depending on the attitude of the coroner, the investigators and their mental health organisation. If these processes were experienced as hostile or persecutory, clinicians said it was harder to recover emotionally; if they were experienced as understanding and compassionate, it was reparative for them.

"The suicide was upsetting, however the aftermath, the SIRI investigation and attending the Coroner's Court were very traumatic for me. It made me feel very upset, sad, angry and it felt like people were out to blame us/me/services."
Psychiatrist

- Remember, whatever you might be thinking or feeling, or how the investigation is conducted, the general aim is to find out what happened and not to blame you.
- It is often helpful to have a supportive colleague accompany you to enquiries (and inquests). You may need some extra support at these times, and it is important to feel that you can ask for this.

If you are an investigator

In the surveys it was clear that how investigations were conducted affected the wellbeing and recovery of many of the respondents. If you are investigating, please remain curious but sensitive. Remember how distressed and emotionally vulnerable some of the mental health staff you are interviewing might be feeling.

Formal processes when a child under 18 years dies

When a child under 18 dies by suicide a process is automatically started to check every aspect of what has happened.

- This is the responsibility of the Child Death Overview Panel (CDOP). Their enquiry runs alongside the inquest, and its aim is to protect other children and young people. The CDOP reports to the Local Safeguarding Children Board, and both work with the coroner to share information.

- The Local Safeguarding Children Board includes a Rapid Response function, which is a comprehensive and multi-agency review of all unexpected child deaths. Professionals involved in this process provide initial support to the family and help to inform the subsequent CDOP review process. The aim of the CDOP is to classify the cause of death, identify modifiable factors, decide on preventability of death, consider whether to make recommendations and to whom they should be addressed.

How to support the family and friends of the deceased

Not all clinicians have direct contact with patients' families and friends of the deceased. In our surveys, those who didn't expressed deep sadness and empathy for them. Those who reported contact wished that they had been able to access help in communicating, and to have known about resources to offer them. This section seeks to address some of these issues.

- If an individual dies while an in-patient or whilst under the care of a community team, then mental health services usually offer support to the relatives. You may feel that you want to contact the family yourself immediately after the death. It may well not be your job to do this. Think about this and take advice. Contact with the family is very important, even if it solicits anger or rejection, but this is not your role alone, you are part of a service. A senior clinician, manager, or another member of staff who worked with the patient may be better placed to meet them, particularly if you are feeling overwhelmed.
- It is important to be sensitive to how the family may perceive contact with the professionals who were caring for their relative. Offering contact early on is crucial; however, families may not be able to take this up at this point. They may find

contact with the service intrusive or provocative. It is a good idea to discuss and make a plan with experienced colleagues and your manager. Make sure that you are acting as part of a service and in the best interests of the family - and yourself. Some clinicians and families report contact as very helpful and reparative. However, this is not true in every case and doesn't need to happen in the immediate aftermath of the death. Empathy with the pain of loss is the key. Below is a quote on this issue from a father whose son died by suicide.

"It was several months before I would have been able to think through my son's death in the round ...and then further years before I could place this in a perspective that allowed for the unknowability, the limits to intervention, and allowed agency of some kind to my son in his own death.

There is a time when finding others responsible was important in preserving the integrity of my son ..., finding causes in myself and others who did not keep him safe. ..., it might help professionals to place the anger or blame they may experience from families in the context of the process of grief they (the families) are going through. The point is that families' engagement with professionals in the early period may be shaped by their need for a narrative of the suicide with which they can live, driven by their need for emotional survival. Narratives of blame serve to protect a family's relationship with the one they love and have lost."

Particularly comprehensive resources that may be helpful for the family and friends are the booklets *Help is at Hand* and *After a Suicide*. These and other resources are listed at the end of this booklet.

Clinicians' suggestions about resources and activities that they found helpful, or wished they had access to, following the death of a patient by suicide

The preferences for help and support from the clinicians who responded to the survey are listed below; however everyone is different, and it is important to ask for the help you personally require. You may not be sure about what support you need. If this is the case talk to your manager, supervisor, Occupational Health or other external sources of support about what might help.

In order of frequency, the desired sources of help identified by the clinicians included:

- A senior clinician who understands the impact of suicide and is able to offer confidential advice and support, possibly a Trust Lead in Suicide Prevention and Support.
- Support for the formal processes following a patient's suicide.
- A confidential reflective practice group or space to process the effects of a patient suicide.
- Personal debriefing.

- Information, training and workshops:
  - From clinicians who have experienced a death of a patient by suicide
  - Workshops to share experiences
  - Information about the processes following patients' death by suicide
  - Support for the community (including schools)
- Support with communicating and/or meeting the family/ friends of the patient who has died.
- Information about support available for family and friends (e.g. Help is at Hand).
- Organised peer support.
- Counselling and therapy.

Concluding remarks

Having a patient die by suicide may well be one of the most challenging and painful experiences you will face in your professional career. You are not alone - many of your colleagues have been through a similar experience, often more than once. The emotional pain will generally ease with time. Make sure to look after yourself and do not underestimate the care you might need from others or from yourself. Mental health professionals find it notoriously difficult to attend to their own emotional needs, but this is the best thing you can do for yourself, your team, your family and your patients.

It is also important not to collude with the idea that you or someone else is to blame for this death. Blame implies that the responsibility lies with one person only. This is clearly not the case and denies the complex reality of suicide and the diverse nature of responsibility. Whilst we may have some responsibility for an aspect of the care provided, or not provided, to assume too much responsibility for an act we often cannot understand, and the uncertainty of which cannot be resolved, is not reasonable. It is our role as mental health professionals to maintain engagement with reality and, in this way, to help others in this challenging task, as well as helping ourselves.

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Resources and further reading for all mental health professionals

Online

- **When a Patient Dies by Suicide a Resource for Psychiatrists.** Located on the Royal College of Psychiatrists webpage.

  Find out more

- **If a Patient Dies by Suicide.** Webpage on the Royal College of Psychiatrists website where there are many resources including videos of clinicians and families talking about their experience following a death by suicide.

  Find out more

- **Clinicians as Survivors of Suicide.** The Clinician Survivors Task Force, under the auspices of the American Association of Suicidology provides a postvention web resource and opportunity for linking for clinicians who had lost a patient to suicide.

  Find out more

- **Helping Residents Cope with Patient Suicide.** Produced by the American Psychiatric Association to support doctors in training who have had the death of a patient from suicide.

  Find out more

- **Finding the Words: How to support someone who has been bereaved and affected by suicide.** Provides useful simple advice for how to speak to someone who has been bereaved by suicide. Helpful for family and friends of those who have suffered bereavement and also for clinicians. There is a leaflet that can be downloaded.

  Find out more

Free online CBT resources

Computer based self-help for everyone.

- Living life to the full:

  Find out more

- NHSInform:

  Find out more

- **Healthtalkonline. Bereavement by Suicide**

  Thematically arranged clips of interviews with bereaved individuals to show impacts of bereavement by suicide and ways of coping.

  Find out more

- **Royal College of Psychiatrists Leaflet: Post-Traumatic Stress Disorder.** Online information on Post Traumatic Stress disorder that can be downloaded, detailing symptoms, treatment and links to sites providing further help.

  Find out more

- **Suicide Bereavement UK.** Specialises in suicide bereavement research, providing consultancy on postvention and delivering evidence-based suicide bereavement training.

  Find out more

- **Support After Suicide.** A special interest group of The National Suicide Prevention Alliance which campaigns for the development of services and support of those bereaved by suicide. The website provides helpful online information and details of local and national support services.

  Find out more

- **Improving Access to Psychological Therapy services (IAPT)** Primary care mental health services in England offering a range of evidence-based treatments for common mental health problems via telephone, online and face-to-face services. Accept self-referral. Search IAPT for your local service contact information.

Private therapy

- BABCP accredited CBT therapists.

  Find out more

- UKCP accredited psychotherapists and counsellors.

  Find out more

- **Samaritans.** Charity aimed at listening to people who are angry, depressed and suicidal any time – night or day. Email: jo@samaritans.org Tel: 116 123

  Find out more

- **BMA Counselling and Peer Support**
  24/7 helpline, individual counselling and Doctors Advisor Service (peer support). Free telephone support for all doctors and medical students.
  Tel: 0330 123 1245

  Find out more

- **DocHealth.** Independent psychotherapeutic consultation service for doctors. Based in London but available to all doctors in the UK. Fees payable. Tel: 020 7383 6533

  Find out more

- **NHS Practitioner Health Programme.** Confidential NHS treatment service for Healthcare Professionals working in England with mental health or addictions problems. Free.
  Tel: 020 3049 4505

  Find out more

- **NHS England Mental Health and Wellbeing Hubs.** Set up to provide rapid access to assessment and local evidence-based mental health The hub offer is confidential and free of charge for all health and social care staff.

  Find out more

- **Royal College of Psychiatry Psychiatrists Support Service** Confidential support and advice service for psychiatrists at all stages of their career. Free. Tel: 020 7245 0412

Find out more

- **Sick Doctors' Trust.** Helpline for Psychiatrists with drug or alcohol issues. Free. Tel: 0370 444 5163

Find out more

- **Cavell Nurses Trust** Helpline for Nurses, midwives and healthcare assistants, both working and retired.
Tel: 01527 595 999

Find out more

Resources for family and friends

- **Help is at Hand.** Very useful and widely used resource to provide important information and support relatives and friends after a by suicide. There is a downloadable booklet that is a first line resource used by many Mental Health Trusts and community services.

Find out more

- **After a Suicide.** A thoughtful and helpful booklet for those bereaved produced by The Scottish Association for Mental Health (SAMH)

Find out more

- **The Listening Place.** Offers free face-to-face support 7 days a week between 9am and 9pm for those experiencing suicidality. Self-referral by email or phone.

Find out more

- **Healthtalkonline: Bereavement by Suicide.** Thematically arranged clips of interviews with bereaved individuals to show impacts of bereavement by suicide and ways of coping.

Find out more

- **Alison Wertheimer (2013). A Special Scar: The Experiences of People Bereaved by Suicide.** Routledge: Abingdon. Book with very sensitive accounts of experiences of bereaved individuals, which clinicians will also find informative.

Support agencies for family and friends

- **Cruse Bereavement Care.** A confidential bereavement service.
  Tel: 0808 808 1677

  Find out more

- **Survivors of Bereavement by Suicide (SOBS).** Offering emotional help and support to those bereaved by suicide.
  Tel: 0300 111 5065

  Find out more

- **Scottish Association of Mental Health:** Scotland's national mental health charity offer a range of mental health support and services.
  By email: info@samh.org.uk
  Tel : 0141 530 1000By post: Brunswick House, 51 Wilson Street, Glasgow, 1 1UZ.

  Find out more

- **The Compassionate Friends.** Charitable organisation supporting bereaved parents and their families after a child die. Tel: 0845 123 2304

  Find out more

- **Samaritans.** Charity aimed at listening to people who are angry, depressed and suicidal any time - night or day.
  or email: jo@samaritans.org Tel: 116 123

  Find out more

- **The Way Foundation.** Supporting young widowed men and women as they adjust to life after the death of their partner. Tel: 01332 869 222

  Find out more

- **Winston's Wish.** A national grief support programme for bereaved children.
  Tel: 08452 03 04 05

  Find out more

This booklet was written based on information from surveys of mental health professionals and on clinical and research experience by a multidisciplinary group of clinicians, all of whom had themselves experienced deaths of patients by suicide. The aim of sharing this information is to support mental health professionals at all stages of their career, to reduce isolation and to recommend helpful resources for those professionals who have this experience. We hope that you will find this booklet useful and will share it with anyone you think may benefit from it.

Developed by a team of mental health professionals in collaboration with the
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