

# **GUIDELINES TO ASSIST CLINICAL STAFF AFTER THE SUICIDE OF A PATIENT**

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## **Introduction**

Even though suicide is a well known risk factor in recipients of psychiatric help, it can be shocking and devastating for the personnel who have been involved in the treatment and care of a deceased patient.

When a suicide of a patient occurs – be it in the hospital, at home on the weekend when the patient is otherwise hospitalized, or as an out-patient – it is often unexpected, and can catch the therapist and the rest of the staff unaware.

Treatment of patients with mental illness is often done by a multidisciplinary team, which consists of various members with different responsibilities. They differ in the degree of understanding and knowledge of the patient and have different relationships with the patient. Consequently they differ in their reactions and the depth of their response to the patient's suicide. The reactions are influenced by personal traits of individuals, their personal and professional experience and knowledge, their understanding and anticipation of the event, their own current emotional state and phase of life, as well as many other personal factors. All of these factors lead to differing needs and expectations which have to be taken into account when planning help and support following the suicide of a patient. Support measures need to be flexible and adapted to manage the specific needs of the individual or team.

Some intervention measures, therefore, are recommended for the entire team, whereas others are advised for individuals or smaller groups of close co-workers. Some measures are obligatory whilst others are optional, depending on the individual needs of the person.

## REQUIREMENTS AND OBJECTIVES OF HELP MEASURES

When a patient dies by suicide members of their whole support network are affected (relatives, friends, and co-workers), as well as those involved in his/her care (the attending physician, psychiatrist or psychotherapist, social worker, hospital staff etc.). In order to reduce the impact of a suicide on the staff, four requirements have to be met: administrative, institutional, educational, and emotional.

Administrative requirements:

- ▶ provide a report of the responsible clinician on the specific treatment of the patient, including reports of all professional contacts with the patient;
- ▶ provide a review of the course of treatment conducted by independent reviewers;
- ▶ provide information to the relatives of the patient, referring them to support services (eg self-support groups and relevant clinicians) and providing them with relevant resources (i.e. websites, information on books, flyers, etc.);
- ▶ communicate with other patients involved and provide clinical follow up, to allow them to process the event;
- ▶ review of all legal and ethical matters, particularly those concerning confidentiality and information sharing, being mindful of which aspects of communication may be subject to subpoena in the case of a lawsuit, (as well as research around minimizing this risk - i.e. quick and compassionate outreach to family members...).

Institutional requirements:

- ▶ provide guidance and support for all employees impacted by the patient's suicide;
- ▶ maintain a high level of service and provide an unchanged working and living environment for the employees, patients and patients' families;
- ▶ appoint key persons to review the case
- ▶ define actions to support the family of the deceased patient (meetings, funeral...);
- ▶ provide support and advice for clinicians on how to communicate and help other patients who have been effected by the event.

Educational requirements:

- ▶ give the team the option of reviewing the case with an external or internal consultant – aimed at understanding the patient’s possible risk factors and motives for suicide,
- ▶ provide training on how to recognize risk factors for suicidal behavior and optimal intervention strategies,
- ▶ provide education about the “normal” sequelae of suicide loss (for clinicians, family and friends) and optimal interventions for survivors of a suicide.

Emotional requirements:

- ▶ enable professionals to recognize, understand, accept, and express emotions felt for the deceased patient (sorrow, guilt, anger, wrath, disappointment, compassion, relief etc.);
- ▶ enable professionals to recognize, understand, except, and express emotions felt towards him/herself as the person involved in the treatment (disappointment, doubt, uncertainty, incompetence, fear, shame, anxiety etc.);
- ▶ enable the professionals to recognize how feelings about loss are handled (eg.denial or dissociation of feelings or, conversely, being flooded with overwhelming affect);
- ▶ enable professionals to verbalize and reduce the fear of legal action on behalf of relatives, advocates, institutions or colleges and discuss what to expect if a lawsuit does occur, and ways of minimizing this risk
- ▶ enable professionals to realize the limited control the therapist has over the patient’s behavior and life and develop a tolerance for ambiguity;
- ▶ enable professionals to recognize the likelihood that, at least in the short term, the loss is likely to affect their work with subsequent patients as well as professional identity

It is important to monitor this!

#### FOR WHOM ARE THE MEASURES MEANT?

The fact that the suicide of a patient affects many staff members, who had different professional and personal relationships with the deceased, has to be taken into consideration when planning help for the team, individual groups of health professionals, and individuals. The following groups will require specific and different attention:

I: mental health professionals with the highest level of responsibility for patient care (psychiatrists, psychotherapists, physicians). Suicide of a patient may shatter the basic goal of a professional, which is to heal or at least help the patient. When suicide of a patient occurs, the working alliance and semi-personal (in a way intimate) bond between the patient and his/her therapist is not only destroyed but also contaminated with guilt and a sense of involvement of the caregiver. Responsibility for the patient can thus turn into a sense of a failure, incompetence and betrayal. This can be quite devastating and calls for support.

II: professionals who spent the most time with the patient (eg. nurses, occupational therapists, other members of the team in the hospital) are also highly affected by the suicidal death of a patient, as they know them very well, know their relatives, know their daily routine and feel responsible for their well being. Many of them may feel a similar degree of incompetence as the therapists do but for different reasons.

III: professionals who have, for various reasons, become particularly close to the patient. Some members of the team pay special attention to a certain patient due to some special obligations this team member may feel or because of special difficulties of a patient that connect them more than the others. They tend to spend more time together and the caregivers can blame themselves for not preventing the act of suicide.

IV: the individual or group who found the body of the patient. Finding the body may provoke many repetitive flashbacks, anxiety and even impairment in clinical work shortly after the event.

V: other patients. It is very important to plan how the information about the suicide of a fellow-patient is transferred to the others in the group and who should do this. Time and opportunity should be offered for patients to speak up about their own fears and doubts.

V: support staff such as catering and domestic staff, porters etc with whom the patient may have developed a relationship. Sometimes this group remains outside the focus of concern, even though some of them may have strong feelings and reactions to the death of the deceased. They need an opportunity to talk about their experiences.

A special problem can arise when one suicide triggers some more in the same department and suddenly the staff is faced with a cluster of suicides and a possible contagion effect. Such multiple losses can provoke intense reactions that multiply all the sorts of difficult feelings mentioned above.

## WHEN TO OFFER HELP?

Assistance should be offered as soon as possible after the suicide occurs and staff is informed of it. Sometimes this is not possible because many work related factors can impact on the person's ability to access help.

It is necessary to inform all staff who worked with the patient about the event, as well as the management of the institution, relatives, and other key personnel (eg police, the patient's general practitioner, etc.).

Arrangements have to be made so that everyone who wants to attend a meeting can do so, despite their usual working obligations.

## WHY HELP?

The suicide of a patient is one of the most distressing events in the professional life of healthcare workers. It affects them not only on a professional, rational level but also as an emotional, personal experience. Emotional reactions differ widely. Some begin to doubt their competence in treating patients, as well as their knowledge and abilities. Others may deny any involvement and emotional reaction to the suicide of a patient. Unresolved emotional experiences in a professional can have a long-term effect and can be harmful for him/her as well as his/her future patients. The consequences of this may be manifest in many ways:

- rushed or prolonged hospitalization of suicidal patients
- delay in a patient's first discharge for the weekend
- excessive use of medication
- refusal to work with suicidal patients
- distrust of patient's claims that he/she is not contemplating suicide
- burn-out symptoms with loss of motivation for work or even a change in occupational field itself.

## HOW TO HELP?

In principle, help can be divided into two parts: mandatory and optional.

It is recommended that everyone involved in the treatment of the patient should have mandatory help, whilst those who were not in direct contact with the deceased patient should have the option of accessing help.

### A) MANDATORY HELP

(Caveat: As some countries are extremely litigious, anything said in such a public forum is subject to subpoena in a lawsuit. Any acknowledgment of feelings of guilt, or of a missed risk factor or warning sign, could be taken as evidence of malpractice. So, clinicians are often advised by lawyers to only do emotional processing in confidential settings, and even to avoid speaking about personal feelings to supervisors. Nonetheless experts advise that the more open processing of emotions is the best way to deal with the grief. These guidelines might therefore change according to national and local practice, and legal representatives should be consulted accordingly).

The institution should be responsible for regulating mandatory help. This includes:

- Arranging a meeting of the entire team immediately after receiving the information about the suicide (the date, time, and length of the meeting should be set in advance);
- Appointing a moderator – a neutral expert with experience of working with a group and suicide postvention (the list of experts in the institution should be compiled in advance – the team selects the most appropriate expert from the list);

Meeting aims:

1. review and reconstruct the last known events and behavior of the patient prior to suicide;
2. determine how each member of the team understands the patient's "decision" for suicide;
3. determine how members of the team view their involvement in the patient's life and how they view themselves after the suicide (enable a safe disclosure of potential feelings of guilt, doubt, and worries related to "the failure");
4. allow and stimulate venting of various feelings (sorrow, anger, disappointment);
5. neutralize potential accusations or blame by individuals or a group against anyone who was supposedly responsible for the patient's protection;
6. remind team members of discretion within the group
7. talk about feelings of supposed responsibility for the suicide;
8. offer further help – individual or group based (again, the choice of the supervisor is left to the group).

## B) OPTIONAL HELP

This will vary according to individual needs/requests:

- the needs of the individual or group seeking help have to be defined;

- supportive counseling should occur in working hours;
- it is important to respond to clinical requests such as a change in the content of work, a short leave of absence or the withdrawal from a difficult situation (eg a distressing locality in the work-place).

## PRACTICAL GUIDELINES IN ORGANIZING HELP

### I. INFORMATION ABOUT THE SUICIDE OF A PATIENT

Immediately after the suicide of a patient the following people have to be informed by the Clinical Director or delegate

1. the attending physician
2. the person who had the last contact with the patient before the suicide
3. all professionals who treated the patient
4. other patients
5. relatives (if the suicide occurred in the hospital, or if they had not already been informed about it)
6. police (and/or coroner)

The notice should contain the basic information about the patient's death by suicide. The recipient has to have the opportunity to express his/her feelings and thoughts (the notice should not be posted on a door/notice board, the information should not be presented in a big group or in a casual manner, and if possible not over the telephone).

### II. HELP PLAN

#### II./1 MANDATORY PART – HELPING THE STAFF

- a) compile a list of staff members who have to be notified of the team meeting;
- b) inform everyone of the time and place of the meeting;
- c) arrange an additional date for those staff members who cannot attend the meeting;
- d) ask one or two colleagues (depending on the size of the team) from a list of possible consultants to chair the meeting;
- e) arrange sufficient time, space and opportunities for every team member to speak about the patient and themselves;

- f) neutralize feelings of guilt (if there are any) in therapists, make sense of the ambiguity around the loss and prevent allegations of others as to what caused the suicide; (it is important to draw distinction between feelings of guilt and actual responsibility for the patient);
- g) enable various explanations and interpretations as to why the patient died by suicide by reviewing short and long-term risk factors, with the acknowledgement that retrospective understanding does not mean that the suicide could have been prevented; recognize the limitations of what was known before the suicide.

## II/2. MANDATORY PART – OFFICIAL REPORT

Each institution is responsible for the formal reporting of any suicidal incident that has occurred in the institution.

This involves:

- a) review relevant documentation (conducted by another team of experts)
- b) compile a record of the patient's treatment
- c) write an official report

## II/3. OPTIONAL PART – INDIVIDUAL HELP

a) The affected therapist or staff member should choose the consultant/therapist with whom he/she wants to work.

b) When?

Immediately after the suicide – as soon as possible

c) When?

The staff member and the consultant should meet in working hours.

d) How long?

For as long it is necessary – there should be no limitations.

## II/4. OPTIONAL PART – GROUP HELP

The same guidelines apply for the group as for individual help - the only difference is that the group can decide the format. The group may include various professionals from the team or from outside the institution.

All of the above-mentioned formal help adds to the informal help provided by colleagues and friends throughout the process of surviving the suicide of a patient.



## KEY RECOMMENDATIONS

When suicide of a patient strikes the therapeutic team, it is difficult for each member of the team to accept, understand and cope with this traumatic fact. The event calls for a prompt response of different help measures for the team members that should be on four levels: administrative, institutional, educational and emotional. It should be available as soon as possible after the event and it should involve all team members who knew and worked with the patient. It is important that the clinician can articulate, express and accept his/her own doubts, fears, guilt and other difficult feelings – either individually or in a group, whatever suits best. It is necessary to provide time and place for the processing and understanding of feelings and reactions, preferably with supervision or at least professional consultation.

It is considered that a core set of recommendations are universally applicable, but there are specific culture dependent guidelines that may be applicable in certain countries and environments.

## APPENDIX

### PREVENTION

1. for psychiatry and clinical psychology residents
2. for novices – social workers, occupational therapists, registered nurses
3. for novices – nurses

Provide basic knowledge of suicidology, prevention and postvention – what every healthcare professional should know and do when a suicide occurs, and what kind of help they can receive.

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#### CONTRIBUTORS

The author asked a few internationally distinguished colleagues from the field of postvention to revise the text, which all have done generously and thus I would like to express my thanks and gratefulness to the most valuable remarks and suggestions to:

Karl Andriessen, M. Suicidology, Coordinator, Suicide Prevention Program of the Community Mental Health Centres in Flanders-Belgium

Dolores Angela Castelli Dransart, PhD, Head of the Research Department, University of Applied Sciences, Fribourg, Western Switzerland;

Nina Gutin, PhD, Pasadena, USA

Seán McCarthy, Regional Suicide Resource Officer, St Patrick's Hospital, John's Hill, Waterford, Ireland

Prof. Konrad Michel, MD, University Hospital Bern, Switzerland

John Peters, M. Suicidology, Volunteer - Survivors of Bereavement by Suicide,  
Birmingham, UK