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Original Article

Effects of patient deaths by suicide on clinicians working in mental health: A survey

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ABSTRACT: *In the UK, at least a quarter of suicides occurs in patients whilst under the care of mental health services. This study investigated the effects of such deaths on non-medical mental health clinicians. An online survey was conducted within a single NHS mental health Trust to elicit both quantitative and qualitative responses from staff across a range of professions. The survey focused on personal and professional impacts and available support. Participants reported significant negative emotional and professional effects that were long-lasting for some. These included mental health difficulties, loss of confidence regarding clinical responsibilities, and actual or contemplated career change. However, there was also some evidence of positive effects and professional growth. Support from colleagues and line managers is clearly important following deaths of patients by suicide. Clinicians' experiences of the support they had received in the workplace were polarized, suggesting that there is no single nor ideal approach that will meet everyone's needs. Participants made recommendations for the types of support that may be helpful. Most commonly, clinicians desired opportunities for focused reflection and support and help with the formal processes following the death. Sensitivity around how clinicians are notified about the death was highlighted as being particularly important. Conclusions are drawn as to how training institutions and employers can help staff to be better prepared for the potential occurrence of patient suicides and the formal processes that follow, with a view to mitigating risks of more serious harm to staff and hence indirectly to patients, and potential loss of highly trained clinicians to the workforce.*

KEY WORDS: *clinicians, effects, mental health, patient, suicide.*

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INTRODUCTION

Sadly, deaths by suicide of mental health patients remain relatively common, for example, 27% of all suicides in the UK (Appelby *et al*. 2022). Awareness of the significant impact that such deaths can have on the personal and professional lives of mental health practitioners is growing (Gibbons *et al*. 2019; Gutin 2019a; Leaune *et al*. 2020; Whisenhunt *et al*. 2017). This has consequences for staff wellbeing, recruitment and retention, and patient care. Most studies have concentrated on the impact on a specific group of professionals, usually psychiatrists and psychologists (e.g. Chemtob *et al*. 1988; Finlayson & Simmonds 2018). There has been less attention to other mental health clinicians such as nurses, social workers, and occupational therapists (including qualified, students and support staff), who are just as likely to experience and be affected by these tragic events (Linke 2002; Sandford *et al*. 2020; Takahashi *et al*. 2011; Ting *et al*. 2006).

The emotional effects following a patient's suicide described in different studies have been relatively consistent, with clinicians reporting strong feelings of responsibility, guilt, blame, shock, anger, sadness, anxiety, and grief (Gulfi *et al*. 2010; Gutin 2019a; Sandford *et al*. 2020). In some cases, these effects have been compared to a life event such as the death of a parent (Chemtob *et al*. 1988). Clinicians can struggle with feelings of isolation and stigma, experiencing 'disenfranchised' grief, that is, grief felt not to be legitimate when compared to the experience of others who have been bereaved, such as family members (Doka 1999). There is frequently anxiety about being blamed by employers or professional bodies, with concern about losing professional registration (Shanley, O, unpubl. Data, 2012). These fears can be exacerbated by responses of organizations, including post-death investigations (Gibbons *et al*. 2019).

For some clinicians, the personal and professional repercussions are long-lasting and extensive, in some cases leading to career change or early retirement (Gibbons *et al*. 2019; Gutin 2019a). Authors consistently report negative effects on clinical confidence, with avoidance of looking after suicidal patients and general aversion to risk (Gibbons *et al*. 2019; Sandford *et al*. 2020). However, there is increasing interest in post-traumatic growth and enhanced resilience after these traumatic events (Sandford *et al*. 2020; Smith *et al*. 2011; Tedeschi & Calhoun 2008). Reported changes include a greater likelihood to consult with other team members, improved understanding of professional limitations, and increased willingness to provide support to colleagues (Gill 2012; Gutin 2019a; Valente & Saunders 2002).

Given the profound effects this experience can have on clinicians and a growing awareness of how consistent and reliable support may mitigate adverse outcomes (Gibbons *et al*. 2019; Gutin 2019a; Sandford *et al*. 2020; Whisenhunt *et al*. 2017), there has been very little investigation into the most helpful form or structure of support. A previous survey of psychiatrists conducted by the current authors concluded that interventions should include access to a senior clinician with a specialist focus on suicide, support during formal post-suicide processes, opportunity for reflection on practice, information about resources to support families, and help communicating with families and friends of the deceased (Gibbons *et al*. 2019).

We have conducted a survey of clinicians working in mental health, excluding doctors, (who were the focus of an earlier study, Gibbons *et al*. 2019), to investigate their experiences following the death by suicide of patients and their requirements for support in the aftermath.

METHOD

Design & data collection

An online cross-sectional survey was designed by the authors who are a multi-disciplinary group of mental health clinicians. Design was informed by the authors' experiences of deaths of patients by suicide, of supporting staff following deaths, and by our previous research (Gibbons *et al*. 2019; Wolfart 2011). The survey was developed using Survey Monkey and consisted of 45 items, including sliding scale, multiple choice, and open questions (see Appendix I). The survey was conducted among clinicians working in mental health, excluding doctors, from one large NHS mental health service in England. Whilst it is recognized that not all those clinicians responding to the survey would hold a specific mental health qualification (e.g. physical health nurses), they would all have been working with mental health patients. The Trust is a very large organization and as far as we are aware, the occurrence of suicides of patients is similar to that of other large Trusts which include mental health services.

The survey was publicized on the Trust intranet and distributed by clinical leads and managers. It was available for a period of 2 months, with a reminder email

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sent after 1 month. Whilst the survey focused on the experience of the death of patients by suicide, it was open to staff who had not had this experience to elicit their views on support they think might help prepare them for it. Participants who had experienced more than one death of a patient by suicide were asked to focus on the death that had been the most impactful experience. No time limit was imposed on when the death of the patient(s) had occurred.

Participant information included signposting to support services should complete the survey and cause any distress. Anonymity was assured and participants were asked for explicit consent for their responses to open questions to be used for publication. Only qualitative data from consenting participants have been included. Survey data were only accessed by some members of the research team (authors Rachel Gibbons, Alison Croft, Karen Lascelles and Fiona Brand).

Data analysis

Participants were free to choose whether to respond to each survey item without giving reasons for non-responses. Percentages are calculated according to the total number of responses for each question (*N*/total responses on item, %). Numerical data were analysed using SPSS to summarize the descriptive statistics and calculate means and standard deviations for each of the quantitative survey items. Independent *T*-tests were conducted to determine significance of respective impacts on men and women.

An inductive content analysis approach was used to analyse qualitative data, using a process of open coding, creating categories and abstraction (Elo & Kyngas 2008). The emphasis was on manifest content and therefore description rather than interpretation. This involved line-by-line reading of data for each question by two researchers (authors Karen Lascelles and Fiona Brand) individually, to elicit and group categories. These categories were then shared and discussed to address differences and achieve consensus. Subsequently, main categories were created (see Appendix II). Data were organized in Excel by grouping all responses to each open question.

RESULTS

Participants

Two-hundred-and-twenty professionals completed the survey. Calculating the response rate is problematic as it is not possible to know how many clinicians viewed the survey advert or emails. Based on staff numbers at the time of distribution, it is estimated that approximately 2140 clinicians may have had the opportunity to view the survey, yielding an approximate response rate of 10.3%. Whilst this is probably an underestimate (given that some individuals would not have seen the announcement), the response was considerably lower than expected. One reason for this may have been the COVID-19 pandemic, which resulted in national lockdown shortly after the survey began and greatly increased pressures on clinical staff.

All the main healthcare professions (excluding doctors) were represented, with nurses being the largest staff group $N = 72$ (32.7%), followed by psychological therapists $N = 44$ (20.0%), psychologists $N = 41$ (18.6%), social workers $N = 23$ (10.5%), healthcare assistants/support workers $N = 16$ (7.3%), occupational therapists $N = 9$ (4.1%), and other professions, including pharmacists and a chaplain, $N = 15$ (6.8%). Half of all participants were aged between 35 and 54 years ($N = 111$, 50.5%) and had more than 10 years of experience working in mental health ($N = 118$, 54.1%). Most (160, 72.7%), were currently working in a community setting and a large proportion in general adult psychiatry ($N = 94$, 42.7%).

Clinicians who had experienced deaths of patients by suicide

134 of all participants (60.1%) reported having experienced deaths of patients by suicide.

The characteristics of the clinicians who had experienced deaths of patient by suicide are shown in Table 1.

Most participants ($N = 121/134$, 90.0%) had experienced between 1 and 5 suicides of patients, with a few ($N = 4/134$, 3.0%) having experienced more than 10 such deaths. The most impactful death had occurred between less than 6 months (16/116, 13.8%) and 10 years ago (15/116, 12.9%). The largest subgroup of participants ($N = 31/116$, 26.7%) responded in relation to a death occurring 18 months-3 years ago.

The majority of clinicians had experienced the death of a patient by suicide whilst working in general adult psychiatry ($N = 60/104$, 57.7%). Deaths in the community were most frequently reported ($N = 71/107$, 66.4%), followed by those in inpatient settings ($N = 23/107$, 21.5%).

A quarter of staff (33, 24.6%) had considered making a change to their career because of the death, and

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TABLE 1 *Characteristics of staff who experienced deaths of patients by suicide* N/*134 (%)*

Profession	Nurse 59 (44.0)	Psychologist 15 (11.2)	Social worker 14 (10.4)	Psychological therapist 22 (16.4)	Occupational therapist 8 (6.0)	Healthcare assistant 9 (6.7)	Other 7 (5.2)
Current area of work†	General Adult 58 (43.2)	Older Adult 13 (9.7)	Child & adolescent 32 (23.9)	Forensic 11 (8.2)	Psychological services 26 (19.4)	Liaison psychiatry 12 (9.0)	Other‡ 35 (26.1)
Years in mental health	1–3 9 (6.7)	4–6 19 (14.2)	7–10 14 (10.4)	10+ 91 (67.9)			
Age group (yrs.)	22–28 9 (6.7)	29–34 24 (17.9)	35–44 35 (26.1)	45–54 35 (26.1)	55–64 25 (18.7)	65+ 5 (3.7)	
Gender	Male 25 (18.6)	Female 108 (80.6)	Non-binary 1 (0.75)				

†Many staff had split posts across different areas; hence, %s total > 100%.
‡Includes eating disorders, addictions, intellectual disability, perinatal, rehabilitation, neuropsychiatry.

qualitative responses indicated that some people changed role due to the experience. However, more than half (69, 51.5%) were still working in the same clinical area at the time of the survey.

> The suicide affected me in ways I could not articulate for a long time. My job felt intolerable, and I ultimately left. (Social Worker)

Effects on clinicians' emotional wellbeing and mental health

Clinicians (N = 89/107, 83.2%) rated the greatest emotional effect of the suicide at any point since the death on a sliding scale from 0–100 (scores are reported as percentages). The mean rating was 61.1% (SD = 18.3). A large number (50/106, 47.2%) indicated that they thought their mental health had been adversely affected by the death, with another 25/106, (23.6%) being 'unsure'.

Participants were asked to describe their emotional responses to the deaths and the effects on their mental health. The most common immediate emotions were shock, sadness, feeling upset and, for many, feelings of guilt, shame, and responsibility. Clinicians also reported anxiety related to fears of being blamed, the formal processes following the suicide (investigations and inquests) and the responses of patients' families.

> I felt confused and shocked at first and this made it hard to really take on board or process for quite a few days. I felt strong sadness that the client I had got to know very well was now dead. I felt very sorry that I had not helped him enough. I doubted myself as a professional and I felt guilty and ashamed as if I had done something wrong. (Psychologist)

For some clinicians, these emotional reactions were pervasive, in some cases involving a sense of internal criticism and persecution, with individuals ruminating about the patient and the incident. The most common mental health problems reported were disturbed sleep, low mood, and anxiety. A small number of respondents reported symptoms indicative of PTSD-like reactions, such as hyperarousal and flashbacks.

> Overwhelming sense of guilt, a personal responsibility. Grief. Tearfulness. Reduced appetite. Difficulty sleeping. Difficulty Concentrating. (Nurse)

> ....in shock, sad, blaming self, questioning self..., could not sleep, on hyper-arousal for weeks, lost 3 kg, tearful. (Psychological Therapist)

Some participants described a sense of loss, particularly when they had worked with the patient for some time, and for a few the depth of this feeling of loss was unexpected.

> 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)

Despite the distress reported, most participants (N = 84/107, 78.5%) had taken no time off work following the event. Of those who had, most were absent for a day to a week (N = 9/23, 39.1%). A smaller number (4/23, 17.4%) had been absent from work for more than a month following the death.

Some respondents reported that finding out about the death second hand or via insensitive communication had contributed to their distress, particularly when they found out unexpectedly and/or were not included in communications because they were outside the immediate team.

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> I heard of it through word of mouth… the awful feeling stayed with me for months… (Nurse)

> 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)

Effects on clinical confidence

Emotional responses were often entwined with considerable effects on clinical confidence and practice. In free-text responses, many clinicians reported experiencing a strong sense of failure and professional anxiety around working with suicide risk, reporting fear of another suicide, self-doubt, becoming hypervigilant and risk averse, and engaging in defensive practice. They reported preoccupation with 'what ifs', questioning their clinical practice, what they could or should have done, and whether or not this would have made a difference. Some participants indicated a sense of surprise and confusion following the death because their patient had appeared to be improving at the time. Some reported reduced emotional presence and motivation at work. Others expressed a sense of frustration at the mental health care system, with a small minority of participants questioning whether services can help patients who are suicidal.

> 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)

> I felt as though I was not as emotionally available as I normally am for patients and that I did not give hope with the same conviction as I normally would. (Nurse)

> I felt hopeless that anything could help someone with their mental health. I lost confidence and passion as it just felt like a losing battle all the time. (Psychological Therapist)

Rating the extent of detrimental effects on clinical confidence following the death on a 0–100 sliding scale, clinicians (N = 98) gave a mean score of 46.5% (SD = 27.7). Independent samples t-test indicated no significant differences in scores between men (M = 48.8%, SD = 27.0) and women [(M = 45.2%, SD = 27.5); t (95) = 0.517, P = 0.606].

The duration of these effects ranged from days to years, with around half of participants (N = 50/96, 52.1%) reporting negative effects on their clinical confidence lasting between one and 6 months. Some (N = 15/96, 15.6%) reported that the effects were ongoing. The following quotes from the same participant show how the impact of loss of a patient to suicide can change over time yet continue to have effects.

> **(Short term)** I felt unable to make decisions about risk assessment, I wanted to avoid cases with suicidal patients completely. I started to feel that people might think I was bad at my job ………
> **(Longer term)** I feel more confident now but am still quick to feeling anxious and jump to the conclusion that a patient will kill themselves. I am still very anxious if a manager asks to have a word with me as this is what has been said just prior to being told a patient has died (Social Worker)

Some clinicians reported experiencing professional growth in relation to knowledge and skills, increased diligence with risk assessment and documentation, and improved capacity for deeper and more reflective perspective on role responsibility and psychological safety.

> **[Short term]** Mistrusting the system and my own judgement.
> **[Longer term]** Being more aware of the possibility of completed suicide, making use of support/supervision (Nurse)

Perceived responsibility for the death

Overall, clinicians gave a mean score of 39.9% (SD = 24.9) on a 0–100 sliding scale when reporting how responsible they felt for the death of their patient by suicide at the time it happened. There were no significant differences between men (M = 37.6, SD = 23.8) and women (M = 39.7, SD = 24.6) [t (95) = −0.333, P = 0.740]. This perception of responsibility reduced over time for all clinicians, with the mean dropping to 15.9% (SD = 17.4) when reporting on how responsible they now felt.

Qualitative responses suggested that most participants did not perceive themselves to be held responsible for the death by others, although some indicated that they perceived an inference of blame from their organization (through investigations or by managers), colleagues, or the patient's family.

> The family were very angry and felt their loved one's death was preventable, they were angry with me personally for not contacting them. (Social Worker)

> I was made to feel as if I had seen the patient the day before she committed suicide and not 3 months previously within a different service. (Psychological Therapist)

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Perceptions of the formal processes following the death

Generally, participants who experienced the death of a patient by suicide reported having felt unprepared for the formal processes that followed the death; however, they subsequently felt more knowledgeable [Mean before = 43.9% (SD = 32.6); Mean after = 61.7% (SD = 25.3)].

Of those who responded to the question about whether they had received advice or support with the formal processes, the majority (*N* = 82/114, 71.9%) reported that they had. Just over half of the participants (*N* = 63/114, 55.3%) had received support from their organization or training institution, with the rest having been supported informally by colleagues.

There was a broad range of responses from clinicians who had participated in their Trust's internal inquiry as to how helpful or unhelpful they found it, with no apparent consensus. Open question responses indicated that some staff found it very unhelpful.

> The trust review found some learning points on one death but were insensitive in giving the feedback. I felt I had to be defensive... like the learning points were what caused the death, yet they were systemic rather than human. (Nurse)

Free-text responses suggested that investigations and inquests could be very stressful and frightening, including writing reports, but this could be mitigated by feeling prepared and also by experiencing fair and transparent processes.

> I only had to write a report, but this in itself was very stressful because I kept thinking that I was going to be held responsible even though I wasn't. (Occupational Therapist)

> Harrowing, terrifying, sobering, felt like I was going on trial, but the coroner was clear and made it easier. (Nurse)

Perceptions of support received

Whilst most respondents reported receiving support following the death of a patient by suicide, a sizeable proportion of participants reported that they had received no support at work (*N* = 11/104, 10.6%), or outside work (*N* = 35/104, 33.6%). Most people were offered support by their manager or supervisor (*N* = 74/104, 71.2%) and by their immediate colleagues (*N* = 78/104, 75.0%), often from their own profession. A few were supported by chaplains (*N* = 19/104, 18.3%), occupational health (*N* = 6/104, 5.8%), and support services within the organization. Most of those who had accessed help outside of work had done so from family (*N* = 52/104, 50.0%) and friends (*N* = 28/104, 26.9%), rather than by seeking formal support.

Participants were asked to rate any support received from their employer on a sliding scale of 0–100, according to both how helpful and unhelpful they had found it. This yielded polarized responses, with 23/89, (25.8%) rating the help received as very helpful (deemed to be >75/100), and 20/80 (25.0%) rating the help received as very unhelpful (>75/100).

This polarization was also evident in the qualitative responses, which indicated that unhelpful support was often due to how organizational interventions following suicide were delivered rather than the intervention per se. Support experienced as most helpful was reflective and relational in nature, such as clinicians having the opportunity to talk with others about their experiences and reactions, either informally or in a facilitated forum. Structured support and guidance focusing on the formal processes following the death was also valued, as was timely and sensitive notification, being kept informed of processes and knowing that support was available if needed. Helpful and unhelpful categories derived from the qualitative data are summarized in Table 2.

Support wanted

A checklist of potential sources of support following suicides of patients was generated, based on previous research and the researchers' own experience of supporting staff following patient suicides. Participants were invited to endorse as many options from this list as they wished. Responses of all participants, regardless of whether they had experienced the death of a patient by suicide, are shown in rank order in Table 3. The most commonly endorsed options were in two areas: opportunities for focused reflection and support and help with the formal processes following the death.

Additional suggestions included preparation for the possibility of suicide during training, including the emotional responses staff may have and the processes they may need to go through; sensitive notification of the death; opportunity for compassionate leave; reflective space in the longer term (e.g. 6 months after) as well as in the short term; and organizational awareness of the intense impact a suicide can have on staff.

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TABLE 2 *Helpful and unhelpful support*

Helpful support	Unhelpful support
Timely notification. Being kept informed of processes and new information	Being informed insensitively; being told as an afterthought; finding out unexpectedly; lack of detail about circumstances; not communicating availability of support; not updating staff about processes; lack of communication systems
Management support, not feeling judged or blamed	Perceived inferences of blame; emphasis on processes; disjointed processes; feeling swamped by senior management support
Reflective space and time to talk Management support Collegial/peer support Clinical supervision Chaplaincy support Counselling Time off Support over time	Support that was promised but not delivered; support not extended to staff outside immediate team or those not directly involved; support not individualized; no time off or reflective space; counselling not offered; support short term only; lack of practical support; lack of support during processes; lack of reassurance; not talking about it
Debriefs	Unhelpful debriefs: too early; too late; poorly facilitated; traumatic
Sensitive and comprehensive investigations	Insensitive investigations; overzealous investigators; inference of blame
Guidance, support and preparation for processes (e.g. inquest, investigations)	Lack of guidance; not being aware of or prepared for processes
Knowing that support was available and offered even if not taken up	Organization not recognizing the emotional impact; expectation to get back to business as usual; not recognizing longer-term impact, or cumulative impact of suicides; not recognizing the link between impact of suicide and changes in practice

TABLE 3 *Sources of help endorsed by respondents* (*N* = *220*)

What would be helpful to MH professionals having experienced the death of a patient by suicide?	*N*	%
Personal debrief	104	47.3
Support for formal processes following a patient's suicide	102	46.4
A senior clinician with a role as suicide lead who could give confidential advice and support	101	45.9
Information about the process following patients' death by suicide	97	44.1
Confidential reflective practice group/space specifically for processing the effects of a patient's suicide	96	43.6
Information about resources for families affected by suicide	83	37.7
Help in communicating or meeting the family/ friends of the patient who has died (e.g. Public Health England's Help is at Hand)	81	36.8
A training session about this topic	80	36.4
Access to a general reflective practice group	70	31.8
Counselling & therapy	68	30.9
Organized peer support	62	28.2
All of the above	58	26.4
Information about support for the community (including schools)	55	25.0
A workshop to share experiences	42	19.1
Nothing	1	0.5

Beliefs/perceived pressure regarding suicide prevention

Participants were asked to make ratings on a 0–100 sliding scale for each of three items focusing on their beliefs about the preventability and predictability of suicide. The responses are shown in Table 4, represented as mean % scores for all those responding to the question (higher scores indicate stronger beliefs).

Qualitative responses related to these questions indicated consensus that most respondents regarded suicide prevention to be part of the mental health worker's role, with some emphasizing it as being a key aspect of care. Many shared a pragmatic perspective, articulating that whilst suicide prevention is part of their role, it is not possible to prevent all suicides. Overall responses to these questions did not differ between clinicians who had or had not experienced the death of a patient by suicide. Shared responsibility around suicide prevention was highlighted, emphasizing roles of patients, families, and wider social systems in suicide prevention. Some participants expressed beliefs around patient self-determination and the associated limitations of mental health care, for example, only being able to work with what patients tell us.

> If I believe it is completely down to us, I think I would struggle to do my job! I have to believe to some extent they have a choice in this too. I believe we can do a lot to try and keep them safe, but we must not allow people to become reliant on us completely. (Psychological Therapist)

Some views were expressed relating to pressures and unrealistic expectations placed upon mental health staff by organizations.

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TABLE 4 *Beliefs about suicide prevention*

Survey question	*N* responses, Mean score (%), (SD)
How much do you believe it is role of mental health professionals to prevent suicide?	102, 68.5 (22.9)
How much do you feel pressure from others to prevent suicide?	97, 73.3 (27.5)
How predictable is suicide in secondary care?	101, 50.1 (16.5)

> Zero suicides is an unattainable target and to continue pushing toward that is to continue to make health care professionals suffer unnecessary guilt when people decide they no longer wish to continue living. (Nurse)

DISCUSSION

The results of this study of clinicians working in mental health add to those of previous research in the field and confirm that the professional and personal impacts of deaths of patients by suicide are usually very significant and can be long-lasting. The key themes identified from the overall analysis (content analysis and responses to structured questions) are discussed below.

Emotional effects

Findings of the survey indicated that the death of a patient by suicide frequently affects emotional wellbeing, professional practice and, in some cases, even future career choices. These deaths are both loss events and traumatic experiences, and therefore, the emotional responses are complex. Very common responses, as in previous research, (Gutin 2019a; Sandford *et al*. 2020), were feelings of shame, guilt and grief, as well as rumination and searching for meaning. Whilst these are all very human responses to traumatic loss, some clinicians reported uncertainty about whether their reactions were acceptable in the context of a professional relationship. This may explain why, although half of our sample reported a negative effect on their mental health, another quarter were 'unsure', and very few took any time off work. It may be that the meaning of acknowledging vulnerability or mental health needs continues to carry a stigma for clinicians.

Notification of a patient death by suicide

One important theme emerging from the current study, which has not commonly been highlighted by other research, was the manner in which clinicians were notified of their patient's death. When handled insensitively, this seemed to magnify initial emotional effects. Previous research has shown that a poorly executed death notification, particularly following a sudden or traumatic death (such as by suicide), can negatively influence grief responses, increasing risk of psychopathology in the bereaved (De Leo *et al*. 2020). In relation to clinicians being informed about deaths of patients by suicide, Scupham (Scupham, S., unpubl. Data, 2017) identified that the timing and mode of communication, the setting in which they received the news and their relationship with the notifier can influence the way in which clinicians respond. Given that death by suicide is a sad reality of mental health care, it is reasonable to expect that employing organizations give due consideration to compassionate notification, so that no one need suffer additional distress through hearing this news as an 'afterthought' or 'by accident'.

Effects on clinical practice

Echoing previous research (Gibbons *et al*. 2019; Sandford *et al*. 2020), most participants reported that their clinical confidence was adversely affected following the death of a patient by suicide, particularly in relation to risk assessment and management. Despite these effects reducing or changing over time, in some cases, effects on clinical confidence were enduring.

For some participants, their experiences led to professional wisdom, perhaps akin to post-traumatic growth, such as greater acceptance of suicide as a possibility and a more realistic sense of the limits of professional responsibility, again reflecting previous research (Sandford *et al*. 2020).

Support after a patient dies by suicide

It was clear from our survey that support was both needed and wanted. Many clinicians endorsed the value of opportunities to reflect on their experiences, whether individually or with others. Practical support and guidance to navigate the formal processes following a patient's death by suicide was also ranked highly. This is an issue which has been addressed in guidance for psychiatrists (Oxford University Centre for Suicide Research 2020) and merits attention for other mental health clinicians.

Most clinicians experienced support from managers and other colleagues as being helpful. However, some found the support offered to them to be inadequate or

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unhelpful, or they received no support at all. There could be many reasons for this, including individual clinicians' responses, such as withdrawal due to feelings of shame, perceived stigma, fear of being blamed, concern about negative professional consequences, the constraints of confidentiality around formal or legal processes (Gutin 2019a), and/or inadequate support systems (Sandford *et al.* 2020). Responses to the survey suggested that lack of clarity and disorganization around support meant that, even when it was available, it did not necessarily benefit clinicians as intended. These experiences point to the need for clear and coordinated responses to the needs of clinicians following patient's suicide. The polarized views on support that was offered to participants suggest that there is no 'one size fits all' intervention that is ideal. Rather it seems important that clinicians are offered a range of options and can exercise choice as to whether and when they accept support, and what is most appropriate for them. Furthermore, support should continue to be available in the long term, not only in the immediate aftermath of the death.

Training

Many participants felt inadequately prepared for the experience of a patient's suicide and the formal processes following the death. Previous research has recommended that clinicians should be prepared for the possibility of suicide through education or training and organizational support, to try and counter the extent of negative effects when incidents do occur (Castelli Dransart *et al.* 2015, Sandford *et al.* 2020). As most mental health workers will experience at least one and sometimes several suicides of patients during their career, training institutions, professional bodies, and employing organizations have a responsibility to ensure provision of appropriate training, guidance and support. Many participants perceived pressure, self-imposed or from others, to prevent suicide. Training should also enable clinicians to develop balanced beliefs and expectations of their capacity to prevent these deaths.

Strengths and limitations

This survey research involved collection of both quantitative and qualitative data, which generated a richness of data that neither a quantitative nor qualitative approach alone could achieve. The study was conducted within a single NHS Trust, where most of the authors are employed, and where there is investment and active research around suicide prevention. The low response rate and the fact that the sample was self-selected may have introduced bias to the results if respondents were individuals who held particularly strong views due to personal experience. In addition, these factors may mean that the results are not generalizable even to the organization in which the study was conducted. However, the high concordance with findings of previous research is striking. Respondents reflected on deaths by suicide ranging from those occurring very recently, to those many years previously. This may have affected responses, as for most people, the impact diminishes over time and perceptions of the event may also change. Future research could usefully investigate what support might be most helpful at which points in the aftermath of experiencing death of a patient by suicide. Although our study did not aim to investigate whether effects, support, or training needs vary among different professional groups, this could be a valuable area for future research, particularly given the differing roles and responsibilities within clinical teams.

CONCLUSIONS

This research confirms that the death of a patient by suicide is a traumatic experience for clinicians and one that can have profound and enduring effects. Mental healthcare organizations, including associated training and education establishments, have a responsibility to prepare staff for the possibility of suicide and provide tailored support should it occur. Support in the workplace following suicide has received increasing attention, and various guidance and research findings are available to help organizations establish appropriate systems (Gutin 2019b; Leaune *et al.* 2020). It is important to consider whether it is possible to facilitate recovery and growth and to prevent ongoing negative impacts on staff, which, if left unattended, have the potential to be detrimental to clinical and personal functioning and which may lead to poor staff wellbeing and difficulties with staff retention.

RELEVANCE TO CLINICAL PRACTICE

This research adds to the existing body of knowledge in this area by providing information from a range of mental health professionals on the personal and professional effects of patient death by suicide. The importance of sensitive and inclusive notification following

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suicide is highlighted as well as providing evidence for the need for varied support systems available to suit individual clinicians' needs. Mental health organizations, educational institutions, and professional bodies should ensure availability of tailored training and support for their workforce.

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Approval for the study was granted by the Health Research Authority/Health and Care Research Wales (project ID 261157).

DATA AVAILABILITY STATEMENT

Research data are not shared owing to confidentiality offered to survey participants.

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APPENDIX I:

The Experiences of Mental Health Professionals Following Patient Suicides/Suspected Suicides

IRAS Project ID: 261157 Date: 21st October 2019 Version: 2

Participant Information Sheet

Please read the following information

What is the purpose of this survey?
This survey has been designed to investigate the effects of patient suicides on Mental Health Professionals and the subsequent support required. It is hoped that the knowledge gathered will help to improve training, information and support.
Why have I been invited?
This survey is being sent to all non-medical Mental Health Professionals at Oxford Health Foundation Trust NHS Trust.
Do I have to take part?
Completion of the survey is voluntary. Your employment and role will not be affected if you decide not to take part.
What will happen to me if I take part?
Once you give your consent by ticking the box below you will be presented with the survey.
- **You can decide to stop at any time**
- **You need not answer questions that you do not wish to**
- **It will not be possible to identify anyone from our reports on the study but to help with this please ensure that your responses to not include identifiable data**
- **If you do not wish for anonymous extracts of your qualitative responses to be included in the published report please complete Q46**

What are the potential benefits or advantages of taking part?
Although there is no immediate benefit for you, the survey will offer the possibility for personal-reflection. You will also be contributing to developing future support mechanisms for fellow Mental Health Professionals.
Are there any risks or disadvantages of taking part?
Completion of the survey will take up some of your time (approx 15 mins). This is a sensitive topic. If you would like to access support please see the list of resources at the end of the survey.
Can I withdraw from the study?
If you decide to stop part way through the survey that is fine; if you submit the survey the data collected will still be used.
Will the information I give be kept confidential?
Yes, we will follow ethical and legal practice regarding confidentiality. Oxford Health NHS Foundation Trust & Oxford University will act as the data controller for this study.
Your results will be coded and no identifiable personal information will be attached to the data. If you withdraw from the study, we will keep the information about you. Once you complete the survey your rights to access, to change or to move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate
Where will the information be kept and who will have access to it?

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All data is securely stored in Surveymonkey accredited data centers that adhere to security and technical best practices. Data is encrypted using industry standard encryption algorithms and strength and password protected. Access is by the research team only (Gibbons, Brand, Carbonnier, Croft, Lascelles, Wolfart & Hawton). When the survey is completed all data will be stored securely on a data and password protected computer within the University of Oxford and Oxford Health NHS Foundation Trust and deleted from Surveymonkey
What will happen to the results of the survey
We aim to publish them in an academic journal

1. I have read the participant infomation sheet and I agree to take part in this survey.

◯ Yes

◯ No

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The Experiences of Mental Health Professionals Following Patient Suicides/Suspected Suicides

IRAS Project ID: 261157 Date: 21st October 2019 Version: 2

Demographic Information

2. Are you?

- ○ Male
- ○ Female
- ○ Non binary

3. What is your age?

- ○ 22-28
- ○ 29-34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

4. How many years have you been working in mental health?

- ○ 1-3 years
- ○ 4-6 years
- ○ 6-10 years
- ○ More than 10 years

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5. What is your professional group

- ◯ Nursing
- ◯ Psychology
- ◯ Social work
- ◯ Occupational therapy
- ◯ Dietician
- ◯ Psychological therapy
- ◯ Other (please specify)

6. Are you are student in your Core Profession?

- ☐ Yes
- ☐ No

7. Which age group of patients do you work with (select all that apply)?

- ☐ Child and Adolescent
- ☐ General Adult
- ☐ Older Adult
- ☐ Other (please specify)

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8. Your Current area of work is (select all those that apply)?

- [ ] Addictions
- [ ] General Adult
- [ ] Child and Adolescent
- [ ] Eating disorders
- [ ] Forensic
- [ ] Intellectual Disability
- [ ] Liaison
- [ ] Psychological services
- [ ] Neuropsychiatry
- [ ] Older Adults
- [ ] Perinatal
- [ ] Rehabilitation
- [ ] Other (please specify)

9. What setting do you work in now (select all that apply)?

- [ ] Inpatient
- [ ] Crisis or Home Treatment
- [ ] Community and outpatient
- [ ] Specialist service (e.g Learning Disability or Eating Disorders)
- [ ] Liaison

Other (please specify)

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10. What is your current role (select all that apply).

- ◯ Nurse
- ◯ Psychologist
- ◯ Social Worker
- ◯ Occupational Therapist
- ◯ Dietician
- ◯ Care co-ordinator
- ◯ Health Care Assistant/Support worker
- ◯ Manager
- ◯ Psychological Therapist
- ◯ Other (please specify)

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The Experiences of Mental Health Professionals Following Patient Suicides/Suspected Suicides

IRAS Project ID: 261157 Date: 21st October 2019 Version: 2

11. Have you worked with a patient who died by suicide or suspected suicide (henceforth referred to as "suicide")? If your answer is 'never' you are directed to Part 2 of the survey.

- ◯ Never
- ◯ Once
- ◯ Twice
- ◯ Three to five times
- ◯ Six to ten times
- ◯ More than 10 times
- ◯ More (please specify how many times)

If you have had more than one patient die by suicide please relate your responses to the following questions to the death that had the most significant effect on you.

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The Experiences of Mental Health Professionals Following Patient Suicides/Suspected Suicides

IRAS Project ID: 261157 Date: 21st October 2019 Version: 2

Part 1

12. How long ago was this?

- ◯ In the last three months
- ◯ Between 3-6 months ago
- ◯ Between 6-18 months ago
- ◯ Between 18 months and 3 years ago
- ◯ Between 3 and 5 years ago
- ◯ Between 5 and 10 years ago
- ◯ Over 10 years ago

13. Please specify the service/client group in which you worked with this patient.

- ◯ Addictions
- ◯ General Adult
- ◯ Child and Adolescent
- ◯ Eating Disorders
- ◯ Forensic
- ◯ Intellectual Disability
- ◯ Liaison
- ◯ Medical Psychotherapy
- ◯ Older Adults
- ◯ Perinatal
- ◯ Rehabilitation
- ◯ Other (please specify)

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14. In which psychiatric setting did this suicide occur?

- Inpatient
- Community
- Crisis, Home Treatment Team
- Specialist services (e.g Learning disability or Eating Disorder)
- Liaison
- Other (please specify)

15. Consider the effect that this patient's death had upon your own emotional wellbeing. Please rate the greatest extent to which it affected your emotional wellbeing at any point following the event (by moving the marker).

None Moderate Severe

16. Please use the box below to describe the emotional effect it had on you?

17. ***At the time*** to what extent did you ***feel*** responsible for the suicide/suspected suicide?

None Moderate Severe

18. Did you experience anyone else holding you responsible for this death? Please describe.

19. ***With hindsight*** how responsible do you feel you were for this death now.

None Moderate Severe

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20. Did this event affect your mental health?

- [ ] Yes
- [ ] No
- [ ] Uncertain

21. Can you describe the effect?

22. At the most difficult point do you feel that this had a detrimental effect on your confidence in your clinical practice?

None | Moderate | Severe

23. Can you describe this effect?

24. Approximately how long did this effect last?

- ○ Less than a week
- ○ 1-4 weeks
- ○ over a month but less than 6 months
- ○ between 6 months and 2 years
- ○ 2-6 years
- ○ 6 years +
- ○ Ongoing
- ○ Other (please specify)

25. Did the experience of a patient dying by suicide have an effect on your clinical practice in the longer term? If so please describe how.

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26. Did you ever consider or act in any way to change your career path as a consequence of a patient suicide?

- ◯ Yes
- ◯ No

Any other comments

[ ]

27. Are you working in the same clinical area as you were at the time of the death?

- ☐ yes
- ☐ no
- ☐ Please give my details about this in relation to the suicide if possible.

[ ]

28. If you were working within a Trust or private hospital, how helpful do you rate the level of support that was provided by the Trust or private hospital at the time?

Unhelpful — Not helpful or unhelpful — Helpful

29. Did you take any annual leave or sick leave because of your experience?

- ◯ No
- ◯ One day to one week
- ◯ More than one week but less than one month
- ◯ One month or more
- ◯ Other (please specify)

[ ]

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30. Please indicate who you were offered support at work by: (Select all that apply)

- ☐ No one
- ☐ Colleagues (doctors)
- ☐ Colleagues (nurses)
- ☐ Colleagues (psychologists)
- ☐ Colleagues (multi-disciplinary team)
- ☐ Manager
- ☐ Mentor
- ☐ Educational supervisor/ Clinical supervisor
- ☐ Clinical director /Assistant Medical Director /DME/ Medical Director
- ☐ Chaplain
- ☐ Occupational Health
- ☐ Other (please specify)

31. Did you access support outside work? (Select all that apply)

- ☐ No one
- ☐ Family
- ☐ Friends
- ☐ GP
- ☐ NHS counselling or therapy
- ☐ Private counselling or therapy
- ☐ Voluntary sector counselling or group e.g Cruise or Bereavement Care
- ☐ Mentor
- ☐ Internet: Web based psychoeducation
- ☐ Internet: Social networking
- ☐ External independent supervision
- ☐ Training institution
- ☐ Other (please specify)

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32. How familiar/ knowledgeable ***were you then*** with the process that takes place following a patient suicide?

Not at all | Somewhat | Very

33. If you gave evidence at the inquest how did you find this experience?

34. At the time of the death which procedures were you***not*** prepared for? (Select all that apply)

- [ ] Giving evidence at an inquest
- [ ] Writing a Coroner's report
- [ ] The internal enquiry
- [ ] Communicating with next of kin
- [ ] Duty of Candour
- [ ] Support for School (If CAMHS patient and you were a CAMHS clinician)
- [ ] Rapid response meeting (If CAMHS patient and you were a CAMHS clinician)
- [ ] Other (please specify)

35. Were you offered advice/ help / support with the processes that follows a patient suicide? (Select all that apply)

- [ ] No
- [ ] Yes formally from someone within the Organisation I worked in
- [ ] Yes informally from a colleague
- [ ] Yes from the training institution
- [ ] Other (please specify)

36. Did anything help make this event easier to cope with?

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37. Did you find anything unhelpful?

38. If you were involved in the Trust or organisation's internal enquiry did you find it helpful or unhelpful?

Unhelpful Neither helpful or unhelpful Helpful

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The Experiences of Mental Health Professionals Following Patient Suicides/Suspected Suicides

IRAS Project ID: 261157 Date: 21st October 2019 Version: 2

PART 2

39. How familiar/ knowledgeable are you ***now*** with the process that takes place following a patient suicide?

Not at all — Somewhat — Very

40. Please select the procedures that you are ***not currently*** familiar/ knowledgeable about ***now***? (Select all that apply)

- [ ] Giving evidence at an inquest
- [ ] Writing a Coroner's report
- [ ] The internal enquiry
- [ ] Communicating with next of kin
- [ ] Duty of Candour
- [ ] Support for School (If CAMHS patient and you were a CAMHS clinician)
- [ ] Rapid response meeting (If CAMHS patient and you were a CAMHS clinician)
- [ ] Other (please specify)

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41. One of the aims of this survey is to identify mental health professionals' specific needs and develop better support for those affected by a patient death by suicide. From the following list, which do you think would be helpful for mental health professionals affected by the death of patient by suicide (select all that apply):

- ☐ Nothing
- ☐ Personal debriefing
- ☐ Access to a general reflective practice group
- ☐ Organised peer support
- ☐ A confidential reflective practice group or space specifically for processing the effects of a patient suicide
- ☐ A senior clinician with a role as suicide lead who could give confidential advice and support
- ☐ Support for the formal processes following a patient's suicide
- ☐ Counselling and therapy
- ☐ Help in communicating or meeting the family/ friends of the patient who has died (e.g Public Health England's Help is at Hand)
- ☐ Information about the process following patients' death by suicide
- ☐ Information about resources for families affected by suicide
- ☐ Information about support for the community (including schools)
- ☐ A training session about this topic
- ☐ A workshop to share experiences
- ☐ All of the above
- ☐ Any other suggestions for what might be helpful?

42. To what degree do you believe preventing suicide is the role of the mental health professional?

Not at all — To some degree — Very much

43. Why do you think you gave the answer you did to question 41?

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44. To what degree do you feel under pressure (by external sources) to prevent suicide in your role as mental health professional?

Not at all To some degree Very much

45. To what degree do you think suicide is predictable in secondary care?

Not at all To some degree Very

46. If you do not give your permission to use anonymised extracts of your answers in any future report or research please select the box

☐ I do not give consent to any of my answers being used by the research team

This space is in case you wish to make any further comments including on this survey, or any other aspect of this topic.

47. You have now reached the end of the survey. Thank you very much for your responses. The space below is if you have any other ideas about what might be helpful for mental health professionals after a patient suicide or any other comments that you think might help understand the impact of the problem on clinicians and how best to help them.

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Debriefing Information

What is the purpose of the study?

Having a patient die by suicide can be painful and sensitive subject that many professionals avoid talking about. Some of us have little knowledge about the effect this experience can have. This is often because many professionals who have experienced a patient's death by suicide avoid talking about it. There is very little research on this area and few resources to support affected professionals.

The survey you just finished was originally completed by 174 psychiatrists. Their responses indicated that a patient suicide usually had a major effect on them. The strong emotional and professional effects noted on psychiatrists, suggests that this may also be the case for other mental health professionals. There may be scope to develope a broad range of information and support for all mental health professionals following such incidents. To this end our group is currently working on such resources. We hope your responses will help us with this, as well as increase awareness of the effect of suicide on all mental health professionals.

What if I have any further questions about the study?
If you have any further questions about this research, please contact the team via email impactofsuicideonclinicians@gmail.com

Where can you find out more about how your information is used?
by sending an email to:impactofsuicideonclinicians@gmail.com

Reference:
Gibbons, R., Brand, F., Carbonnier, A., Croft, A., Lascelles, K., Wolfart, G., & Hawton, K. (n.d.). Effects of patient suicide on psychiatrists: Survey of experiences and support required. BJPsych Bulletin, 1-6. doi:10.1192/bjb.2019.26

Thank you for your participation

List of Resources & Support
Immediate Telephone Support: Should you require immediate telephone support after the survey, please feel to contact:
- Karen Lascelles (Suicide Prevention Consultant). Telephone number: 07920 275 028 E-mail: Karen.lascelles@oxfordhealth.nhs.uk
- Guy Harrison (Head of Pastoral Care & Staff Support). Telephone number:0845 219 1145.E-mail:guy.harrison@oxfordhealth.nhs.uk
- Oxford Health Staff Wellbeing Services - Occupational Health Team https://www.oxfordhealth.nhs.uk/careers/staff-wellbeing/ Contact: 0845 219 1150

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Other resources:

- The Royal College of Nursing. The professional body provides free short-term counselling and psychological support for members. Please see: https://www.rcn.org.uk/get-help/member-support-services/counselling-service National contact number: 0845 7726100 or e-mail: counselling@rcn.org.uk

- Healthtalkonline. This is an online resource with reliable information on a variety of health care topics, including Bereavement by Suicide. It has been developed by a Charity called DIPEx working in partnership with the Health Experiences Research Group at Oxford University's Department of Primary Care. It has life experiences about suicide survivorship that are presented in text and audio-visual format. It can be accessed on the internet via the following web link: http://healthtalkonline.org/peoples-experiences/dying-bereavement/bereavement-due- suicide/topics

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APPENDIX II: Main categories from qualitative content analysis

Category	Supporting quotes
Notification	
	I heard of it through word of mouth… the awful feeling stayed with me for months… (Nurse)
	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)
Questioning of self and practice	*That I had failed him. Lots of 'should have' thoughts.* (Social Worker)
	… self-doubt and guilt…. it also 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)
	Anxious and not confident, I was not sure if I was making right decisions. I had a lot of supervision and was reassurance seeking (Psychological Therapist)
	….very wary and still have feelings of dread (Nurse)
Preoccupation/rumination	I noticed I was thinking about it a lot out of work. I was thinking about suicide in general more and felt sensitive about the topic when it came up out of work, for example films (psychological Therapist)
	Could not stop thinking about it (Nurse)
	Ruminating on "missed opportunities" and "what ifs" (Nurse)
Detachment	*For a long time I felt a bit numb to it and lost some compassion for the work I do.* (Psychological therapist)
	I felt as though I was not as emotionally available as I normally am for patients and that I did not give hope with the same conviction as I normally would. (Nurse)
Sense of loss	*I was very tearful and heartbroken that they had ended their life. I was sad and felt grief for months after their death.* (Healthcare Assistant)
	I believe I went through the grieving process for one particular patient I did not realize I was fond off. I was upset by their death. I felt like I had lost a friend even though the relationship was clearly a professional one. (Nurse)
Impact of processes	*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 trust review found some learning points on one death but where insensitive in giving the feedback. I felt I had to be defensive, it felt like the learning points were what caused the death, yet they were systematic rather than human. (Nurse)

(*Continued*)

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1,2 (Continued)

Category	Supporting quotes
Questioning mental health services/hopelessness	*It made me feel like the work I was doing was not necessarily going to make a difference, that it was a bit futile.* (Nurse)
	I felt hopeless that anything could help someone with their mental health. I lost confidence and passion as it just felt like a losing battle all the time. (Psychological Therapist)
Enduring effects	*When the case was brought up recently, I did not realize how strongly it would still affect me now.* (Social Worker)
	'I felt that after 6 months the team and managers had moved on and this when I think I felt the impact the most and felt unable to discuss in work or outside of work, so felt isolated and alone with my emotions.' (Nurse)
Professional growth	*I have a more detailed view of my responsibilities in my role, it has strengthened my confidence in my ability to deal with the challenges of the role.* (Psychological Therapist)
	It had a positive effect on my clinical practice as it made me be more direct when assessing suicide risk in clients, and not shy away from those 'difficult' questions. (Occupational Therapist)

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