

Collegial support when patients take their own life

PERSPECTIVES

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Suicide is a rare occurrence – which comes at a great cost to the closest family and friends, and to society. If the person who takes his or her own life has been treated by a mental health practitioner, this person will also be affected. We want to show how a collegial support group in the hospital may help to safeguard the lead doctor/psychologist following a suicide.



Illustration: Espen Friberg

The prevention of suicide is one of the main tasks bestowed on the mental health services. While predicting an individual's risk of suicide is problematic, the ability to do so is often expected by organisations that provide support for relatives and by supervisory authorities (1–3). Conflicting considerations are often at play when assessing the risk of suicide and the degree of protective measures required. The patient's autonomy and right to self-determination must be weighed against his or her safety. The new legislation (4) brings an increased emphasis on autonomy, which means increased complexity when it comes to the risk assessment.

We are unable to prevent all suicides. A recently published study on suicides in the Agder counties in the period 2004–13 concluded that two thirds of those who took their own lives had been in touch with the mental health services or a cross-disciplinary specialist service for substance abusers at one point in their lives, and 7 % were either hospitalised or on leave from hospital when the suicide happened (5). This means that in almost 40 cases of suicide per year, at least one doctor or psychologist will be directly affected, often in their capacity as the lead practitioner or as the on-duty doctor.

When a patient who is undergoing mental health treatment takes his or her own life, this triggers a number of procedures and actions which are intended to review the factual circumstances and the assessments made. The specialist health service has a duty to report the incident to the Norwegian Board of Health Supervision, and an inquiry may be launched into the conduct of the regional health authority or the practitioner, either via the Chief County Medical Officer or the Board of Health Supervision.

Local procedures at Stavanger University Hospital involve the writing of a report on the clinical pathway and the assessments that were made along the way, to be submitted by the principal practitioner and the medical officer in charge. All personnel involved,

including the doctor or psychologist but also welfare workers, take part in a debriefing with their immediate superior. The relatives of the deceased are contacted, and endeavours are made to help them; they are informed of their right to complain and the opportunity to apply for compensation from the Norwegian System of Patient Injury Compensation. All health trusts have an occupational health service that may be contacted if members of staff should suffer health problems as a consequence of suicide.

Despite the current procedures, we who work at the mental health clinic for adults at Stavanger University Hospital have found that in the aftermath of a suicide, practitioners are left to grapple with difficult emotions on their own. At a system level there has been little room to accommodate common but difficult reactions, including feelings of guilt and shame (6–8). The reasons may be complex. There will be considerable differences between individual practitioners in terms of when and if health or welfare problems arise as a consequence of a patient's suicide. The occupational health service is often contacted far too late, or not at all, and the debriefing covers only the acute phase.

Practitioners who were involved with the patient's treatment at an earlier stage, but who were not responsible for providing treatment at the time of death, are often not included in the debriefing and other follow-up initiatives. They are nevertheless susceptible to emotional reactions and difficulties in the aftermath.

It is not the primary task and function of the supervisory authorities to provide support for practitioners or to comment favourably on good work (9). Practitioners can experience the process that follows a suicide as very stressful, and it may trigger a strong sense of doubt that leads to them questioning their own suitability, if they have done something wrong and if they are to blame for the patient's death.

We have found that existing procedures and structures do not always cover the need for a more systematic emotional and supportive approach to the provision of care amongst equal colleagues in the aftermath of a suicide. In the following we will describe our thoughts on the workings of a collegial support group.

A collegial support group at Stavanger University Hospital

The eight in-patient locked wards in the mental health clinic for adults at Stavanger University Hospital see around five suicides per year in total. The clinic has procedures in place for systematic training in suicide risk assessment, conducting such assessments and implementing protective measures. These measures include the frequency of patient observations, assessment of medication for the alleviation of symptoms, and assessment of whether patients may go outside on their own or need to be accompanied. There are also alert procedures and documentation requirements as well as procedures for the safeguarding of relatives and the bereaved.

There has previously been no systematic follow-up of the practitioners involved. In joint meetings with doctors and psychologists at the clinic it emerged that they felt the lack of a type of follow-up that would focus on emotional responses and difficulties

over time. Several practitioners who had experienced suicide among their patients, expressed the view that they were left to grapple with many difficult feelings largely on their own.

Possible differences were pointed out between the ways that practitioners and welfare workers experience suicide among patients. Among practitioners, the thought of being responsible for a treatment that may have been deficient or incorrect weighed more heavily on their shoulders, while the welfare workers were closer to the patients over time. They would often be the ones who found the deceased.

Consequently, the clinic's senior consultant and head of department took the initiative in 2014 to set up a collegial support group to assist practitioners in cases of serious incidents and in the aftermath of patient suicides. The group will also step in when patients commit serious acts of violence against members of staff or others.

The members of the group work in different psychiatric inpatient wards and sections. The group currently consists of two specialists in psychiatry and two specialist psychologists, all females of different ages. Participation in the support group is accommodated within the constraints of a normal job, and participants do not receive supplementary pay.

When a suicide happens, the group is alerted by the Head of Department or his/her deputy, with details of the staff member or members involved. These may be doctors on duty or on call, the doctor or psychologist treating the patient, or indeed the senior consultant who is clinical lead on the patient's ward.

The members of the group agree among themselves who should contact which practitioner, and the follow-up is provided one a one-to-one basis. It is endeavoured to establish contact with the practitioner within one or two days during normal working hours. This contact may be made in person, via email or telephone. During the first meeting the practitioner will receive summary information about the group and an offer of further conversations.

Since its formation, the group has been involved with the follow-up of 16 practitioners in the aftermath of seven suicides. A few have declined the group's offer of follow-up, on the grounds that they were receiving sufficient support within their own private networks. They did however express a positive attitude to the group's existence and appreciated the offer of support. Among those who have accepted the invitation, a range of diverse needs have been addressed.

The duration of the follow-up period has varied from a couple of weeks to several months. Practitioners may suffer a reaction some time after the suicide, which is why a point of contact at least a month after the incident is endeavoured. The group has focused on presenting a listening attitude and has sought to support their colleagues and fellow human beings at a difficult time. Providing emotional support for the practitioner is important, and it is made clear that that this support has no association with the formal debriefing. Also, the support group's work is not a substitute for the occupational health service or any other type of follow-up.

The group has received feedback that suggests it is perceived as an in-house resource, and the group participants consider their contributions to be meaningful. Whenever a potential for improvement is recognised, the group feeds this back to the management of the clinic.

In Stavanger the group has helped to bring about a change to the on-call roster system for doctors, so that any doctor who is directly involved with a suicide while on duty, is now excused from working the remainder of the shift. The Head of Department finds a replacement, and doctors who are directly involved with a suicide are given space to recover and time to debrief, and they are relieved of undertaking any further acute suicide risk assessments or making other similarly difficult judgements. The duration of this duty exemption is agreed between the doctor and the Head of Department, but it has most commonly lasted for a week.

The group has no knowledge of practitioners who have quoted a patient's suicide as their reason for leaving their job, whether before or after the formation of the support group. The group has no basis for expressing an opinion on sick leaves as a consequence of suicide among patients.

Other professional groups have asked why the group has consisted of doctors and psychologists only. The capacity and resources of group members have been contributing factors, but it is also the case that clinical practitioners are in a special position when it comes to suicide, as they are responsible for the treatment in a different way than welfare workers. The group's strength, we feel, lies in the fact that we recognise ourselves in the situation and the responsibility it entails.

Input for the formation of similar support groups

The mental health clinic for adults at Stavanger University Hospital has had positive experiences with this form of collegial support. We would like to recommend other mental healthcare institutions where no such arrangements are in place, to establish similar support groups. In order to avoid an overlap of remits, the management should give the group a clear mandate, with responsibilities that are clearly defined and distinguishable from those of other services. This is important in order to prevent situations that would lead to practitioners failing to receive a referral to the occupational health service, as it was assumed the collegial support group would be looking after these aspects.

There should be clear procedures for alerting the group when a suicide happens, including rules for who should be notified and in what way. Collegial support groups should have no link to internal and external supervisory functions. This can be essential for the relevant practitioner to dare to open up about their own role prior to the suicide, including their potential doubts and feelings of guilt, without the worry that this will impact negatively on their work situation.

Group members should have some clinical experience, i.e. they should be psychiatrists/ specialist psychologists or close to completing their specialty. Participation must be voluntary, to ensure engagement and an interest in the topic. Group members should be attentive to the wishes and needs of the individual practitioner, both with regard to the type of contact and the duration of the support period. The literature tells us that important topics may include acute symptoms of stress, such as anxiety and sleeping difficulties, and emotions like anger, shame, guilt and grief. Reviewing the case while taking a listening attitude may also be appropriate.

The work load for the collegial support group must be achievable within the framework of a normal clinical position. In addition to meeting as required when a new incident happens, the group could for instance meet for an hour once every second month to review cases they have been involved with and to reflect on and discuss other difficult suicide-related situations and assessments.

It should be possible to give in-house feedback if potential improvements are found with respect to suicide prevention or the safeguarding of staff in the aftermath of a suicide.

Conclusion

Predicting an individual's risk of suicide is problematic, contrary to what organisations that provide support for relatives, and the supervisory authorities, often believe. Doctors and psychologists find themselves in an exposed position following a suicide and are often left with a sense of inadequacy, shame and guilt.

Our experience is that a collegial support group can be sustained in an affordable way since contributions are required only in case of rare and serious incidents. Such support groups may be important for the prevention of burn-out and other causes of sick leave, and to stop people from leaving their jobs in the aftermath of a suicide among patients.

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