

Correspondence

The value of assessing suicidal ideation

The paper by Gibbons *et al*¹ concerning the distress experienced by psychiatrists who lose a patient through suicide is very welcome. We all know that such an event is difficult to bear, and this paper will encourage us to get support from others if things get really difficult, rather than soldiering on alone.

In describing how hard it is in clinical practice to detect suicide risk, let alone prevent it, the authors assert that recent research based on meta-analyses provides no evidence that suicide risk assessment in clinical practice can usefully guide clinical decision-making.

I believe that such a bald overall dismissal is regrettable because it discourages acquisition and critical evaluation of relevant clinical skills. Furthermore, I submit that it is not justified in the case of psychiatric in-patient care when addressing the problem of suicide prevention in the immediate or short-term future.

Surely all would agree that in managing severe short-term risk we ignore evaluation of suicidal ideation at our peril. When less immediate short-term risk is considered, there is also much to affirm the important role of assessing suicidal ideation in guiding clinical decision-making.

We described two series of psychiatric in-patients (1982–1984, N = 27; 1991–1993, N = 18) who died by suicide either during hospital admission or within 2 months of discharge from hospital.² In each of these, a high proportion of patients, 20/27 (74%) and 15/18 (83%), had discussed their suicidal ideas with members of staff in the ward during their in-patient stay. Suicidal ideation, as recorded contemporaneously in the case notes and not retrospectively, was a key clinical feature in delineating these patients, because they could not be distinguished from others in the ward across a range of behaviours. 12/27 (44%) and 9/18 (50%) showed significant clinical improvement during their in-patient stay, even though stress in the community had remained unresolved. In the 10 years that had elapsed between our two series, the proportion of patients that killed themselves after discharge from hospital increased from 7/27 (26%) to 11/18 (61%).

These findings, based as they are on two small series of suicides, must be regarded as provisional. Yet they do suggest that knowledge of suicidal ideation can be useful in guiding clinical management decisions. Clinicians should be vigilant that clinical improvement in these particular patients may be temporary and misleading, possibly related to removal from stress in the community. They should be particularly careful to ensure that such stress has been resolved, or at least contained, by planned provision of adequate ongoing support in the community if discharge from hospital is envisaged. With the increased emphasis on community care, the proportion of these patients who kill themselves after discharge from hospital is likely to have increased further since our studies took place. Our findings suggest that clinicians should be mindful of the increased hazard which is likely to be associated with premature discharge of these patients from hospital.

Our in-patient psychiatric wards should be fertile ground for the necessary further research that is needed to clarify the many other possible aetiological factors in these suicidal deaths, and so help in the development of good clinical practice. The identification and evaluation of suicidal ideation must surely have a central role in this.

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- 1 Gibbons R, Brand F, Carbonnier A, Croft A, Lascelles K, Wolfart G, Hawton K. Effects of patient suicide on psychiatrists; survey of experience and support required. *BJPsych Bull* 2019; **43**: 241–63.
- 2 Morgan HG, Stanton R. Suicide among psychiatric patients in a changing clinical scene. *Br J Psychiatry* 1997; **171**: 561–3.

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Do foundation doctors meet the mental health competencies in the foundation programme curriculum?

In recent years, the UK Foundation Programme has been adapted in order to meet the changing demands of patients, as well as those of foundation year doctors. A broadening of the Foundation Programme in 2014 stipulated that 100% of foundation year doctors should undertake a placement including community care from August 2017.¹ Further to this, in 2015, Health Education England set a target that 45% of foundation year trainees should complete a psychiatry placement to gain exposure to mental healthcare.² However, it is important to recognise that mental health problems do not present just in the psychiatry setting. General practice (GP) and accident and emergency (A&E) are arguably 'gateways' to accessing mental healthcare in the National Health Service.

The Foundation Programme Curriculum 2016 outlines the expectations for what foundation doctors should learn. With the changes to community placements outlined above, I conducted a study to assess whether doing a foundation year placement in psychiatry, A&E and/or GP affects trainees' ability to meet the Foundation Programme mental health competencies. I used a cross-sectional questionnaire to ask foundation year 2 (FY2) and CT1/ST1 trainees whether they felt they had met 17 mental health-related competencies from the curriculum.³ This was sent electronically via Foundation Schools.

A total of 360 trainees took the survey. Of all the trainees, only 29.7% (n = 107) were aware that there are specific mental health competencies in the Foundation Programme curriculum