

Impact of patient suicide on consultant psychiatrists in Ireland

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Aims and method To study the effects of patient suicide on both personal and professional life of consultant psychiatrists in Ireland. A questionnaire was sent to all practising consultants.

Results Most respondents (80%) had experienced patient suicide in their careers; in up to 97% it had an impact on either their professional or personal life. The most common effects were preoccupation with the suicide and guilt. Unpredicted suicides and perceived effect on patients' families worsened the distress. Informal support was of most help, with a large proportion of study participants suggesting independent case review would be helpful.

Clinical implications Patient suicide is an almost universally distressing event for psychiatrists. Although consultants receive psychological support from family and friends, many would also welcome an objective professional review.

Declaration of interest None.

Suicide of a patient is a very distressing event for a consultant psychiatrist and can adversely affect both their personal and professional life. Consultant psychiatrists have been shown to have higher levels of work-related exhaustion than their medical and surgical colleagues and patient suicide potentially contributes to this.¹ A review of studies from the USA, Canada and the UK suggests that 50–70% of consultant psychiatrists will experience the suicide of a patient at some point in their career.² Despite it potentially being one of the most distressing events in a psychiatrist's career, the number of studies in the literature is relatively small and there has been only one Irish study to date.³ The studies conducted thus far have all identified patient suicide as a cause of considerable distress, yet it is an event for which training leaves psychiatrists underprepared. We conducted a nationwide study of all consultant adult psychiatrists in Ireland to establish the impact on their personal and professional life.

Method

We sent a confidential postal questionnaire to 292 consultant psychiatrists in Ireland (not including child and adolescent psychiatrists), identified through records held by the Irish Medical Council and the Irish Medical Directory (www.imd.ie) that were cross-checked with each individual hospital. To maintain confidentiality and thus optimise our response rate, the questionnaires were not coded or numbered in any way and were sent with a non-coded, stamped, addressed return envelope. However, each participant was assigned a number and was sent a

corresponding numbered envelope and asked to post this simultaneously with their questionnaire, to aid identification of non-responders. Non-responders were contacted again by post after 10 weeks and after a further 8 weeks they were contacted by email if available.

We examined each consultant's most recent experience of patient suicide as well as the suicide they perceived to be most distressing. We did not specify that the deaths had to have been recorded as suicides in the coroner's court, instead leaving the choice of case to each individual's judgement.

The questionnaire (available from the author on request) was divided into three sections: the first gathered basic demographic data; this was followed by a section relating to the consultant's most recent experience of patient suicide, the individual patient's characteristics, the effect the suicide had on the consultant, both personally and professionally, and what coping strategies they used in its aftermath. The final section of the questionnaire asked the psychiatrists to provide that same information regarding the suicide they had found to be most distressing during their consultant career. Consultants had the opportunity to provide additional information in free-text boxes.

Results

Study sample

A total of 292 questionnaires were sent. We received 182 responses, of which 4 were excluded owing to incomplete information; this gave us a response rate of 61%. The

majority of responders (56%, $n = 102$) were aged between 40 and 49, and 55% ($n = 101$) were male. The majority (55%, $n = 101$) had been working in psychiatry for 10–20 years and 33% ($n = 60$) had between 10 and 20 years' consultant experience. Over three-quarters of the consultants (76%, $n = 138$) worked in general adult psychiatry, with 13% ($n = 24$) in old age psychiatry, 4% ($n = 7$) in forensic psychiatry, 3% ($n = 5$) in rehabilitation psychiatry, 2% ($n = 4$) in liaison and 2% ($n = 4$) in addiction psychiatry. More than half of the consultants (56%, $n = 102$) worked in a mixed urban and rural setting, with 30% ($n = 55$) working exclusively in urban and 14% ($n = 26$) in rural settings.

Overall, 143 respondents (80%) reported having had at least one patient die by suicide during their consultant career; 33% ($n = 60$) reported only one suicide (mean = 4, range 0–30). For those working as general adult psychiatrists, the mean number of suicides was 5.2; the mean was 1.8 for old age psychiatrists and 1.7 for all other subspecialties combined.

Most recent suicide experienced

All consultants who had experienced at least one patient suicide ($n = 143$) provided information in this section; 68 of the suicides (48%) had occurred in the same calendar year as the survey. The majority (68%) of the patients were male and 33% were aged 17–30. The most common diagnosis was unipolar non-psychotic depression (25%); 20% had a dual diagnosis of major mental illness with alcohol and/or substance misuse. Almost half (49%) of the suicides had occurred by hanging; drowning was the next most common method (22%). As much as 44% of the deaths had occurred in the patient's own home, with 8% taking place in a psychiatric hospital. At the time of the suicide, the majority of individuals (81%, $n = 116$) were out-patients, 14% were in-patients and 5% were day-care patients. Of the in-patients, 85% were of voluntary status and 75% were on routine levels of nursing observation at the time of suicide. Almost a third of out-patients (28%) had been recently discharged from hospital and of the 7 day-patients, 3 had recently been discharged from in-patient care.

Effect on personal life

Some disturbance of personal life was reported by 87% ($n = 124$) of consultants. The most common effect reported was a preoccupation with the suicide (84%, $n = 120$), persisting for up to 1 month in 70% ($n = 83$) of cases. A sense of guilt or blame was reported by 69% of consultants ($n = 99$) and lasted up to 1 month in 70% ($n = 69$). Other effects reported were disturbed sleep (27%, $n = 39$) and low mood (21%, $n = 30$).

Effect on professional life

Some effect on their professional and working life was reported by 88% ($n = 126$) of consultants. A heightened awareness of risk was the most frequently reported effect (87%, $n = 124$), persisting for longer than 6 months in almost half of the sample (46%, $n = 57$). Consultants' confidence was affected in 52% ($n = 75$) of cases, and this lasted for up to 1 month in 65% ($n = 49$) of cases. A quarter had altered their work practices, with increased nursing observation and detention under the Mental Health Act (17% ($n = 24$) and 8% ($n = 11$) respectively). A more detailed analysis of the self-reported effects of patient suicide on psychiatric consultants is presented in Table 1.

Support

In the aftermath of the suicide, 95% ($n = 136$) of consultants sought support informally from colleagues, with 66% ($n = 94$) also seeking support from family and friends; 61% ($n = 87$) undertook a formal case review or psychological autopsy. No one reported having sought formal support such as professional counselling, debriefing or other psychological intervention. Two consultants (1%) described hostility from the bereaved family as quite distressing; another two recalled having briefly thought of a career change. Conversely, two other consultants believed that suicide was 'part and parcel' of the job of a psychiatrist and thus not a cause for disruption to one's personal or professional life.

Most distressing experience of suicide

Information on the most distressing patient suicide was provided by 143 consultants. For 33% ($n = 47$) of them it was

Table 1 Effects of the most recent suicide on personal and professional lives of consultant psychiatrists in Ireland

	Preoccupation with the suicide, % (n)	Guilt, % (n)	Disturbed sleep, % (n)	Low mood, % (n)	Decreased confidence, % (n)	Increased risk awareness, % (n)	Increased nursing observation, % (n)	Increased use of MHA, % (n)
Strength								
Not at all	16 (23)	31 (44)	73 (104)	79 (113)	48 (68)	13 (19)	83 (119)	92 (132)
A little	53 (76)	47 (67)	17 (24)	12 (17)	43 (62)	35 (49)	9 (13)	4 (5)
Quite a bit	23 (33)	18 (26)	6 (9)	7 (10)	4 (6)	41 (59)	6 (8)	4 (6)
A lot	8 (11)	4 (6)	4 (6)	2 (3)	5 (7)	11 (16)	2 (3)	0 (0)
Duration, months								
1	70 (83)	70 (69)	71 (27)	73 (22)	65 (49)	21 (26)	33 (8)	18 (2)
1–3	21 (25)	22 (22)	26 (10)	20 (6)	16 (12)	18 (22)	12 (3)	18 (2)
3–6	7 (8)	4 (4)	3 (1)	7 (2)	7 (5)	15 (19)	12 (3)	18 (2)
> 6	2 (4)	4 (4)	0 (0)	0 (0)	12 (9)	46 (57)	42 (10)	46 (5)

MHA, Mental Health Act.

the same case reported as their most recent experience of suicide. Similarly, as with the most recent suicides, the majority of the patients (60%) were male and 39% were aged 16–30. The most common diagnoses were unipolar non-psychotic depression (25%), schizophrenia (15%) and psychotic depression (13%); only 5% of patients had a dual diagnosis of major mental illness with alcohol and/or substance misuse.

Of the most distressing suicides reported, 13% had occurred in the year of our study, with the oldest reported dating back almost 40 years. Almost half of the suicides (45%) had occurred by hanging; again, drowning was the next most common method (18%), followed by overdose and jumping from a height (10% each). More than half (52%) of the deaths had occurred in the patient's own home and 15% took place in hospital. The majority (71%, $n=101$) of individuals were out-patients at the time of the suicide, a quarter were in-patients and 4% were day-care patients. Of the in-patients who died by suicide, 83% were of voluntary status; 40% of out-patients had been recently discharged from hospital and 47% of them were being followed up more frequently than usual at the time of suicide. Of the 6 day-patients, 2 had recently been discharged from in-patient care.

Effect on personal life

Almost all consultants (97%, $n=139$) acknowledged an effect on their personal life after the most distressing suicide. All of those reported a preoccupation with the suicide, which persisted for between 1 and 3 months in 41% ($n=56$) of cases. A sense of guilt or responsibility was reported by 82% ($n=117$), lasting up to 1 month in 39% ($n=46$) of cases; 42% ($n=60$) reported disturbed sleep and over a third (36%, $n=52$) low mood.

Effect on professional life

Only 10% ($n=14$) of consultants reported no effect on their professional life or working practices. The remainder most commonly reported a greater awareness of risk but this only persisted beyond 6 months in 52% ($n=66$) of consultants. Over two-thirds (68%, $n=97$) experienced decreased confidence after the suicide, lasting 1 month or less in 42% ($n=41$) of cases. Only 26% ($n=37$) reported a greater

use of increased nursing observation and 11% ($n=15$) reported increased use of the Mental Health Act; for the majority of consultants these effects did not persist beyond 3 months. A more detailed analysis of the effects of the most distressing patient suicide on consultants' personal and professional life is presented in Table 2.

Factors which contributed to distress

Overall, 94 consultants commented on factors which they thought had contributed to their distress. The most commonly cited reason was that the individual was either an in-patient or had been recently seen and assessed (21%, $n=20$). For 20% ($n=19$) this was the effect the suicide had on the patient's family, even more distressing when the patient was a parent of young children. In 17% ($n=16$) the distress was related to the suicide being unpredicted. A sense of failure was felt by 15% ($n=14$). Negative reactions from the patient's family or health service executive staff and media publicity were reported as a cause of distress by 9% ($n=8$) of the 94 consultants who responded to this question.

Support

In the aftermath of the suicide, most consultants (97%, $n=139$) sought support informally from colleagues and 80% ($n=114$) also received support from family and friends. Two-thirds (66%, $n=94$) undertook a formal case review or psychological autopsy. No consultant reported having sought formal support.

Support received Informal support from colleagues was of greatest benefit to 67% ($n=96$) of consultants; for 20% ($n=29$) this was their own family and for 6% ($n=9$) the non-critical reaction of the patient's family. Sixteen consultants (11%) were critical of the lack of support they had received in the workplace. Specifically, some remarked ($n=6$, 4%) that there was no automatic procedure for dealing with a suicide of a patient, either in terms of offering support or a case review.

Suggested support Although 33% ($n=47$) of consultants felt the best support to have available would be the opportunity to discuss the case informally with colleagues,

Table 2 Effects of the most distressing suicide on personal and professional lives of consultant psychiatrists in Ireland

	Preoccupation with the suicide, % (n)	Guilt, % (n)	Disturbed sleep, % (n)	Low mood, % (n)	Decreased confidence, % (n)	Increased risk awareness, % (n)	Increased nursing observations, % (n)	Increased use of MHA, % (n)
Strength								
Not at all	4 (5)	18 (26)	58 (83)	64 (91)	32 (46)	12 (17)	74 (106)	89 (128)
A little	32 (46)	35 (48)	24 (34)	22 (31)	42 (60)	22 (32)	15 (21)	6 (8)
Quite a bit	46 (66)	32 (46)	12 (17)	8 (12)	18 (26)	44 (62)	6 (9)	2 (3)
A lot	18 (26)	12 (17)	6 (9)	6 (9)	8 (11)	22 (32)	5 (7)	3 (4)
Duration, months								
1	37 (51)	39 (46)	62 (83)	60 (31)	42 (41)	16 (20)	30 (11)	13 (2)
1–3	41 (56)	39 (46)	25 (34)	25 (13)	32 (31)	17 (21)	14 (5)	33 (5)
3–6	15 (21)	14 (17)	8 (17)	12 (6)	13 (12)	15 (19)	21 (8)	27 (4)
>6	7 (10)	8 (8)	5 (9)	3 (2)	13 (13)	52 (66)	35 (13)	27 (4)

MHA, Mental Health Act.

20% ($n=29$) felt there should be formal support, such as psychological debriefing, automatically offered in the aftermath of a suicide. A further 10% ($n=14$) felt this should be available if required but not as an automatic response. A case review performed by an independent psychiatrist was suggested by 16% ($n=23$) of consultants. Medico-legal assistance in the coroner's court and in the event of litigation was suggested by three consultants (4%).

Discussion

We conducted a national survey of the effect of patient suicide on consultant adult psychiatrists in Ireland. Our response rate of 61% was comparable with or superior to similar studies internationally.^{4,5}

When compared with the national population of consultant psychiatrists our respondents appear to be largely representative of this population (48% male and 43% aged 40–49, information obtained from the Royal College of Psychiatrists' database). International studies have shown that patient suicide is a relatively common experience for consultant psychiatrists, with 50–70% experiencing it at least once.² We found the effect on both the personal and professional life of the consultants to be consistent with or greater than previous studies, with up to 97% reporting some disturbance in their personal life.^{2,6}

Informal support from colleagues was identified by the majority of respondents as the most effective support, which is again reflective of other studies.^{6,7} However, the number seeking formal and independent reviews suggests that, although many receive psychological support from family and friends, consultants would also welcome an objective review from a professional view point. It is likely that such service, protected from legal disclosure, would be welcomed, although rather surprisingly fear of legal consequences was rarely cited by our respondents as a factor increasing their distress. This contrasts with Hendin's study, which cites fear of litigation as one of four factors contributing to severe distress in professionals in the aftermath of a suicide.⁸

A number went on to suggest that there should be an independent and confidential support available such as a telephone helpline or debriefing from a psychologist. However, many felt that although such support should be available, it should be left to an individual consultant's discretion whether to avail oneself of it and one should not be pressured into doing so. This ambivalence towards employer-provided support is mirrored in Pilkinton & Etkin's study.⁷ Formal interventions should ideally be evidence-based and those availing themselves of them should be cognisant of the dangers as well as the benefits of debriefing.⁹

Chemtob *et al* identified a lack of established protocols to help a psychiatrist in the aftermath of a suicide.⁵ This was also borne out in our study and a number of psychiatrists were quite critical of this fact. As most services do in fact have existing protocols, these criticisms suggest that either the psychiatrists are not aware of them or that the protocols are perceived to be deficient or unhelpful in some way.

For 17% ($n=24$) of our consultants a suicide was particularly distressing when it was unpredicted. This had been described before by both Alexander *et al* and

Morris.^{6,10} Hendin *et al*⁸ identified guilt resulting from failure to hospitalise a suicidal patient and treatment decisions which in hindsight were perceived to have been wrong as contributing factors to severe distress in professionals. In Alexander *et al*'s study,⁶ some consultants stated that suicide needed to be regarded as inevitable in some cases, and a small number in our survey also reported this view. Gitlin¹¹ argued that death is the natural history of severe medical disorders and should similarly be regarded as the natural outcome of severe psychiatric disorders. However, our mean number of four patient suicides in a group of consultants, many of whom have 10–20 years' experience, argues against this view. Admittedly, such an attitude might lessen the sense of personal responsibility in the event of a suicide, but the danger of what has been described as 'therapeutic nihilism' might be enhanced.⁶

Greater emphasis on dealing with patient suicide during psychiatric training has been previously highlighted as a potential way to reduce the distressing effect on psychiatrists. In Dewar *et al*'s study,¹² those who had received such training found it helpful in the long run. Chemtob *et al*⁵ and Hendin *et al*⁸ both identified trainee psychiatrists and those with less experience to be at greater risk of distress after a patient dies by suicide, and thus highlight the need for training; in one study only a third of psychiatric residents had received any instruction in this area.⁷ Such training should emphasise the likelihood of experiencing patient suicide and prepare the psychiatrist for their potential personal and professional reactions. It should also emphasise help-seeking, pointing to the finding that fellow professionals and family have been found most helpful. Resources such as the UK Department of Health policy documents might be useful in this training.¹³

Limitations of the study

The retrospective nature of the study lends itself to recall bias, particularly as regards the duration of the consequences – providing four different time scales was an attempt to minimise this (1 month, 1–3 months, 3–6 months, over 6 months). Furthermore, although there is a chance that those consultants who perceive patient suicide as particularly distressing were more likely to respond and those with a more pragmatic approach may not have done so, there is also the possibility that those who have a more robust or neutral approach to the issue might respond more willingly than those who find the topic distressing. Two attempts to follow-up non-responders were made in an effort to counteract this.

We did not use any validated rating scales in the questionnaire, as we felt that existing scales did not adequately reflect the aims of the study and might limit the potential responses. The questionnaire was designed based on our own personal experiences, which we hoped would be reflective of those of our colleagues, and a review of the literature.

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Postcode lottery? Hospital transfers from one London prison and responsible catchment area

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Aims and method To consider the link between responsible commissioner and delayed prison transfers. All hospital transfers from one London prison in 2006 were audited and reviewed by the prisoner's borough of origin.

Results Overall, 80 prisoners were transferred from the audited prison to a National Health Service (NHS) facility in 2006: 26% had to wait for more than 1 month for assessment by the receiving hospital unit and 24% had to wait longer than 3 months to be transferred. These 80 individuals were the responsibility of 16 different primary care trusts. Of the delayed transfer cases ($n=19$), the services commissioned by three primary care trusts were responsible for the delays.

Clinical implications There are significant differences in performance between different primary care trusts related to hospital transfers of prisoners, with most hospitals able to admit urgent cases within 3 months. This suggests that a postcode lottery operates for prisoners requiring hospital transfer. Data from prison services may be useful in monitoring and improving the performance of local NHS services.

Declaration of interest None.

Growing dissatisfaction with the state of the UK prison medical service throughout the 1970s and 1980s¹ led to the publication by the government of *The Future Organisation of Prison Health Care*.² This document set out plans for a formal partnership between the National Health Service (NHS) and the Prison Service. Various prisons, including the one in our study, piloted mental health in-reach teams in 2002, part of a process which ended with the NHS taking over the commissioning of health services for all prisons in 2006. The principle of equivalence of care states that prisoners are entitled to the same standard of healthcare as

they would have were they not in prison.^{2–4} Those prisoners who have mental disorders of a nature or degree such that their needs can only be appropriately met by in-patient treatment are meant to be transferred from prison to hospital for treatment.⁵ Prison in-reach teams take referrals from a wide range of sources and generally support a high volume of prisoners with stable mental illnesses. The prisoners described in this paper represent the most acutely unwell.

Although the principle of equivalence is meant to underpin the working of a mental health in-reach team, there is no equivalent of a prison healthcare wing.⁶ A prison