

# Education and Training

## Effects of patient suicide on psychiatrists: survey of experiences and support required

Rachel Gibbons,<sup>1</sup> Fiona Brand,<sup>2,3</sup> Anne Carbonnier,<sup>2</sup> Alison Croft,<sup>2</sup> Karen Lascelles,<sup>2,3</sup> Gislene Wolfart,<sup>4</sup> Keith Hawton<sup>2,3</sup>

BJPsych Bulletin (2019) 43, 236–241, doi:10.1192/bjb.2019.26

<sup>1</sup>Barnet Enfield & Haringey NHS Mental Health Trust; <sup>2</sup>Oxford Health NHS Foundation Trust; <sup>3</sup>University of Oxford; <sup>4</sup>Oxford Mind & Body

Correspondence to Dr Rachel Gibbons ([rachelgibbons@nhs.net](mailto:rachelgibbons@nhs.net))

First received 9 Jan 2019, final revision 18 Feb 2019, accepted 13 Mar 2019

© The Authors 2019. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is unaltered and is properly cited. The written permission of Cambridge University Press must be obtained for commercial re-use or in order to create a derivative work.

**Aims and method** Death of patients by suicide can have powerful effects on psychiatrists. We report the findings of a survey completed by 174 psychiatrists on the effects of patient suicide on their emotional well-being and clinical practice, and the support and resources they felt would be helpful.

**Results and clinical implications** The death of a patient by suicide usually had a major effect on respondents. Clinical practice was often negatively affected, and over a quarter of respondents considered a change of career path as a result. There were some gender differences in responses, with women reporting more sense of responsibility for the deaths and a greater effect on their clinical confidence. Desired support included a senior suicide lead clinician, 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.

**Declaration of interest** K.L. is Nurse Consultant for Suicide Prevention at Oxford Health NHS Foundation Trust. K.H. is a member of the National Suicide Prevention Strategy for England Advisory Group. G.W. offers independent workshops on working with suicidal patients.

**Keywords** Patient suicide; psychiatrist; trauma; post-traumatic stress disorder.

The death of patients by suicide has profound effects on the personal and professional life of many psychiatrists.<sup>1</sup> Patient suicide can have an influence on staff recruitment and retention, quality of professional life, patient care and professional well-being. Currently there is limited and idiosyncratic support for clinicians who experience patient suicide. This important issue has not been well examined.

The majority of psychiatrists experience the death of a patient by suicide such at least once during their career, with many experiencing this more often.<sup>2,3</sup> In one study, 53% of psychiatrists reported stress levels in the weeks following a suicide comparable to those reported in studies of people seeking treatment after the death of a parent.<sup>4</sup> The intensity of this experience can result in a combination of symptoms of post-traumatic stress disorder, shame, guilt, anger, isolation, and fear of litigation and of retribution from the psychiatric community.<sup>5,6</sup> The stress following a patient suicide can be exacerbated by organisational responses, including serious incident enquiries, and the pressure of attending the coroner's court.<sup>7</sup>

The result can be increased anxiety in clinical situations and changes in practice.<sup>2</sup> In those suffering a severe stress reaction, retirement<sup>2</sup> and change in career<sup>8</sup> are often considered.

### Aims

The aims of the present study were to investigate: (a) how patient suicide affects the emotional well-being and clinical practice of psychiatrists; and (b) the resources that psychiatrists would find helpful before and after the suicide of a patient. In addition, we wanted to find out about psychiatrists' attitudes to suicide and suicide prevention, and their perceptions of institutional and societal pressures.

### Method

#### Design

A web-based survey was designed by a multidisciplinary team of clinicians experienced in this area and informed by past research.<sup>9</sup> The survey consisted of 42 questions on

SurveyMonkey and was sent out via medical directors to psychiatrists in two National Health Service (NHS) trusts where the researchers were based and where there were particular concerns about supporting clinicians affected by patient suicide, as well as two neighbouring trusts that had shown an interest in participation. Two trusts were based in London and two in south-east England. All had a similar local suicide rate, corresponding to the average rate in England of 9–10 per 100 000. Respondents were requested to focus on the patient suicide that had the most significant emotional effect on them (assuming they had experienced one). They were asked about the effects on them personally and on their clinical practice, what they had found helpful and unhelpful following the incident, and suggestions for possible helpful resources and actions. Respondents were also asked their opinion on: (a) the predictability of suicides in secondary care; (b) their experience of feeling under external pressure to prevent suicides; and (c) their views of their role in relation to suicide prevention. The layout of the questions varied (see Appendix 1). The survey was open for 1 month, and there was a follow-up email prompt after 2 weeks.

## Participants

Psychiatrists at all levels of training and experience in four trusts were emailed about the survey.

## Analysis

Data were examined numerically and via thematic analysis. Responses of men and women were compared with parametric *t*-tests.

## Results

The survey was circulated to 520 psychiatrists, of whom 174 responded (34%). The characteristics of the respondents are shown in Table 1. Of the 140 respondents who had experienced death of a patient by suicide, 100 (72%) had experienced more than one, 18 (15%) had experienced more than six, and (3%) five had experienced more than ten. Looking at the number of suicides experienced by psychiatrists in the older age groups, the average number over a working life-span was approximately four.

## Change in career path

Seventy-one psychiatrists reported experiencing their most impactful patient suicide as an ST 4–6 or a consultant in general adult services. Of these 71, 28 did not work in general adult services at the time of the survey. This indicates a possible 39% shift away from general adult psychiatry from the time of the death to the time of the survey. This shift might in part have reflected the usual changes during training. However, from the 16 consultants and one SAS doctor that reported experiencing their most impactful suicide when they were in a training grade in adult psychiatry, only one continued to work in general adult psychiatry. Furthermore, 33 professionals (27%) noted in the free text that they had considered a change in their career path as a result of the suicide of their patient.

*'The effect of this death heightened my determination to retire as soon as possible'*

*'It was just before choosing higher training specialty, and I had applied for both adult and CAMHS, but felt quite disillusioned with adult services after the incident, which probably affected my decision to choose CAMHS.'*

*'All the suicides directly influenced my career choice in not wanting to work in General Adult services.'*

## Effects on emotional well-being

Respondents were asked to rate the effect of the death on their emotional well-being on a Likert scale, where 0 = 'no effect', 50 = 'some' and 100 = 'a very severe response'. Most ( $N = 105$ , 92%) rated their experience above 50, with an average rating of 66 out of 100. Only nine (8%) felt that their symptoms had met a clinical threshold for diagnosis of a psychiatric disorder at any time, although 15 (12%) were uncertain. Six (5%) had taken time off work. Leave, when taken, was of short duration (between 1 day and 1 week).

When asked to describe the primary emotional effect of the death, all 120 psychiatrists who answered this question reported experiencing painful emotions, such as sadness ( $N = 85$ , 71%); worry, anxiety and fear ( $N = 40$ , 33%); guilt and self-blame ( $N = 36$ , 31%); regret ( $N = 24$ , 20%); anger ( $N = 23$ , 19%); shame ( $N = 16$ , 13%); shock ( $N = 15$ , 12%); and blaming others ( $N = 4$ , 3%).

It was clear from the free text section that some psychiatrists had experienced serious emotional effects, for example:

*'initially shock and intrusive memories – things deteriorated after a month so tearfulness, unable to focus, intrusive thoughts and memories, nightmares resentment, shame, helplessness, finally PTSD'*

*'like being deeply wounded'*

*'Shame, guilt, it kept me awake at night. It affected subsequent career choices. It affected my capacity to work.'*

*'I feel it's something I'll have to carry forever. I think of the boy often. And yet when it boils down to it I don't blame myself. It's the line of work, isn't it? One thought I had at the time (and still have) is that if I had another suicide then I'd resign and do something else with my life.'*

## Effect on clinical duties

One hundred and fifteen (98%) reported a detrimental effect on clinical practice in the period after the death, with women (mean Likert scale score = 48) affected more than men (mean = 35;  $P = 0.01$ ). Forty-five (39%) respondents reported that the effect lasted between 1 week and 6 months, 18 (21%) reported that it affected them for between 6 months and 2 years, and 11 (13%) described an ongoing effect. This ongoing effect was described by some as helpful in that it increased their clinical sensitivity and awareness of their own vulnerabilities.

*'Ongoing thoughtfulness about patient contact – made me more vigilant and risk conscious.'*

*'Ongoing concern that although I believe that I could make valuable contribution, I feel ineffectual in changing systems that I recognize as being ineffective and fragmented... I regret*

**Table 1** Characteristics of psychiatrists responding ( $N = 174$ )

Number experienced $\leq$ patient suicide	140 (80%)				
Area of current work	General adult 52 (30%)	Older adult 35 (20%)	CAMHS 25 (14%)	Forensic 15 (9%)	Other <sup>a</sup> 47 (27%)
Gender	Male 84 (48%)	Female 90 (52%)			
Current grade	Consultant 128 (74%)	CT/ST 37 (20%)	SAS 8 (5%)		
Age group (years)	22–28 3 (2%)	29–34 27 (16%)	35–44 41 (24%)	45–55 75 (43%)	55–64 26 (15%)
					65–74 1 (1%)

a. Included: unspecified CT1-3, liaison, perinatal, psychotherapy, rehabilitation, intellectual disability

*that I am not more robust, but I am also now more realistic about my own limitations.*

### Factors that influenced psychiatrists' experiences following the deaths

The psychiatrists were asked to give a free text response about the people, interventions and experiences that either helped or did not help them in the aftermath of the death. The themes identified are shown in **Table 2** and the free text responses that follow.

*'It helped knowing that some of my colleagues had been through it, that I was not the only one to feel the shame and guilt'*

*'The patient's family were very thoughtful and supportive towards my team even in the midst of their grief. Discussing what had happened with them and attending the funeral and meeting with them again was helpful, hopefully on both sides.'*

*'The suicide was upsetting, however the aftermath, the SIRI investigation and attending the Coroner's Court were very traumatic for me. It made me feel very upset, sad, angry and it felt like people were out to blame us/me/services.'*

*'The sense of shame and responsibility that seems to be accepted in the whole psychiatric community about suicide didn't help.'*

The psychiatrists were asked to select from a list those who supported them both inside and outside the work environment. At work, the most often selected were medical

colleagues ( $N = 57$ ; 46%), other disciplines (36; 30%) and managers (34; 28%). Twenty-six (21%) said they were not offered support by anyone at work. Outside work, family were reported to be helpful by 60 (49%) and friends by 35 (28%). Forty-three (35%) said they had no help from anyone outside work.

### Support wanted after a patient suicide

This question included various answers, where those responding could select multiple alternatives. The seven most frequent responses are shown in **Table 3**.

### Responsibility for the death

Respondents were asked to rate their feelings of responsibility for the death, first at the time, and then in hindsight, on a Likert scale from 0 = 'not at all' to 10 = 'very responsible'.

**Table 3** Support wanted after a patient suicide ( $N = 137$ )

A senior clinician with a role as suicide lead to give confidential advice and support	102 (75%)
Support for the formal processes following a patient's suicide	97 (70%)
A confidential reflective practice group or space specifically for processing the effects of a patient suicide	92 (67%)
Personal debriefing	86 (63%)
Information about the process following patients' death by suicide	86 (62%)
Information about resources for families affected by suicide	84 (61%)
Help in communicating or meeting the family/friends of the patient who has died (e.g. Public Health England's <i>Help is at Hand</i> )	81 (59%)
Access to a general reflective practice/Balint group	74 (54%)
Organised peer support	75 (55%)
A training session about this topic	53 (39%)
Information about support for the community (including schools)	48 (35%)
Workshop to share experiences	45 (33%)
Counselling and therapy	38 (28%)

**Table 2** What helped and what didn't help after the death

What helped	What didn't help
Support from colleagues who had been through similar experiences (43; 48%)	A serious incident process that was experienced as insensitive or persecutory 15 (19%)
Being able to engage with the families of the deceased and not feeling blamed by them (16; 18%)	Coroner's court was cited as unhelpful by nine (11%), owing to the stress of giving evidence, or long delay prolonging the distress and fear of attending. Coroner was seen as having a challenging attitude
Nothing (14; 16%)	Four (5%) reported that if the families were angry or took legal action this made it worse.

The sense of responsibility decreased with time, with the mean score falling from 42.7 (s.d. = 24.6) to 19.9 (s.d. = 17.0). There was a difference between genders, with women feeling somewhat more responsible at the time of the death (mean 46.9, s.d. = 23.2,  $N=57$ ) than men (mean 38.8, s.d. = 25.5,  $N=60$ ,  $P=0.074$ ).

### Suicide prevention and the role of the psychiatrist

Psychiatrists rated the degree to which they felt that prevention of suicide was their role on a Likert scale where 0 = 'not at all', 50 = 'to some degree' and 100 = 'very much'. The majority ( $N=90$ , 66%) rated their responses between 50 and 100. There were 122 free text responses explaining this rating (excerpts below).

*'It is a very frightening world where one professional group is given an impossible task and then censured by society (and themselves) for failing to achieve it.'*

*'The idea that suicide is always preventable (i.e. should be a 'never event' or we should have a 'zero suicide' policy) is invidious, leading to blaming of professionals. After all, if all suicides are preventable, it must be a professional's fault. On the other hand, clearly, some of the things we do reduce the risk of suicide, both long term (most obviously) and possibly short term.'*

Respondents were asked how much pressure they felt from external sources to prevent patient suicide on a similar Likert scale ranging from 0 = 'not at all' to 100 = 'very much'. The mean score from 134 responses was 77.6. They were then asked to what degree they thought that suicide was predictable. The midway point 50 was 'to some degree'. Female psychiatrists thought suicide significantly more predictable than men (mean 50.0 (s.d. 16.4,  $N=69$ ) for women compared with 39.0 (s.d. 21.4,  $N=64$ ;  $P=0.001$ ) for men).

## Discussion

### Effects of patient suicide on psychiatrists

The results of this survey indicate a considerable emotional effect of patient suicide on psychiatrists, in line with findings from previous research.<sup>1,2,8</sup> General adult psychiatry was the specialty where most of the suicides occurred, and only one of the 17 psychiatrists who experienced a suicide while in training grade in adult psychiatry were still working in this specialty at the time of the survey. This suggests that the emotional effect of the death of a patient by suicide might influence specialty choice and contribute to the enduring recruitment and retention crisis in adult psychiatry. Despite reporting significant emotional effects, very few psychiatrists thought they had suffered a psychiatric disorder, such as depression or post-traumatic stress, as a result of the death. Also, very few took any time off work, which could indicate particular psychological resilience and/or a difficulty in acknowledging personal vulnerability.<sup>10</sup> This survey focuses specifically on psychiatrists; however, the findings are likely to apply to other mental health clinicians involved with a patient who dies by suicide. Further work is planned to examine the effects on non-medical staff.

### Factors which affected the experience

Colleagues and families came out strongly as supportive factors after a patient suicide. Responses indicated that this distressing experience was made more or less painful depending on the response and attitude of the psychiatrist's trust, the family of the deceased and the coroner. If the response experienced was hostile or persecutory, it was harder for the psychiatrists to recover; if, however, it was understanding and compassionate, it was reparative for them.

### Predictability and preventability of suicide

The responses indicated that most psychiatrists had high expectations about their own capacity to prevent suicide but found the weight of public expectation that they should always prevent suicide unreasonable. Our ability to predict patients at the highest level of risk is limited. Despite the ubiquity of advice to use suicide risk assessment in clinical practice, the positive predictive value is low and there is no evidence that these assessments can usefully guide decision-making. Meta-analyses indicate that no individual clinical risk factors, including suicidal thoughts and behaviours, are sufficiently accurate to be useful as the basis on which to allocate interventions.<sup>11</sup> The majority of patients who die by suicide have no contact with mental health services,<sup>12</sup> and those that do often receive a low rating at their most recent risk assessment; this is the 'low risk paradox'.<sup>13-15</sup> A clinical review showed that only 2% of patients who went on to die by suicide were rated as immediate high risk in their most recent contact with services.<sup>15</sup> Given this, attribution of personal responsibility for suicide prevention is clearly challenging.

Some responses directly commented on the government's focus on 'zero suicide',<sup>16</sup> emphasising the different opinions that currently exist in the psychiatric community about this approach.<sup>17</sup> These respondents represented one side of this debate, expressing concern that this policy will increase the belief that suicide in secondary care is both predictable and preventable. On the other hand, there are psychiatrists who are supportive of the zero suicide movement, believing that it presents an aspirational challenge and practical framework for system-wide transformation which could help to alleviate feelings of individual blame (<https://zerosuicide.sprc.org>). This approach has clearly encouraged funding of suicide prevention; however, it is also crucial to manage expectations in order to avoid increasing the pressure on psychiatrists and other members of the clinical team following patient suicide.

### Resources used and wanted

The results of this survey indicated a serious unmet need for support and information after these tragic and traumatic deaths. It is reasonable to think that intervention at this point may mitigate distress, effects on clinical practice and career change. The desire for information on resources for families would be relatively easily met, such as through the *Help is at Hand* booklet.<sup>18</sup> Resources should also be developed to assist psychiatrists with the processes following

patient suicide. There is also a clear need for support provided through both individual and group interaction.

## Limitations

This survey was conducted in just four trusts, which were selected primarily through personal relationships and were restricted to the south of England. This may limit the representative nature of the experiences of the psychiatrists surveyed, compared with those working in other parts of the UK with higher suicide rates. The response rate was 34% and respondents were a self-selected group currently working in psychiatry. It was not clear whether those answering were more or less likely to have experienced a patient suicide. A number of responses detailed a desire to retire, change specialty or leave psychiatry altogether as a response to the suicide. It could be possible that some of the psychiatrists who were most severely affected would have chosen to leave psychiatry, and as a result would not be represented in this survey. The responses may be subject to some degree of bias due to social desirability, although the quotes from respondents suggested considerable frankness of expressed views. The choice of sources of support and help were based on a pre-determined list of options and may not have covered all possibilities.

## Conclusions

Respondents to this survey confirmed that the death of a patient by suicide can have very strong emotional effects on psychiatrists. Their clinical practice was often negatively affected for a period of time, and over a quarter considered a change of career path as a result. There were differences in responses between genders in three areas. Women were more likely than men to believe that suicide is preventable, experience greater feelings of being responsible for the death and report a greater effect on clinical confidence for a period afterwards. The findings of the survey suggest that there is a need for a broad range of information and support to both prepare psychiatrists for the possible occurrence of patient suicide and provide helpful support following such incidents.

## Acknowledgements

We thank Mark Hancock, Jonathan Bindman, Minoo Irani and Vincent Kirchner (Medical Directors) for approving the survey; Alexandra Pitman, Kate Saunders and Helen Killaspy for advice; Brad Mullins for assistance with the analyses; and Nora Turjanski, Siobhan Jeffreys, Nisha Shah and Rob Hale (consultants from the Suicide Group for Consultants) for piloting the survey.

## About the authors

**Rachel Gibbons** is the Therapy Director of the Priory Group, and at the time of this work she was a Consultant Adult Psychiatrist and the Suicide Lead for Barnet Enfield and Haringey Mental Health Trust, UK. **Fiona Brand** is a psychiatric nurse with a clinical role in psychiatric liaison at Oxford Health NHS Foundation Trust and a research nurse role at the Oxford University Centre for Suicide Research, UK. **Anne Carbonnier** is a Consultant Child and Adolescent Psychiatrist in South Oxfordshire Child and Adult Mental Health Services (CAMHS) and Medical Lead for South Oxon CAMHS, UK. **Alison Croft** is a Consultant Clinical Psychologist with the Medic Support

Service, Oxfordshire Psychological Services and Oxford Cognitive Therapy Centre, Oxford Health NHS Foundation Trust, UK. **Karen Lascelles** is a Nurse Consultant in Suicide Prevention, Oxford Health NHS Foundation Trust, UK. **Gislene Wolfart** is the Lead Psychologist at Oxford Mind & Body, and also holds a post in the Specialist Eating Disorder Service, Oxford Health NHS Foundation Trust, UK. **Keith Hawton** is Director of the Centre for Suicide Research at Oxford University Department of Psychiatry, and Consultant Psychiatrist, Oxford Health NHS Foundation Trust, Warneford Hospital, UK.

## APPENDIX 1

### Survey questions

1. Are you? Male, Female, Non binary
2. What is your age? 22–28, 29–34, 35–44, 45–54, 55–64, 65–74, 75 or older
3. How many years have you been working in psychiatry? 1–3, 4–6, 6–10, More than 10
4. What level are you currently working at? FY, CT, ST, Consultant, SAS, Other
5. Which age group of patients do you work with? Child and Adolescent, General Adult, Older Adult, Other (please specify)
6. Your area/s of speciality?
7. What setting do you work in?
8. Have you ever been working with a patient who died by suicide or suspected suicide?
9. How long ago was this? In the last three months, Between 3 and 6 months ago, Between 6– and 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
10. When in your career did this suicide happen? Medical Student, Foundation, CT1–3, ST4–6, Consultant 1–3, Consultant 4–9, Consultant 10 or more, Staff Grade/Associate Specialist/Speciality Doctor
11. Please specify the service/client group in which you treated or encountered this patient.
12. In which setting did this suicide occur?
13. Approximately how many patients did you have some clinical responsibility for at that time?
14. Consider the effect that this patient's death had upon your own emotional well-being. Please rate the greatest extent to which it affected your emotional well-being at any point following the event.
15. Please use the box below to describe the effect it had on you. What type of emotions you experienced and if possible why you felt that way? (e.g. shame, sadness, anger, contempt, fury, regret, relief, paranoia etc)
16. At the time what extent did you feel responsible for the suicide/suspected suicide? Some psychiatrists feel responsible even where an event was judged to have been beyond their control.
17. With hindsight how responsible do you feel you were for this death now.
18. If this event affected your mental health do you think your symptoms met the clinical threshold for the diagnosis of a disorder at any point as a consequence of your patient's suicide?
19. At the most difficult point do you feel that this had a detrimental effect on your confidence in your clinical practice?

20. Approximately how long did this effect last?
21. Did the experience of losing a patient by suicide have an effect on your ability to carry out your clinical duties in the longer term?
22. Did you ever consider or act in any way to change your career path as a consequence of a patient suicide?
23. 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?
24. Did you take any annual leave or sick leave because of your experience?
25. Please indicate who you were offered support at work by:
26. Did you access support outside work?
27. How familiar/knowledgeable were you then with the process that takes place following a patient suicide?
28. At the time of the death which procedures were you not prepared for? (Select all that apply)
29. Were you offered advice/help/support with the processes that follows a patient suicide? (Select all that apply)
30. Did anything help make this event easier to cope with?
31. Did you find anything unhelpful?
32. If you were involved in the Trust or organisation's internal enquiry did you find it helpful or unhelpful?
33. How familiar/knowledgeable are you now with the process that takes place following a patient suicide?
34. Please select the procedures that you are not currently familiar/knowledgeable about now? (Select all that apply)
35. One of the aims of this survey is to identify doctors' specific needs and develop better support after the loss of a patient by suicide. If any of the following were available, which do you think would be helpful for doctors affected by the death of patient by suicide (select all that apply):
36. To what degree do you believe preventing suicide is the role of the psychiatrist?
37. Why do you think you gave the answer you did to question 36?
38. To what degree do you feel under pressure (by external sources) to prevent suicide in your role of the psychiatrist?
39. To what degree do you think suicide is predictable in secondary care?
40. Which Trust do you work for (optional)
41. If you do not give your permission to use anonymised extracts of your answers please select this box
42. Do you have any other ideas about what might be helpful for psychiatrists or other clinicians after a patient suicide (free text)?

## References

- 1 Séguin M, Bordeleau V, Drouin M, Castelli-Dransart D, Giasson F. Professionals' reactions following a patient's suicide: review and future investigation. *Arch Suicide Res* 2014; **18**: 340-62.
- 2 Alexander D, Klein S, Gray N M, Dewar I, Eagles J. Suicide by patients: questionnaire study of its effect on consultant psychiatrists. *BMJ* 2000; **320**: 1571-4.
- 3 Courtenay K, Stephens J. The experience of patient suicide among trainees in psychiatry. *Psychiatr Bull* 2001; **25**: 51-2.
- 4 Chemtob C, Hamada R, Bauer G, Kinney B, Torigoe R. Patients' suicides: frequency and impact on psychiatrists. *Am J Psychiatry* 1988; **145**: 224-8.
- 5 Gitlin M. A psychiatrist's reaction to a patient's suicide. *Am J Psychiatry* 1999; **156**: 1630-4.
- 6 Ruskin R, Sakinofsky I, Bagby R, Dickens S, Sousa G. Impact of patient suicide on psychiatrists and psychiatric trainees. *Acad Psychiatry* 2004; **28**: 104-10.
- 7 Campbell D, Hale R. *Working in the Dark: Understanding the Pre-Suicide State of Mind*. Routledge, 2017.
- 8 Dewar I, Eagles J, Klein S, Gray N, Alexander D. Psychiatric trainees' experiences of, and reactions to, patient suicide. *Psychiatr Bull* 2000; **24**: 20-3.
- 9 Wolfart G. *Coping with self-destructive forces*. Doctoral dissertation, City University 2011; 84-161.
- 10 Brooks S, Gerada C, Chalder T. Review of literature on the mental health of doctors: are specialist services needed? *J Men Health* 2011; **20**: 146-56.
- 11 Large M, Ryan C, Carter G, Kapur N. Can we usefully stratify patients according to suicide risk? *Br Med J* 2017; **359**: j4627.
- 12 Healthcare Quality Improvement Partnership. *National Confidential Inquiry into Homicide and Suicide: Report 2018*. HQIP, 2018 (<https://www.hqip.org.uk/resource/national-confidential-inquiry-suicide-homicide-report-2018>).
- 13 Berman A. Risk factors proximate to suicide and suicide risk assessment in the context of denied suicide ideation. *Suicide Life Threat Behav* 2018; **48**: 340-52.
- 14 Rahman R, Gupta S, While D, Rodway R, Ibrahim S, Bickley H, et al. *Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study*, June 2013. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, University of Manchester, 2013 (<http://documents.manchester.ac.uk/display.aspx?DocID=37576>).
- 15 Windfuhr K, Kapur N. Suicide and mental illness: a clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide. *Br Med Bull* 2011; **100**: 101-21.
- 16 NHS England. Suicide Prevention and Reduction. NHS England, 2018 (<https://www.england.nhs.uk/2018/05/suicide-prevention-and-reduction/>).
- 17 Karlsson P, Helgesson G, Titelman D, Sjöstrand M, Juth N. Skepticism towards the Swedish vision zero for suicide: interviews with 12 psychiatrists. *BMC Med Ethics* 2018; **19**: 26.
- 18 *Help is at Hand - Support After Suicide*. Public Health England, 2015 (<http://supportaftersuicide.org.uk/support-guides/help-is-at-hand/>).

