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CR234

Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework

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COLLEGE REPORT

Contents

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Purpose of this guidance

> I felt as though I was deeply wounded.
>
> — Psychiatrist

The death of a patient by suicide can have a profound effect on the clinicians who have been involved in their care. The consequences of this distress can include burnout, mental health problems, not progressing with training and in some cases, leaving the mental health sector. Staff support following a death of this nature varies widely across organisations. Some staff report feeling prepared and well-supported, whilst others describe feeling blamed or even scapegoated by the organisation employing them (Julia L Whisenhunt, Robin M DuFresne et al., 2017; Barajas A, Binder A et al., 2019; Gibbons R, Brand F et al., 2019; Gutin NJ, 2019a; Leaune E, Cuvillier B et al., 2020; Croft A, Lascelles K et al., 2022;).

There are currently no national guidelines for organisations that employ mental health clinicians for the pastoral care of their staff either in preparation for these events (prevention), or to aid recovery (postvention). This is important because when organisations provide effective support it can mitigate the damaging personal and clinical effects, enhance resilience, and facilitates realistic reflection and post-traumatic growth (Maltsberger JT, 1992; Tedeschi RG and Calhoun LG, 1996; Al-Mateen CS, Jones K et al., 2018; Gutin NJ, 2019a). A few postvention programmes have been suggested and early evidence demonstrates their effectiveness for organisations that use them consistently (Barajas A, Binder A et al., 2019; Gutin NJ, 2019b; Leaune E, Cuvillier B et al., 2020; Kinman G and Torry R, 2020).

This guidance has been written by the Royal College of Psychiatrists' Working Group on the Effect of Suicide and Homicide on Clinicians (ESHC) and the Oxford Centre for Suicide Research. It outlines best practice recommendations for mental health and training organisations for supportive operational strategies and pastoral care of staff after a patient death by suicide. It is aimed at the organisational board, senior clinical leadership including the medical and nursing directors, suicide leads currently in post, and more broadly as guidance to all clinicians.
Recommendations are based on recent research studies (Cryan et al., 1995; Gibbons R, Brand F et al., 2019), suggested postvention models (Julia L Whisenhunt, Robin M DuFresne et al., 2017; Barajas A, Binder A et al., 2019; Gutin NJ, 2019b; Leaune E, Cuvillier B et al., 2020) and focus groups, as well as examples of good practice currently provided within some mental health organisations. Quotes below are from clinicians in the surveys conducted by Gibbons et al. (2018) and Croft et al. (2022).

The death of individuals by suicide is a powerful experience encountered by different professional groups in a variety of work settings. The current document provides guidelines for professionals working in mental health. Despite the specificity of recommendations, we hope they can be of use to other professional environments where patients, clients, or prisoners also die by suicide.

Members of the Operational Board will need to value, endorse and support the ethos of this guidance for the recommendations to be successfully integrated into their mental health organisations. There is a manager's checklist at the end of this guidance (Appendix 5).

Aims

- **Recommend evidenced-based and best practice interventions so as to:**
    - mitigate the impact of a patient death by suicide on mental health professionals, improve the sustainability of mental health services and increase staff wellbeing, progression with training, resilience and retention.
    - assist mental health and training organisations in their legal obligation of duty of care for their employees
- **Increase awareness of the impact that a death of a patient by suicide can have on professionals and to:**
    - encourage transparent and open dialogue about the impact on staff of working with suicide risk and death.
    - facilitate expansion of suicide prevention and awareness training to include preparation for the emotional effects and the processes that follow the death of a patient by suicide.
- **Help support cultural transformation:**
    - from one where individual clinicians may feel isolated and personally held responsible following a death, to a systemic understanding about the uncertainty and complex aetiology of suicide and its consequences on staff.
- **Improve the quality of patient care:**
    - by helping staff feel less anxious working with suicidality and in this way maintain their capacity to think clearly and provide safe, high-quality, care.
- **Increase the possibility of truly learning from these tragic events.**
    - To learn takes time, space for reflection and freedom from persecution.

> **Overwhelming sense of guilt and personal responsibility. Grief. Tearfulness. Reduced appetite. Difficulty sleeping. Difficulty concentrating.**

— Nurse

> **I was helped with my caseload to allow me plenty of time to write the coroner's report and plenty of support in doing this. When I took a day off for stress following the funeral and coroner's inquest this was not questioned… service manager and other staff at the time attended the coroner's inquest with me. The trust solicitor was very empathic and sensitive.**

— Occupational therapist

Executive summary of recommendations

1. **Organisational pastoral suicide lead role**
2. **Pastoral senior management support**
3. **Support for the processes following the death**
4. **Buddy systems and other individual support**
5. **Group psychological support**
6. **Family liaison officer (FLO), FLO service or similar**
7. **Training on the effect of patient suicide on clincians and on the processes that follow**
8. **Resource availability**

Summary of research

- **Most mental health professionals will experience a patient death by suicide at least once in their career; many will encounter these events several times.**
    - The number of patient suicides can vary but it is estimated that mental health clinicians will experience between 1 and 4 patients dying by suicide during their professional life (Alexander D et al., 2000; Courtenay KP and Stephens JP, 2001; Gibbons R, Brand F et al., 2019; Croft A, Lascelles K et al., 2022).
    - Many of these deaths are experienced whilst clinicians are in training (Courtenay KP and Stephens JP, 2001; Leaune E, Cuvillier B et al., 2020).

- **The death of a patient by suicide has a significant emotional and clinical effect on clinicians.**
    - Mental health professionals are usually unprepared for a patient death by suicide, and this can increase the distress and trauma after the event (Julia L Whisenhunt, Robin M DuFresne et al., 2017; Barajas A, Binder A et al., 2019; Gibbons R, Brand F et al., 2019; Gutin NJ, 2019a; Leaune E, Cuvillier B et al., 2020; Croft A, Lascelles K et al., 2022).
    - For some clinicians there is a profound impact that affects all aspects of their functioning with some developing secondary care level mental health problems, including post-traumatic stress disorder, depression, anxiety and adjustment disorders (Julia L Whisenhunt, Robin M DuFresne et al., 2017; Al-Mateen CS, Jones K et al. 2018; Gibbons R, Brand F et al., 2019; Gutin NJ, 2019a; Leaune E, Cuvillier B et al., 2020; Croft A, Lascelles K et al., 2022).
    - For some staff the effect is experienced sometime after the event (Croft A, Lascelles K et al., 2022; Gibbons R, Brand F et al., 2019).
    - This effect on mental health professionals is variable due to individual vulnerability linked to personal characteristics, resonance with the patient, clinical involvement and support received after the event (Julia L Whisenhunt, Robin M DuFresne et al., 2017; Barajas A, Binder A et al., 2019; Gibbons R, Brand F et al., 2019; Gutin NJ, 2019a; Leaune E, Cuvillier B et al., 2020; Croft A, Lascelles K et al., 2022).
    - The psychological support provided should accommodate differences in need (Julia L Whisenhunt, Robin M DuFresne et al., 2017; Barajas A, Binder A et al., 2019; Gibbons R, Brand F et al., 2019; Gutin NJ, 2019a; Leaune E, Cuvillier B et al., 2020; Croft A, Lascelles K et al., 2022;).

- **The response of the mental health and training organisations matters; if clinicians experience the mental health and training organisations as:**

    - supportive, then this reduces the traumatic impact.

    - unsupportive, then it can increase the traumatic impact and recovery becomes problematic. It can also lead to clinicians leaving the team, organisation or profession (Cryan, et al., 1995; Julia L Whisenhunt, Robin M DuFresne et al., 2017; Barajas A, Binder A et al., 2019; Gibbons R, Brand F et al., 2019; Gutin NJ, 2019a; Leaune E, Cuvillier B et al., 2020; Croft A, Lascelles K et al., 2022).

- **Mental health staff may need to be encouraged to attend to their own well-being after these events.**

    - Clinicians can find it difficult to acknowledge their vulnerability and may benefit from temporary adaptations to facilitate recovery, a more successful return to a state of wellbeing and being able to carry out full duties. These adaptations may include compassionate leave (Cryan et al., 1995; Gibbons R, Brand F et al., 2019).

- **There can be significant consequences for the mental health and training organisations**

    - ***There is significant attrition of mental health staff following patient deaths by suicide*** (Gitlin M, 1999; Alexander D et al., 2000; Gibbons R, Brand F et al., 2019).

    - The negative impact on service provision and clinical performance in affected teams can be considerable.

    - Clinical practice in the organisations can be detrimentally affected, for example:
        - staff tend to become more risk adverse.
        - discharges from services may be delayed.
        - the threshold for admission to hospital decreases.
        - patients are referred to alternative teams more frequently.

- **Mental health staff want help and support before and after a patient death by suicide.**

    - The different types of help that clinicians want based on two staff surveys (Gibbons et al., 2019; Croft et al., 2022) are summarised below. The support is organised in descending order with the most frequently wanted at the top.

Support wanted

- A senior clinician with a role as suicide lead who could give confidential advice and support
- Support for formal processes following a patient suicide
- Personal psychological support
- Confidential reflective practice group/space specifically for processing the effects of a patient suicide
- Information about the practical process following patients' death by suicide
- Information about resources for families affected by suicide
- Help in communicating or meeting the family/friends of the patient who has died (e.g. Public Health England's Help is at Hand)
- Access to a general reflective practice group
- Organised peer support
- A training session about this topic

Recommendations in detail

Appointment of an organisational pastoral suicide lead role

- The working group recommends that each mental health organisation appoint an organisational pastoral suicide lead. A suicide lead should be a senior clinician with a pastoral role in the organisation. This is a different leadership role than suicide prevention.

  The feedback from organisations that have suicide leads is uniformly positive. NHS England has advised on Wellbeing Guardians for all NHS organisations, which is a Board member who has responsibility for staff wellbeing (NHS England, 2022). The suicide lead role may link well with this development. This clinician needs protected time for the role within their job plan that includes:

  - leading, overseeing, supervising the organisational response in the pastoral care of clinicians experiencing loss of patients to suicide.
  - preparing the staff and organisation for the reality of this event.
  - supporting staff and families through the formal processes that follow a death by suicide.
  - signposting to resources for staff and families.
  - advocating for clinicians and families after critical events within the organisation.

> **Conversation with my manager was helpful, she was empathetic and supportive. She helped to complete some trust paperwork.**
>
> — Occupational therapist

1. Pastoral senior management support

Most clinicians value the support received from the direct line managers or supervisors. In the surveys they found it helpful to have someone in their workplace to turn to both for emotional assistance and to guide them through the practical tasks that may be required of them following the death, such as internal inquiries and inquests. Managers/supervisors should adopt a compassionate leadership style to support individuals through this traumatic event. Some guidance for those fulfilling this role can be found below, and a relevant manager's checklist is also available in Appendix 5.

- **Be kind.**

    - Send compassionate letters/emails to those clinicians and teams affected (Julia L Whisenhunt, Robin M DuFresne et al., 2017; Gutin NJ, 2019b; Kinman G and Torry R, 2020).

    - Support adjustments to work demands and compassionate leave as appropriate (Julia L Whisenhunt, Robin M DuFresne et al., 2017; Gutin NJ, 2019b; Kinman G and Torry R, 2020).

> **I feel after such incidents there should be a push from leadership to strongly encourage a short break from clinical work. Otherwise, I feel often we don't want to let clients down or pass work over to colleagues so are likely to continue as normal.**
>
> — Nurse

    - Help team members find ways to be more supportive towards one another after a death by suicide.

- **Break the news thoughtfully.**

    - How the news about a patient's suicide is imparted influences the emotional impact of the death and is therefore very important (Cryan, et al., 1995; Julia L Whisenhunt, Robin M DuFresne et al., 2017; Gutin NJ, 2019b; Kinman G and Torry R, 2020).

    - Consider all staff members who have been involved in the patient's care, however peripherally. These may be clinicians and non-clinical staff who are not currently part of a team, have left, or have come across the patient while on call/duty. Ensure as best you can that everyone is informed in a timely manner. Some staff who have been involved in looking after the patient may have recently left the team (e.g. students or trainees on placements). Non-clinical staff (e.g. housekeepers, ward clerks) may be particularly vulnerable to being affected by the death because they have less training and preparation for the possibility of a death by suicide than clinical staff and are often forgotten in provision of support.

> **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

- **Intervene on behalf of the clinician if there are any professional sanctions following the suicide of a patient.**

> **As I was part of an external company, I didn't feel that I was given any support by the staff at the hospital. They didn't see me as a colleague or member of staff so didn't offer any support or even ask me how I was.**
>
> — Advocate

  - Any professional sanctions, such as a referral to the GMC or NMC or HCPC, need to be carefully reviewed, and intervention on behalf of the clinician by the mental health organisation strongly considered. The specific reasons for suicide in individual patients are unlikely to be known and therefore any premature conclusions that an individual professional's input had a role in the death is likely to be erroneous, and action taken around this assumption unnecessarily harmful.

  - Advise clinicians to contact support services to received advice or support early on if this might be helpful. For example, psychiatrists can contact the Royal College of Psychiatrists Psychiatrist Support Service (PSS) and/or Practitioner Health (PH).

- **Be aware of the different support needs of different clinicians.**

  - There is no ideal form of support that suits everyone, and clinicians and non-clinicians can vary in what they want and need. However, most individuals will likely value knowing there is support available if and when they want to access it.

  - Some clinicians will need to be able to access that support at different times, depending on their particular circumstances. In some cases, this might need to be very soon after the death. Being able to respond to the need for urgent support is important.

  - Within the NHS People Plan there is an ambition for all staff to have a health and wellbeing conversation with their line manager. Part of this conversation should include discussions on support required and how to access it. National training for all line managers on having safe and effective wellbeing conversations can be found on the NHS website.

2. Support during the processes following a death

i. Serious incident investigation

Serious incident investigations are very important. When conducted well they can generate important practical learning for the organisation about the services they provide. However, the uncertainty and anxiety resulting from suicide can lead to confusion and disturbance in organisational functioning. Organisations need to ensure that the formal processes do not become persecutory by ensuring that investigators are supervised and that contextual and system factors are appropriately addressed. Persecutory investigations have the potential to re-traumatise staff and families, arrive at unhelpful conclusions and prevent productive learning and recovery.

- **Be clear about the remit of the investigation.**
    - The aim of the formal investigation is to learn from a close examination of the care pathway provided to the patient, to ensure it has followed local recommendations and policies. The learning from this examination is used to improve the quality of care in the future and guide service development. It is not intended to identify causes for the death as this is purely speculative. It is the coroner's remit to determine who has died, how they died and where and when they died.

> **The suicide was upsetting, however the aftermath, the serious incident 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.**
>
> — Psychiatrist

- **Encourage systemic recommendations and not individual clinician responsibility.**
    - Try not to use words such as 'fault' and 'blame' within formal processes and reports.

- Investigators can feel that they have failed if they do not generate recommendations. Small imperfections in areas such as note-taking can be identified as serious 'failures' and lead to unhelpful or unrealistic recommendations. This results in meaningless reports, additional detrimental emotional impact on families, and little systemic learning.

- Investigators should also highlight good practice where this is found, to ensure a balanced report is produced.

- It needs to be kept in mind that any problems identified cannot be reliably connected with the aetiology, or cause, of the death. These problems, if identified, need to be considered systemically and not personalised.

- **Family involvement.**

  - Involve the family as far as possible in the investigation process but be sensitive to tensions that may exist between the family and the services. Involve a family liaison service if you have one.

  - Review the communication and care provided for the family as part of the investigation process.

ii. Support during legal processes; Coroner's Inquest (England, Wales and Northern Ireland), Fatal Accident Inquiry (Scotland)

> **I think training on Coroner's Court would be helpful for clinicians to attend routinely as it will make it a little less daunting, maybe a visit to the actual court at a time when they are not highly emotional.**
>
> — Psychiatrist

- **Encourage clinicians to attend the inquest/Fatal Accident Inquiry (FAI) with supportive colleagues.**

  - Having a supportive colleague attend the Coroner's Inquest can be very valuable for clinicians.

- **Ensure protected time for clinicians to prepare for the inquest/FAI and to write the report.**
    - It is vital that clinicians are able to prepare thoroughly for the inquest and have appropriate supervision, support, and protected time to ensure that the coronal process is not frustrated.
    - Mental health organisations should:
        - provide legal support in cases where this is appropriate to do so (guidance from the MPS is found here).
        - consider training from clinicians with lived experience of being a witness to guide colleagues on how to prepare as a witness (see buddy system guidance below).

- **Encourage a thoughtful return to work after the inquest or Fatal Accident Enquiry, for example by allowing the clinician to have:**
    - the rest of day of the inquest/FAI as supported leave.
    - the opportunity to reflect the following day with a supervisor/manager/suicide lead before starting usual duties.

> **I feel there is a pressure to bounce back quickly from these incidents, and be 'ok' and to continue our work with high-risk and suicidal patients shortly after these incidents.**
>
> — Nurse

3. Buddy systems and individual support

- **Consider mentoring from a consultant or mental health professional with lived experience (buddy system).**
    - 'Buddy systems' are starting to develop in different organisations. These systems mean that clinicians who have recently experienced the suicide of a patient are put in touch with a colleague in a different part of the mental health organisation who has been through a similar experience in the past and has an interest in providing support. The 'buddy' can give collegiate support and information, helping to guide the clinician through the processes that follow the event.

- **Provide additional supervision, psychological support and mentoring as required.**
    - See resources in Appendix 1.
- **Encourage use of the occupational health service where this is relevant.**
- **Regular reviews of wellbeing as agreed with the clinician by both the line manager and, if involved, occupational health.**
    - At certain times, distress may increase, for example during formal hearings, reviews, anniversaries and subsequent deaths. It is important to acknowledge this, as well as possibly increasing or re-instating support at these times.

> **When the case was brought up recently, I didn't realise how strongly it would still affect me now.**
>
> — Nurse

4. Group psychological support

- Reflective spaces embedded within the structures of the teams and organisation can provide an environment where trauma and grief associated with the death of a patient by suicide can be processed.

> **The impact of losing clients to suicide has been vast on our team. It feels each time this happens that it takes away from the great work we do …. I have been grateful for time spent as a team to reflect and support one another following these incidents, having a space to be honest and open about the difficulty of our roles. …It has been helpful to have an outside clinician providing a space to reflect.**
>
> — Psychiatrist

    - Access to a general reflective practice group such as a Balint group, case discussion group and/or group staff support can be very helpful.
    - Many staff find reflective practice sessions, such as Schwartz rounds helpful for seeing senior members of the organisation modelling openness and vulnerability.

- **A separate reflective group specifically to process the effects of suicide.**

    - Some clinicians responding to research surveys (Gibbons et al., 2019; Croft et al., 2022) wanted a confidential, safe, space specifically designed for reflecting on deaths by suicide within the organisation. Several organisations have such groups running successfully. These groups tend to run on a monthly or bi-monthly basis and cover the whole mental health organisation. Support and commitment from senior management has been essential for these groups to become embedded within practice and the culture of the organisations. Facilitation is an important consideration when planning these groups. The current groups are facilitated by clinicians with training in psychotherapy and vary in whether they are internal or external to the organisation. A model for the group is described in Appendix 3. In some organisations facilitation of suicide groups is being written into the job descriptions of new consultant medical psychotherapists.

5. Family liaison officer (FLO), FLO service or similar (see Appendix 6)

This working group recommends that mental health organisations employ a family liaison officer (FLO) or family liaison service. FLO's are increasing in number nationally as their value to mental health organisations becomes clear. These services can provide effective support and help bridge the gap that can arise between the organisation, the treating team and the family and friends in the aftermath of a death.

Family liaison services have an advocacy role and can act as a conduit between the family and the incident investigation team (see Appendix 6 for job description as used by Southern Health and FLO Leaflet).

- **Be thoughtful about family contact: take clinician vulnerability and distress into account.**

    - The initial liaison with family and friends of a patient who has died by suicide is very important in establishing the family's immediate needs and their views and concerns on the care of the patient. It offers them an opportunity to ask questions and to be signposted to bereavement support and counselling services. A distressed member of the team may not be the right person for this task.

6. Training on the effects of patient suicide on clinicians and the processes that follow

- Encourage training institutions to have a major role in awareness and pastoral care.
    - This subject is now in the national curriculum for psychiatrists but not for other professional groups.
- Formalised training as part of induction.
    - These should cover the potential impacts of suicide and mitigation measures, and should be able to include frank discussions of suicide.
- Regular teaching sessions on the emotional effects of patient death by suicide as part of local teaching programmes.
- Clinicians to be encouraged to attend an inquest and serious incident review as part of training and induction
- Regular and accessible workshops on:
    - The effect of patient suicide on clinicians
    - Lived experience: opportunities for clinicians to talk openly and share their experience of both recent and historical patient deaths, without fear of judgment or censure; this develops the understanding that experiencing the death by suicide of a patient is part of the shared experience of working within mental health
    - The internal and external inquiry processes
    - Working with families
- Training on inquests and the Coroner's Court.
    - Regarding the Coronal Process, there has been good feedback when solicitors experienced in these processes have been involved in this training.
    - Training on report writing should also be available.

7. Resource availability

- See Appendix 1

Appendix 1

Resources and further reading for all mental health professionals

- **When a Patient Dies by Suicide a Resource for Psychiatrists**
  Located on the Royal College of Psychiatrists' webpage:

  https://www.rcpsych.ac.uk/members/supporting-you/if-a-patient-dies-by-suicide.

- **When a Patient Dies by Suicide a Resource for Clinicians**
  Located on the Royal College of Psychiatrists' webpage:

  https://www.rcpsych.ac.uk/members/supporting-you/if-a-patient-dies-by-suicide

- **The Webpage If a Patient Dies by Suicide**
  On the Royal College of Psychiatrists' website where there are many resources including videos of clinicians and families talking about their experience following a death by suicide.

  https://www.rcpsych.ac.uk/members/supporting-you/if-a-patient-dies-by-suicide

- **NHS England Mental Health and Wellbeing Hubs**
  Set up to provide rapid access to assessment and local evidence-based mental health. The hub is confidential and free of charge for all health and social care staff.

  https://www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs/

- **NHS Scotland Wellbeing Hub**

  https://wellbeinghub.scot/

- **Clinicians as Survivors of Suicide**
  Located on the website of the American Association of Suicidology. The Clinician Survivors Task Force provides a postvention web resource and opportunity for linking for clinicians who had lost a patient to suicide.

  http://pages.iu.edu/~jmcintos/basicinfo.htm

- **Helping Residents Cope with Patient Suicide**
  Produced by the American Psychiatric Association to support doctors in training who have experienced the death of a patient from suicide.

  https://www.psychiatry.org/residents-medical-students/residents/coping-with-patient-suicide

- **Finding the Words: How to support someone who has been bereaved and affected by suicide**
  Provides useful simple advice for how to speak to someone who has been bereaved by suicide. Helpful for family and friends of those who have suffered bereavement and also for clinicians. There is a leaflet that can be downloaded:

  http://judimeadows.com/wp-content/uploads/Finding-the-words-online-version.pdf

- **Free online CBT resources**
  Computer based self-help for everyone.

  - **Living life to the full**:
    https://llttf.com/
  - **Mood juice**:
    https://www.moodjuice.scot.nhs.uk/

- **Healthtalkonline. Bereavement by Suicide**
  Thematically arranged clips of interviews with bereaved individuals to show impacts of bereavement by suicide and ways of coping.

  http://www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics

- **Royal College of Psychiatrists Leaflet: Post-Traumatic Stress Disorder**
  Online information on post-traumatic stress disorder (PTSD) that can be downloaded, detailing symptoms, treatment and links to sites providing further help.

  https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-traumatic-stress-disorder

- **Suicide Bereavement UK**
  Specialises in suicide bereavement research, providing consultancy on postvention and delivering evidence-based suicide bereavement training.

  https://suicidebereavementuk.com/

- **Support After Suicide Partnership (SASP)**
  An umbrella organisation of suicide bereavement organisations and people with lived experience. The website provides helpful online information and details of local and national support services.

  https://supportaftersuicide.org.uk/

- **Improving Access to Psychological Therapy services (IAPT)**
  Primary care mental health services in England offering a range of evidence-based treatments for common mental health problems via telephone, online and face-to-face services. Accepts self-referral. Search IAPT for your local service's contact information.

- **Private therapy**

  - **BABCP accredited CBT therapists**:
    http://www.cbtregisteruk.com/
  - **UKCP accredited psychotherapists and counsellors**:
    https://www.psychotherapy.org.uk

- **Samaritans**
  Charity aimed at listening to people who are angry, depressed and suicidal any time – night or day.

  Website: https://www.samaritans.org/
  Email: jo@samaritans.org
  Tel: 116 123

- **BMA Counselling**
  24/7 helpline, individual counselling, and Doctors Advisor Service (peer support). Free telephone support for all qualified doctors and medical students.

  Website: http://www.bma.org.uk/advice/work-life-support/your-wellbeing/bma-counselling-and-doctor-advisor-service
  Tel: 0330 123 1245

- **DocHealth**
  Independent psychotherapeutic consultation service for medics. Based in London but available to all doctors in the UK. Fees payable.

  Website: http://www.dochealth.org.uk
  Tel: 020 7383 6533

- **NHS Practitioner Health Programme**
  Confidential NHS treatment service for Healthcare Professionals working in England with mental health or addictions problems. The service is also free.

  Website: https://php.nhs.uk/
  Tel: 020 3049 4505

- **Workforce Specialist Service**
  Confidential, free NHS mental health service for regulated health and social care professionals working in Scotland.

  Self-referral: https://wellbeinghub.scot/the-workforce-specialist-service-wss/

- **Health for Health Professionals**
  Free confidential mental health support for NHS staff and students in Wales.

  Website: https://hhpwales.nhs.wales/

- **Royal College of Psychiatry Psychiatrists Support Service**
  Free, confidential support and advice service for psychiatrists in all stages of their career.

  Website: https://www.rcpsych.ac.uk/members/supporting-you/psychiatrists-support-service
  Tel: 020 7245 0412

- **Sick Psychiatrists Trust**
  Free helpline for psychiatrists with drug or alcohol issues.

  Website: http://sick-doctors-trust.co.uk/
  Tel: 0370 444 5163

- **Cavell Nurses Trust**
  Helpline for Nurses, midwives and healthcare assistants, both working and retired.

  Website: https://www.cavellnursestrust.org/
  Tel: 01527 595 999

Appendix 2

Resources for family and friends

- **Help is at Hand**
  Very useful and widely used resource to provide important information and support to relatives and friends after a death by suicide. There is a downloadable booklet that is a first line resource used by many Mental Health Trusts and community services.

  Booklet: https://supportaftersuicide.org.uk/support-guides/help-is-at-hand/

- **After a Suicide**
  A thoughtful and helpful booklet for those bereaved produced by the Scottish Association for Mental Health (SAMH).

  Website: https://www.samh.org.uk
  Booklet: https://www.samh.org.uk/documents/After_a_suicide.pdf

- **The Listening Place**
  Offers free face-to-face support 7 days a week between 9am and 9pm for those experiencing suicidality. Self-referrals can be made by email or phone.

  Website: https://listeningplace.org.uk/

- **Healthtalkonline: Bereavement by Suicide**

  Thematically arranged clips of interviews with bereaved individuals to show impacts of bereavement by suicide and ways of coping.

  Website: http://www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics

- **Alison Wertheimer (2013). A Special Scar: The Experiences of People Bereaved by Suicide** Routledge: Abingdon. Book with very sensitive accounts of experiences of bereaved individuals, which psychiatrists may find helpful.

Support agencies for family and friends

- **Cruse Bereavement Care**
  A confidential bereavement service.

  Website: https://www.cruse.org.uk/

Tel: 0808 808 1677

- **Survivors of Bereavement by Suicide (SOBS)**
  Offering emotional help and support to those bereaved by suicide.

  Website: https://uksobs.org/
  Tel: 0300 111 5065

- **Scottish Association of Mental Health**
  Scotland's national mental health charity offer a range of mental health support and services.

  Postal address: Brunswick House, 51 Wilson Street, Glasgow, G1 1UZ
  Website: www.samh.org.uk
  Email: info@samh.org.uk
  Tel: 0141 530 1000

- **The Compassionate Friends**
  Charitable organisation supporting bereaved parents and their families after the death of a child.

  Website: www.tcf.org.uk
  Tel: 0845 123 2304

- **Samaritans**
  Charity aimed at listening to people who are angry, depressed and suicidal any time – night or day.

  Website: https://www.samaritans.org/
  Email: jo@samaritans.org
  Tel: 116 123

- **The Way Foundation**
  Supporting widowed men and women under 51 years of age as they adjust to life after the death of their partner.

  Website: https://www.widowedandyoung.org.uk/
  Tel: 01332 869 222

- **Winston's Wish**
  A national grief support programme for bereaved children.

  Website: https://www.winstonswish.org/
  Tel: 08452 03 04 05

Appendix 3

Model for a group designed to reflect on deaths of patients by suicide

- **Frequency:** monthly or bi-monthly
- **Time:** 60 – 90 mins
- **Number of cases discussed:** 1
- **Type of case:** death by suicide
- **Facilitator or convener:** usually two; one who has psychotherapy training and one who has lived experience of patient suicide.
- **Boundaries:** if possible, to be held at the same time and place every session.
- **Style:** similar to Balint groups (these offer a structured form of psychodynamic reflective practice, which allows members with little psychotherapy or group experience to explore the emotional aspects of the patient-clinician relationship in a contained manner.)
- **Core membership:** around four core members who commit to attend frequently. It is advisable to start with a pilot group to establish the core members. The core members should have their lived experience of losing patients to suicide which can be starting point for their own reflection.
- **Attendance:** clinicians who have had a death by suicide either ask to attend, or are invited by a colleague who is aware that they have just had a death. They may come once to tell their story, or more frequently. They can also stay in the longer term and join the group. Quite often, individuals come once after the death and then again at the time of the Coroner's Court.

Functioning or process

1. When a new member (e.g., Dr X) joins after they lose a patient to suicide, they are first given space to share their story while the rest of the group listen; initially they will have between 10 – 20 minutes to talk without any interruption. Dr X should also speak without the use of notes so they can express their emotions more freely.
2. Dr X is asked to sit back and listen to the group discuss what they have heard for around 20 minutes.
3. Dr X is then asked to re-join the group and share their thoughts. If needed, they

are given more time (around 10 minutes) to continue their narrative. After this, they are asked to sit back again.

4 The group again discuss the further material for around 20 minutes.

5 Dr X is asked back into the group, to provide feedback.

6 There is a final discussion involving the whole group.

Appendix 4

Formal processes following death by suicide in Scotland

Introduction

1 Mental health services are part of Health Boards/Health and Social Care Partnerships (HSCP).

2 This appendix will describe the different processes and agencies/organisations that could potentially be involved following the death of a patient by suicide.

3 Local serious adverse event review (SAER) processes are all based on Healthcare Improvement Scotland's (HIS) national framework for reporting, reviewing and learning from serious adverse events, although the exact processes can vary between Boards/HSCPs.

4 In some cases, the Crown Office and Procurator Fiscal Service (COPFS) – also referred to as the Procurator Fiscal, or Fiscal – can also conduct a Fatal Accident Inquiry (FAI).

5 The Mental Welfare Commission (MWC) may have a role, particularly if the patient was detained under the Mental Health (Care & Treatment) (Scotland) Act (2003).

6 NHS Boards send quarterly review data to HIS.

Local SAER processes

1 All deaths, near misses and serious incidents are reported to the serious adverse event review team via local electronic reporting systems. The SAER team will usually be led by the senior medical and nurse managers of the organisation.

2 Adverse event reviews are not about apportioning blame. The aim is to be open and honest with people when things do go wrong, and to offer an apology as soon as an event has been identified. A review of the care provided determines whether there are learning points for the organisation, or organisations, to improve the service. Organisations then need to implement the improvements identified to support a greater level of safety for all people involved in its care systems.

3 Following an event, the senior doctor or clinical manager (where no doctor was involved in the care) will make contact with the deceased's family to offer condolences, advise on avenues for accessing support, inform them of the independent internal review process (and that reviewers will be in touch with them) and offer to meet.

4 The senior doctor/manager will provide a report to the review team.

5 The reviewers will gather data from the case notes and relevant staff interviews as well as any information from the bereaved relatives. They will use standardised documentation to provides a chronology of the event, to identify challenges to care delivery as well as any contributory factors, and to make recommendations. The commissioners of the review then develop an improvement plan based on the recommendations.

Fatal Accident Inquiries

1 Unlike England, there is no system of coroners' inquests in Scotland, Wales or Northern Ireland. The investigation of deaths in Scotland is the responsibility of the Crown Office and Procurator Fiscal Service (COPFS), often referred to as Procurator Fiscal. In certain circumstances these investigations will result in the holding of a Fatal Accident Inquiry (FAI). This is the judicial process for the public examination of the circumstances of the death in the public's interest.

2 FAIs are an inquisitorial process, which seek to establish the facts surrounding the death. The purpose of an FAI is not to apportion blame for the death. They are mandatory where the death was the result of a work-related accident, or where the death was in custody. Discretionary FAIs can be held where the death was sudden, suspicious, unexplained or if it occurred in circumstances which give rise to serious public concern, for example, the death of a detained patient in hospital. COPFS will make a recommendation if they believe a discretionary FAI should be held. FAIs are held in the Sheriff Court.

3 The majority of evidence at the hearing is normally led by the Procurator Fiscal, who presents the Inquiry for the Crown. Other parties involved may include the deceased's family, employer (if the death occurred at work), and any others with a potential interest in the circumstances of the death.

4 After conclusion of the hearing, the sheriff will issue a Determination, which will include the cause of the death or accident, and reasonable precautions which could have been taken. They may also include recommendations of steps to be taken to avoid deaths in the future. Participants to the FAI may need to respond to these.

5 Importantly, the process is a 'fact-finding' one, not a 'fault-finding' one.

Mental Welfare Commission

1 The Mental Welfare Commission for Scotland (MWC) is a statutory body set up to protect the rights and welfare of people with mental illness and learning disability.

2 The Commission should be notified of instances where a person has died following suicide in an inpatient setting, or within a month of discharge from hospital, or if the person is subject to the Mental Health Act. There is a specific form for the latter event currently available through contacting the Commission (Notification of

death form ND1). A list of instances for which the Commission requires notification can be found here.

3 The Commission has the option, through its powers and duties under the 2003 Act, to conduct its own review in the case of any suicide where it appears to the Commission that there may have been a deficiency of care and treatment.

Other resources

1 The Scottish Association for Mental Health (SAMH) has produced an extremely informative guide to support and inform people bereaved by suicide.

Appendix 5

Checklist for senior management teams (SMT) and managers of affected clinicians

Prevention

Staff wellbeing	Have you provided regular health and wellbeing conversations with your staff, or delegated the provision of these conversations to an appropriate individual? The NHS website has helpful information on safe and effective wellbeing conversations.	
Team training and information	**Have you provided training on:**	
	1. The emotional effects of a patient's suicide on clinicians, and what may or may not be helpful?	
	2. The processes that follow including the serious incident inquiry and the Coroner's Court?	
	3. How to write and present a statement to the coroner?	
	4. How to investigate a serious incident in an impartial way, that is supportive to staff and teams?	
Team culture	**Do you:**	
	1. Foster a safe, open team culture?	
	2. Regularly have discussions about serious incidents and use them to normalise emotional responses?	
	3. Encourage employees to access support in and outside of the team whenever it is needed?	
	4. Have links with occupational health?	

Type of support	Action	Tick (✓) box when completed
Supportive systems	**Have you:**	
	1. Helped to develop reflective spaces for staff and to embed them into the workplace so they can be utilised regularly?	
	2. Developed a buddy system/network of employees who have experience of patient death?	
Processes	**Do you have processes:**	
	1. To notify you following a death?	
	2. To bring the senior management team together to discuss and delegate tasks?	
	3. That will enable all clinicians involved to be informed in a timely and sensitive manner?	
	4. For all those involved (not just those in the current team) to be notified sensitively?	
	5. Systems for feedback and provision to meet the emotional needs of different staff members after a death?	
	6. To ensure you can provide robust challenges to internal investigative processes?	
Resources	**Have you identified staff members involved and provided them with:**	
	1. Both local and national information and advice about services that can offer psychological intervention/support?	
	2. National/local information about resources for families and friends?	

Postvention (first few days)

Type of support	Actions	Tick (✓) box when completed
Immediate protocol	**Have you met to communicate and delegate tasks, including:**	
	1. Communicating with the family of the deceased (see below)?	
	2. Identifying and thoughtfully informing staff members involved?	
	3. Offering condolences to staff involved?	
	4. Identifying who will liaise with internal and external agencies?	
Immediate support	**Have you:**	
	1. Thought about your own support needs?	
	2. Offered health and wellbeing conversation to staff involved?	
Liaising and further team support	**Have you:**	
	1. Linked up with the trust/organisation's suicide prevention lead and identified local support resources available?	
	2. Considered in collaboration with team mangers, if any staff members need work adjustments, compassionate leave and/or referral to occupational health?	
	3. Organised a facilitative pastoral reflective space for all clinicians involved to come and talk together – both in the first week and the following month?	
	4. Liaised with the GP?	

Support for families and/or friends

Type of support	Actions	Tick (✓) box when completed
Liaising and external support provision	**Have you:**	
	1. Identified the most appropriate senior professional to liaise with the family after the death?	
	2. Offered condolences to the family?	
	3. Signposted the family to appropriate local and national services and resources?	
	4. Encouraged the involvement of the family liaison service?	
	5. Ensured other people in the community (including fellow inpatients) who might need help are identified by the team or their GP and other agencies (e.g., school for pupils) and signposted them to supportive services as needed?	

Long-term support for staff

Type of support	Actions	Tick (✓) box when completed
Practical	**Have you:**	
	1. Allocated sufficient time for staff involved in writing statement to the coroner, internal investigations and attending Corner's Court?	
	2. Ensured a supportive colleague will be present at the inquest?	
	3. Involved the organisation's legal department for advice?	
Longer term and emotional	**Have you:**	
	1. Organised regular follow up meetings with management teams to re-group, receive feedback from affected team managers and discuss further task delegation?	
	2. Had another wellbeing conversation with staff involved?	
	Has the SMT, in collaboration with affected team managers,:	
	3. Identified staff who appear to be still affected after the first month?	
	4. Considered whether work adjustments are needed by affected staff members for the medium term?	

Appendix 6: Family liaison officers

Job description

Job Title:	Family liaison officer
Band:	Band 7
Hours:	37.5 hours per week, worked Monday to Friday
Location:	Travel across all Trust locations and beyond as required by the role
Accountable to:	Associate director of quality governance
Responsible to:	Centralised lead investigating officers

1. Main purpose of the job

Southern Health NHS Foundation Trust has created a family liaison officer role (FLO) to support families and loved ones through the difficult process of an investigation into a serious incident or a serious complaint which has occurred within a service provided by the Trust. This will include the day-to-day management of the interaction of the family in the investigation and close liaising with the investigating officer to ensure that families are treated appropriately, professionally and with respect of their needs.

This role has been in place in the Trust since 2016 and whilst family support is paramount in the culture of the Trust it is also a recognised requirement of the National Quality Board 2018 Learning from deaths; Guidance for NHS trusts on working with bereaved families and carers.

Those performing this role must always act with the highest degree of professionalism and integrity whilst undertaking sensitive duties. There will be a requirement to develop communication plans with the individuals, which will include accurate communication by different methods as agreed, such as:

- face-to-face meetings
- telephone
- email

The purpose of this role is to provide explanation and support through what can be a difficult process for families. Whilst compassionate and excellent listening skills will be required the person must not assume the role of family counsellor or registered health professional which would be wholly inappropriate. If it is felt that family need further professional support the FLO will provide signposting to other qualified services.

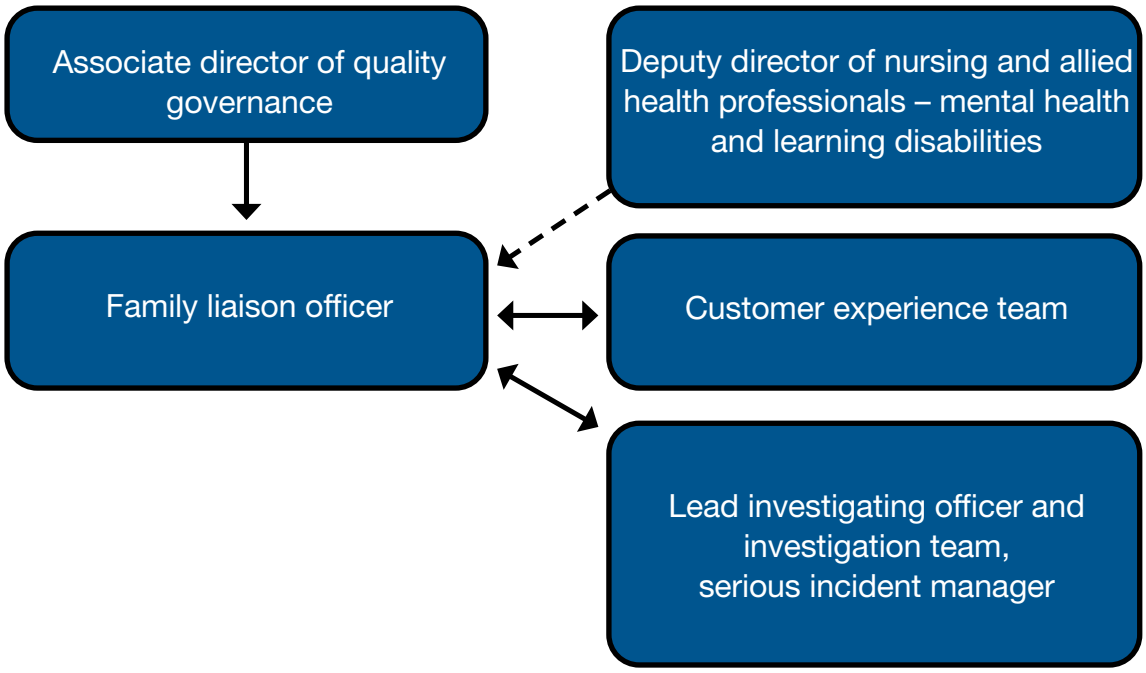
This role will include dealing with and providing support to newly bereaved individuals some of whom will be deeply distressed. The postholder must be aware of the impact this can have on themlseves and must attend professional supervision.

Circumstances may arise where the individual as the subject of the investigation has chosen not to have sensitive information shared with their family members and this should be handled appropriately by the FLO with full explanations provided as to why confidentially is respected.

The post holder will be expected to report to and attend the Patient Experience, Engagement and Caring meeting to share factual reports, case studies and best practice guidance to enable Southern Health to improve its communication with families. There is also a requirement to teach others best practice and key skills related to having difficult but open and honest conversations.

It is envisaged that the post will operate Monday to Friday with core hours of 9am until 5pm however is some circumstances, with agreement from the line manager, it may be necessary to facilitate a visit to family members outside of these core hours. These visits will need to be conducted in line with Southern Health NHS Foundation Trust's lone working policies and procedures.

2. Position in organisation



3. Key relationships

- Associate director of quality governance
- Deputy director of nursing and allied health professionals – mental health and learning disabilities
- Head of patient safety, risk and legal services
- Head of patient engagement
- Lead investigating officer
- Serious incident manager and teams – central and divisional
- Customer experience team
- Divisional investigating officers

4. Main duties and responsibilities

4.1 To provide a main point of contact for all families and loved ones involved in serious incident or complaint investigations.

4.2 To establish communications with all affected families and loved ones and guide and support them through the investigation process to the conclusion as naturally dictated by the circumstances. The FLO will assist in providing clear and accurate information about the Trust's investigation processes.

4.3 To work closely with the central investigation and customer experience teams to identify families and loved ones who require the support of the FLO and establish a clear communications plan/route for each individualised case. In circumstances where families are estranged the FLO will need to deal with the challenge of appropriate sharing of information.

4.4 To work with families and provide an individualised and appropriate level of support that is identified as being required. This communication could be by telephone or home visit.

4.5 To create a professional relationship of trust and honesty, which will enable the families to ask the questions that they wish to be answered as part of the investigation process.

4.6 To listen and manage queries in a proactive manner, signposting individuals to other services when necessary, for example but not exclusively:

- general practitioner.
- counselling services, for example, Cruise, Hospice Services, Red Lipstick Foundation, Survivors of Bereavement by Suicide (SOBS).
- coroner's officer for details on pending inquests.

It may be necessary to establish the first contact with these services of behalf of the individuals.

4.7 To accurately record all communication records and plans, and assure that the Ulysses Safeguard Family Liaison module is updated to incorporate this information.

4.8 To support the family or loved one with the receipt and interpretation of the final investigation report, signposting questions back to the original investigating officer or service manager as appropriate.

4.9 Maintain accurate record keeping providing data analysis and learning stories for inclusion in board level reporting; this must include themes and the capture of satisfaction with the role function for future planning. The postholder must be confident to present these stories in a multitude of professional meetings inclusive of the Trust Board.

4.10 Provide formal reports to the Patient Experience, Engagement and Caring Group and Clinical Quality Review meeting with commissioning stakeholders analysing the effectiveness of the family liaison service offered by Southern Health.

4.11 Become an expert in legal terminology of Duty of Candour as applicable to the NHS Standard Contract and the Care Quality Commission regulation 20 requirements.

4.12 Attend coroners courts when required as a representative of the Trust in coordination with the lead investigation officers.

4.13 Provide family liaison skills training to the investigators course, customer experience team officers and the divisional governance teams.

4.14 Has the ability to risk assess and escalate concerns to the most appropriate person.

4.15 Is able to research and update Trust policies and practices with regard to difficult but honest and open conversations becoming an internal expert.

4.16 Responsible for horizon scanning and developing external networks to stay updated on national best practice and initiatives relating to family and carer liaison support.

Information on family liaison officers (FLOs) for family members and loved ones

Southern Health NHS Foundation Trust have also created a leaflet (pdf) outlining the role of family liaison officers and the support they can offer to family members and loved ones during the investigation of a serious incident or complaint.

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