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The Incidence and Impact of Service User Suicide on Healthcare Staff: an exploration of the literature

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Literature Review

Abstract

Background: Healthcare professionals working primarily in mental health services may well encounter a service user who completes suicide at some point during their career. The impact of this experience on the member of staff may be significant and potentially compromise their ability to function effectively.

Aims and Objectives: To identify the incidence of professional carer experience of service user suicide, the impact of service user suicide on professional carers, and the training undertaken or recommended.

Methods: A range of databases were accessed and utilised, together with literature recommended by colleagues and contacts.

Results: Studies were limited in their number and focused mainly on medical practitioners. Some articles took the form of a case study. Professionals tended to reflect similar reactions to those seen in family and friends of a service user who completed suicide. In addition a number of 'professional' reactions were identified and explored.

Conclusions: The literature reflected an expectation that this group of people would be expected to support others but little evidence emerged of specific training aimed at preparing them for the impact that a service user suicide may have on them.

Introduction

The World Health Organisation estimated that the suicide rates have increased worldwide by 60% in the last 45 years and about one million people completed suicide in 2000, with 150,000 of these occurring in the countries that made up Europe. Within different countries the number of people completing suicide varies dependent on a variety of factors. An indication of the impact on specific countries can be seen in the selected examples for the year 2004, as shown in Table 1.

Table 1: Sample of countries and numbers of completed suicides in 2004

Country	Population	Nos. of Suicides	Rate per 100,000 of population
United States	302,000,000	32,439	10.74
Japan	128,000,000	32,325	25.25
United Kingdom	60,000,000	5,554	9.25
Australia	20,100,000	2,098	10.43
New Zealand	4,100,000	486	11.85

The countries outlined in Table 1, together with many others, have strived to address suicide as an area for the investment of resources to reduce the number of people who die by this means. The impact of suicide on survivors (see Table 4) is well documented in the literature and in many strategic documents there is also acknowledgement of the potential impact on many professional groups, notably police and paramedical services (Bennett et al 2004, Richards 2002). In his research into police involvement with both those who attempt or complete suicide, together with the role of frequently being required to inform survivors, Richards (2002) recommends training for all police cadets in an effort to prepare them for this possibility. The National Institute for Mental Health in England (NIMHE) in 2007 indicated that 25% of people who had completed suicide 'had had a registered contact with a police officer within three months of death', which is the same percentage as those who had been in contact with mental health services in the year before their death. Against this recognition it is surprising to note little acknowledgement within strategic plans of the need to prepare healthcare professionals for these experiences. Documents, such as those identified in Table 2, appear to identify the need for highly trained staff to deal with the impact of suicide on survivors (family, friends, significant others) but not the impact on professional colleagues.

The potential for service user suicide exists in a diverse range of healthcare situations but perhaps is most frequently associated with the area of mental health services. This statement recognises that some 70-75% of people do not present to any services, therefore it is the 25% of those who do that will encounter professional services. It has been reported that whilst the number of people who completed suicide whilst in a mental health unit has decreased to 154, as recorded in 2004, the number who have been in contact with mental health services prior to completed

suicide has increased (NIMHE 2007). The impact of suicide on survivors has been acknowledged in a wide range of reports and articles published worldwide for some considerable time. The American Association of Suicidology (2007) estimated that for every person who completed suicide there were six survivors, consisting primarily of family and friends. Although Hawton and Simkin (2006) indicated that one of these groups of survivors deeply affected are healthcare professionals, what is less apparent is how many of these survivors are healthcare professionals.

Table 2: Sample of countries and strategic documentation related to suicide

Department of Health - National Suicide Prevention Strategy for England	2002
Scottish Executive – Choose Life	2002
Health Service Executive (Ireland) – Reach Out	2005
Australian Government – National Suicide Prevention Strategy	1999
Department of Health & Human Services (US) – The Surgeon General's Call to Action to Prevent Suicide	1999
Akita Prefectural Government (Japan) – Health Akita 21	2001
New Zealand Suicide Prevention Strategy	2006

Method

Literature was identified and accessed utilising a variety of databases, primarily electronic. In addition, material was suggested after contact was made with colleagues and individuals who had direct experience related to the topic area.

Key search terms including 'suicide', 'professionals', 'healthcare', 'support', 'impact' and 'staff' were utilised together with related terms in an effort to gather a cross section of relevant work. In an effort to both identify pertinent literature and ensure response within a reasonable time frame, a number of parameters were set, including:

1. Published in English or available in an English version.
2. Subject explored related to impact of suicide completion and involvement of healthcare professionals (doctors, nurses, therapists). In addition, related literature that informed some of the themes emerging (e.g. impact, training) was identified and included.
3. Documents and articles readily available without any significant delay or financial payment. This was identified as important to ensure that material utilised should be that which most practitioners could acquire reasonably easily if interested.

4. Use of keywords was utilised to identify material for appropriateness and consideration. These consisted of combinations involving the terms: suicide, staff, completion, committing, doctors, nurses, professionals.
5. Systems accessed and searched included CINHAL, MEDLINE, PsycINFO, ASSIA, NLH – Mental Health, Google, Google Scholar. A number of other sources were accessed utilising an ATHENS account. Additional material was suggested following contact with a number of people and colleagues.
6. In addition to this, strategic documents that identified key policy and practice developments were accessed and included as appropriate within the discussion.

Incidence of suicide in mental health services

The variation in incidence rates within the literature is marked. Ruskin (2004) indicates that 14-33% of psychiatric residents had experienced a service user on their caseload who completed suicide, whilst Foley and Kelly (2007) state that this applied to 50-70% of consultant psychiatrists. Wozny and Zinck (2007) indicate that approximately 25% of mental health professionals will experience a service user who completes suicide. Sakinofsky (2007) predicts that 50% of psychiatrists will experience such an event at least once during their career, closely mirroring the 51% revealed in a survey of 259 psychiatrists by Chemtob et al (1988). Alexander et al (2000), in their study of consultant psychiatrists, indicated that 68% of the respondents (n=247) had had a service user complete suicide. Shooter (2004) states that suicide is an 'occupational hazard' for psychiatrists. Studies that have included medical students within their research have identified an equally diverse range of figures. Pieters et al (2003) in their study (n=114) indicated that 30% of first year trainees had experience of a service user who completed suicide, similar to Ellis (1998) who indicated 33%. Yousaf (2002) cited 43%, Dewar et al (2000) 47% and Foley and Kelly 40-50%. Pilkinton and Etkin (2003) in their study introduce an additional element indicating that 61.4% of psychiatric residents have direct experience of suicide; 61% involving service users and 16.5% by a colleague, friend or relative. In addition to the above, a survey carried out by Hendin et al (2000) suggested that 'the loss of a patient to suicide is a common and traumatic experience for the treating psychiatrist… during a clinician's training, a particularly traumatic experience'.

Much of the literature identifying incidences has a focus orientated towards medical staff and in particular psychiatrists, both qualified and in training. Considerably less material is available on other healthcare

professional groups such as nurses and psychologists. Bromley (2000) in his paper indicated that 11% of psychology trainees had encountered a service user who completed suicide.

Hendin et al (2000), in their study of 26 therapists (21 of whom were psychiatrists) representing a range of healthcare professionals, indicated that 81% of them had treated someone who completed suicide. Linke et al (2002) in their study indicated a figure of 86% for staff who were primarily nurses and social workers. Walmsley (2003) indicates in his article that a 'typical' crisis team may be involved in up to a dozen attempted or completed suicides by service users each year. Akechi et al (2003) indicated that nurses encountering suicide on a ward was 'practically inevitable', being further supported in an article by Bohan and Doyle (2008) who stated that a staff nurse working in an acute mental health setting had a high chance of encountering a service user who attempted or completed suicide.

Table 3: Risk of health and social care professionals encountering a service-user who subsequently completes suicide

Professional Groups	Incidence of suicide encountered
Consultant psychiatrists	50-70%
Psychiatrists	33-80%
Medical students	14-61%
*Mental health nurses	*50-86%
*Clinical psychologists	*81-86%
*Psychologist 'trainees'	* 11%
* figures related to limited literature	

Impact

The literature identified a range of reactions generally similar to those found in family and friends of someone who has completed suicide. Plakun and Tillman (2005) state that 'there is reason to believe that the impact of suicide on a psychiatrist or other mental health clinician is considerably greater than the impact of the death of a patient treated by other medical specialists'. Gordon (2002) in his exploration of secure mental health facilities acknowledged that the completed suicide of a service user had a potentially traumatic effect on all those involved, including the healthcare professionals caring for that person. Eagles et al (2001) suggested that the more predictable and potentially preventable suicide caused greatest distress to psychiatrists. McAdams III and Foster (2000) stated that the

completed suicide of a client resulted in significant emotional stress for counsellors. SIEC (2005) stated that the impact on many professionals is one of a 'significant sense of personal loss and considerable personal turmoil', and Ellis et al (1998) concluded that suicide is identified as the leading source of stress for mental health practitioners.

The impact on the healthcare practitioner is considered to consist of two groupings (see Table 4), one of which has been classified as 'personal' by a number of authors (Campbell & Fahy 2002, Linke et al 2002). These reactions include grief, sadness, shock and disbelief, sleep disturbance, anger and guilt. These reactions are seen to reflect those that would be expected in family members and friends of a person who had completed suicide.

Another group of reactions were classified as 'professional', as these were distinctly related to the professional and their role. These included an avoidance of service users perceived to be at risk (Linke et al 2002), shame, over-cautiousness with other service user's prescribing, self-doubt and increased use of mental health legislation. In addition, fear of litigation and reduction in referrals were noted.

Hodelet and Hughson (2001) indicated that although all staff are affected, those with the least professional training are vulnerable to poor outcome. They also raise the issue of potential disruption within the staff group with some valued members considering the option of leaving the profession. Heydt and Potschigmann (1989) in their survey of 40 nurses identified a wish for better training and to improve their own ability to handle feelings of inadequacy and guilt. Valente and Saunders (2002) in their exploration of literature related to the nurse's reactions to suicide identified the degree of grief and stress that occurred. Soreff (1975) added the additional variable of issues related to a nursing colleague completing suicide.

A number of articles explored the impact of suicide on healthcare professionals in the form of a case study or survey. Akechi et al (2003) explore the reaction of a nurse who discovered a service user who had completed suicide on a medical ward. Gitlin (1999) in a detailed case discussion of one doctor identified the marked impact the event had, particularly as it occurred early in the clinician's career. Biermann (2003) examined the reaction of a resident-in-training with a view to the

opportunity offered to learn and grow from the experience. Ellis et al (1998) indicate that suicide is identified as the leading source of stress for mental health practitioners.

Campbell and Fahy (2002), in their article, develop the theme to incorporate the psychiatrist's role after experiencing service user suicide, to other service users, staff and self.

Table 4: A summary of personal and professional reactions identified

Personal	Professional
Grief	Increase in use of legal restrictions
Shock and disbelief	Fear of litigation
Guilt and anger	Fear of loss of referrals
Crying	Changed relationships with colleagues
Sadness	Avoidance of clients considered to be at risk
Sleep disturbance	Professional self-doubt
Low mood, irritability	Consideration of early retirement
Withdrawal	Change in medication management
Isolation	Shame and embarrassment

Discussion

Much of the literature examined identifies the significant impact that completed suicide has on the healthcare practitioner. The identification of both personal and professional reactions to this event further signifies the need to consider how best to prepare practitioners for the possibility of this experience.

Glair-Gajewski (1993) identified that practitioners are sometimes reticent about talking about the experience and seeking help due to perceptions about their role and being in control, a view that is echoed by Hotelet and Hughson (2001) who indicated that this reticence might also be due to not wishing to burden a colleague. The organisational structure and the practitioner's view of the support available occurs as a common thread through the literature (Hodgkinson 1987, Valente and Saunders 2002).

Misch (2003) suggests that 'the failure of psychiatric trainees to undergo personal intensive psychotherapy is identified as a major obstacle' in terms of helping to prepare them to be able to learn from such a traumatic experience. Coverdale et al (2007) in their editorial indicate their support of other authors who have called for the continued development and

evaluation of suicide care programmes but with the added inclusion of medical students, an approach mirrored in the article by Fang et al (2007), though with an additional focus on exploring the impact of service user suicide on residents. Wozny and Zinck (2005) identified a significant lack of suicide intervention / training in some counselling programmes (98% and 94%).

Dexter-Mazza (2004) suggests that graduate programmes need to 'do a better job of providing formal training'. Coverdale et al (2007) discuss the lack of a coordinated approach to curriculum development and place an emphasis on early preparation of the practitioner together with the need to prepare a policy for debriefing the practitioner in the event of the suicide of a service user. Little (1992) cautioned on the ambiguous nature of meetings exploring feelings with the possibility that positively it might help to reassure but equally could negatively reinforce blame.

Tillett (2003) identified the increased morbidity related to health professionals but notes that staff tend to be ambivalent towards their own potential morbidity. He sees an important role for personal therapy or counselling in assisting staff to reflect and regain a balanced perspective with regard to work and personal life. Valente and Saunders (2002) offered a number of ideas including counselling (individual and group), workshops and the opportunity for the practitioner to write about grief as part of the healing process. This is set against the recognition that engagement by staff who have been directly affected by the event may be difficult and, occasionally, individuals may feel that they have been ignored and isolated by their colleagues, though have engaged in a process of distancing themselves for fear of receiving a negative reaction from them.

Conclusion

From the literature explored, evidence has emerged that suggests a number of points, which include:

- The staff involved with a service user who completes suicide are very likely to be markedly affected, both personally and professionally.
- The probability of staff encountering a service user who completes suicide is variable but considered highest for healthcare staff working in mental health services. These include doctors, nurses, psychologists and therapists.

- The majority of the literature explored is related to doctors and medical students, with limited material looking at other professional groups such as nurses.
- The strategic documentation explored tended to focus on the impact of completed suicide on a range of people (e.g. family, friends, police), but contained very little information related to either the impact on those healthcare staff involved or the support that was available specifically for them.

In addition to the above, a number of other aspects emerged but with less clarity and consensus, including:

- The specific nature of training that healthcare staff should receive by way of preparation for the completed suicide of a service user they had been directly involved with. The literature identified a rather patchy picture with some areas investing more time and effort than others in incorporating elements of the subject in the curriculum. There is clearer consensus on the need for a proactive rather than reactive approach.
- The need for postvention is identified but again the nature and structure that this should take is less clear. A degree of ambivalence exists over the value of encouraging healthcare staff to talk about the experience with concern expressed that, although this might permit opportunities for the extinction of self-blame and allow closure, it could exacerbate feelings of guilt and shame. Whether staff should be encouraged or required to engage in individual and/or group sessions is not explored and the approach taken to assist staff who withdraw from the team is not clearly identified.
- There is a need for more research around the potential and actual impact of service user suicide on healthcare staff, and particularly nurses. As indicated previously, much of the existing literature has a focus on doctors and medical students.

With the continuing changes in the focus of provision and support for users of mental health services, particularly in the UK, there is a need to recognise that healthcare staff will be faced more frequently with decisions related to risk with service users living in the community rather than in specific mental health units. Given the fact that of the 5,554 people who completed suicide in the UK in 2004, 154 were in a mental health unit (NIMHE 2007), the inevitable conclusion drawn is that most people who

will complete suicide will do so outside specialist mental health units. Recognising this point is important in considering what steps need to be introduced to ensure that healthcare staff have an opportunity to access services and support that already exist in a structured and explicitly recognised format, rather than a hastily convened event after the incident. The risk of some mental health service users completing suicide has been clearly demonstrated within this work. The recognition of these facts by healthcare services, together with a clear and workable framework to accommodate the impact of service user suicide on staff, has not been clearly evident within the available literature.

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