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PERSPECTIVE PIECE

Support for community mental health teams post-suicide

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Suicide is a relatively common event in those seeking psychiatric care. However, its impact is nonetheless traumatic and devastating for those involved in the care of the patient. Community mental health teams (CMHTs) address every aspect of a patient's life, which creates a unique relationship between the team and the patient. Patient suicide can have serious, detrimental effects on individual team members, on the functioning of the team itself and on the care of other patients in the aftermath of such an event. In spite of this, there are limited protocols to guide CMHTs in this situation. This article seeks to emphasise the impact of patient suicide on CMHTs as a specific entity. It highlights the need for more research in this area, in order to direct the formation of more coherent local and national guidelines.

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'Suicide stands alone as a most powerful, indelible event' (Kaye & Soreff 1991). It is well known that suicide has a devastating effect on those left behind. For families and loved ones of a patient who completes suicide, there are many support groups and structures available. When a suicide occurs in an inpatient unit, there are guidelines available on how best to support staff and patients in the unit through this difficult time (HSE, 2014). There is no evidence to suggest that suicide is less likely to occur in the community, yet there are limited protocols available to guide community mental health teams (CMHTs) during this time.

CMHTs

In its strategy document for the Mental Health Services in Ireland, *A Vision for Change* (HSE, 2006), the HSE sets out the need for improved delivery of services to patients in the community. To this end, we have seen the establishment of CMHTs nationwide. These teams are usually comprised of the consultant psychiatrist, psychologist, nursing staff and allied health professionals as well as trainee-grade psychiatrists and psychologists. Team meetings are generally held on a weekly basis where various aspects of patient care are discussed. In this way, the entire team becomes familiar with a patient, even if they are not directly involved in their care. Members of the team also attend inpatient rounds if a patient is admitted to hospital, lending continuity to the care of the patient. Community nurses will often call to a patient's home and become familiar with their families and friends. All aspects of a patient's life are thus addressed by the multidisciplinary team, and it is this level of trust and familiarity that creates a unique relationship between the patient and the CMHT.

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Epidemiology

Studies have shown (Meehan *et al*. 2006; Appleby *et al*. 1999; Canning & Gournay 2014) that around one quarter of patients who complete suicide will have been in contact with the mental health service within the 3 months leading up to the event. Arensman *et al*. (2013) found that 22% of patients who completed suicide had been attending the psychiatric out patient department (OPD) services in their local area and 5% had been involved with the local alcohol and drug addiction services. It is no surprise then that Cryan *et al*. (1995) found that 82% of Irish psychiatrists had experienced a patient suicide, 42% of which had occurred during the first 5 years of training. While other studies which looked at psychiatrists' experience have reported a lower incidence (Alexander *et al*. 2000; Dewar *et al*. 2000), Linke *et al*. (2002) found similar rates occurring among multidisciplinary CMHT members.

Impact

Individuals

Even though suicide is a well-known risk factor in recipients of psychiatric help, it can be nonetheless

extremely shocking and devastating for the personnel who have been involved in the treatment and care of the patient. As Kelleher (Kelleher *et al*. 2014) points out, 'at the most fundamental level, patient suicide negates the very essence of the mental health professional's role, which is to heal or at least to help the patient'. A number of studies (Joyce & Wallbridge 2003; Midence *et al*. 1996; Bohan & Doyle, 2008; Cryan *et al*. 1995) have looked at the feelings evoked among the staff by this situation. Shock, anger and frustration are commonly described as well as emotional upset, irritability and guilt. One study (Chemtob *et al*. 1988) reported that 65% of clinicians suffered levels of stress that were comparable to the levels found in people seeking help after the loss of a parent. Dewar *et al*. (2000) reported a continuing preoccupation with the suicide among trainee psychiatrists. In 2004, Ruskin *et al*. (2004) identified a significant minority (25%) of trainees and consultants who experienced significant morbidity due to the emotional impact of the event.

CMHTs

In one of the few studies carried out on the impact of suicide on CMHTs, Canning & Gournay (2014) found, common to the above studies, feelings of shock, sadness, self-reproach and self-doubt among team members. Interestingly, a key finding from Canning's paper was that the suicide of a patient had the potential to impact not only on the professional directly involved with the patient but also on other members of a CMHT.

Response

Many factors can influence how an individual will respond to such an event. Hendin *et al*. (2004) noted that female clinicians were almost twice as likely as their male counterparts to experience severe distress. They also found that higher levels of distress were inversely associated with years of training – almost 50% of clinicians with less than 15 years of training described severe distress compared to just 10% of those with more than 15 years of experience.

Different team members will respond differently to the event. Hodelet & Hughson (2001) point out that some untrained members of the team may not have the benefit that doctors and nurses do, of experiencing death routinely and developing coping methods for this.

Regardless of their role in the CMHT, Gaffney *et al*. (2009) found that the closeness of the therapeutic relationship had an impact on how staff adjusted to and coped with a patient suicide, a finding that has been replicated in other studies (Mitchell *et al*. 2004; Joyce & Wallbridge 2003).

Reactions will also be influenced by other factors, such as a clinician's current emotional state and phase of life and also their understanding and anticipation of the event (Grad, 2014). This is again of particular relevance to those members of the team who may have little or no medical training and who may not be as attuned to this risk as other members of the team.

Care

It seems obvious that such a traumatic event would have an impact on the care provided by the CMHT, at least in the short-term (Ruben, 1990). In their extensive review of the literature pertaining to professionals' reactions following a patient's suicide, Seguin *et al*. (2014) identified changes in both the way professionals conducted their clinical assessments and how they reached treatment decisions after a patient's suicide. Yousaf *et al*. (2002) found that psychiatric trainees had an increased tendency to hospitalise, sought more collegial consultation and were more conservative in note keeping in the aftermath of a suicide. Linke *et al*. (2002) found similar, long-lasting (more than one month) consequences reported by individual members of the team.

Linke *et al*. (2002) also pointed out the detrimental effect that suicide could have on the functioning of a team. Indeed, Hodgkinson (1987) reported that splits within the affected staff group could be magnified in these circumstances, ultimately leading to some members moving away from the group permanently.

Current Practice

In spite of these significant sequelae, there are few formal protocols to guide CMHTs in this situation. A review of practice in the Sligo Leitrim Mental Health Service revealed that most teams have adopted an informal protocol to deal with this issue, whereby, following the reporting of the death to the mental health commission, the case is discussed at the team meeting. A review session is then carried out for the people directly involved in the care of the patient, which often doubles as a preparatory review of documentation for the ensuing investigation. This is where the matter usually ends and staff continue with their day-to-day work, as before.

Recommendations

A number of papers have made suggestions on how to lessen the traumatic impact of suicide on clinicians. Brown (1987) suggested that the response to such an event should be both comprehensive and pragmatic. It

should include an 'anticipatory phase' where trainee psychiatrists would be not only educated on the epidemiology and dynamics of suicide but also encouraged to imagine their own response in such a situation. This could certainly be applied to the broader community team and could be of particular use to the aforementioned less clinically trained staff.

Hodelet & Hughson (2001) emphasise the role of a dedicated team review following the death, possibly in the form of a 'suicide review conference' (Bartels, 1987) that looks at the death in the context of the psychological profile of the patient. Linke *et al*. (2002) also suggest a dedicated team review, focusing on establishing and sharing the facts and allowing staff to offer support and encouragement to each other. They (Linke *et al*. 2002) suggest that an experienced group facilitator be employed to correctly contain and normalise the strong emotions evoked by this situation and they also emphasise the need for any formal enquiry to be handled in a sensitive, non-threatening manner, so as not to add to the trauma of the already suffering team member.

Colleagues are consistently identified as an important source of support following patient suicide (Chemtob *et al*. 1988; Alexander *et al*. 2000; Dewar *et al*. 2000; Courtenay & Stephens, 2001) and support by senior members of the team and management (Linke *et al*. 2002) has been shown to be helpful. These individuals should have a pivotal role in supporting and directing the CMHTs response in the aftermath of a suicide.

Campbell & Fahy (2002) recommend that clinical services have written guidelines to advise staff on good practice following the suicide of a patient. Grad (2014) emphasises the disparate nature of community health teams and suggests that guidelines should be flexible and adaptable to individuals and groups, depending on the need.

These are certainly very valid points that could be considered when formulating an appropriate set of guidelines for CMHTs.

Conclusion

The purpose of this review was to look at the literature relating to the impact of suicide on CMHTs and to investigate how this event is handled by the CMHT. On researching this topic, it became clear that there is a paucity of literature and guidance available in this area. This might be due to the fact that the CMHT itself is a relatively new entity in the mental health service. Given that suicide is arguably the most likely and most traumatic critical incident to affect staff in the mental health service, it would seem only appropriate that more studies are conducted to explore the impact of suicide on CMHTs and to direct the establishment of more coherent local and national guidelines to support our front-line workers in CMHTs.

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Conflicts of Interest

None

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

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