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Suicide

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In an attempt to discover what can be learnt from records kept on suicide victims, all data collected by one health district about suicides occurring in patients in close contact with psychiatric care over four years were examined.

These comprised 12 in-patients, six recently discharged patients, and four patients in close contact with the CMHT. They were treated by eight different consultants and CMHTs. No one team had an excess of deaths.

In this district, as in many others, there is a policy that following a suicide, the care team should meet as soon as possible to review the case. The stated aim of this meeting is to offer staff support and constructive self-criticism. Following this a report is sent to the Mental Health Unit Manager. An examination of the reports of 22 suicides (certified as such by the Coroners' courts) revealed that in all cases the care plan was seen as "appropriate". Only six cases had been recognised as "at risk of suicide", that is in most cases the risk had been considered low and ongoing. Although all patients had had previous contact with the psychiatric services, often over a long period of time, in only three cases was any attempt made to suggest why the suicide had occurred now. In only six cases were recommendations for change made. These all concerned measures to increase the supervision of the patient by the care team.

While it is impossible to say whether or not these written reports are a reasonable reflection of what was said or thought at the time, they are the only documentary evidence of the cases that are kept and can be studied. They were produced following the mental health team reviews and thus must represent some consensus view on how the case was seen. Private thoughts and reflections always remain so. Thus although the individual may have learnt something from the suicide no-one else will have access to that new understanding. Learning from personal experience cannot be the best way to increase knowledge about the risk factors for suicide. Is it reasonable to expect more useful information?

We are members of the 'caring professions'. The unexpected death of a patient leaves all staff to a greater or lesser extent shocked and distressed.

We know from work with bereaved relatives (Murray Parkes, 1985) that grief is complicated when a death is unexpected, inexplicable, and when the relative in some way feels responsible. One way to help staff through their grief is to attribute the suicide to within-patient factors, i.e. his/her illness, and to assure everyone that all possible steps had been taken. While such statements cannot be construed as constructive self-criticism, they may be absolutely essential at the time to enable staff to continue working with an often difficult patient/client group. Placing the problem solely with the patient can reassure staff that their judgement was correct, and their caring skills remain intact. Such statements may also be what many people want to hear. Many professionals are uncertain about their job security as mental hospitals close and units are relocated in the community. Managers are fearful of litiginous relatives and relatives themselves may feel that the professionals' judgement "nothing more could have been done" absolves them from any guilt.

The danger is that nothing new is learnt. Many years of research have produced good epidemiological information about groups of patients at risk, but are of little use in defining individuals at risk (Hawton, 1987). Goh *et al* (1989) recently called for more research into interpersonal and environmental aspects of suicide. This information can be given only by those people who knew the patient well. It can be collected only if the informants can recall and discuss their memory of their patient and their interactions

with him in a safe non-threatening environment. Timing of such an event is important. It must be after the acute shock, apart from the legal proceedings but early enough to allow easy recall of the events, and before too many staff have been changed. The composition of the meeting and the nature of record-keeping is important. Junior staff of all disciplines will find it harder to admit to some subtle misjudgement of a patient's mood or the significance of his actions in the presence of their senior managers.

An audit meeting that seeks to establish that the standard of care given was reasonable, that it was as good as the patient would have received from most psychiatric teams, and there was therefore no negligence, is similar but not the same as a review which seeks to understand why a suicide happened, in the hope of preventing suicides in the future.

It is tempting to do both, and to offer staff support in one meeting and 'get it over with' as no-one seeks to dwell on unpleasant events. The danger is that the bureaucratic need to provide reports and to assure managers, relatives, and staff that there was no negligence may take precedence. The individual needs of staff, some of whom have formed a close relationship with the patient, may be inadequately met. The spirit of enquiry, which seeks to evaluate the course of the patient's illness and to formulate a deeper understanding of the suicide, is often missing.

In summary, a number of inter-related but different issues are raised by the suicide of a patient:

Legal. Clearly facts must be established and reports prepared for the Coroner and hospital managers.

Emotional. At the same time, the suicide of a patient can be deeply upsetting to staff who have tried their best to help and treat the patient. The availability of effective counselling and understanding of suicide is important not only to maintain staff morale but to prevent a temporary over-reaction when resources are tied up with increased supervision of large numbers of patients impersonally, and possibly unhelpfully.

Relatives also need appropriate counselling and the chance to ask questions and have them answered honestly. This is important not only for their mental health but also because research has suggested that if an opportunity for discussion is not given informally, patients and relatives may increasingly resort to the legal system to have their legitimate concerns heard.

Educational. Every suicide is a tragedy but may be less so for all concerned if something can be learnt from it to help others in the future. Any new understanding must be shared with colleagues. The need to identify additional risk factors for suicide in this high risk group becomes more urgent as current policies provide fewer in-patient beds for intensive observation and require more accurate targeting of resources.

How and when these issues can be accurately dealt with must be the subject for further discussion in each Mental Health Unit.

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