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RUNNING HEADER: HOW DO MENTAL HEALTH STAFF RESPOND
TO SUICIDE RISK?

SARAH CROWLEY BSc Hons

RECOGNISING AND RESPONDING TO SUICIDE
RISK IN A COMMUNITY MENTAL HEALTH SETTING

**Section A: How do the findings of retrospective studies of
completed suicide help with recognising and responding to suicide
risk?**

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**Section B: Perceived responsibility, anxiety and uncertainty
direct practitioner attributions of causes and interventions with those
at risk of suicide.**

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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

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Summary of Major Research Project

Section A:

Section A presents a narrative synthesis of the findings of retrospective studies of completed suicide since 1997, considering their utility for recognising and responding to suicide risk in clinical settings. The emphasis on assessing epidemiological risk factors in best practice guidelines is considered. Research pertaining to the challenges of recognising and responding to suicide risk is reviewed and findings highlight a paucity of evidence pertaining to what informs clinical assessment and judgements in mental health settings. Finally, clinical and research implications are considered.

Section B:

A grounded theory study of how practitioners in community mental health settings work with those at risk of suicide. Semi structured interviews were conducted with twelve staff and a grounded theory was constructed from the data. The findings indicate that professionals in community mental health services feel personally and professionally responsible when encountering suicide risk in the workplace, which creates anxiety when faced with the uncertainty of not being able to predict subsequent risk. The model shows that professionals attribute low responsibility to clients for the causing their distress, most often making medical model attributions and thereby attributing low responsibility to clients for the solution. The findings are discussed in relation to existing research and implications for clinical practice and further investigation.

Section C: Appendices.

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MAJOR RESEARCH PROJECT

SARAH CROWLEY BSc Hons

Section A

HOW DO THE FINDINGS OF RETROSPECTIVE STUDIES OF
COMPLETED SUICIDE HELP WITH RECOGNISING AND RESPONDING TO
SUICIDE RISK?

Word count: 8,432

**A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of Doctor of Clinical
Psychology.**

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

Abstract

Suicide of a client is a tragic and anxiety-provoking event for those working in mental health services. This paper considers the evolution of the 'suicide prevention' paradigm in mental health settings reviewing twelve retrospective studies provides a narrative synthesis of their findings. This review finds that there has been a focus on identification of epidemiological risk factors that are related to suicide in research to date. The identification of risk factors associated with suicide risk has been used to inform 'best practice' guidelines. The review finds that attending to epidemiological risk factors is limited in the reality of clinical risk management finding evidence of the importance of emotions, relationship with the client and helper bias towards wanting things to be 'normal'. Findings highlight a paucity of evidence pertaining to what informs clinical assessment and judgements in mental health settings and suggests that further qualitative research is needed to inform best clinical practice.

Keywords: suicide, risk assessment, clinical responsibility, risk management.

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1. Introduction

Context

Over 800,000 people die of suicide worldwide every year (World Health Organisation, WHO, 2012) and many more people attempt suicide.

In England between 2002-2012 there were 49,047 suicides in the general population, an average of 4,459 per year (National Confidential Inquiry into Suicide and Homicide, 2014). The rate of suicide in England has decreased overall since 2002 however, after initially decreasing between 2002-2008 began to increase in 2008 onwards. The increase was thought to be linked to the economic crisis in England creating additional pressure and higher rates of unemployment amongst the general population. The rate of suicide amongst men was three times higher than amongst women (NCISH, 2014).

Suicide prevention has become the focus of public concern in the United Kingdom (UK) since the Government founded the National Confidential Inquiry into Suicide and Homicide in 1996 (NCISH, 1997). This enquiry highlighted changes that could be made at a high level, such as reducing access to pesticides and changing the law regarding the number of painkillers a person could purchase at any one time. Since the publication of this document, the rate of suicide has been reducing (Department of Health [DoH], 1999). However, the rate of those known to mental health services who complete suicide has remained roughly the same, with 24% of those who committed suicide between 1996-1998 (DoH, 1999) and 28% between 2002-12 (NCISH, 2014) having been in contact with mental health services in the 12 months prior to the suicide.

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The most recent review of contact with health services prior to suicide was conducted by Louma, Martin and Pearson (2002) who outlined the results from retrospective studies relating to contact with both primary care and mental health care services prior to suicide. The review concluded that there was a need to understand what made a difference to individuals acting on suicidal thoughts following contact with services. Louma et al. (2002) described this as identifying the ‘mechanisms of action’ and highlighted that little is known about clinical interventions that make a difference.

The World Health Organisation (2014) recommend that ‘selective prevention strategies’ should be used to target vulnerable groups, such as those who have suffered trauma or abuse. They also recommend education and training for health workers and ‘improved identification and management of mental and substance use disorders’ as strategies to reduce suicide. In particular, follow-up for those leaving health-care facilities was recommended.

Predicting and preventing suicide:

Questions have been asked as to why the rates of suicide of those in contact with mental health services have remained largely the same over the past 20 years. There have been debates within research about how preventable suicide is (Preventing suicide in England, a Cross Governmental Strategy to save lives DoH, 2012a).

Several Government enquires have taken place since the first in 1996 (National Suicide Prevention Strategy, Department of Health (DoH, 2012b)). This has resulted in a considerable volume of research seeking a definition of what constitutes best practice when responding to those at risk of suicide in mental health settings (e.g. Logan & Johnston, 2012). Literature in the field has illuminate practical changes that

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services can make to reduce the rate of suicide (e.g. While, 2014 reviewing the implementation of the NCISH guidelines, 2006).

The literature has also identified epidemiological and contextual risk factors that are correlated with subsequent suicide. These variables have been developed into risk assessment tools and more recent recommendations suggest that these tools should be used by clinicians as part of structured assessment to inform management plans (DoH, 2007).

Risk assessment tools and training programs:

As Large and Nielsen (2013) note, there is no evidence that risk assessment tools are effective in predicting suicide. Jobes, Eyman and Yufit (1995) found that clinicians rarely use these tools and Godin (2004) found that checklist risk assessments were viewed by nurses as unhelpful, or only helpful for 'back covering' rather than being a useful clinical tool.

There is some evidence to suggest that training mental health practitioners can increase their skills in suicide risk assessment, and that training can be enjoyable (Rogers, 2010). However, Gask, Dixon, Morriss, Appleby and Green (2006) evaluated a UK based training programme and found that there was no increase in mental health practitioner's skills in recognising epidemiological risk factors following the training course although there was an improvement in participant's reported confidence, in particular, amongst newly qualified staff.

Underhill (2007) and Power (2004) have cautioned against the emphasis on risk assessment tools, stating that these may promote a culture of 'box ticking' and the culture of responsibility for accurate risk assessment may have promoted practice

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which is more about managing risk to the clinician than effective practice in suicide risk management.

Therefore, there are mixed views about the utility of structured risk assessment tools despite their being recommended for clinicians to use in recognising and responding to suicide risk. There is a need to understand in more depth more about the attitudes and experience of professionals in community mental health setting to make sense of how or how not these tools could be useful.

Aims of the review:

The aim of the review is to consider how the findings of retrospective studies of completed suicide help with recognising and responding to suicide risk. The review will consider this question by first considering the findings of retrospective studies, followed by the usefulness of the best practice guidelines that they have informed and finally, studies of clinical practice.

These findings will then be discussed in the context of theoretical and philosophical questions about what is the role of a clinician in contact with a person at risk of suicide. In particular, issues of responsibility for prediction, prevention and the emphasis on risk assessment and management in mental health services will be critically considered. The review will highlight the potential gap between best practice recommendations and clinical practice and outline the clinical and research implications of this.

2. Method

A literature search was conducted by searching the following databases:

PsychINFO, Medline, Web of Knowledge, Cochrane Library and
Googlescholar using the keywords: “Suicid*” AND/OR “risk assessment” OR
“management” OR “assessment” OR “positive risk” OR “clinician” OR “nurse” OR
“psych*”.

Searches were limited to literature published since the first National Confidential Enquiry was published, in 1997 (NCISH 1997). Reference lists of articles identified were searched to find further relevant studies and the “find citing articles” and “find similar” functions were used during database searches to ensure that all relevant articles were sourced.

2.1 Inclusion criteria:

In line with the aim of the review, the studies had to meet the following core criteria namely:

1. The studies had to be empirical
2. The studies had to be either retrospective, related to an individual in contact with healthcare services
3. The studies had to be written in English and report results from Western countries, due to the proposed link with the diagnostic system used in the Western world.

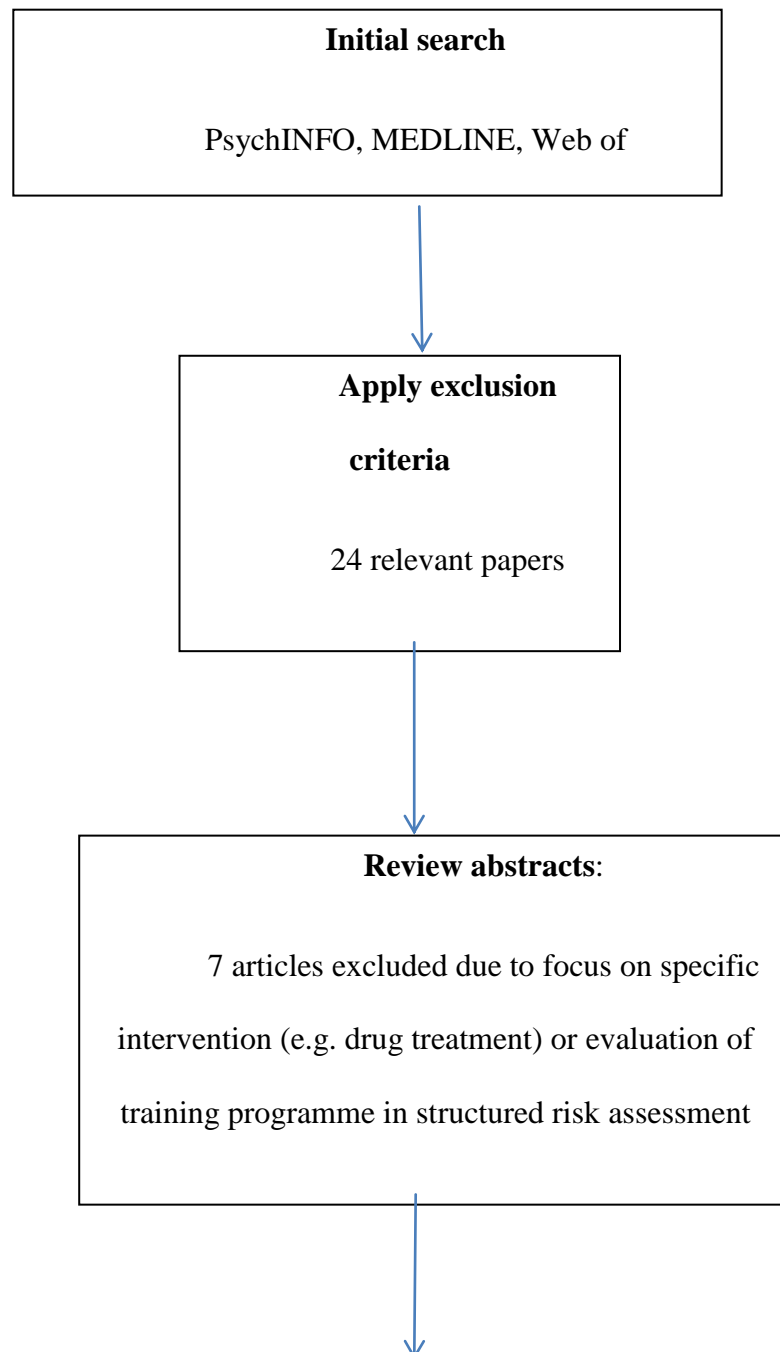
2.2 Results of the literature search

Initial searches returned 793 results. Figure 1 shows the process of searching for relevant literature.

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After reviewing abstracts of the results, relevant articles were selected. There was a paucity of experimental literature therefore data of varying quality and utilising a variety of methodologies was included. An integrative review methodology was employed because the aim of the review was not to systematically review the methodology of the research, but to summarise the research findings, noting quality considerations but primarily for the purpose of reviewing the existing evidence and highlighting gaps in the literature (Whitemore & Knafl, 2005).

Figure 1: Diagram of search processes and results



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**Search reference
pages**

1 article found



19 articles:

- 13 retrospective studies following completed suicide
- 6 pertaining to clinical practice

3. Literature review

3.1 How do the findings of retrospective studies of completed suicide help with recognising and responding to suicide?

The results of the literature search identified 19 relevant articles (see Appendix 1): 8 studies reported and developed national survey data, 5 explored contact with an individual prior to their suicide and 6 explored how clinicians recognise and respond to suicide risk in practice.

In order to answer the research question, the literature review will first report the findings of retrospective national survey data and studies exploring contact prior to suicide. It will then explore how the findings of these retrospective studies have been translated in to Best Practice Guidelines and risk assessment tools. Finally,

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review will report the findings of studies exploring the realities of clinical practice before discussing, in light of the literature reviewed, how the findings of retrospective studies help with recognising and responding to suicide.

3.2 National survey data.

The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (the NCISH) is a national survey which has been the main source of data on which the Best Practice in Managing risk (DoH, 2009) have been developed. The collection of this survey data began in 1996, with the founding of the enquiry into suicide and homicide. The survey data was collated by collecting national data on all deaths with the verdict of suicide or 'undetermined', identifying those who were in contact with mental health services and contacting the relevant consultant psychiatrist who was responsible for the care of the person who completed suicide. The psychiatrist was then sent a questionnaire to complete which included factual information (e.g. the person's demographic information) and clinical judgements, including preventability of the suicide and the client's treatment compliance.

Whilst the most recent NCISH was published in 2014, data from the 2006 NCISH have been developed and published in a number academic papers. These research articles have either reported the results of the survey (Appleby et al., 2006; Meehan et al., 2006 & Hunt et al., 2006) or have used case control methodologies (Hunt, Kapur, Webb, Robinson, Burns, Shaw & Appleby, 2009) to explore particular research questions. Statistics from this publication have also been used to explore the effect of implementing recommendations of the NCISH (While et al, 2012). Furthermore, as described in the introduction, rates of suicide for those in contact with mental health services have remained the same since 2006. Therefore, in this section, the findings of publications that build on data from the NCISH (2006) will be outlined

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and implications for responding to suicide risk in community mental health settings will be discussed.

3.2.1 Client characteristics

Those in contact with mental health services.

Hunt et al. (2006) reported the results from the NCISH to determine factors for suicide within three months of discharge from psychiatric inpatient care. Findings were consistent with previous studies (e.g. Appleby et al., 1999). Of those who completed suicide, 65% were male, 40% had a primary diagnosis of a major affective disorder, 18% of schizophrenia, 12% of alcohol dependence and 10% of personality disorder. Over two thirds of the cases had a secondary diagnoses (61%) indicating co-morbid diagnoses of mental health problems.

Periods of high risk.

Hunt et al. (2006) found that 43% of suicides occurred within a month of discharge from inpatient care and 47% of these were before the first follow-up appointment, with the day after discharge being a time of particularly high risk.

Factors placing a client at greater risk

The literature regarding risk factors is inconsistent. Compared with a living comparison group, Hunt et al. (2009) found the following factors present in those who completed suicide following discharge from inpatient care: a lifetime of self-harm, a diagnosis of affective disorder, a short duration of illness and psychiatric co-morbid conditions. Adverse life events within three months prior to completing suicide were higher amongst those who completed suicide than the comparison group, with relationship break ups being the most common event (16% vs 8% comparison group).

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Meehan et al. (2006) found that in the case of those who completed suicide following discharge from an inpatient ward, it was most likely for their preceding admission to have been a readmission to hospital (nearly 25% of cases) and this admission to have been of less than 7 days duration. A fifth of clients were out of contact with services at the time of death and nearly a quarter had missed their last appointment.

Large, Shama, Cannon, Ryan and Nielssen (2011) conducted a meta-analysis of studies following up those discharged back to the community following a suicide attempt. Reporting odds ratios, Large et al. (2011) found that both a history of self-harm and depressive symptoms were moderately strongly associated with post-discharge suicide. Reports of suicidal ideas, unplanned discharge, being male, recent social difficulties and a diagnosis of major depression were weakly associated with post-discharge suicide. Two significant findings were that those who had less contact with services were significantly less likely to commit suicide. Finally, those who were rated high risk prior to discharge were more likely to commit suicide than other discharged clients, but this finding was not greater than the association with some individual factors. Furthermore, different risk factors were combined to rate individuals according to risk and no single risk factor was common across all those studies who categorized participants as high or low risk. This finding demonstrates that there is not a consistent picture of risk factors that predict future suicide.

3.3 Summary

The findings of the national survey data study bear some useful information for service planning. Findings indicate groups who are at higher risk of suicide are men, those with a primary diagnosis of affective disorder, and those who are using substances as well as having a diagnosed mental health problem. It is also clear that

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the period following discharge from hospital is a time of high risk, with the first day being a particularly risky time. These statistics also highlight that chronic mental health problems are a risk factor for completing suicide following discharge from hospital. However, these findings arguably have limited utility when it comes to clinical interventions. The retrospective identification of these risk factors does not indicate what interventions might make a difference to those in contact with services. For example, little is known about why there is a high rate of suicide following discharge from hospital. Appleby et al. (2006) speculate that it could be the client returning to a particularly stressful environment, whilst psychodynamic theories (Seager, 2010, cited in Briggs, Lemma & Crouch, 2010) have suggested that the break of relationships built in inpatient care might increase suicidality for a person who has chronic difficulties in attachment relationships.

Therefore, national survey data is useful for identifying epidemiological characteristics of those who complete suicide which are vital for increasing awareness of those at risk and potentially useful for developing targeted interventions for supporting those most at risk but does not provide information related to the how of clinical practice.

3.4 Retrospective studies exploring contact with an individual prior to their suicide:

Having reviewed national survey data, the review will now consider the findings of five smaller-scale retrospective studies exploring contact with eventual suicide completers prior to their suicide. Four studies employing a qualitative methodology and one reporting the results of a clinical audit will be reviewed in order to answer the research question: how do their findings help with recognising and responding to suicide risk? Due to the paucity of research for those in contact with

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mental health services, research relating to those not in contact with services will also be reviewed.

The results of these studies will be organised thematically according to following themes: problems attributed to inadequate assessment of mental health difficulty; problems attributed to the individual at risk and problems in those in contact with the individual's ability to recognise and respond to the crisis.

3.4.1 Problems attributed to the inadequate assessment of mental distress

Burgess, Pirkis, Morton and Croke (2000) audited 629 cases of suicide of those in contact with psychiatric services in Victoria, Australia and concluded that 20% were preventable. They concluded that some mental health difficulties were under treated, including there being a lack of assessment of depression and psychological disturbance. In their case review of 26 clients who completed suicide whilst in psychotherapy, participants in Hendin, Pollinger Haas, Maltsberger, Koestner & Szanto (2006), identified untreated or undertreated symptoms (N=17) of substance abuse, psychosis or anxiety which were thought to have been inadequately addressed.

This has been a common conclusion of many previous Psychological Autopsy (PA) studies (see Hjelmeland, Dieserud, Dyregrov, Knizek & Leenaars, 2012, for a review), namely that undertreated mental health problems were strongly associated with suicide. The implication being that if underlying mental health problems were properly identified and treated, suicide would be prevented. PA studies involve a retrospective analysis of factors such as: personality, mental health diagnosis, social circumstances, demographics, family situation, relationships that 'are **associated** or **linked** with suicide' (e.g. Cavanagh, Carson, Sharpe and Lawrie, 2003; Appleby,

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Cooper, Amos and Faragher, 1999; Pouliot, Crise & De Leo, 2006). Such studies are limited by several factors namely: the retrospective nature of the data collection, third party informants used to diagnose mental health problems, and attribution bias namely, there are likely to be many people in the general and psychiatric population who have the same demographic factors but who do not complete suicide.

More recent PA studies have employed case controlled studies to investigate factors linked to suicide. Case controlled PA studies mean that researchers are blind to the condition (completed suicide or not) of the person they are assessing and mental health diagnoses have been given in order to explore whether access to healthcare services is important for being able to diagnose and treat mental health problems for the purposes of suicide prevention.

Two studies which have employed this retrospective case controlled methodology investigated the importance of professionals identifying and diagnosing a mental health problem in the prevention of suicide. De Leo, Draper, Snowdon and Kolves (2013) investigated contacts with both primary and secondary care services prior to suicide to investigate the recognition of mental health problems by the professionals. The study found that nearly 80% of those who completed suicide had contact with a GP and 30% had contact with a mental health practitioner within the three months leading up to completing suicide. De Leo et al. (2013) found that it did not make a difference whether the client had a distinguishable mental health problem or not in terms of whether the professional recognised the risk of suicide. This is consistent with the findings of Owens, Lloyd and Campbell (2004).

Owens et al. (2004) investigated recognition and treatment of mental distress by GPs of those who were not in contact with mental health services prior to suicide.

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Of the 100 cases investigated, the authors identified 68 who were suffering from a severe mental distress. 30 of these people (44%) had not consulted their GP in the month leading up to the suicide and all except 9 of the 38 people who were ill and had consulted their GP were being treated for mental health problems by their GP. The findings of this study suggest that it was not the failure to recognise mental health problems that led to suicide, in fact when a diagnosis and treatment had been given, this did not prevent suicide.

3.4.2 Problems attributed to the person at risk:

In their two case review seminars, Hendin, Maltzberger, Lipschitz, Pollinger Haas & Kyle, (2001) and Hendin et al. (2006) recruited therapists who completed questionnaires on standard risk items (i.e. client's background, psychiatric history, affective state) and asked the therapist to comment on psychodynamic phenomena thought to contribute to the person's suicide. Participants took part in a seminar reviewing their work with a client who completed suicide. The qualitative methodology used in the case review offered the opportunity to gain a deeper understanding of the psychological state of the client at the time of their death. In 21 out of 26 cases, suicide was precipitated by a significant life event, such as the loss of a job or a client's son being diagnosed with leukaemia. The therapists concluded that it was not the life event per se that precipitated the suicide, but the meaning of the life event for the individual. The review found that all 26 patients had a depressed mood and this was seen as associated with the life event. Fifteen of the clients reviewed were felt to suffer from a chronic sense of abandonment, feelings of being alone and unsupported. The authors reported that feelings of desperation, abandonment, anxiety, guilt, rage or humiliation were triggered by the life event and desperation was felt to be the state most associated with suicide. The authors identified this sense of

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desperation in 22 out of the 26 patients. 21 out of 26 either reported feeling suicidal (N=17) to the therapist or someone they knew and the remaining 5 clients demonstrated suicidal feelings by serious self-harm or a suicide attempt.

Owens, Lambert, Donovan and Lloyd (2005) conducted a qualitative psychological autopsy study, interviewing relatives or close friends of 66 suicide victims to investigate help seeking behaviour of those who sought help from their GP (N=33) and those who did not (N=33) in the month prior to a suicide. Informants felt that some suicides could not have been prevented by the GP, citing a pattern of long-term help seeking on the part of the at-risk individual, who were thought by informants to consistently seek help that was felt to be manipulative of the medical system. Of those who did not seek help (N=33), many informants reported that their loved ones were 'help-resisters' by nature, namely, that they were self-reliant and resourceful and expected to solve their problems by themselves.

3.4.3 Problems attributed to those in contact with the individual:

Relationship with the professional:

In their audit of assessments of those with a history of contact with psychiatric services who completed suicide, Burgess et al. (2000) judged 20% of the suicides to have been preventable. The study found that poor staff-client relationships were a barrier to assessment and treatment in both inpatient and outpatient settings. However, the authors do not state how the quality of these relationships was assessed which seems important, particularly given that this is a retrospective evaluation based on the subjective judgements of three auditors who were not involved with the client and have the benefit of hindsight.

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In their later study, Hendin et al. (2006) reviewed 36 cases of clients who died by suicide using the same research methodology. Some of these cases may have been included in the previous study; it is unclear from the reporting of the results which is a limitation of this study. Five key problems were identified in the therapist's contact with the person at risk of suicide. These included the following: lack of communication between therapists when a client had changed therapist (N=23), permitting patients or their relatives to control therapy (N=17), avoidance of issues related to sexuality (N=7) and ineffective or coercive actions resulting from therapist's anxiety (N=11). Avoidance of issues related to sexuality was reported as a trigger for further difficulties in life and it was felt by therapists that addressing this in the therapy might have impacted on the eventual suicide. It was felt by therapists that at times they had complied with requests of the client or family member due to the fear of the threat of suicide and the anxiety about not complying.

Failure to recognise the communication:

In their qualitative study, Owens et al. (2005) found that contact with the GP did not prevent 33 patients/people completing suicide. Informants felt that this was either to do with the at-risk individual not reporting their distress or the practitioner not taking it seriously enough (some respondents felt that their loved one was given medication and sent home). The findings of Hendin et al. (2001) provide support for the work of Owens et al. (2005). Thirteen therapists involved in reviewing cases of clients who had died by suicide reported having recognised the suicidal crisis. The therapists reported that suggestions of hospitalisation were refused. The authors concluded that the therapist's response had failed to address the underlying suicidal intent by attending to the needs of other members of the family or not taking this expression of suicidality seriously enough. This finding was supported in their later

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work. Hendin et al. (2006) identified therapists not recognising the meanings of patients' communications (N=9), meaning that the therapist did not take the threat of suicide seriously enough or misunderstood the intensity of the distress. This was also found in the study conducted by Owens et al. (2011) who hypothesised that friends or family did not take the clear signs of suicidality seriously due to a normalcy bias, whereby having not experienced a crisis themselves, there is a tendency to ignore signs of suicidality because the desire is for things to be okay, or normal (Owens et al., 2011).

Habituation to disturbance:

In their qualitative study of help seeking prior to suicide, Owens et al. (2005) found that many lay informants had lived with the distress of their loved one for a long time, and felt that this was characteristic of the person who completed suicide. Some reported growing tired of what they felt were distressed 'performances' and other informants reported experiencing signs of distress as natural responses to adverse life events. Lots of practical solutions, such as consultation of financial advisors, relationship counsellors etc. had been consulted by the distressed individuals, and it seemed that informants felt that if the source of distress were removed (e.g. financial troubles) that the distress would resolve itself. It seemed that amongst those who did not seek help, there was a lack of thinking of the behaviour as that of illness. The authors conclude that it is unknowable if these practical solutions, or contact with mental health services, might have changed the outcome of the suicide because it is impossible to evaluate this.

Being unaware of the 'signs' of distress/ client concealing signs of distress:

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Some lay informants in the qualitative PA study conducted by Owens et al. (2005) described not being aware of the signs of distress that a person may have been exhibiting, citing family secrets, where other members of the family were aware of behaviour such as self-harm. Some informants felt guilty that they had been too preoccupied to respond to signs of distress

Hendin et al. (2001) found that of the therapists who participated in the case review, 14 of the 26 had not recognised the crisis. In 5 cases where the suicide was not recognised, it seemed that problems in communication between therapist and client had led to the client concealing suicidal feelings from the therapist. This finding, that a person seems to be presenting as though things are okay prior to completing suicide is in line with the findings of Owens, Owen, Belam, Lloyd, Rapport and Lambert (2011). When Owens et al. (2011) interviewed lay people, they reported that their friend or family member who went on to complete suicide was either exhibiting signs of suicide risk, or countersigns, whereby their mood improved or they were carrying on with normal daily activities. There are many possible explanations for this but it was postulated by Hendin et al. (2001) that the client at risk did not want to reveal this to the therapist and was masking their true feelings intentionally.

Hendin et al. (2001) conclude that the suicide attempts of those who are in contact with services may have a different meaning from those who are not, namely, that the communication may be that the care the person is receiving is insufficient. This has implications for clinical practice in terms of how to respond to this communication.

3.5 Summary

Findings from five retrospective studies exploring contact with an individual prior to their suicide have been discussed thematically. Factors such as: not recognising the signs of distress, difficulties in the relationship with the person, not adequately treating psychological disturbance, not treating sexual dysfunction and not taking the communication of distress seriously have been reported as barriers to recognising or responding to their risk of suicide. The review found that studies employing a qualitative methodology offered a greater insight into personal and relational factors that were thought to be important when responding to someone at risk of suicide, rather than simply better recognition of epidemiological risk factors.

The studies reviewed in this section indicate the paucity of qualitative literature relating to contact with those at risk prior to suicide. This section has also found that despite the correlation between diagnosed mental health problems and suicide (NCISH, 2012), there is some evidence to suggest that diagnosing a mental health problem and prescribing medication designed to treat it does not prevent suicide for those in contact with a GP (Owens et al. 2005). This finding suggests that there might be other, perhaps psychological processes taking place that could help with recognising and responding to those at risk of suicide.

3.6 Theoretical perspectives:

Studies such as Owens et al. (2006) and Hendin et al. (2006) suggested that there may be individual factors taking place within the individual in contact with the person at risk which might be impacting on their response. Owens et al. (2006) suggested that loved ones might be influenced by normalcy bias, i.e. viewing signs of suicide as normal, due to their inexperience of such distress and their desire for this to be the case.

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Hendin et al (2006) found that some interventions made by clinicians when faced with an individual at risk were harmful. Hendin et al (2006) described the impact of the clinician's anxiety on their decision making. These harmful interventions could be understood as an attempt by the clinicians to manage their anxiety, and to create a 'safe certain' solution (Mason, 1993). These findings warrant further empirical investigation in order to understand what processes might be taking place to inform best practice.

3.7 Best practice guidelines and risk assessment tools.

'Life is about risk, we take risks every minute of the day. We must not let it inhibit us, we must use it to guide us and make us think but it should not restrict our ability to lead lives to the full' (DoH, 2007a).

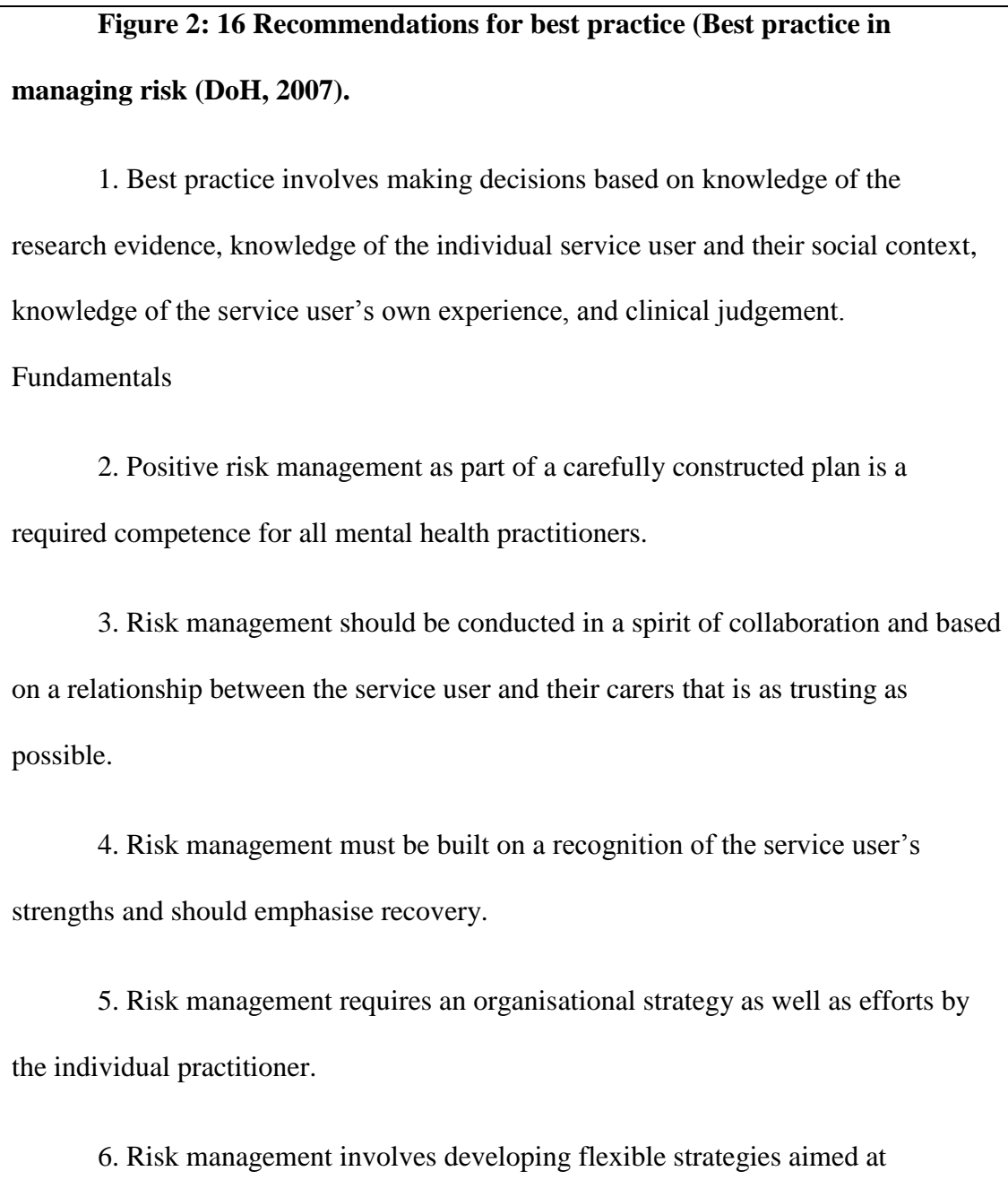
Best practice guidelines and structured risk assessment tools for clinicians working with those at risk of suicide (e.g. DoH, 2007) have been developed from retrospective studies, such as the NCISH (2006) reviewed above. This section will first outline the current best practice guidance and then review two empirical studies exploring the utility of these guidelines for recognising and responding to suicide, in order to further address the review question. This section will explore how the findings of retrospective studies have informed best practice guidelines.

The most recent best practice guidelines were published by the DoH in 2007 (Best practice in managing risk, DoH, 2007b). These guidelines were based on the results of epidemiological studies such as the NCISH (2006) and the findings of a consultation process for the National Mental Health Risk Management Programme (Whittington & Logan, 2011). Guidelines are intended to promote best practice and are therefore not compulsory. However, the aim of them is to promote Evidence Based

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Practice (EBP) or, as outlined by Whittington and Logan (2011), ‘to create a set of guidelines that recommend a procedure (e.g. pressurised, metred-dose inhalers) in response to condition (e.g. asthma) because the best quality research evidence indicates that procedure A is the most effective in generating the outcome of choice’.

The Best practice guidelines offer sixteen recommendations are outlined in Figure 2.



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preventing any negative event from occurring or, if this is not possible, minimising the harm caused.

7. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

8. Knowledge and understanding of mental health legislation is an important component of risk management.

9. The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

10. Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.

11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user. Working with service users and carers

12. All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.

13. Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach. Individual practice and team working

14. Risk management plans should be developed by multidisciplinary and

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multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.

15. All staff involved in risk management should receive relevant training, which should be updated at least every three years.

16. A risk management plan is only as good as the time and effort put into communicating its findings to others.

There seem to be two key issues attempting to be addressed by these guidelines: how clinicians can collect and record evidence and use it to make good clinical decisions, as well as ensuring that the process is collaborative and leads to a plan which takes into account the context and experience of the individual at risk.

These guidelines recommend the use of actuarial tools to collect data to inform a risk management plan. However, the authors caution against using these tools for suicide prediction but recommend that they are used to identify relevant factors alongside clinical judgement and the view of the person at risk.

Linked to this document was that published by the DoH in the same year entitled, 'Independence, choice and risk: a guide to best practice in supported decision making' (DoH, 2007a). This document outlined the importance of decisions about risk being the least restrictive, promoting independence and choice for those who use services. This document was developed with the increasing emphasis on personal choice for those using services and growing body of literature which suggested that the emphasis on risk prevention was in fact creating a negative experience of services

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for those who were in receipt of them, evidenced by this quote as one example, ‘nothing good has come out of risk management except that I have had to learn to cope and rise above the issues that became commonplace in my life when and since being in hospital and becoming unwell’ (Sheldon, 2012, cited in Whittington & Logan, 2012, pg.17).

Therefore, it is clear from both government documents that there are two that must be balanced: that of ‘risk management’ and that of choice, independence and least restrictive action.

3.8 Summary

So far, this review has considered the question of how retrospective studies can help with recognising and responding to suicide by first reviewing national survey data and studies exploring contact with those at risk of suicide. It has shown how best practice guidelines have been informed by the findings of national survey data and the findings of a working group. It has also identified some potential difficulties with the emphasis on predicting and preventing suicide for the person in receipt of service and has found evidence to suggest that this may have led to service users experiencing restrictive practice when at risk and found that the emphasis in best practice guidelines encourages clinicians to practice in the least restrictive way, promoting choice and autonomy.

3.9 Retrospective studies exploring the impact of implementing Best Practice guidelines.

There have been two recent studies exploring the utility of the recommendations from the NCISH (2006) and the subsequent guidelines in Best Practice for Managing Risk (DoH, 2009). The first study by Rahman et al (2013)

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considers the practice of clinical risk management and the second considers changes on a service level (While et al, 2012).

Rahman, et al. (2013) piloted a framework for assessing the quality of risk assessments prior to suicide. The authors retrospectively applied the criteria outlined in Figure 2, identified from national guidance and research, to risk assessments that were carried out prior to 42 suicides of a clients considered ‘low risk’ by the clinician who had last contact with them:

Figure 2: domains of the quality evaluation framework (Rahman et al., 2013)

1. Assessment of past psychiatric history and other events;
2. Assessment of current mental state and current circumstances,
3. Risk factors associated with adverse outcomes to be brought together in an overall risk formulation
4. The development of a risk management plan based on this risk formulation;
5. The management plan to be communicated effectively.
6. Overall quality of the assessment.

The results of the study indicated that the overall quality of the risk assessment was satisfactory in 64% of the cases examined. Rahman et al. (2013) found that past history was assessed satisfactorily in 98% of cases, mental state in 86% of cases, the

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risk formulation was satisfactory in 74% of cases, communication was satisfactory in 83% of cases and the management plan was satisfactory in 62% of cases. The rating of low quality for risk management planning might be limited due to assessor bias. Assessors were aware of the outcome of suicide and there was no comparison group of those who did not complete suicide.

However, the findings suggest that failure to adequately assess risk based on these criteria was not the reason for outcome of suicide. As Large and Nielssen (2013) note, there is no empirical evidence to suggest that risk assessment is of any use in preventing rare events like suicide. These considerations provide some evidence to indicate that either the criteria that are identified through such large surveys are based on principles of prediction rather than prevention or, it may be that the nature of clinical work in preventing suicide might be a slightly different thing to measuring demographic data that predict suicidality.

While et al (2012) conducted a national review to explore whether implementing recommendations from the NCISH (2006) made a difference to suicide rates for those in contact with services. In 2002, 2004 and 2006, questionnaires were distributed to all mental health services in the UK asking which of their 9 recommendations had been implemented. The recommendations included: removal of ligature points from inpatient wards, community services to include an assertive outreach team to engage those who were deemed 'harder to engage', community teams to have a 24 hour crisis team, to have a 7-day follow up policy following discharge from an inpatient ward, a non-compliance written policy for those who are 'non-compliant' with 'treatment', to have a policy on those with substance misuse and psychological problems deemed 'dual diagnosis', to have a policy on sharing information with the criminal justice system, to have a written policy on review and information sharing with families

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following a suicide and finally, for front line staff to receive training in the management of suicide risk every three years. Using self report data and by recording rates of suicide for these service, While et al (2012) found that rates of implementing recommendations increased over the course of the three years of data collection. Further, they found that implementing 7 or more of their recommendations significantly reduced suicide. Three recommendations were statistically significant: 24h crisis team included in community services, dual diagnosis policy and post suicide multidisciplinary review.

3.10 Summary:

This section has summarised current best practice guidelines and evidence for the sorts of decisions these can inform. It has found that implementing service changes seems to have an impact on suicide rates, but, based on retrospective research, risk management based on identification of epidemiological risk factors and a plan based on this may not be provide the most useful guidance to clinicians of how they might recognise and respond to suicide risk. Therefore, the next section will review literature exploring clinical practice.

3.11 What do we know about how clinicians recognise and respond to risk in clinical practice?

Having reviewed research findings from retrospective studies informing best practice guidelines the review will now consider empirical evidence exploring how clinicians respond to suicide risk in clinical settings . The aim of this section to see how the recommendations from best practice guidance shake down in practice which will be further considered in the discussion section.

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3.11.1 Use of risk assessment tools

Godin (2004) conducted a qualitative evaluation of how mental health nurses reflect on and practise risk assessment and risk management. The results of a thematic evaluation of interviews with twenty Community Mental Health Nurses indicated that all nurses were aware of formal risk assessment tools and some used them in their practice. Some found them too mechanical, behaviourally reductive and dehumanising, favouring a more individualised approach. Nurses talked about using 'intuition' or a 'gut feeling' and suggested that they use observation of a person's living situation to assess risk. Several nurses described a culture of risk and suggested that this stifled their creativity of their work however, some described the tools as useful guidelines which could inform less able or less experienced practitioners. Regarding risk management, nurses primarily described judging risk to themselves based on how they felt in the situation and safety protocols designed to protect them in this instance. Some nurses reported that this emphasis on 'not wanting to make mistakes' was detrimental to their clients who now had to contend with being 'a risk' as well as being 'mentally ill'. One nurse in primary healthcare expressed 'the positive aspects of working here' because she could see a client every day at risk of suicide and 'work out other means to support them'. She referred to the 'psychiatric system' as 'getting people into hospital'.

Alflague and Ferst (2010) observed nurses conducting suicide risk assessments in a psychiatric hospital setting in the USA to develop an understanding of how the nurses conceptualised suicide and the strategies they employed in the assessment. The results of this study indicated that suicide assessment tools or structured interviews were not used. When interviewed following the interaction, nurses referred to using their 'intuition' or 'gut feeling' in making their decision.

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3.11.2 Cues/ factors that clinicians attended to:

A variety of methodologies have been used to determine what cues clinicians are attending to when making clinical judgements. Paterson, Dowding, Harries, Cassells, Morrison and Niven (2008) explored the factors that influenced clinicians' judgements regarding suicide risk by presenting participants with case examples and asking them to rate relevance of risk factors. They found that both psychiatrists and nurses associated suicidal ideation with increased suicide risk and that psychiatrists were significantly more influenced by the patient's diagnosis than nurses were. The number of previous attempts, being male, lack of clinical improvement, lack of compliance and shorter admissions were all cues sometimes reported by both groups of clinicians in their judgement. The client's insight, adverse events and protective factors were not found to be significant. This study is limited in its usefulness by the use of fictitious case examples which were given to clinicians in a written format. This is likely to increase the salience of cues reported because they are written and are not being attended to in a clinical situation. Therefore this study lacks ecological validity.

Baca-Garcia (2006) conducted a large-scale study of 509 psychiatrists' decisions to hospitalize adults who had attempted suicide by using data mining to filter the variables that most commonly predicted hospitalization rather than discharge. They found three factors which were associated with a clinician's decision to hospitalize a person namely: substance misuse; lack of family support and attitude to attempt signifying an intention to repeat the attempt.

Buckingham et al. (2002) applied content analysis to interview data with 46 mental health professionals to ascertain the cues and knowledge structures used when making risk assessments. They found that nurses in psychiatric settings linked suicide

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with depression when making suicide risk assessments and that they listened out for current risk factors such as access to means, plans and states such as substance misuse which may place the individual at greater risk, although the client was not directly asked about these factors (Aflague & Ferszt, 2010).

Buckingham et al. (2002) interviewed 46 mental health professionals to ascertain what factors were considered when making risk judgements about self-harm, suicide, harm to others and self-neglect. Interviews were analysed using content analysis and participants cited past client episodes of suicide as a cue that they considered in their judgements about risk. Following this, other historic factors such as: family history of suicide and exposure to suicidal episodes in others were listed. All but one participant discussed mental health problems in their description of how they make risk judgements. Some professionals felt that self-harm behaviour was indicative of suicide while some felt that it was not. The two most common presenting factors reported were: reporting plans to commit suicide and describing feeling suicidal. In a further study, Buckingham (2007) used this content analysis to propose the introduction of a computerized system that helped clinicians with their decision making by rating the importance of variables, modelling the decision making of clinicians based on available information. These studies were the first to use qualitative evaluations to begin to develop a foundation of understanding about real-world practice in the mental health field. They offer a very interesting insight into the list of factors which are considered by clinicians in terms of cues when assessing risk and offers a perspective about which are most salient.

This section has reviewed six studies of how clinicians recognise and respond to suicide risk in practice. The studies reviewed have used a variety of methodologies including interviews, fictional case examples and survey data. The findings of this

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section indicated that some professionals view structured risk assessment tools as helpful for guiding less experienced practitioners, indicating that they view this as something which is now tacit knowledge for them as more experienced practitioners. Findings from studies investigating what cues clinicians attend to whilst assessing risk indicated an inconsistent picture across professions, with psychiatrists being more likely to attend to psychiatric diagnoses.

The findings from this section indicate that there may be a number of other important factors involved with the process of recognising and responding to a person at risk of suicide other than those captured by best practice guidelines. These include the practitioner's opinion and attitudes, professional training and judgements about the clients they are working with.

4. Discussion

The question posed at the beginning of this review was: how do the findings of retrospective studies of completed suicide help with recognising and responding to suicide risk? This has been answered by reviewing the findings of retrospective studies following a completed suicide and studies pertaining to clinical practice. The findings of these studies will now be discussed in terms of their theoretical implications and relevance to clinical and research practice.

4.1 Good practice guidelines and clinical practice:

The Best Practice Guidelines made recommendations for clinical practice based on the findings of empirical studies, such as the NCISH and as a result of discussions in a working party (Whittington & Logan, 2011). The recommendations will be considered here in light of the empirical evidence reviewed to consider how they are supported by the findings of the review.

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4.1.1 Recommendations supported by the evidence reviewed:

There are several important recommendations in relation to working with those in receipt of mental health services. These include: ‘risk management being conducted in a spirit of collaboration, based on a relationship between the service user and their carers that is as trusting as possible’ (recommendation 3). Evidence from retrospective studies exploring barriers to recognising and responding to suicide risk highlighted the importance of the relationship with the service user and their carer for recognising and responding to suicide risk (e.g. Burgess et al, 2000 and Hendin et al, 2006).

Secondly, the recommendations (2 and 4) that risk management must be positive and built on recognition of the service user’s strengths and emphasise recovery seems to be important and in line with aspirational best practice. However, service user reports (e.g. Sheldon, 2011, cited in Whittington & Logan, 2011, pg. 24-5) and clinician’s experience of risk management (e.g. Power, 2004) would suggest that this is not always the case currently. This is an important recommendation as there is some evidence to suggest that coercive actions may contribute to a subsequent suicide (Hendin et al, 2006).

The fifth recommendation that risk management requires an organisational strategy is supported by the findings of While et al’s (2012) study which found that implementing changes to services reduced suicide rates. Therefore, a culture of attending to suicide risk and implementing organisational changes seems extremely important.

Finally, the findings from this review have highlighted the importance of attending to and addressing individual factors that might be contributing to the

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distress of the person in contact with services. For example, Hendin et al. (2006) highlighted the importance of discussing problems that they felt might be contributing to their client's distress, such as sexual problems, that the clinicians were perhaps reticent to discuss. Guideline twelve recommends that all staff must demonstrate sensitivity in relation to diversity, which is perhaps noting that professionals should be aware of the differing beliefs and differing needs in terms of responding to their risk based on their protected characteristics. However, there is a paucity of research considering the importance of these individual factors for the way that professionals recognise and respond to suicide risk.

4.1.2 Recommendations unsupported by the findings of this review:

There are three recommendations pertaining to developing risk management plans based on risk assessment. These state that risk management plans should include a summary of all risks identified and a formulation of the situation they could occur in (recommendation 9). The risk management plan should be based on assessment using the 'structured clinical judgement approach' where suitable tools are available and these assessments should inform the appropriate kind of intervention for the service user (recommendations 10 and 11). Risk assessment tools can be helpful for alerting clinicians to factors to attend to, and their introduction arguably brings to the fore discussions about risk, which could be at risk of being avoided. However, as this review has shown, there is no evidence that accurately identifying risk factors has an impact on completed suicide (e.g. Owens et al 2004, Large & Neilssen, 2013).

A further recommendation is that all staff should receive training in risk management every three years (recommendation 15). However, evidence reviewing risk management training programmes has shown that these are not

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4.1.3 Inconclusive evidence:

Little is known about the importance of the following factors recommended by best practice guidance:

- The importance of an understanding of mental health legislation (recommendation 8)
- How far clinicians are attending to the fact that risk changes over time (recommendation 13)
- The level of multidisciplinary and multiagency team working and reflective practice associated with the process of risk management in mental health setting (recommendation 14).

In summary, the guidelines provide a helpful set of recommendations for clinicians in their everyday practice in recognising and responding to suicide risk. It is apparent from the guidelines, however that there is an emphasis on professionals preventing suicide risk; guideline number six states that, 'risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused'. Implicit in the guidelines is the need for clinicians to ensure that they are constantly monitoring risk and intervening in order to ensure a persons safety. Of course, clinicians do have a duty of care to those who they are working with to protect them (Health and Social Care Act, 2012) however, some authors have suggested that the emphasis on prediction and prevention could have negative consequences for clients and professionals. For example, Logan and Whittington (2011) state that at worst, the discourse of risk could be seen as 'just another phase in the long history of the stigmatization routinely faced by people with mental health problems based largely on exaggerated, largely false,

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sense of their dangerousness, fears about risk, then limit rather than energize progress' (Whittington & Logan, 2011, p.g.1). Whilst protecting those we are working with from harm has to be an important priority, there are questions raised about the implications for research and clinical practice.

4.2 Implications for clinical practice:

Having considered how best practice guidelines are supported by the findings of this review, implications for clinical practice will now be considered in terms of how retrospective studies of completed suicide can inform clinicians in recognising and responding to suicide risk. It is clear from the review that risk of suicide creates anxiety for professionals and this can influence the way they work with clients they are in contact with (Hendin et al., 2006). Some studies have suggested that there is a desire for things to be 'normal' for those in contact with people at risk of suicide, or that professionals feel pulled to act in certain ways based on individual factors, such as their relationship with the person or their family or their anxiety about risk (Hendin et al., 2006). A recommendation from this review for clinical practice is the importance of ensuring that decisions are made in line with the best interests of the person at risk, and not in order to protect the professional or relieve their anxiety about a client committing suicide. This is outlined in the best practice guidance (DoH, 2007), that professionals should take positive risks, however, there have been some concerns about the increasing emphasis on risk assessment in mental health services. For example, the clinician may become concerned with protecting their reputation in case they 'fail' to manage the suicide risk (Power, 2004 and Underhill, 2007) The authors argue that this becomes a secondary risk to manage distracting from the primary risk of suicide.

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This review has also found that there is inconsistency amongst professionals about which cues are important to attend to with someone at risk of suicide (Paterson et al. 2008 and Buckingham et al. 2002) and whether or not risk assessment tools are helpful (Godin, 2004). There is some evidence to suggest that experienced professionals are taking account of these variables but that this information has become tacit knowledge, rather than requiring prompts from structured risk assessment tools (Gask et al, 2006).

The review has found that it is important for there to be an organisational approach as well as an individual approach to risk management, which supports the Best Practice Guidelines (DoH, 2007). This approach should include implementing recommendations from the NCISH (2013) in order to ensure that the service is in line with best practice.

4.3 Implications for research:

As shown by this review, the vast majority of research in the field of suicide has been about identifying factors that predict suicide (i.e. through large epidemiological studies and a great number of papers in the three main suicide journals: Crisis, suicide and life threatening behaviour and the Archives of suicide research). This review has found that there is a paucity of research considering other factors thought to be important by professionals or service users about what is helpful when recognising and responding to suicide risk.

Anxiety of the professional and responsibility to prevent suicide might go some way towards explaining the emphasis on measuring what is measurable through the use of risk assessment tools and documentation in best practice guidelines. However, as this review has shown, since the introduction of such practices, there has been no

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reduction in the rate of suicide with those in contact with mental health services. In her seminal paper on social systems against anxiety, Menzies-Lyth (1960) highlighted the defensive practices that can be employed when health care professionals are faced with a distressing task. This may be further compounded by the responsibility that a professional feels and which was promoting a drive towards finding safe and certain solutions (Mason 1993).

4.3.1 Recommendations for future research:

The review has outlined a number of areas where it would be useful to know more about how professionals recognise and respond to suicide risk with those they are working with. In particular, it would be helpful to understand more about issues of diversity, the level of multiagency and multidisciplinary working, and research to gain a psychological understanding of the factors that influencing a professional's ability to recognise and respond to suicide risk. It would also be helpful to understand more from a service-user perspective about what they would find helpful- whether this is in line with the professional approach to risk management or whether it would be something different.

Research has focussed on epidemiological factors and cues in terms of how professionals in mental health settings recognise and respond to suicide. There is some evidence to suggest the importance of emotions in the judgements that those in contact with the individual are making. There is a lack of qualitative research that explores factors that contribute to decisions to intervene or not amongst those in contact with an individual at risk of suicide except studies of lay respondents (e.g. Owens, 2005). One obvious gap in this evidence is the development of a theory that explores the meaning of working with someone at risk of suicide, possible psychological processes and perceived solutions or treatments considered by those in

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mental health settings. In particular, there is a need to explore the extent to which the responsibility being located within a clinician to prevent suicide impacts on their recognition and responses to suicide in order to make sense of what might be the realities in clinical practice.

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TO SUICIDE RISK?

MAJOR RESEARCH PROJECT

SARAH CROWLEY Bsc Hons

Section B

PERCEIVED RESPONSIBILITY, ANXIETY AND UNCERTAINTY
DIRECT PRACTITIONER ATTRIBUTIONS OF CAUSES AND
INTERVENTIONS WITH THOSE AT RISK OF SUICIDE.

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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

Abstract

Despite the number of best practice guidelines for working with those at risk of suicide, there remains a paucity of research pertaining to the realities of clinical practice. The aim of this study was to develop a grounded theory of how clinicians respond to those at risk of suicide in UK community mental health settings. Semi-structured interviews were conducted with eleven members of staff including social workers, nurses, psychologists, psychiatrists and occupational therapists. A theory grounded in the resulting data was developed.

Results: Anxiety, uncertainty and practitioners' perceived responsibility for preventing suicide influenced their attributions in relation to a client's distress. Findings indicated that clinicians most often attributed low responsibility to clients for both the cause and the solution. Therefore, clinicians sought solutions to suicidal presentations within services, rather than attending to contextual or environmental 'triggers' to offer a resolution, potentially increasing dependency on services.

Feeling supported and an environment of psychological safety enhanced professionals' capacity to tolerate the uncertainty inherent in this work which allowed professionals to 'hand the responsibility back'. This highlights the importance of services creating an environment of psychological safety in order for clinicians to tolerate the uncertainty of working with those who present with suicide risk.

Key words: suicide, grounded theory, attribution, medical model, psychodynamic.

1. Introduction

1.1 Political context

Suicide is a major issue in the UK. In 2010, over 4,200 people in the UK committed suicide (Preventing suicide in England, a Cross Governmental Strategy to save lives DoH, 2012a). Death by suicide was the cause of 27% of the deaths of people in contact with mental health services in 2010 (National Confidential Enquiry into Suicide and Homicide [NCISH], 2012). Whenever a suicide occurs, it impacts on those directly and indirectly involved with the individual who committed suicide. When a suicide occurs within mental health services, it has many consequences for the service, including an enquiry into the death in addition to the difficult feelings for those working with the person (Whittington & Logan, 2011, pp.279).

The meaning of suicide has changed throughout history and across cultures. Over the course of history and in differing social contexts, suicide has been conceptualised as an heroic act (e.g. as a legitimate death in the Greek military), as sinful (e.g. in European, Christian cultures) and arguably, in the UK has moved towards an understanding of suicide as pathological and preventable (Marsh, 2010).

1.2 What do guidelines say?

The idea that suicide is something that can and should be prevented is evident in UK policy and guidelines (e.g. National Confidential Enquiry Into Suicide and Homicide [NCISH], 2006). Government policies and ‘best practice’ guidelines (Department of Health, [DoH] 2007) emphasise the use of structured risk assessment in mental health settings and call for clinicians to assess demographic and situational risk factors to create care plans to modify factors contributing to the suicide risk (e.g. Whittington & 2011).

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Ostensibly, the aim of the development of these tools is to assist clinicians with their task of preventing suicide (suicide prevention strategy). Critics such as Underhill (2007) highlight the implicit assumption that if risk factors can be identified, then a suicidal outcome can be prevented. In line with critical literature surrounding the medicalization of distress (e.g. Speed, Moncrieff & Rapley, 2014), it seems that a culture has developed in mental health services towards identifying and treating various risk factors thought to be modifiable and contributing to suicidality. This includes psychiatric diagnoses, demographic factors and situational factors further creating an individualistic and pathological model of distress, and reinforcing a link between 'severe mental distress' and 'risk' (Whittington & Logan, 2011, pg.1).

There have been many critics of the culture of risk assessment, including Aldridge (1999) and Bell (2008 cited in Briggs, Lemma & Crouch, 2008, pg. 47) who have argued that the broad grouping together of risk factors for suicide may detract from good clinical care, which should include understanding of the individual's motivations and their social and relational context.

1.3 Importance of exploring clinical practice:

Broad, de-contextualised concepts of suicide prevention may divert attention away from individualised care that could otherwise reveal factors contributing to suicidality. Enquiries note that only 20% of suicides of those in contact with mental health services were considered preventable by the staff members involved (NCISH, 2007). The 'Avoidable Deaths' report (NCISH, 2007) calls for practitioners to treat each person at risk individually, rather than expecting that there is an inevitability that some people will commit suicide.

The evidence base exploring how clinicians respond to those at risk of suicide is limited. Hendin, Maltzberger, Koestner and Szanto (2006) identified six factors that

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were seen by the clinician as contributing to poor management of suicide risk with clients who had completed suicide. These included: lack of communication between therapist and other clinicians; allowing relatives to control therapy; not recognizing the meaning of the patient's communications; the therapist's anxiety leading to coercive decisions which encouraged the patient into a power struggle; untreated or undertreated symptoms, including substance misuse, psychosis or depression. The results of this study indicate that there may be dynamics between a clinician and a client at risk of suicide in the room, which may be contributing to difficulties with responding to the client's risk communications (either explicit or implicit).

1.4 Responsibility and attribution bias:

It is well documented that working with those at risk of suicide is anxiety provoking for the clinician (e.g. Tillman, 2006).

In an increasing culture of litigation (Logan, Nedopil & Wolf, cited in Whittington & Logan, p.g.153) and emphasis on individual professional responsibility (Power 2004) there have been concerns that the current organisational culture within the NHS is placing an emphasis more on suicide prediction and prevention, than helping and supporting the whole person within a containing, caring context. Aldrige (1999) argued that the environments of mental health services might be inadvertently reinforcing suicidal behaviour because this is a communication that must be attended to by clinicians, thereby being a legitimate form of communication for clients within these services.

Little is known about how clinicians in mental health services respond to those at risk of suicide, in particular, how they weigh up what action to take and what impact feelings of responsibility and anxiety might have on their understanding of the client's suicidality.

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Some scholars suggest that the behaviour of clinicians towards an individual in trouble is affected by whether or not the clinician attributes causes directly to the person in question, or to contextual factors. Brickman, Rabinowitz, Karuza, Coates, Cohn and Kidder (1982) developed a four factor model of helping emphasising the importance of attributions of responsibility for causing the problem and responsibility for solving the problem. They hypothesised the following four models of attributions might explain approaches to helping by those in healthcare settings:

1. Moral model: people are responsible for problems and solutions
2. Compensatory model: people are not responsible for problems but are responsible for solutions
3. Medical model: people are not responsible for problems or solutions
4. Enlightenment model: people are not responsible for solutions but are responsible for problems

The relevance of this attribution theory for the way that professionals might intervene with those who had self-poisoned was explored by Jack and Williams (1991) who reiterated the concept of the dilemma of helping. Jack and Williams (1991) discuss the strengths and weaknesses of professionals in health services assigning these attributions. For example, the authors hypothesised that if a professional adopted a medical model of understanding, the professional could be viewing people at risk of suicide as suffering from diagnosable mental distress which means they are attributing low responsibility to the person at risk for their problem and clinicians may also believe that the solution to this problem lies outside the person (i.e. in treatment for the illness). Jack and Williams (1991) hypothesise that this could limit the self-help behaviour of the client. On the other hand, if an attribution is made based on the moral model, which suggests that the individual are

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in trouble on account of their own doing and are responsible for enacting change a professional might view their role as secondary, and the support offered to the person might be limited. It may be that these attributions are being made by professionals at times when relationships with services break down. Jack and Williams (1991) hypothesise that if a professional employs a compensatory model, namely understanding that a client is not at fault for their distress, but has the resources to make changes, this might lead to support that fosters the client's self-helping resources. Finally, the enlightenment model, which suggests that the clinician can enlighten the client regarding their trouble is a risk for those working in services because it could promote an intervention whereby a professional seeks to 'bring the client around to their way of thinking', potentially alienating the client.

These models of attribution provide sound rationale for exploring the approach of professionals working with those at risk of suicide. Jack and Williams (1991) further emphasise the importance of being open about the position of the professional and for this to match that of the client.

Given the culture of increased individual responsibility for risk management (Whittington & Logan, 2011, pp.2), it is timely to explore the attributions that clinicians are making for the location of solutions to client's suicidality, in order to inform best practice in mental health settings when responding to suicidal crises.

1.5 Rationale and aims of the present study

Despite the wealth of clinical guidelines and assessment tools, there is a paucity of research exploring how community mental health professionals work with those at risk of suicide. Understanding how clinicians work in community mental health settings is essential for improving practice, and exploring whether current

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guidelines match up to the reality of the experience of the professional on the coalface.

The aim of this study is to develop a psychological theory of what informs decisions and practices in mental health settings when professionals are presented with a client at risk of suicide. This is particularly important with the current emphasis on individual responsibility located within the clinician (Power, 2004) and the implications this might have for their attribution of solutions to suicidal distress (Jack & Williams, 1991).

2. Method

2.1 Participants

Twelve community mental health staff were interviewed. The first interview was excluded from the main analysis because it was conducted with a team manager of an older adults service who did not have direct contact with clients presenting at risk of suicide. This interview was used as a pilot for the interview schedule. Data for the main study is based on interviews with eleven participants (referred to as Participants 2-12). The sample consisted of ten members of staff from a community mental health team. Consistent with the aims of a Grounded Theory, this research hoped to explain, interpret and guide the practice of those working in community mental health settings. Based on existing knowledge regarding the nature of community mental health teams, professionals from a range of professional backgrounds including social work, occupational therapy, psychology, psychiatry and nursing were recruited because all of these professionals were likely to be working with clients at risk of suicide. Recruiting a range of professionals therefore increased

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the ecological validity of the study because it increased the relevance of the research to the real-world setting.

Eleven participants were recruited in all. The aim was to recruit twelve participants because previous research had found that this was the optimum number for reaching theoretical saturation in Grounded Theory research (Guest, Bunce, & Johnson, 2006). Twelve participants were initially recruited but one interview was excluded as described above.

2.2 Demographics

An overview of participant's demographics has been given in order to protect the anonymity of those who took part in the study. The eleven participants comprised of 5 women and 6 men. Professional roles included: social work, community mental health nurses, psychologists, psychiatrists, and occupational therapists.

2.2.1 Care coordinator/ Responsible clinician: of the eleven participants, 8 participants were either care coordinators or responsible clinicians.

2.2.2 Permanent staff members: 8 members of staff were permanently employed in the team and three were either on temporary contracts or on training/placement.

2.2.3 Time worked in Community Mental Health: 1.5 years- 34 years.

2.3 Procedure

Eleven participants were recruited across three Community Mental Health Teams in one NHS trust. One participant was recruited for theoretical sampling by convenience sampling (a colleague of the researcher in training at a research institute, also a practicing NHS clinician). The rationale for recruiting another psychiatrist was to ensure that the hypotheses were relevant to this professional group.

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The manager of each CMHT was contacted by the researcher through email and an appointment was agreed to attend a team meeting. At these meetings, the researcher presented some information about the research, distributed information sheets (see Appendix 3) and answered questions that staff members had. A follow-up email was then distributed to team members by the team secretary; this also included the information sheet and team members could opt-in. All participants chose to be interviewed at their place of work. Interviews lasted between 30- 72 minutes (M = 50 mins)

2.4 Semi-structured interview:

A semi-structured interview aimed at exploring staff's experiences of work was developed and piloted with Participant 1.

The interviewer asked the participant to think of an example of someone they had worked with who was at risk of suicide and to describe what this work was like. This included follow-up questions which explored the participant's role, feelings, and questions aimed to elicit reflection on what frameworks of understanding the participant was drawing on and what had helped or challenged the participant in the work (including the role of training, supervision, risk assessment tools). A copy of the interview schedule is included in Appendix 4. Interviews were tape recorded, transcribed and anonymised.

2.5 Data analysis

The interviews and analysis were approached using a grounded theory methodology, based on a critical realist epistemology (Glaser & Strauss, 1967). The aim was to develop a theory of the social or psychological processes taking place, which was grounded in the data from the interviews (Tweed and Charmaz, 2012, cited in Harper and Thompson, 2012). The researcher assumed that what participants

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reported reflected their experience in a real sense, but that the results represented the researcher's interpretation of what the participant was saying and the participant's own interpretations of their experiences.

Three interviews were transcribed by the researcher and the remaining nine were transcribed by a professional transcriber who was made aware of the importance of keeping the data confidential and safe (see Appendix 5 for consent form). All data were analysed by the principle researcher. The process of data analysis is described by Hawker and Kerr (cited in Lyons & Coyle, 2007, pp. 88) and techniques described by Charmaz (1995) and Strauss and Corbin (1998). The first four interviews were line- by- line coded. Following this, axial coding was used to make links between the codes and generate hypotheses. Following these initial analyses, both temporary and permanent team members were theoretically sampled and those with and without care coordinating responsibility to test out emerging hypotheses. Higher order categories, categories and subcategories were based on participant quotes to ensure the theory was grounded in the data.

2.6 Quality assurance

Prior to the first interview, a bracketing interview was undertaken (see Appendix 8). This identified key potential biases and experiences held by the researcher which were regularly reflected on during data analysis, memo writing and through a reflective diary, in order to enhance the process of reflexivity and theory development (Mays & Pope, 2000).

Coding of transcript 2 was shared with a colleague and her interpretations were discussed. Differences were discussed until a consensus and further interpretation was reached. Excerpts and coding from all subsequent interviews and emerging theories were shared during four meetings with research supervisors and

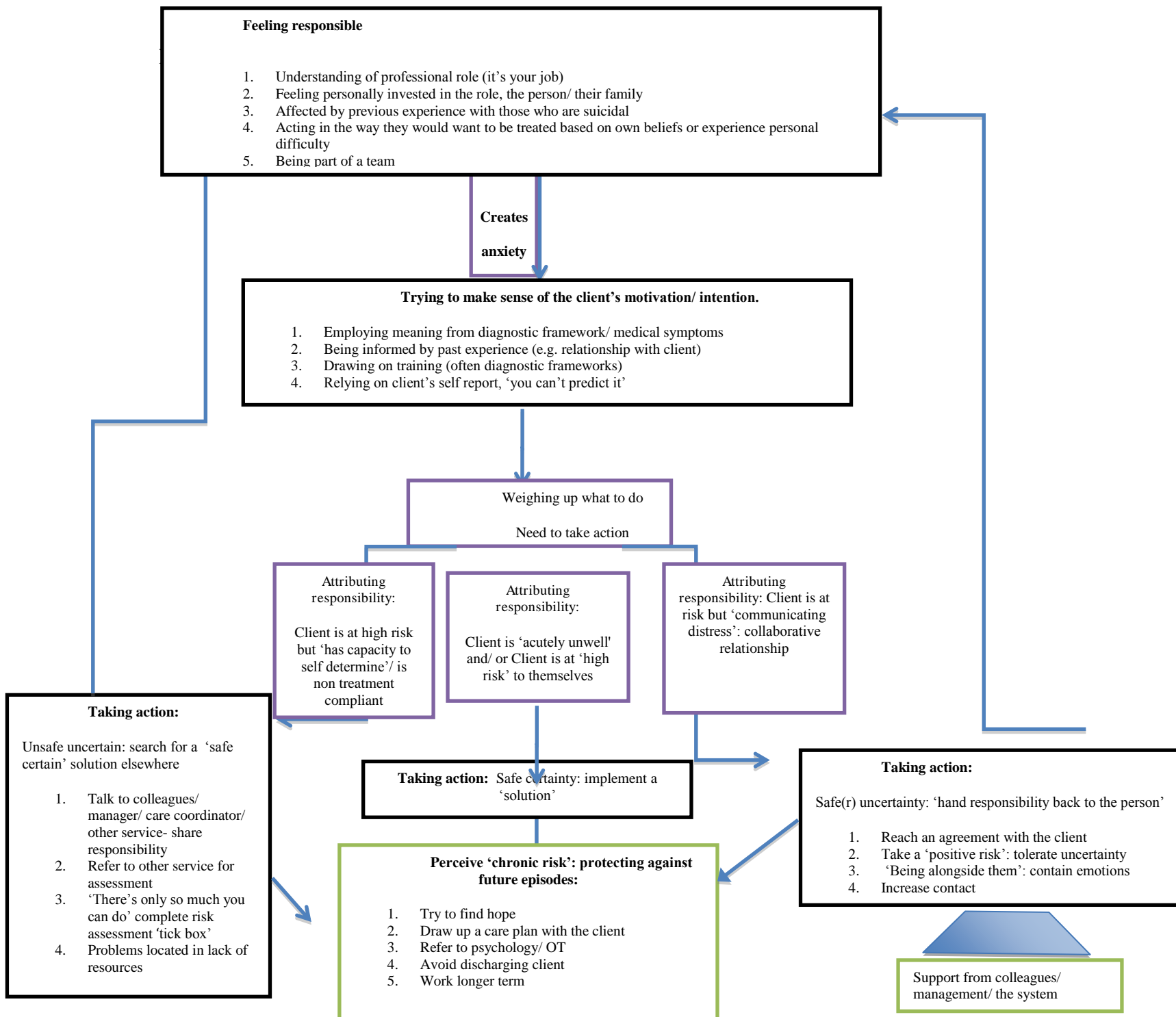
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workshops with other researchers throughout the data analysis process to ensure data quality. The researcher used reflective spaces such as the research diary, supervisory meetings and peer support and therapy to reflect on issues arising from interviews, to limit researcher bias.

The hypothesized model was shared with Participant 4 and the internal supervisor to obtain respondent validation (Mays & Pope, 2000). The participant felt the research accurately reflected their experience and requested one point be further emphasized. This amendment was made.

2.7 Ethical considerations

Ethical approval for the study was granted by the Canterbury Christ Church University Research Ethics Board (see Appendix 12). Research and Development approval was granted by the Trust involved (see Appendix 13). The study followed the code of conduct specified by the BPS (2010) and HPC (2009). Informed consent was obtained from all participants (see Appendix 5 for consent form) and due to the content of the interviews, time for debrief without the tape recorder was included with each participant. Participants were made aware that data included in the research would be anonymised and stored on a protected USB disk drive.



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3. Results

3.1 Overview of results.

Figure 1 illustrates the hypothesised process for the professionals interviewed. It shows how participants moved from their feelings, thoughts to action. There were three higher order categories identified through the interviews. These were: 'Feeling responsible', 'trying to make sense of the client's motivation/ intentions' and 'taking action'. The diagram illustrates how these higher order categories are linked together. It shows how the professionals interviewed all described a sense of feeling responsible for the people they worked with. This sense of responsibility created anxiety within the professionals and generated a desire to understand the clients' expressions of suicidality. Making sense of what the client was saying was the point at which professionals drew on a number of meaning-making frameworks such as their past experience, training and medical models and clinicians reported reaching an impasse at this point because they often felt that there was a difference between the client's self report and their intention. At this point, professionals interviewed would feel under pressure to take action or not depending on the attributions they made about the client's intentions and how they attributed responsibility for the distress. Professionals reported feeling their duty could be to implement a 'solution', such as admitting the person into inpatient care, they sometimes felt more able to reach a joint decision with the person about what to do (increased when they felt supported by colleagues and the system) and sometimes, often when their relationship with the individual was challenging, felt that they reached an impasse and would feel unsure and seek a certain solution elsewhere in healthcare system. Overall, the diagram seeks to illustrate the profound sense of responsibility to the client that influenced the way a professional felt and described their experience of this work.

3.2 Higher order category 1: Feeling responsible

3.2.1 Subcategory 1: Understanding of professional role: it's your job.

All of the professionals expressed a feeling of responsibility and duty to their clients. This was not necessarily in relation to preventing suicide.

I do not feel that it is my role to stop her killing herself (Participant 3)

Although several participants did describe their professional role in relation to either the responsibility of a care co-ordinator,

As care co-ordinator I don't want a dead person. (Participant 12)

or what they interpreted as their duty in relation to their professional position.

Several professionals were clear that they thought that predicting suicide was impossible and described their sense of responsibility in relation to working with the client through their perception of their professional training

I think that my job is to be able to recognise the psychiatric factors that are predictors of suicide and to try and modify those factors. Or identify the social factors and refer appropriately to services that can modify those factors (Participant 10).

Professional role also seemed to be related to feeling personally invested in the care of the client as well as this being a separate subcategory.

'I have agreed to look after them because I am a PROFESSIONAL ROLE'
(Participant 11).

This quote reflects the participant's investment in caring for the client through their understanding of the meaning of their professional role. Participants communicated a sense of responsibility which formed part of their professional identity.

3.2.2 Subcategory 2: Feeling personally invested in the role/ client/ their family

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Some participants conveyed their sense of responsibility to the client that they were working with.

It feels like a responsibility, but you know it is somebody's life (Participant 2)

This conveys the gravity of responsibility experienced by participants; they described their sense that they were directly responsible for the clients' life and that their actions could directly impact on the clients' actions.

All participants communicated investment in their role, and the people they work with by referring regularly to people as 'their clients'. This seemed to be particularly common when the professional was the care coordinator for the client.

I have other clients (Participant 4).

There was a link between the personal responsibility in the role, and self-criticism or feeling extremely affected by the death of a client for some participants.

And I think that you are - I have had two patients who have committed suicide, right and I was the last person to see them and it is heart breaking- and it is a really upsetting thing to happen- and you look back at your practice- and you look back at what you have *done and what you have not done, um, and I think that the questioning in the CLINICIAN'S* minds is- was I negligent? – did I ask all the right questions – did I not manage this risk adequately. Um I think – you know – broadly speaking that when I look at these cases – I had done what I was supposed to do – but you are still left feeling that – that sense of failure I suppose (Participant 10)

Underpinning their personal responsibility seemed to be the emotional investment that the participants felt in their work with clients and their families. Therefore, if a client committed suicide, professionals would feel both affected and responsible.

I just feel that professionals when things like that happen we want to make sure that we are *very strong and we are but we are human* if anybody dies in anybody's

family of course you emotionally feel it and if anything happens to your patient – these are people that you have worked with for so long and they just get switch off like that – you will *feel it.... not only for yourself but for their families which you have come across. It is an end to a relationship* (Participant 11).

Think of the consequences of the grief this is going to give to the family if he kills himself (Participant 12).

It seemed, therefore, that the professional felt responsible for protecting both themselves, and the family of the client from the pain of the loss.

3.2.3 Subcategory 3: Affected by previous experience with those who are suicidal

Chronic risk:

Some participants described having been affected by scrutiny resulting from previous clients' suicide, and how this subsequently impacted on this influenced the way they approached their work.

And – you know – a lot of people have complaints from the family which they need to deal with and – you know complaints from their seniors and all these kinds of things which are very – which you have to think – you know - people are mindful of and that will without *doubt can have implications on your practice'* (Participant 10).

Several professionals described their on-going relationships with clients who they felt were likely to attempt suicide again and recognised that although they felt responsible for the wellbeing of these clients, they had to live with this.

He can't be in hospital forever. He has in the past...He has attempted to take his life – but he has not done such thing for a while. He is not happy with life – he is not happy with the world – he is not happy with himself he is a very very sad man. Yeah but he is very honest and tells me – but sometimes we have to live with it – I find it is very difficult - I'm just

empathising with other colleagues. who have a similar case, we don't know how to move on – (Participant 9). Alongside an enormous sense of duty was a feeling of helplessness, for not being able to provide a ‘solution’.

3.2.4 Subcategory 4: Acting in the way they would want to be treated

based on own beliefs or experience of personal difficulty: 'Everybody is a patient somewhere' (Participant 11)

Personal beliefs about the meaning of being a client influenced the way they described their responsibility towards the client. For example, one participant commented that she felt

Everybody is a patient somewhere (Participant 11).

This seemed to be linked with a sense described by another participant regarding the vulnerability and dependency of a client on a professional. This participant described the influence of his personal experience of this vulnerability on his practice:

I had a sobering experience some years ago when I was involved in a near death experience – a terrible accident – and it put me in a situation of victim and in the context of client because I had to receive physical treatment as well as therapy treatment for trauma. The benefit is that it has made me reflect differently on my contact work. Um, absolutely Because it has taken me back to point zero and this is what it is like to be a client. Ok I have seen lots of clients and I have got very practised in seeing them, but I had forgotten about the vulnerability of being a client, the sense of despair and desperation (Participant 6).

Personal beliefs about morality and a client’s agency sometimes seemed to go against how a professional felt that they had the responsibility to act. Three participants described this, feeling that there were some cases where contemplating suicide was understandable given the individual’s life circumstances and this was not always a pathological act.

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We definitely should be trying our hardest to try and stop people committing suicide whilst they are of unsound mind you know whether through depression or psychosis whatever. It is always a tragedy if someone.....but does someone have the right to commit suicide if they want to if they have weighed it *all up, I don't know. I don't believe that it is immoral* (Participant 4).

There was a sense that acknowledging these complex personal feelings about suicidality was somehow not within keeping with a context which demanded the person to view it as 'preventable' and where the professional was mandated to prevent suicide at all costs. It seemed that there may rarely be a place for such reflections.

3.2.5 Subcategory 5: Being part of a team: 'risk was shared with the team'

Several participants described processes where the feeling of responsibility was 'shared' or 'understood' by a team.

You could sense with this person that the risk was very much shared within the Team because of what had happened in the past and I was a trainee at the time. (Participant 3).

This provided some relief from the professional feeling solely responsible for the client.

This category also described a process whereby responsibility could be located within other professionals, (e.g. the care coordinator) which allowed the professional describing the process to be responsible for other tasks, which they perceived to be more their role, such as supporting the person to engage with social activities.

They might already be known and done by to the care co-ordinator prior to PROFESSIONAL ROLE. (Participant 5).

However, this sense that some professionals did not get involved with risk assessment was not evident from the descriptions of other participants with the same job title. This

suggests that the perception of responsibility could be associated with a broader team dynamic. It was hypothesised that this difference could partly be related to the length of time in the team and the level of permanency in the team because this participant was working under a temporary contract, but this was not able to be fully explored in the current study.

3.3 Higher order category 2: Trying to make sense of client's motivation/intentions

All participants described trying to make sense of a client's motivation/ intention. Participants drew a distinction between clients who they felt were expressing suicidal ideation, and times when they felt that the client was seriously at risk of suicide. Many participants described instances with clients whom they had an existing relationship with who they felt sometimes were expressing genuine feelings of suicide, and sometimes, their expressions of suicidal feelings were motivated by other factors,

'it is tricky to work out what is actually going on' (Participant 3)

Clinicians would sometimes feel that it led to them feeling quite stuck and at a loss because of the responsibility they felt to act if someone reported feeling suicidal and again the sense of 'not knowing'. This was communicated through their difficulty in understanding the clients' communication.

3.3.1 Subcategory 1. Employing meaning from diagnostic framework/medical symptoms

The most common framework of understanding employed by participants when trying to make sense of the clients' motivations was that there were two distinct groups of clients: those who presented with an episodic risk, who were often described as suffering from '*depression*' or a '*mood dip*' (Participant 9) and those who, whilst expressing suicidal feelings, it was understood by professionals that these clients did not have suicidal intent.

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People with functional mental health problems are at great risk of suicide at times as well but it is a different way of assessing it with a functional mental health problem because um, for one thing there are chemicals going on there that are, well pharmacological and there is something there which needs to be sorted out but obviously it is much wider than that there is often a trigger so then you assess them in quite a different way. Say somebody with personality disorder who IS at a high risk of suicide you know if you think that they are at risk of actually dying. So that is a tricky one because sometimes there is a feeling that they *are not and that they are saying it because they don't want to be discharged from the service.*

It seemed that understanding the motivation or intent of the client was triggered particularly with clients who had a diagnosis of personality disorder. Several professionals described their understanding that for these clients, the meaning of expressing suicidal feelings was to get other needs met. It was interesting that those perceived as presenting with a more 'one off' suicide risk seemed to be understood in more medical terms, and those with more 'chronic' presenting to services, in more psychosocial terms.

3.3.2 Subcategory 2: Being informed by past experience (e.g. relationship with client)

In terms of what participants found most helpful in understanding a client's motivation, *'knowing the person very well'* (Participant 4) was thought to be helpful.

Professionals interviewed thought it was important for the relationship with the client to be collaborative, and several participants spoke of relying on the client to 'be honest' about how they were feeling.

Part of my role as a Care Co-Ordinator is to work with you, that means that we will *work in partnership.... I know that I need to have open communication, I need to see him, I need to be able to talk to him, and for him to be intelligent and to talk to me* (Participant 6).

3.3.3 Subcategory 3: Drawing on training

No professionals interviewed talked about having received specialist training for working with those at risk of suicide, although one participant had enrolled on such a training course. Two professionals interviewed described drawing on training in working with people with a diagnosis of personality disorder in order to help them ‘understand the communication’. These participants had found this very helpful, commenting:

I think it would transform society as it has far reaching consequences if every Trust had a good personality disorder service and just good training generally across the board of Mental Health professionals on personality disorder (Participant 2).

Two participants also felt that ‘*training on theories and causes is really important*’ (Participant 3) and this was related to understanding demographic variables that are correlated with completed suicide, but these were felt to be different from the clinical experience of working with the person which was much more about trying to make sense of what the client needed at that time.

3.3.4 Subcategory 4: Relying on client’s self-report: you can’t predict...

The challenge there is that you can only work with the information that the client gives you.... and if you have no other collateral sources you really are dependent on their self-report (Participant 6). All professionals described the unreliability of a client’s self-report and the impossibility of predicting whether or not they would commit suicide

but to know actually if they are going to do it is really, really difficult it is impossible (Participant 12).

This seemed fundamentally linked to the sense of impasse, or stuck-ness that clinicians described, as though despite collecting information, there was a pressure to from then be able to predict and therefore prevent suicide.

3.4 Higher order category 3: weighing up what to do/ need to take action

Professionals described a number of actions they would take, depending on the attributions they made about the client's intention, capacity and level of responsibility for their distress which is encapsulated by this higher order category. Following an initial mapping of the routes that professionals took, it was observed that these corresponded with categories proposed by Mason (1993) in his paper proposing that therapeutic practice can usefully work with uncertainty. The higher order category will be discussed alongside the applicability of this theoretical model.

3.4.1 Subcategory 1: Safe certainty: implement a 'solution'. Participants described times when they felt certain that the client was at risk of completing suicide. These were times when, *'whether you want to or not... we would say we are going to bring you into hospital'* (Participant 10) because *'you just think that they are a high risk to themselves'* (Participant 10). These were times, described by professionals that they felt confident either that the client was *'unwell'* and therefore *'everything is out of perspective'* and *'they don't have capacity'* (Participant 11) or the person was at high risk to themselves.

Some professionals described this as their role.

As a Health professional you would be saying, well, you wouldn't be saying anything as it would be your responsibility you would be right in there trying to sort it out (Participant 2).

Professionals described situations where they could see a client was *'acutely unwell'* (Participant 2) and felt confident that the client would want them to take charge and to make a decision in their best interest which primarily meant a hospital admission. This reflects one route described by professionals whereby there was a clear crisis which warranted a 'safe certain' intervention.

3.4.2 Subcategory 2: Unsafe uncertain: search for a ‘safe certain’ solution

elsewhere. Professionals described the struggle of ‘not being able to predict’ someone completing suicide. As illustrated earlier, this ‘not knowing’ created understandable anxiety for professionals who felt responsible and invested in ‘doing what we can’. There were times described by professionals when they felt far less certain because clients might be refusing the help offered, which perhaps might have otherwise relieved some of the professional’s anxiety about the client’s risk level. In these moments, having tried to make sense of the meaning or intention of the client, a professional might seek a ‘safe certain’ solution from elsewhere, particularly when they felt that they did not have an existing relationship with the person.

3.4.2.1 Talk to colleagues/ manager/ care coordinator/ other service- share the responsibility. *‘it is quite big, to be taking that responsibility... and you have to share it don’t you’.* Several participants described feeling that other, more senior members of staff could be helpful in offering counsel, that they may have a better understanding of ‘what to do’ and that ultimately, they would be responsible for a decision. This seemed to provide some relief for participants,

but also I think coming and sometimes sharing it with their care co-ordinator and other people it is important. If you thought that someone was going to. Yeah Well I mean you could always stay with the person and call the office and talk to somebody, talk to the care co-ordinator or you can call if it comes to it you can call...(Participant 5).

3.4.2.2 Refer to other service for assessment

Another solution to relieve the sense of unsafe uncertainty was to refer a client to another health service.

'Or of course if we take them to our inpatient unit then they will be assessed by the Psychiatric Liaison Team so again it takes some of the pressure of you and it is a Team decision as to whether to admit or not.' (Participant 4).

3.4.2.3 'There's only so much you can do' Linked to the sense of seeking help from colleagues or other professionals was the need for confirmation that sometimes, there was only so much a professional could do

They won't accept help and he may say, "well they may well commit suicide then" and you have to accept that is what might happen, which I suppose is liberating for a Manager to say that. I imagine that they would only say that if they were sure that we were competent that we were doing all that we could do and all that we should do and that we have tried everything and that everything had been offered but in the end you can't force people to accept help not unless they are so vulnerable that they are sectionable. (Participant 2).

This quote communicates the professional's feeling that the manager may possess some knowledge that they, as a professional didn't have. The quote communicates the need to ensure that 'everything had been offered' and that they were 'competent' and that they had done all that they can. It again illustrates a belief that there were a set of clients who, professionals felt a clear need to intervene through hospitalisation. This seemed to be linked to psychiatric diagnosis.

3.4.2.3 complete risk assessment 'tick box'. *'From a bureaucratic point of view, you feel a lot more covered'*. Doing all you can was linked to the need for 'defensible practice'. It seemed that one way of coping with the uncertainty was to ensure that documentation communicated practice that was 'defensible' (Participant 6)

So communication in terms of the written word and how you present it and for me I present things in a very structured, explicit way.....So that when you name it, it becomes real and makes you think about it and you are protected then. (Participant 6).

Almost all other participants talked about using clinical records systems or the risk assessment tools that were included on these systems in order to ensure that they felt they had ‘done what they could’ or as useful for ‘covering their back’. This seemed to be one of a range of ways that professionals coped with the uncertainty generated by not being able to predict the outcome of an intervention.

3.4.2.4 Problems located in lack of resources. Three participants described a service that had been cut that they had found particularly useful.

There used to be a respite house where people could go and stay if they were wanting *to get away and feel safe but didn't quite need admission. That was useful but again this got cut to save money.* (Participant 4).

There was a sense that both clients and professionals found safety in provision of a containing service, like a respite house or an admission.

Several participants described increasing caseloads and a lack of inpatient beds increasing the demand on secondary care mental health services. Several participants described a dissatisfaction with ‘*crisis admission(s)*’ (Participant 3)

I do find it quite frustrating that you know the reason still is not much of a choice for people in terms of us managing that risk (Participant 2). Inpatient beds were felt by some participants to be ‘*the main resource that we have got*’ (Participant 2). There seemed to have been an increase in lack of safety due to fewer respite resources. Respite admissions seemed to have offered a place or containment that was useful for both staff and clients.

3.5 Subcategory 3: Safe(r) uncertainty: hand responsibility back to the person.

During interviews it seemed that professionals oscillated in their practice between feeling driven ‘to do’ and being able to take what they described as ‘positive risks’.

Professionals had a clear sense that for some clients, hospitalisation would be detrimental,

partly because they felt that the client expressing suicidal feelings had a different function to them wishing to die.

He mostly will tell you that he has taken an overdose of sleeping tablets or some tablets and then you ask can we take him to hospital because with that number of tablets in his system or liver is under attack, but we say no as nothing will happen. So we really do not understand what is going on, so is this a call for attention or is there a desire for somebody *to talk to somebody or....* (Participant 8)

Also because they felt that an admission would make things worse for that person,

And he said actually the hospital cannot help you - you have been here eighty/ninety times has it helped? (Participant 9).

Some ways of negotiating this impasse thought to be helpful by clinicians, as well as being goals to aspire to were:

3.5.1 Reach an agreement with the client. One way of negotiating the responsibility was to reach an agreement with a client through a ‘collaborative’ relationship.

We will come to a plan together about how to manage the things that she is saying and you know that you can document that but that you have all come up with that plan and it feels like the best outcome for the patient whilst also giving her the responsibility, she has the responsibility ultimately (Participant 2).

The term ‘safer uncertainty’ has been used to describe this position because there is still a sense from what professionals were saying that part of the ability to take these positive risks was dependant on the client collaborating with the professional, in order to navigate the dilemma of protection vs. working with the person.

3.5.2 Taking a ‘positive risk’: tolerating uncertainty. Several participants described how they felt that the support they received from the team they were in allowed them space for them to ‘*think about it*’ (Participant 9).

'The key in all of it is to feel supported' (Participant 2). There seemed to be a parallel process where the professionals felt supported by colleagues and management and were then able to tolerate more uncertainty with their client.

There is some element of positive risk taking. There is some but I am not sure that the Trust would always back you up (Participant 7).

Five participants described positive risk taking as a form of not taking responsibility away from the client,

she got really cross with me and I said that I am leaving this with you, a kind of positive risk management in a way – I am leaving it with you to decide weekly or monthly – I am not going through the whole scenario again regarding the pot of medicine (Participant 5).

It seemed that some professionals felt that this meant tolerating difficult feelings, both from within, from the client and from colleagues who perhaps disagreed with their thinking

the hierarchy in the system is that the doctor should have offered to go with me – but that's not true- *that's not my recollection, so for me I feel confident that she is rather* delaying the discharge and getting in to - but it is interesting – with colleagues as well (Participant 7).

There was a clear sense that the participants interviewed had their client's best interests at heart but acknowledged that decisions that were carried out could depend on other clinicians' capacity to tolerate the uncertainty.

3.5.3 Being alongside them: containing client's emotions. All participants described the importance of their relationship with their clients. Inherent in many of these parts of the interview was a sense that the professional was *'engaging on an emotional level'* (Participant 3).

Clients often seemed to provoke very strong feelings in professionals and being alongside the client did not always seem possible. Engaging with the feelings and being alongside a

client was a category that emerged which seemed to facilitate a sense of the responses to the client remaining less 'certain' and professionals feeling perhaps more rewarded by successes in the work as the client took up the responsibility.

'To have people who are sometimes angry and upset, distressed in the way that they are and you have to be able to contain them, what I mean by contain them is to acknowledge the pain that they have but offer some sense of hope. You are not going to walk this journey *on your own*' (Participant 6).

3.5.4 Increase contact. Another way in which it seemed possible for professionals to feel safer with the uncertainty was to increase contact with the client.

And part of the action that I normally use is my frequent contact' (Participant 11).

It is about I will see you today, I will see you tomorrow fine. I will see you in two days *time. I will see you in three days time and so you build up their exposure'* (Participant 6).

It seemed that this served both to support the client through a difficult period, through the support of the relationship with the professional and to provide some sense of safety for the professional.

Some of them would come to me all of the time you see and for the slightest thing although worrying it is in some ways, safer (Participant 4).

Some professionals talked about the feeling that they should be monitoring clients every day, but acknowledging that this wouldn't necessarily make a difference.

There are times when you can't you can't see them every day— we do not have the facilities – the luxury of being able to assess them every day. (Interviewer: If we could assess them everyday do you think that would make a difference?) No- these are the challenges (Participant 9).

It seemed that increasing contact in the community was one way of professionals being able to 'hand the responsibility back' in order to alleviate some of their responsible feelings

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which they felt was ultimately doing the best by the client. This was also felt to be a way of managing the anxiety which seemed to underpin the pressure to 'take action'.

Do you give in and how long to you give? I am talking about anxiety (Participant 9).

4. Discussion

The analysis above described community mental health team members' experiences of working with clients at risk of suicide and the challenges of making an assessment of risk and taking appropriate action. The hypothesised model shows that professional's perceived responsibility for preventing suicide lead to feelings of anxiety and uncertainty. The data analysis found that motivated by their felt responsibility and uncertainty, professionals sought to make sense of the meaning of the behaviour. In order to do this, professionals made attributions about responsibility for both the cause of the distress and the solution to the distress. The findings suggested that clinician's anxiety and perceived responsibility when encountering suicide risk limited the options of interventions available to them, leading to most interventions being perceived as located within their, or another service.

The aim of this study was to develop a psychological model of how mental health professionals recognise and respond to suicide risk. The study has provided empirical support for and developed existing psychodynamic and attribution theories which will now be explored. It is hoped that this will expand thinking in the field which to date has been primarily focussed on predicting and preventing suicide, rather than an in depth exploration of clinical practice.

The findings of this study will now be discussed in the context of theoretical literature, outlining their relevance for clinical practice and implications for future research.

4.1 Psychodynamic theory:

This study provided empirical evidence for psychodynamic theories such as that proposed by Menzies Lyth (1959), Mason (1993) and Foster (1999). Clinicians felt anxious about their responsibility for protecting the clients. They tried to make sense of the client's motivation but could often feel stuck because they had to rely on self-report and therefore could not predict the outcome. This created an enormous sense of uncertainty. In line with

psychodynamic theories, participants negotiated these difficult feelings through a number of actions. Foster (1999) hypothesised that there could be a tendency in community settings to use three defences against this anxiety, namely: marginalisation (of client or professional), institutionalisation (splitting off the distress from the community) or rationalisation (in this instance, explaining distress through medical language). Based on this research, there is evidence that these defences could be acted out when the anxiety created by risk of suicide enters into a community mental health team system.

4.2 Attribution theory:

The uncertainty and inability to predict suicide lead clinicians to make attributions about responsibility for both cause and possible solutions to the problem. This supports the four-factor attribution model outlined by Jack and Williams's (1991). The data suggested that all professionals viewed most clients as not responsible for their distress, most often commenting that the client 'couldn't help it' or recognising contextual factors that triggered a client's distress (e.g. a breakdown in a relationship).

4.2.1 Medical model.

The majority of professionals employed the medical model (Jack and Williams, 1991), feeling that clients had low responsibility for the both the cause and the resolution to their problem. This was most likely when the explanation for the distress was that of a 'functional mental health problem' and clients were felt to be in 'crisis'. Professionals described feeling quite certain about their response often describing feeling that sectioning the person was a clear decision. Some clinicians recognised that the client was not responsible for their problems but were limited in the range of interventions they employed, citing referrals to other members of the team, for example, to psychology to support the person with managing their emotions.

4.2.2 Compensatory model.

Professionals were most likely to employ a compensatory model, attributing low responsibility to client for their distress but high responsibility for the solution when the clinician and client had a good relationship and the professional felt supported by colleagues in tolerating some of the uncertainty. Professionals described ‘handing the responsibility back’ to the person and collaborative care planning. This was the case with a number of clients that professionals had worked with long-term.

4.2.3 Enlightenment model.

Professionals were unlikely to employ an enlightenment model, perceiving high responsibility to client for the cause of their problems but not the solution. There were some instances where professionals described work with some people who abused substances, who were ‘not motivated to change’ and had not responded to interventions offered by the professional. This seemed most likely when clinicians felt alone in their work and therefore more responsible for providing a solution.

4.3.4 Moral model.

The data in this study found that no clinicians attributed both the cause and solution to the client’s problems within the client. Professional’s attitudes towards their clients reflected their desire to be of use to them and barriers to supporting clients were often attributed to difficulties in the system (e.g. lack of resources) or with negotiating relationships with other professionals (e.g. inpatient care).

4.3.5 Feeling supported Participants described the most important factor for being able to tolerate some of this uncertainty was support from colleagues or from a manager. There were times when it seemed that this support was partly about legitimising the difficulty of the work, legitimising the struggle of ‘not knowing’ and also a sense that those in authority might somehow ‘know what they were doing’. This finding provides support for the notion of ‘organisational safety’ proposed by Power (2004).

4.4 Clinical implications

4.4.1 Best practice guidelines:

Best practice guidelines make 16 specific recommendations, many of which relate directly to client- practitioner interaction which will now be considered in light of the findings of this research. Suicide has been conceptualised in these guidelines as something that can and should be prevented, stating that ‘risk management involves developing flexible strategies aimed at preventing any negative event from occurring or...minimising harm’. The guidelines recommend a ‘structured risk assessment’ approach, using ‘suitable tools’ and ‘a summary of all risk identified, formulations of the situations in which the risks may occur and actions to be taken by practitioners and the service user in response to crisis’.

The guidelines also recommend that risk management be collaborative and be based on an organisational approach. This study has found that the picture is more complex than that conceptualised by these guidelines. It has found evidence of psychological factors that are not taken into account within these recommendations. For example, there is evidence to suggest that the responsibility that clinician’s feel, which is perhaps partly generated by such guidelines, can hinder their capacity to support the client to generate solutions to their distress. In other words, this research has found that clinicians feel under pressure to provide a solution to the client, which could perhaps reinforce a client’s dependency on services, rather than supporting ‘recovery’ as recommended by the guidelines (Bell, 2010 cited in Briggs, Lemma & Crouch, 2010). This finding provides support for both Mason (1993) and Jack and Williams’s (1991) hypotheses that if both client and professional attribute responsibility for the solution to the professional, this can lead to low self- help behaviour.

The guidelines highlight the importance of an organisational approach to responding to suicide risk which was strongly supported by this research. Participants described the

importance of feeling supported by their colleagues and managers, as well as the damaging impact of feeling that they could be scapegoated by colleagues in other services.

Recommendations for practice:

Based on the findings from this research, several recommendations for clinical practice will be summarised below:

1. Responsibility for the solution to the distress should be located between the person in distress, the organisation and the professional, and not solely within one location. This study has found that the responsibility that clinicians feel for protecting clients can cause them to hold responsibility for finding possible solutions.

2. Professionals of all disciplines benefit from supervision and support in order to be able to tolerate the anxiety and uncertainty caused by this work. This study found that medical model attributions were more likely to employ an enlightenment model when they were unsupported in thinking through the meaning of the client's behaviour.

3. Organisational structures should acknowledge the reality of the dilemma of uncertainty for the clinicians working with clients. This study found that some participants had felt that structures at times encouraged them to practice defensively, rather than taking positive risks in responding to clients due to their sense that they may not have the support of the organisation.

4. Finally, it may be useful for professionals to work more jointly, rather than employing a traditional one to one consultation. Foster (1999) recommends inviting a third party to consult when working with clients at risk in order to prevent the marginalisation of the client or professional as the anxiety provoking problem becomes located within either party. This research has supported the findings of previous psychodynamic theories, namely

that professional anxiety can inhibit thinking (Mason, 1993) and encourage defensive practices (Menzies Lyth, 1959). In practice, services could perhaps invite a colleague or member of the client's network into consultations. This may increase the opportunity for alternative solutions located outside of the service to be possible.

4.5 Implications for research

The emergent theory has suggested an important role of mental health practitioner's attributions in their approaches to responding to suicide risk. This has implications for best practice guidance, as it may be that current training in static and dynamic risk factors does not equip a clinician for the clinical task of risk management. This emergent theory could usefully be developed into a quantitative study in order to explore the generalizability of the findings more broadly across community mental health services to inform future guidance and training.

4.6 Methodological critique:

As a mental health professional, throughout the interviews, the researcher was aware of being drawn towards ideas expressed by participants and surprised by things that other participants said. As the main tool for the theory development, Harper and Thompson (2011) note, the researcher is not expected to be a tabula rasa and having knowledge of the issues at hand can mean a more in depth exploration of the nuances of the experience for the participant, however, it can also influence the interaction between the participant and the researcher and the researcher's interpretation of the findings. The process of undertaking the interviews and developing the emergent theory facilitated a much broader and deeper understanding of the organisational, social, interpersonal and unconscious processes that had not yet been considered by the researcher. The research was conducted predominantly within one NHS Trust with the exception of one participant. This may have had implications for the

results in terms of this Trust having specific approaches to risk management, supervision and resources available. The aim of a grounded theory is to theoretically sample so that the model is tested for its applicability to a wide range of relevant groups. Theoretical saturation was therefore not reached because it is not clear whether the model would be applicable to other community mental health teams. However, preliminary findings from the participant working within and training in a different Trust suggest similar findings although this would need to be explored further.

4.7 Conclusion:

This study has built on existing research in the field of suicide research by considering how professionals respond to suicide risk. It has provided an insight into the experience of professionals practicing in community mental health teams and proposed a new psychological model of how the clinician's felt responsibility can influence the attributions they make. This has been discussed in the context of best practice recommendations. Authors, such as (Gask et al., 2006), have recommended that there is a need to understand why skills in recognising epidemiological risk factors does not necessarily make a difference to preventing suicide.

This study provides a new insight, suggesting that practitioners make attributions about risk based on their assessment of diagnosable mental health problem (cause of the problem), their assessment of the meaning of the behaviour (or the client's intention) as well as their relationship with the client. These factors, as well as practical factors impact the attribution that professionals make about potential appropriate interventions. In terms of recommendations for clinical practice, this study has highlighted the importance of organisational safety (Seager 2010, cited in Briggs, Lemma & Crouch, 2010) for professionals to be able to encourage positive risk taking. It is hypothesised that increasing practices such as joint working, supervision for all staff and a culture of support and

reflective practice would increase the possibilities for acknowledging the impasse or stuckness that can occur.

It is hoped that implementing these recommendations could increase opportunities for responsibility to be shared between the client, service and clinician, rather than becoming located within client or clinician who can experience actual or feared marginalisation.

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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

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MAJOR RESEARCH PROJECT

SARAH CROWLEY Bsc Hons

Section C

Appendices

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church
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Appendix 1: Summary of studies reviewed

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
1	Aflague and Ferszt (2010) USA	Suicide assessment by psychiatric nurses: a phenomenographic study	To develop an understanding of how nurses conceptualise suicide and the strategies they use in the assessment process.	Qualitative study Interviewed 6 psychiatric nurses Analysed using Phenomographic interpretation	None of the nurses used suicide assessment guidelines or suicide assessment instruments. Most of the nurses linked suicide with depression. Nurses regularly used assessments conducted by colleagues to make a decision. Staff often referred to previous clients that they had worked with, used 'intuition' or a gut feeling, and listened out for risk factors like access to means, plans, and associated states e.g. substance misuse although these factors were not routinely asked about.
2	Appleby (2006) UK	Avoidable deaths: Five Year Report by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006	To summarise the results from a national clinical survey into suicide and homicide of those in contact with mental health services 1997-2004	Large scale survey 1271 outpatient suicides and 856 inpatient suicides Questionnaires sent to psychiatrist.	Demographic and characteristics of the suicide had not changed since the previous enquiry (Appleby et al, 1999). Patients were rated as 'low risk' at their last contact with services, highlighting the 'low risk' paradox. 18% of the suicides were identified as 'preventable' due to service failure citing need for better monitoring and better treatment compliance of the client. Breakdown of relationships with care teams was often cited as a factor that precipitated suicide for those in the community. The week after discharge was a period of particular high risk for suicide.
3	Baca-Garcia et al (2006) Spain	Using data mining to explore complex clinical decisions: a study of hospitalization after a suicide attempt	To reanalyze a study to find out which factors predicted psychiatrists' decision to hospitalise 509 suicide attempters in an emergency department	Data mining based on structured assessment. 509 suicide attempters, 196 who were hospitalised in a psychiatric unit and 313 (61%) who were discharged.	The main variables associated with the clinician's decision to hospitalise a patient after a suicide attempt are related to drug or alcohol consumption during the attempt, lack of family support and attitude toward the attempt (criticism and intention to repeat)

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
4	Buckingham, Adams and Mace (2008) UK	Cues and knowledge structures used by mental- health professionals when making risk assessments	To identify cues used by clinicians to make risk judgements and to explore how these combine with clinician's psychological representations of suicide, self-harm, self-neglect and harm to others.	Qualitative evaluation. 46 mental health professionals 21 nurses, 14 psychiatrists, 3 social workers, 3 GPs and 5 psychologists Content analysis was applied to semi-structured interviews and mind maps were used to represent the hierarchical relationships of data and concepts.	The results of the content analysis indicated that past client episodes of suicide was made widely cited by participants. Following this, other historic factors such as: family history of suicide and exposure to suicidal episodes in others were listed. Some professionals felt that self- harm behaviour was indicative of suicide while some felt that it was not. The two most common presenting factors reported were: current ideation to commit suicide and suicidal ideation
5	Burgess, Pirkis, Morton, Croke (2000) Australia	Lessons from a comprehensive clinical audit of users of psychiatric services who committed suicide	To review characteristics of patient and treatment to assess whether a suicide could have been prevented by a service	Retrospective audit of service responses. 629 clients in contact with mental health services in the last 5 years. Three experienced clinicians reviewed client characteristics and treatment.	20% thought to be preventable. The biggest reason for difficulties found by authors was problems in the relationship between the clinician and the client. The authors also found poor assessment of depression or psychological issues. 29% of those thought preventable, issues were attributed to lack of continuity of care e.g. client refusing an inpatient admission or one not being able to be arranged. In 30% of community cases, treatment was refused or abruptly terminated. Poor transition between services (16%) or loss or change of care coordinator (12%).
6	De Leo, Draper, Snowdon & Kolves (2013) Australia	Contacts with health professionals before suicide: missed opportunities for prevention?	To explore contacts with service in the three months prior to a suicide compared with a matched sudden death group to determine differences in contact	Case controlled PA study. Psychiatric diagnoses given based on DSM-IV criteria by 2 psychiatrists. Next of kin to 277 suicide victims and 183 Sudden death victims as controls Diagnoses attributed based	90% of the sample who completed suicide had contact with a GP or mental health practitioner in the three months before their death. There was no significant difference between those diagnosed with mental health difficulties and those who weren't

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
			with services and differences based on psychiatric diagnoses.	on data collected in interviews and diagnosed blind to the condition	
7	Godin (2004) UK	You don't tick boxes on a form': A study of how community mental health nurses assess and manage risk	To explore how community mental health nurses reflect on and practise risk assessment and risk management. Specifically, to explore whether the focus is on epidemiology and how they defined risk (for example, as a hazard rather than a positive opportunity).	Qualitative study using interviews to collect data. Interviews with 20 community mental health nurses. Interviews were analysed into broad thematic categories.	Assessing risk: all 20 CMHNs knew of formal risk assessment tools and some used them in their practice. Some found them too mechanical, behaviourally reductive and dehumanising, favouring a more individualised approach. Nurses talked about using 'intuition' or a 'gut feeling' and suggested that they use observation of a person's living situation to assess risk. Several nurses described a culture of risk and suggested that this stifled their creativity of their work however, some described the tools as useful guidelines which could inform less able or less experienced practitioners. Regarding risk management, nurses primarily described judging risk to themselves based on how they felt in the situation and safety protocols designed to protect them in this instance. Some nurses reported that this emphasis on 'not wanting to make mistakes' was detrimental to clients who now had to contend with being 'a risk' as well as being 'mentally ill'. One nurse in primary healthcare expressed the positive aspects of working here because she could see a client every day at risk of suicide and 'work out other means to support them'. She referred to the 'psychiatric system' as 'getting people into hospital'.
8	Hendin, Maltsberger, Lipshcitz, Pollinger	Recognising and responding to a suicide crisis	To review the treatment of clients in contact with therapists to identify	Questionnaire and case presentation/ audit. Therapists who were treating 26 patients who	Three markers of suicide were identified: a precipitating life event which triggered an intense affective state other than depression and either speech or actions suggesting suicide, deterioration in social

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
	Haas & Kyle (2001) USA		warning signs of suicidal crisis	committed suicide	contact or increase in substance abuse. The study identified problems in communication between client and therapist often interfered with crisis recognition.
9	Hendin, Pollinger Haas, Maltsberger, Koestner and Szanto (2006) USA	Problems in psychotherapy with suicidal patients	To review psychotherapy contact with suicidal patients who completed suicide to identify problems with the work	Non- experimental survey data. 36 therapists working in a community setting: psychiatrists, psychologists and social workers. Questionnaires to identify characteristics of the patient and the therapist's feelings about the work. These were reviewed in a seminar with colleagues.	Six key problems with the therapist- patient interaction were identified: - lack of communication between therapists - Permitting patients or their relatives to control therapy - Avoidance of issues related to sexuality - Not recognising the meaning of patient's communications - Untreated or undertreated symptoms - Ineffective or coercive actions resulting from therapist's anxiety.
10	Hunt, Kapur, Robinson, Shaw, Flynn, Bailey, Meehan, Bickley, Parsons, Burns, Amos & Appleby (2006) UK	Suicide within 12 months of mental health service contact in different age and diagnostic groups	This study describes characteristics of those by age and diagnostic groups in contact within the last year prior to suicide	4859 cases of suicide in England and Wales who completed suicide and had contact with inpatient MH services in 12 months prior to suicide	Those with substance dependence or personality disorder had high rates of disengagement from services. Adverse life events, in particular, relationship breakdowns significantly higher for those aged 33-44 years old. Individuals diagnosed with depressive disorder had reported more symptoms at last contact with services compared to the remainder of the sample. Those with alcohol or drug dependence were more likely to have missed their last appointment or have discharged themselves than the remainder of the sample. Suicide within three months of discharge from hospital was most common among those with personality disorder diagnoses and in 47% of these deaths, the last discharge had been unplanned. Only 1 in 10 of the deaths with of people with personality disorder was thought to have been preventable by mental health teams and services were

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
					least likely to arrange follow-up appointments or re-engage these clients. Suicides thought most preventable by services were amongst those with a diagnosis of schizophrenia, depression and bipolar disorder.
11	Hunt, Kapur, Webb, Robinson, Burns, Shaw & Appleby (2009) UK	Suicide in recently discharged psychiatric patients: a case-controlled study	A controlled study to investigate aspects of mental healthcare for those discharged from hospital who did and did not complete suicide	A questionnaire was sent to clinicians and asked for the following details: socio-demographic characteristics, clinical history, details of the suicide, details of care received including inpatient admission and discharge. 250 clients who died within three months of discharge from psychiatric inpatient care and 238 control cases who did not. Data were analysed using conditional logistic regression.	The first week after discharge was a time of particularly high risk of suicide, with the first day of discharge from inpatient care being the greatest risk. Adverse life events within three months prior to completing suicide were higher amongst those who completed suicide than controls, with relationship break ups being most common (16% vs 8% controls). Those who died within the first month of discharge were more likely to be male with a lifetime history of self-harm (although not recent self-harm was not associated with suicide) and violence and were more likely to have contact with services a within a week of their death compared with those who committed suicide later. Those who completed suicide were less likely to have been detained under the MHA than controls during their last admission, were more likely to have initiated their own discharge and more likely to have missed their last appointment with services. Enhanced CPA was more likely with those who did not complete suicide. Those who completed suicide were more likely to have a diagnosis of an affective disorder.
12	Large, Shama, Cannon, Ryan & Neilssen	Risk factors for suicide within a year of discharge from psychiatric hospital: a systematic meta-analysis.	To establish risk factors for suicide in the year after discharge from psychiatric hospitals	Systematic Meta- analysis studies following up those discharged back to the community following a suicide attempt.	Both a history of self-harm and depressive symptoms were moderately strongly associated with post-discharge suicide. Reports of suicidal ideas, unplanned discharge, being male, recent social difficulties and a diagnosis of major depression were

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
	(2011)		and their usefulness in categorizing patients as high or low risk for suicide in the year following discharge		weakly associated with post-discharge suicide. Two significant findings were that those who had less contact with services were significantly less likely to commit suicide. Those who were rated high risk prior to discharge were more likely to commit suicide than other discharged client, but this finding was not greater than the association with some individual factors. Different risk factors were combined to rate individuals according to risk and no single risk factor was common across all those studies who categorized participants as high or low risk. This finding demonstrates that there is not a consistent picture of risk factors included in risk assessment tools that predict future suicide.
13	Meehan, Kapur, Hunt, Turnbull, Robinson, Bickley, Parsons, Flynn, Burns, Amos, Shaw & Appleby (2006) UK	Suicide in mental health in-patients and within 3 months of discharge	To describe social and clinical characteristics of those who complete suicide in inpatient care and within 3 months of discharge.	Survey of all those who completed suicide, and identification of those who had been in contact with mental health services. Questionnaires were sent to clinicians to complete on demographic, opinions on risk level and adherence to treatment. Findings summarise results pertaining to 271 community patients	Post-discharge suicide was most frequent in the first 2 weeks after leaving hospital; the highest number occurred on the first day. 21% considered preventable. Respondents most often thought risk could have been reduced by improved treatment adherence and closer supervision. 28% of suicides were people who self-discharged from hospital. Compared to planned discharges, this group were more likely to have a diagnosis of PD, history of violence and substance misuse and less likely to be under enhanced CPA.
14	Owens, Lambert, Donovan and Lloyd (2005)	A qualitative study of help seeking and primary care consultation prior to suicide	To review how those in distress and their lay networks make decisions to access	Qualitative psychological autopsy study	The findings of this study suggest that lay people have a role in encouraging a person at risk of suicide to seek medical help. The study suggested that lay people struggled to know when the person's distress

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
	UK		help from a medical practitioner prior to suicide.		was 'abnormal'. Their functioning in work and social roles and emotional distress being understood as an understandable reaction to adverse circumstances discouraged family members from intervening. The study suggested that those who had committed suicide had, in many cases, been distressed for a long time and the findings suggest that perhaps the lay member had developed raised thresholds to this long-term disturbance. Lay persons often intervened with practical solutions or distractions and the study also acknowledges that there is no measure of if the suicide could have been prevented by contact with services, or whether a medical intervention would have been more effective. The study also found evidence to suggest that some people might be engaging in compulsive help seeking and may be overemphasising the significance of their distress. Some lay persons were angry with doctors who they felt did not take the risk seriously when concerns were expressed.
15	Owens, Lloyd and Campbell (2004) UK	Access to health care prior to suicide: findings from a psychological autopsy study	To explore the recommendation that better recognition and treatment of mental illness in primary healthcare would reduce suicide	Psychological autopsy study. Interviews with close friends of relatives and data corroborated from file info to diagnose mental health problems in 100 cases of open verdicts between 1995-1998.	The key finding of this study was that very few GPs failed to detect and treat mental illness (9%) suggesting that detecting and managing mental health problems does not necessarily prevent suicide. Non consultation in the final month before suicide was found to be the greatest barrier to care.
16	Owens, Owen, Belam, Lloyd,	Recognising and responding to suicidal crisis within family and social networks:	To investigate the difficulties faced by relatives, friends and colleagues in	Interviews with informants analysed thematically. Informants for 14 cases of suicide	Participants described signs as difficult to recognise or interpret. They reported focussing on positive signs and when they did notice that something was seriously wrong, it was difficult to say something to

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
	Rapport, Donovan & Lambert (2011)	qualitative study	recognising signs of suicidality and deciding how, or if, to respond.	who were not in contact with secondary mental health services	the person, deciding instead to 'watch and wait'. Findings suggested those who felt that this distress had been ongoing also struggled to intervene because there was an indication of them having become habituated to this.
17	Paterson, Dowding, Harries, Cassells, Morrison and Niven (2008) UK	Managing the risk of suicide in acute psychiatric inpatients: a clinical judgement analysis of staff prediction of imminent suicide risk.	To explore the factors that influenced judgements regarding suicide risk in psychiatrists and nurses	Hypothetical case examples were presented in a booklet to participants to measure how complex judgements were made. Results were analysed using SPSS. Fifty two nurses and twelve psychiatrists returned the completed booklet (53% response rate).	Average number of cues in a judgement policy that predicted risk judgements was between 1 and 6. The average number of cues for both psychiatrists and nurses was 3.7 with a median of 4. Both psychiatrists and nurses associated suicidal ideation with increased suicide risk although psychiatrists were significantly more influenced by this. Psychiatrists were significantly more influenced by the patient's diagnosis than the nurses were. No. of previous attempts, being make, lack of clinical improvement, lack of compliance and shorter admissions were sometimes associated by both groups of clinicians. Insight, adverse events and protective factors were not significant.
18	Rahman, Gupta, While, Rodway, Ibrahim, Bickley, Flynn, Windfuhr, Shaw, Kapur & Appleby (2013) UK	Quality of Risk Assessment Prior to Suicide and Homicide: A pilot Study	To assess the feasibility and reliability of developing a quality evaluation framework of risk assessment and applying this to clinical notes to evaluate the quality of risk assessment prior to suicide and homicide cases.	2 experienced clinicians applied a quality evaluation framework developed from the findings of existing literature to clinical case notes to evaluate the quality of the risk assessment prior to suicide or homicide.	Overall quality of assessments was satisfactory in 64% of suicides explored. History, mental state and quality of communication were found to be very well completed. Risk formulation was found to be satisfactory in 74% of cases but risk management was only found to be satisfactory in 62% of cases. Factors found to be correlated with unsatisfactory quality of risk assessments were: affective disorder, alcohol misuse, being male, time between last contact and fatal incident less than 24 hours. Recommendations RA: should be individual to each patient, should assess current and past risk factors and include a risk management plan that followed from the assessment.

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

No.	Author/ year Country	Study name	Aims	Design/ Sample methodology.	Key findings
19	While et al (2012) UK	Implementation of mental health service recommendations in England and Wales and suicide rates, 1997–2006: a cross-sectional and before-and-after observational study	Data collected across mental health services re implementation of recommendations and suicide rates to see if implementing the recommendations made a difference to outcome.	Descriptive, cross-sectional, and before-and-after analysis of national suicide data in England and Wales.	The findings of this study were that more recommendations were reported to have been implemented each year. Some clinical recommendations did make a difference to suicide rate. For example, Implementation of an assertive outreach policy was associated with significant decreases in the suicide rate in those who were non-compliant with medication or who missed their last appointment. Crisis-team implementation did not seem to be associated with a significant fall in the community suicide rate but was associated with a fall in the rate among inpatients The implementation of a policy for 7 day follow-up after discharge was associated with a significant decrease in the suicide rate within 3 months of discharge, but did not have a significant effect on risk in the first 7 days after discharge. Implementation of a policy on non-compliance in community patients was associated with a reduction in the suicide rate in the appropriate target group.

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

Appendix 2: Transcribers agreement to confidentiality

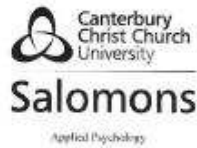
Declaration

I agree that:

1. I will discuss the content of the recording/s only with the researcher/s named on the previous page.
2. I will keep all recordings in a secure place where they cannot be found or heard by others.

macintosh hd:users:sarahcrowley/downloads:transcribing agreement july 2011.doc

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?



3. I will treat the transcripts of the recordings as confidential information.
4. I will agree with the researcher how to disguise names of people and places on the recordings.
5. I will not retain any material following completion of transcription.
6. If the person being interviewed on a recording is known to me I will undertake no further transcription work on the recording and will return it to the researcher as soon as is possible.

I agree to act according to the above constraints

Your name Margaret Jacqueline Tinkler

Signature [Handwritten Signature]

Date 10 June 2014

Occasionally, the conversations on recordings can be distressing to hear. If you should find it upsetting, please speak to the researcher.

Appendix 3: information sheet



Version 3: 7/2/14

Information sheet.

Research project: A grounded theory of how mental health practitioners work with those at risk of suicide.

Dear Colleague,

I am a trainee Clinical Psychologist at Canterbury Christ Church University (Salomons Campus). I am writing to ask you if you would be willing to take part in my Major Research Project (MRP) which will explore how mental health practitioners work with clients who are at risk of suicide. I hope you will consider taking part in the research. This information sheet includes the rationale and outline for the study to assist with your decision.

Rationale for the research:

The aim of the study develop a theory to understand the experience of working both short term and longer term with those at risk of suicide. It is hoped that this theory will help to outline processes that aid assessment, decision-making and ways of working. It is hoped that the results will illuminate some useful ways of working when encountering suicide risk which will be of benefit to both those who use and those who work in services.

Who should take part?

I hope to interview 12-20 practitioners who currently or have previously worked with individuals who present with a 'risk of suicide'. Participation is voluntary and you would be free to withdraw from this study at any time without giving a reason.

What would taking part involve?

Participation in the study would mean attending one interview with me which would last between thirty minutes and one hour in length. The interview would be semi-structured and I would be asking about your experience and reflections on working with clients at risk of suicide. It is hoped that the interview would feel like an open and useful space to reflect confidentially on what are often highly challenging situations. As a follow-up from the interview, I will contact you, if you agree, to ask whether the results of the study fit with your understanding of how you work with those at risk of suicide.

The interview will be recorded using a digital recorder to aid data analysis.

Participation will take place at a venue convenient for you and suitable to conduct a confidential interview. If a participant would prefer to travel to the researcher, travel expenses of up to £10 will be reimbursed.

Personal considerations:

I know that talking about professional experiences of working with suicide risk can raise some difficult and uncomfortable feelings and that there will be some people who have worked with those who have completed suicide. If you believe that these feelings are likely to be particularly distressing for you, you may wish to not take part in the study. There will be space after the interview for debrief and reflection on taking part in the study. If it would be useful, further space for debrief would be available from the research supervisor, Dr John McGowan by contacting him at the address below.

What about confidentiality?

The content of the interview and the recordings will be treated in strict confidence and I will ask for your consent to record the interview. The recordings will be immediately transferred to an encrypted and password protected USB drive and deleted from the digital recorder. Interviews will be transcribed and all identifying details will be removed or changed where necessary to ensure anonymity is protected. Fully anonymised quotes may be used in the study write up. In line with publication requirements, audio-recordings of the interviews will be kept on a password protected USB in a

locked cabinet for 10 years after the study is completed, after which they will be destroyed.

What will happen to the results of the research study?

It is hoped that the information from this study will help to make sense of the complex issues that mental health workers face when working with suicidality. It is anticipated that the research will be published in an academic journal to contribute to the existing knowledge base. The completed project will be available on a searchable database called 'Create'.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by Canterbury Christchurch University Ethics panel.

Further information and contact details

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01892 507673. Please say that the message is for me [Sarah Crowley] and leave a contact number so that I can get back to you. Or you can email me at: s.r.crowley697@canterbury.ac.uk and I will respond to you as soon as possible.

Complaints, concerns or additional debrief:

If you decide to participate in the study and have any concerns, questions, or would like to arrange a space for further debrief following the interview, you can contact me or the lead research supervisor, Dr John McGowan at: john.mcgowan@canterbury.ac.uk

If you still have concerns or wish to make a complaint, you may contact Professor Paul Camic, Researcher Director at the following address:

Professor Paul Camic,
Salomons Centre for Applied Psychology,
Canterbury Christchurch University Salomons Campus,
Broomhill Road,
Southborough,
Tunbridge Wells,
TN3 0TG.

Thank you for taking the time to consider this information sheet.

Appendix 4: interview schedule

1. Can you think an example of when someone you worked with reported feeling suicidal?
 - What did you think was going on for this person?
 - What was your understanding of how they came to feel like that?
 - Can you talk me through what happened and what you did?
 - What went through your mind when they reported this?
 - How did it feel?
 - What effect did the person reporting feeling suicidal have on you?
 - What that you did/ said do you think was helpful to the client in this situation? (or, what could have been different?)
 - What was helpful to you in planning what to do? (training, supervision, previous experiences, risk assessment tools?)

Appendix 5: consent form:



Consent form.

Research project: A grounded theory of how mental health practitioners work with those at risk of suicide.

Thank you for agreeing to take part in the study. Please read through the following statements and tick each one to confirm you are happy with it before signing the form.

- I confirm that I have read and understand the information sheet (version 3: 7/2/14) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason
- I consent to the interview being recorded and transcribed anonymously
- I consent to being contacted following the interview to discuss the results of the study with the researcher
- I agree that anonymous quotes from my interview may be used in published reports of the study findings (if applicable)
- I agree to take part in the above research project

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Sarah Crowley, Trainee Clinical Psychologist.

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

Appendix 6: Example transcript with focused codes: interview 4

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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

Appendix 7: examples of memo writing.

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Appendix 8: Excerpts from research diary and bracketing interview.

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Appendix 9: Categories and associated focused codes with selected quotes.

Higher order category/ superordinate category	Focused code	Selected quote
Professional feeling responsible	<p>1. Understanding of professional role (it's your job</p> <p>2. Feeling personally invested in the role, the person/ their family</p>	<p>Interview 10</p> <p>like doctors have this responsibility and need to manage that in a certain way because – like because you said – that's a way for them to say I did everything I could –</p> <p>Interview 6:</p> <p>but it is a difficult decision because had there been a further attempt people would have said - why wasn't he detained under the Mental Health Act? and I think it really encapsulates the difficult set of values, circumstances and challenges that professionals face</p>

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<p>3. Affected by previous experience with those who are suicidal</p> <p>4. Acting in the way they would want to be treated based on own beliefs or experience personal difficulty</p>	<p>when trying to act in the best interest of their patients</p> <p>....</p> <p>Interview 2:</p> <p>She will contact her father but she will sometimes when I visit her she will say, she will present as quite low in mood and tearful and that is when it's a bigger warning when she is tearful because she is very rarely tearful.</p> <p>Interview 6:</p> <p>I had a sobering experience some years ago when I was involved in a near death experience – a terrible accident – and it put me a situation of victim and in the context of client because I had to receive physical treatment as well as therapy treatment for trauma. The benefit is that it has made me reflect differently on my contact work.</p>
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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<p>5. Being part of a team</p>	<p>Interview 4:</p> <p>I don't make the decision it is the Consultant who makes the decision about admission, which is a comfort for me I suppose. Or of course if we take them to our inpatient unit then they will be assessed by the Psychiatric Liaison Team so again it takes some of the pressure of you and it is a Team decision as to whether to admit or not.</p>
<p>Trying to make sense of the client's motivation/ intention</p>	<p>1. Employing meaning from diagnostic framework/ medical symptoms</p>	<p>Interview 11:</p> <p>It is a bit different because the schizo affective type – when there are multiples they are mostly depressed – because this is now a affective disorder and if that happens it happens mostly in winter – so they are more depressed in winter and when that comes you cannot fault it because you can see it in them. They don't want to get out of bed – they don't want anyone to</p>

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<p>2. Being informed by past experience (e.g. relationship with client)</p> <p>3. Drawing on training (often diagnostic frameworks)</p> <p>4. Relying on client's self-report, 'you can't predict it'</p>	<p>come round – they do not want to do anything – they are just down. That is a genuine presentation – when that happens you just have to act quickly because you don't want them to lose contact.</p> <p>Interview 3: yeah there was a kind of ongoing feeling that this is a risky person.</p> <p>Interview 2: I think it would transform society as it has far reaching consequences if every Trust good personality disorder service and just good training generally across the board of Mental Health professionals on personality disorder.</p> <p>Interview 10: it was a one off – his mental state was bright and cheerful – Yeah – yeah There was no hint of mental illness – Yeah</p>
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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

		<p>you know - he said he was no longer suicidal – he was –</p> <p>you know – he had no past history of mental illness – he was not an alcoholic – not drug dependent – he did not have a terminal illness – you know Yeah – um he ticked all the boxes – he was very low risk.</p> <p>Interview 3:</p> <p>I guess that sometimes it is unclear whether people will mean it or not. So there is a feeling that they are saying this for a reason because they want to go into hospital something like that.</p>
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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

<p>Professional weighs up what to do</p>	<p>Client is at high risk but ‘has capacity to self determine’ or is non treatment compliant</p> <p>Client is ‘acutely unwell’ and/ or Person is at ‘high risk’ to themselves</p>	<p>Interview 6: I think that is right and I think this is a challenge for all of us as professionals whether I am acting in my role as an approved social worker, or acting in my role as a Care Co-Ordinator we have to kind of weight up the pressures of health and safety within protection against mental illness and against self determination.</p> <p>Interview 4: We definitely should be trying our hardest to try and stop people committing suicide whilst they are of unsound mind you know whether through depression or psychosis whatever.</p>

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<p>Client is at risk but ‘communicating distress’: collaborative relationship</p>	<p>Interview 2: we will come to a plan together about how to manage the things that she is saying and you know that you can document that but that you have all come up with that plan and it feels like the best outcome for the patient whilst also giving her the responsibility, she has the responsibility ultimately but we have taken all measures that we can together as a team to manage those risks.</p>
<p>Take action</p>	<p>1. Safe certainty: implement a ‘solution’</p>	<p>Interview 2: your only choice really is to get them into hospital which is actually the worse environment to put somebody in, the</p>

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<p>2. Unsafe uncertain: search for a 'safe certain' solution elsewhere</p> <ul style="list-style-type: none">• Talk to colleagues/ manager/	<p>worse for somebody with personality disorder. Yet somebody with bipolar or depression you know who is at high risk is the only place as you have got to keep them safe, you've got to get them on the right medication and to get them well and they will come out the other side whereas with somebody who has personality disorder it is not just the case</p> <p>Interview 3: So I speak to her care co-ordinator, the psychiatrist and um</p>
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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<p>care coordinator/ other service- share responsibility</p> <ul style="list-style-type: none"> • Refer to other service for assessment • There's only so much you can do' complete risk assessment 'tick box' 	<p>speaking about whether yeah, what they think needs to be done and yeah I guess there are different options.</p> <p>Interview 4:</p> <p>I don't make the decision it is the Consultant who makes the decision about admission, which is a comfort for me I suppose. Or of course if we take them to our inpatient unit then they will be assessed by the Psychiatric Liaison Team so again it takes some of the pressure of you and it is a Team decision as to whether to admit or not.</p> <p>Interview 11:</p> <p>we can't get it right in every sense – that is what I always remember – if I am able to fix it - it is because I am lucky I am have been able to do what is necessary to prevent that from happening- but in some instances doing everything</p>
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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<ul style="list-style-type: none">• Problems located in lack of resources	<p>still wouldn't be enough</p> <p>what will happen – will happen</p> <p>Interview 6:</p> <p>What are we doing with suicides, what are we doing we are linking up with GPs and trying to help them, to give them more money – it is not really going to work – we need real investment. Investment in GP practices, community mental health teams, early intervention teams, hospital beds and crisis teams we need to just accept that suicide is a dreadful factor of life at the moment and we need to start with it more creatively.</p> <p>Interview 3:</p> <p>She didn't want to go into hospital and we tried to work with her around... she still had some tablets so</p>
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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<p>Safe(r) uncertainty: 'hand responsibility back to the person'</p> <ul style="list-style-type: none"> • Reach an agreement with the client • Take a 'positive risk': tolerate uncertainty • 'Being alongside them': contain emotions 	<p>we suggested that she gets rid of the tablets and gives them to us. She didn't think that was necessary but she gave us assurance that she wouldn't do it and she met with her care co-ordinator after she saw me, she happened to have a meeting that day.</p> <p>Interview 6: So in that respect positive risk taking with a small risk or pragmatic risk taking.</p> <p>Interview 2: Yeah it is ok that I get it, but also, I don't get it but I am never going to know how much emotional pain you are in but at the same time it doesn't mean that I can't see that you are in incredible pain and that we need to help you through that and it is ok to say that.</p>
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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<ul style="list-style-type: none"> • Increase contact 	<p>You don't have to show it there are other ways and it will be recognised and supported and you won't be dismissed or rejected because that is the pattern that they have learnt they have been rejected for sharing their emotions.</p> <p>Interview 6:</p> <p>Time related pragmatic goal focused defensive practices. It is about I will see you today, I will see you tomorrow fine. I will see you in two day's time. I will see you in three day's time and so you build up their exposure.</p>
<p>Perceive 'chronic risk': protecting against future episodes</p>	<p>1. Try to find hope</p>	<p>Interview 5:</p> <p>think for us it is about finding strengths and what it is we can do just to make things more bearable maybe, but I don't really, I kind of think that everybody has something. Even if its small and it might not be what they once had but I guess it is about adjusting.</p>

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

	<p>2. Draw up a care plan with the client</p> <p>3. Refer to psychology/ OT</p> <p>4. Avoid discharging client</p> <p>5. Work longer term</p>	<p>Interview 5: so asking them what stopped them doing it before so that they can some how reflect on their protective factors really</p> <p>Interview 3: she has been under the service for a long time and she is now seeing me for therapy</p> <p>Interview 12: finding out how this set of people can be discharged swiftly and without returning within a short time period.... a lot can happen within a month</p> <p>Interview 2: and then to get them on to long term an interventions team where there are such things as OT to help them better manage their lives and hopefully stop it happening again in</p>
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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

		the future.
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Appendix 10: Research Summary Sent to Participants and NHS Trust R&D
Research project: A grounded theory of how mental health practitioners work with those at risk of suicide.

Thank you for taking the time to be interviewed as part of this study, the findings of which I hope will be of use in your clinical work. This document is intended as a summary of my findings which I am submitting in partial fulfilment of the Canterbury Christ Church University Doctorate in Clinical Psychology. If you have any questions, comments or feedback on these results please do get in touch. My email address is s.r.crowley697@canterbury.ac.uk.

Aim:

Despite the number of best practice guidelines for working with those at risk of suicide, there remains a lack of research exploring the realities of clinical practice in understanding how clinicians respond to those at risk of suicide in UK community mental health settings.

Method

Semi-structured interviews were conducted with eleven members of staff including social workers, nurses, psychologists, psychiatrists and occupational therapists. Interviews were transcribed, analysed and a theory grounded in the resulting data was developed.

Results

Clinicians described a high level of personal or professional responsibility in their work with their clients. Practitioners communicated a sense of their investment in their role but described how anxiety provoking and emotionally draining it could be to work with those at risk of suicide, particularly, those who seemed to present with chronic risk. There was a sense of uncertainty caused by the impossibility of preventing suicide, but professionals perceived that it was their responsibility to intervene if they felt someone was 'really at risk'.

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

The findings of the study were that clinicians attributed low responsibility to the clients they worked with for their suicide risk. For example, participants described clients as ‘not being able to help it’ and viewing distress as a symptom of mental illness or as a communication of distress. Practitioners also attributed low responsibility to the client for being responsible for the solution to the problem. In other words, in many cases, practitioners recognised ‘triggers’ to a client’s distress (e.g. a relationship break down, physical health problems) but often sought a solution to their distress from within their service (e.g. increasing contact, referral to psychology/OT), or another mental health service (e.g. inpatient care, home treatment team etc.). This had implications for clinicians feeling that they reached an impasse when clients did not respond to their treatments. Furthermore, many clinicians recognised clients’ dependency on the service which may be reinforced by this approach.

What was reported to be helpful?

Participants emphasised the importance of a team approach to this work. They described feeling that responsibility was ‘shared’ and that this helped with being able to feel less responsible for managing suicide so that the clinician could focus on supporting the recovery of the individual. An environment of psychological safety where there was a culture of peer support, supervision and present, thoughtful leadership was also thought to be essential. Some of this reiterated participants’ concerns that responsibility was shared.

Implications for practice

Feelings of being ‘own your own’, anxiety and responsibility seem to limit the professional’s capacity to tolerate uncertainty, leading to interventions located within mental health services. Two main recommendations are that community mental health teams work collaboratively with other related services to offer an environment of psychological safety for staff, including peer support, supervision and joint working. It is hypothesised that working as a team or in pairs in clinical contact may reduce the felt experience of responsibility and increase thinking about solutions from a client or their context.

Appendix 11: The Lancet Psychiatry guidelines to authors

Title page

A brief title, author name(s), preferred degree (one only), affiliation(s), and full address(es) of the authors must be included. The name and address of the corresponding author should be separately and clearly indicated along with email and telephone details.

Formatting of text

- Type a single space at the end of each sentence
- Do not use bold face for emphasis within text
- We use a comma before the final "and" or "or" in a list of items
- Type decimal points midline (ie, 23·4, not 23.4). To create a midline decimal on a PC: hold down ALT key and type 0183 on the number pad, or on a Mac: ALT shift 9
- Numbers one to ten are written out in words unless they are used as a unit of measurement, except in figures and tables
- Use single hard-returns to separate paragraphs. Do not use tabs or indents to start a paragraph
- Do not use the automated features of your software, such as hyphenation, endnotes, headers, or footers (especially for references). Please use page numbering

References

- Cite references in the text sequentially in the [Vancouver numbering style](#), as a superscripted number after any punctuation mark. For example:

"...as reported by Saito and colleagues.¹⁵"

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

- Two references are cited separated by a comma, with no space. Three or more consecutive references are given as a range with an en rule. To create an en rule on a PC: hold down CTRL key and minus sign on the number pad, or on a Mac: ALT hyphen
- References in tables, figures, and panels should be in numerical order according to where the item is cited in the text
- Here is an example for a journal reference (note the use of tab, bold, italic, and the en rule or 'long' hyphen):

"...15[tab]Saito N, Ebara S, Ohotsuka K, Kumeta J, Takaoka K. Natural history of scoliosis in spastic cerebral palsy. Lancet 1998; **351**: 1687-[en rule]92."

- Give any subpart to the title of the article. Journal names are abbreviated in their standard form as in [Index Medicus](#)
- If there are six authors or fewer, give all six in the form:

surname space initials comma

- If there are seven or more give the first three in the same way, followed by et al
- For a book, give any editors and the publisher, the city of publication, and year of publication
- For a chapter or section of a book, also give the authors and title of the section, and the page numbers
- For online material, please cite the URL, together with the date you accessed the website
- Online journal articles can be cited using the DOI number
- Do not put references in the Summary.

HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

Appendix 12: University ethics approval letter.

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HOW DO MENTAL HEALTH STAFF RESPOND TO SUICIDE RISK?

Appendix 13: NHS Trust R&D approval letter

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