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Suicide bereavement : support, responses, and individual experiences

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Suicide bereavement: support, responses, and individual experiences.

Rachel Newton

Bangor University

June 2014

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Section 1

Thesis Abstract

Suicide bereavement: support, responses, and individual experiences.

A literature review is reported which describes and assesses the effectiveness of interventions for family members bereaved by suicide, incorporating qualitative findings regarding participants' views on what is helpful. A range of interventions are reported to be helpful, and peer support is highly valued. Methodological limitations and questions regarding the generalisability of the findings are raised, as well as ideas for future research.

The experiences of patient suicide in mental health professionals are explored using semi structured interviews with 9 adult mental health professionals in two counties of North Wales. Interpretative Phenomenological Analysis reveals 6 themes: emotional impact on the self, being logical: making sense of suicide, impact in the workplace, unhelpful responses in the workplace, helpful responses and sources of support, and philosophy of mental health care. All participants reported being affected by patient suicides at a personal and professional level. Peer support and contact with patient family were reported as helpful, whilst poor communication and a focus on formal and legal issues was unhelpful and increased feelings of anxiety and isolation. The findings from this study support previous research and highlight specific issues for supporting professionals.

The findings from both papers are discussed in terms of their contribution to research, theory, and clinical practice. Ideas for future research and improving the support offered to families and professionals bereaved by suicide are considered, and personal reflections on the process of carrying out this thesis are offered.

Declarations

This work has not been previously accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed

Date

Statement 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A list of references is appended.

Signed

Date

Statement 2

I hereby give consent for my thesis, if accepted, to be available: I agree to deposit an electronic copy of my thesis (the Work) in the Bangor University (BU) Institutional Digital Repository, the British Library ETHOS system, and/or in any other repository authorized for use by Bangor University and where necessary have gained the required permission for the use of third party material.

Signed

Date

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Section 2: Literature Review

Resources and interventions for people bereaved by suicide:

A review of recent literature

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Abstract

Evidence suggesting the support needs of people bereaved by suicide is growing. There is a need for greater understanding of what types of support or intervention are most appropriate and effective. Previous reviews have not incorporated participant views on interventions. This article reviews the recent literature describing and assessing the effectiveness of interventions for family members bereaved by suicide, and incorporating qualitative findings regarding participants' views on what was helpful. Methodological limitations are discussed, and questions regarding the generalisability of the findings are raised. Implications for clinical practice and future research are suggested, to improve the knowledge base regarding whether different levels of intervention may be required for different levels of need.

Keywords: suicide bereavement, suicide survivor, suicide postvention

Introduction

According to the most recent national statistics on suicide in the UK (Appleby et al., 2012) there were just over 64,000 reported suicide deaths from 2000 to 2010. Whilst it is difficult to make accurate estimates of how many people may be exposed to or affected by each individual suicide, and how many of these identify themselves as being 'bereaved by suicide' or a 'suicide survivor' (Cerel, Maple, Aldrich & van de Venne, 2013), it is apparent that there is a need for increased support, education and resources for family and friends who are left behind following a suicide. There are a number of risk factors for complicated grief which are often common within families or groups who are bereaved by suicide which indicate a need for additional support (Clark, 2001). It has been suggested that only half of participants who feel they need professional help actually access it (Wilson & Marshall, 2010). This highlights the importance of support being offered pro-actively, as well as the need for appropriate bereavement support programmes. In light of this, awareness of the need for support for those bereaved by suicide is increasing, as is the related research literature. In this updated review, recent literature on support for family members bereaved by suicide will be presented, including qualitative and descriptive studies.

There have been a number of reviews on bereavement interventions, two of which included interventions for suicide bereavement as a sub-group (Jordan & McMenemy, 2004; Currier, Neimeyer & Berman, 2008) and one which focussed specifically on suicide bereavement (McDaid, Trowman, Golder, Hawton & Sowden, 2008). These all included interventions for adults and children bereaved by suicide. Jordan and McMenemy (2004) examined eight interventions for those affected by

suicide in addition to generic bereavement interventions and reported that whilst the evidence for suicide specific interventions was more promising and participant satisfaction high, the majority of studies were methodologically flawed and few utilised control or comparison groups. The more rigorous studies in the review tended to demonstrate less convincing findings regarding the effectiveness of the interventions, and it was concluded that more research was required to understand whether these interventions are effective.

A later review of the effectiveness of generic bereavement interventions (Currier, Neimeyer & Berman, 2008), which included selective interventions for high risk groups such as suicide bereavements, reported similar results to Jordan and McMenemy (2004). Whilst overall results with the sub-sample of 'high risk griever' indicated significant effects in terms of a reduction in distress symptoms and improved adjustment immediately after intervention, these were not maintained at follow-up, however when treatments were aimed at those with specific difficulties adapting to loss, effect sizes were larger, suggesting greater improvements in adjustment and well-being. This suggests that a universal approach to bereavement interventions with at-risk groups may not be the most effective.

The only systematic review of interventions specifically for suicide bereavement (McDaid et al., 2008) was limited to studies with controls or comparison groups, and found that seven out of the eight studies reviewed had significant methodological flaws. It was concluded that when compared with no intervention, there was some evidence for group interventions being of benefit to participants, however when compared with an active comparator the evidence was

more limited. The reviewers encouraged the development of methodologically robust controlled studies to provide meaningful evidence for suicide bereavement interventions, although there were questions raised regarding the measurement of outcomes and whether generic mood measures or specific grief measures might be more appropriate. It was also noted that participants' opinions of interventions were rarely included in studies, meaning that no information about which aspects of interventions were thought to be helpful, or how appropriate interventions were deemed to be.

Whilst there is obvious importance in encouraging scientific rigour in research, due to the sensitive nature of suicide bereavement there are a number of ethical and practical considerations which arise when planning studies in this area. In addition to this, due to the individual nature of grief it is possible that some interventions may be better suited for some people than others. With an increase in the use of self-help and online support, it is important to consider interventions beyond traditional group approaches. In order to provide an update from the review in 2008 on research into suicide bereavement interventions, and include qualitative findings to provide additional information as suggested by previous reviewers (McDaid et al., 2008) a broad literature review was conducted. The focus of the literature review was to answer three questions: what the published literature says is available for people bereaved by suicide, how effective the available resources and interventions are, and what participants report about their experience of them. In order to synthesise the findings from a range of studies and present a broad summary of the available resources in addition to answering the review questions, a narrative synthesis approach was taken (Popay et al., 2006).

Method

Search method

An online database search of PsycINFO and Web of Science using the terms *suicide bereavement* and *suicide survivor* was carried out. These broad terms were used in order to be as inclusive as possible. Results were confined to scholarly journals only, published from 2004 onwards. This resulted in 1036 initial results. Titles and abstracts were screened for relevance and duplication. In addition to this titles of articles in the journal *Suicide and Life-Threatening Behavior* were screened from April 2004-January 2014. A hand-search was also carried out from the reference lists of identified papers. All searches were carried out between December 2013 and January 2014. The publication date criterion was applied as a result of the published review by Jordan and McMenemy (2004) which reviewed eight suicide bereavement interventions, in order to provide a useful summary and update without repeating previous reviews. Studies which were included in McDaid et al. (2008) that fit the criteria for this review were included, although the review paper itself was not included in this study.

Inclusion of studies

Three inclusion criteria were employed for this review:

1. Studies were available in English.
2. Studies focussed on supportive resources including self-help and/or psychotherapeutic interventions for suicide bereavement.

3. The adult or child participants were family members or close friends of an individual who had died by suicide.
4. Studies were published in peer-reviewed journals.

Exclusion criteria for this review were as follows:

1. Studies reporting on resources for professionals bereaved by suicide.
2. Studies with mixed groups of bereaved family members (e.g. accidents or other traumatic death).

Data extraction and synthesis

Main findings and outcomes of studies were extracted (see appendix for data extraction form). Included studies are presented in a table according to whether they used a comparison group. Effectiveness studies, descriptive studies and qualitative papers are reported on separately, and findings are synthesised in a narrative to allow for clear presentation and exploration of the findings of different types of studies.

Results

Study characteristics

The review was based on a total of fifteen studies reported in eighteen papers. In one case there were three papers reporting on different aspects of data from one study, and a further two papers reported on data from another study (Feigelman & Feigelman 2008, 2011a, 2011b; de Groot et al., 2007; de Groot et al., 2010).

Of the eighteen papers, ten were descriptive or exploratory, and reported on the process or details of a particular intervention, four studies evaluated an intervention using a comparison group (one of which was retrospectively grouped), and two reported on the effectiveness of an intervention using pre and post measures, with no control or comparison group. Two papers were qualitative evaluations of resources or interventions.

The interventions examined in the studies included: a peer support programme, suicide bereavement support groups (online and face to face, adult and child), family therapy, group therapy for children, cognitive-behavioural family therapy, a psychoeducational bereavement group, a cultural family based postvention programme, a community crisis-intervention programme, an active postvention programme, a self-help resource, a web-based psychoeducational programme for adolescents, online resources, and a range of community and professional support.

Of the fifteen studies, twelve reported data, employing quantitative (N=5), qualitative (N=3) and mixed (N=4) methodologies. Three studies described interventions but did not report any data. Of the studies that included quantitative

data, three of the studies were pilot studies of particular interventions, one study included data from a randomised-control trial, and one study used matched controls. The studies were carried out in the USA ($N=6$), Australia ($N=3$), Canada ($N=2$) the UK ($N=2$), the Netherlands ($N=1$) and South Africa ($N=1$). The professional groups carrying out the studies included: social work, research bereavement services, suicide prevention services, education, healthcare and psychology.

Two studies included interventions for children, with an age range from six to fifteen years. (Mitchell et al., 2007; Daigle & Labelle, 2012) Although both of these interventions had some parental involvement, only one had parent-report measures. The de Groot et al. (2007; 2010) family studies included adolescents, who were aged fifteen and above, alongside their adult relatives. Eleven studies included adult participants only. In ten studies the majority (69%-96%) of the participants were female, and in one the gender split was 50:50. Where age was reported, the majority were aged between 35-60 years. Where data on ethnicity was reported, the majority of participants were white. The studies varied regarding how much information was provided on other factors such as marital status, income level, education, psychiatric history, and the circumstances around the suicide such as the time since the death, their kinship with the deceased, whether they were living with the deceased, or were present at the suicide site.

Of the studies measuring effectiveness of an intervention, only one study included a follow-up measurement after a baseline (de Groot et al., 2010). One study collected data over a long period of time and followed up participants who dropped

out (Feigelman & Feigelman, 2011b). Most of these studies included at least one standardised outcome measure, although there was no consistency in which measures were used, no two studies used the same measure.

Settings for interventions varied, and included participants' homes, crisis centres, the place of suicide, and various community locations. Four studies reported that interventions were facilitated by clinicians, and four were trained volunteers bereaved by suicide.

Study design & limitations

The majority of the quantitative studies reviewed had major methodological limitations. Only five studies compared an intervention with either another intervention or with no intervention. With the exception of de Groot et al. (2007) and de Groot et al. (2010) there was no randomisation of participants to intervention groups. The remaining studies with comparison groups were retrospective in design, and simply compared differences between and within groups. All of these studies had a high risk of selection bias as participants had opted-in to interventions. Studies varied regarding criteria for matching controls. Sample sizes for studies with comparison groups were generally acceptable and ranged from 43-670, although in one case (de Groot et al., 2010) the small size of sub-groups (N=11 and N=16) limited the statistical power of a follow-up study. The qualitative studies reviewed varied significantly in terms of detail provided. There was a lack of clear information provided regarding sampling, data collection and analysis. One study (Trimble, Hannigan & Gaffney, 2012) described the steps taken in the analytic approach.

The limitations of the studies included in the review may affect the validity of the findings, and the design of the studies limits the conclusions that can be drawn. It is possible that effects of interventions may appear greater than they would if the studies were more rigorously controlled, and there is a risk of potential bias in the qualitative studies which provide little detail of the analytic method.

Study findings

What resources are available for family members bereaved by suicide?

The resources and interventions described in the studies ranged from a self-help publication and online resources, in addition to face to face peer support and group psychological interventions. These resources are described in detail below.

Self-help & online resources:

'Help is at hand' is a self-help resource developed as part of England's suicide prevention strategy. It is available as a hard copy and online, and is also aimed at people bereaved by traumatic deaths, as it is acknowledged that a death may not be confirmed as a suicide until after an inquest. The booklet includes sections on practical matters, experiencing bereavement, bereaved people with particular needs, how others can help, and sources of support. It also includes a list of people who may need to be informed of the death (Hawton et al., 2012).

Krysinska & Andriessen (2010) reported the results of a search of four major online search engines using 13 search terms related to suicide bereavement, to review the available online support. Based on previous research on internet search strategies, the most popular hits were classified into categories which revealed 145

websites. The 15 most popular websites were analysed using a set of criteria to provide detailed descriptive information. Personal sites set up by people bereaved by suicide were more common than professional bereavement services or suicide prevention service sites. It was found that the majority of the most popular sites included information on bereavement, suicide, suicide risk for the bereaved, referral information, resources and links to other relevant sites. Half of the most popular sites had opportunities for interactive communication, and one linked to professional online help. It also reported that the majority of the referral options were for support groups, and very few included suggestions of seeking help via general practitioners or mental health professionals. It was suggested by the authors that this may reflect a preference for shared experiences, and possible negative beliefs about mental health professionals. It was also suggested that suicide prevention services and professional bereavement services should utilise research on internet search strategies to increase the rate at which the websites are retrieved using terms regularly used by people bereaved by suicide.

Hoffman (2006) describes the development of an online psycho-educational programme aimed at adolescents bereaved by suicide. This programme provides examples of people bereaved by the suicide of parents, friends, and other relationships. It also describes the range of emotional, cognitive and behavioural experiences reported by people bereaved by suicide, in an attempt to normalise and validate the user's experiences. A further section includes resources for coping following suicide bereavement, as well as recommended reading for others supporting a young person. The design of this programme has been reviewed, although evaluations are yet to be published.

Feigelman, Gorman, Beal and Jordan (2008) explored the characteristics of members of an online support group for parents bereaved by suicide. The support group allows members to submit messages or questions that are shared with the others, and receive responses, and a group facilitator offers support. Data from 104 parents who used the online support group was compared with 297 parents who used face to face support groups, and it was reported that users of online support groups were more likely to be female, younger and less connected to religious institutions. Also those who lived alone, were divorced or separated, receiving a lower income and with less formal education were over-represented in the online group, and they were more likely to have had more recent bereavements. Around 70% of the online support group members had spent at least two hours per week on the site in the year leading up to the study. Of these, 32% had spent more than 10 hours per week online. Around a third of the online support group members also attended face to face support groups, and around half were also in receipt of professional mental health support.

The examples in this review of self-help and online support include those which are widely available, such as an information booklet and a range of websites, as well as a psycho-education programme which may not be made available until pilot studies have been published. It is possible that these types of resource may be more likely to be used in the early stages of suicide bereavement, particularly by those who use the internet frequently as a source of information. Online support groups may be more likely to be used by younger people who are more isolated, although more research into who uses particular resources would be beneficial.

Community and peer support resources

A qualitative study by Trimble et al. (2012) reported that following suicide bereavement, participants found initial informal support from their local community to be the most helpful form of support. This included being visited by friends, neighbours, teachers and clergy and receiving emotional support as well as assistance with practical tasks and finances. However participants stated that it did not last and there was a gradual detachment from the local community, which contributed to feelings of isolation in the long term.

Comans, Visser and Scuffham (2013) reported on a systematic community-based crisis intervention resource in Australia. The Standby Response Service provides a 24-hour crisis telephone service, in addition to face to face outreach work, individual telephone support and referrals to other community services. A similar community-based crisis support resource from the USA was reported by Cerel & Campbell (2008), however in this case an active postvention model is utilised, which provides outreach support at the scene of a suicide from crisis workers and trained volunteers who have been bereaved by suicide. This model offers peer support to individuals bereaved by suicide without them having to seek out support. A further peer support programme in Canada is described by Barlow et al. (2010), where bereaved individuals are offered regular meetings over a period of four months.

Feigelman & Feigelman (2008, 2011a & 2011b) reported on a survey and observations of peer support groups for parents bereaved by suicide. The groups described were open-ended, with dynamic participation and variable structures. Facilitators of the groups have experience of suicide bereavement, although no

formal training is required. Of the survey sample 61.5% of respondents had attended a support group in the previous year, 9.5% had attended only once, 37.5% had attended between two and twenty times, and 14.5% had attended more than twenty times. Around half of the respondents had been bereaved less than four years.

Informal community support has been described as helpful to those bereaved by suicide, however given the stigma around suicide, outreach interventions may be required to enable people to access support when they need it. Individual or group peer support has the benefit of insight into a shared experience, which may be a relief to those who feel isolated in their families or communities.

Professional-led interventions

Two studies in the review describe professional-led group interventions for children. Two describe family interventions, and one describes a group intervention for adults only. Daigle and Labelle (2012) report on a group therapy programme for children bereaved by suicide, consisting of twelve two-hour sessions with a maximum of nine participants aged between six and twelve years. Parents of participants attend the last half hour of sessions. Ten weekly sessions are followed by two fortnightly sessions to facilitate a gradual ending. Sessions are facilitated by therapists and include conversational activities and games to facilitate open interactions, listening to stories, drawing, and an opportunity for children to ask questions by posting them into a box. Children then provide feedback to their parents on the content of each session. The programme is manualised and has clear overall aims, as well as individual session aims. A theoretical model was also

developed to better define the intervention and the model of change, which includes increasing safety, realistic understanding and knowledge, and communication, and reducing inappropriate behaviours, physical and psychological symptoms.

Mitchell et al. (2007) describe an 8-week support group for children bereaved by parental suicide held at an outpatient psychiatric clinic, facilitated by an advanced practice nurse. The group includes six to eight children aged between seven and thirteen years, who meet fortnightly for ninety minutes. Sessions include discussions about suicide and its causes to increase understanding, exploring feelings, sharing memories, instilling hope, understanding grief, and coping skills. A similar process to adult support groups is encouraged, with interactions between participants encouraged and facilitated. A range of age-appropriate methods including drawing, stories and letter-writing, to facilitate the therapeutic aims, and a party is held to mark the end of the intervention. There are similarities between the two groups in terms of the aims to increase understanding, allow a space for children to discuss their experiences and express their emotions, and assisting in the development of appropriate coping skills. Both groups adapt the methods of delivery and acknowledge the importance of marking the ending of an intervention, although it is possible that the additional four weeks and graded ending in the Daigle and Labelle (2012) programme may be beneficial.

A family-based cognitive behavioural intervention delivered by CBT trained psychiatric nurses was reported by de Groot et al. (2007, 2010). This consisted of four two-hour sessions, delivered at two to three week intervals in the family home, for relatives over the age of fifteen. This intervention was offered between three and

six months after the suicide and families were identified through their GP. The intervention addressed issues within the family system and aimed to provide assistance in framing participants' grief reactions, encouraging emotional processing, improving interactions and problem solving. A manual was provided to participants with information on suicide bereavement, homework exercises and resources for additional support. Topics for sessions were semi-structured, with opportunity for families to select optional topics depending on their circumstances, such as grief in children and adolescents, or managing intrusive thoughts.

A family based culturally informed postvention programme for African American families bereaved by suicide was described by Kaslow, Ivey, Berry-Mitchell, Franklin and Bethea (2009). 'Healing and Understanding Grieving Suicide Survivors (HUGSS)' was developed in response to the lack of culturally informed interventions in this area. The manualised psycho-educational intervention consists of ten sessions lasting 2 hours each, delivered in a hospital setting. Early sessions include reviewing the grief process, education about suicide, safety planning, developing a narrative of the suicide, and memorialising the deceased. Following this there is a shift towards a focus on the family, exploring communication strategies, problem solving, self-talk, coping and social support, stigma and community resources and future planning. Sessions are tailored to individual families and activities are adapted depending on age and gender. The programme is co-run by African American and White co-therapists, and also utilises volunteers from African American communities who speak to families about their experience of coping with suicide in a session towards the end of the programme.

Groos & Shakespeare-Finch (2013) reported on suicide bereavement support groups for adults run by a community suicide prevention programme in Australia. These groups are widely advertised and largely self-referred. Groups consist of weekly sessions lasting 2 hours, over a period of six to eight weeks. Sessions are largely psycho-educational, and focus on the grieving process, traumatic loss, physical and emotional feelings, coping, honouring a life and looking to the future. Two facilitators included at least one psychologist, with another psychologist, counsellor or social worker.

Professional-led group and family interventions share similar psycho-educational aims, with specific differences depending on the nature of the group. Particular amendments for children, families, or specific cultures are likely to be necessary in order for these interventions to be acceptable and effective. The involvement of volunteers in addition to professionals in the programme described by Kaslow et al. (2009) may be a useful bridge between the areas of peer and professional support.

How effective are suicide bereavement interventions?

Of the papers included in this review, six measured effectiveness of interventions for adult and child family members bereaved by suicide (two papers were from the same study). Table 1 provides a detailed summary of these papers. The six studies varied greatly in the types of interventions evaluated and measures used; therefore direct comparisons are not possible. The papers evaluated the following interventions: a cognitive behavioural family therapy programme, a group

therapy programme for children, a community based crisis intervention programme, an active postvention outreach programme, and a peer support programme.

The only RCT in the review (de Groot et al., 2007) concluded that there were no significant differences between participants who had received four sessions of family CBT and those who received treatment as usual on measures of complicated grief, depression, or suicidal ideation at a thirteen-month follow-up. However the results did indicate a non-significant trend towards reduced self-blame and traumatic grief reaction in the intervention group. This tentatively suggests that family CBT may be beneficial. A follow-up paper re-analysed this data (de Groot et al., 2010) and grouped participants according to high and low suicide ideation. It was found that those classed as 'suicide ideators' were more likely to benefit from therapy, and in particular were more likely to show a decline in suicidal ideation. Although results did not reach significance, and the sub-sample of 'suicide ideators' was small, it was proposed that reducing suicide ideation may have a role in preventing complicated grief in family members bereaved by suicide, in addition to reducing risk of further suicide.

A community crisis intervention programme was evaluated over a 1 year period (Comans et al., 2013) comparing intervention participants with matched controls, taking into account the time since bereavement and relationship to the deceased. It was reported that the intervention group were less likely to miss work, less likely to access health services, and were more likely to continue to engage with activities of daily living. This study evaluated the intervention in terms of cost effectiveness, using a measure of quality adjusted life years, and indicated more positive results for those who had engaged in the intervention compared to controls.

This indicated that this type of community suicide bereavement intervention can be of benefit at the individual and societal level.

A community intervention utilising a method of active postvention outreach, which offered support and information at the time of death was evaluated retrospectively based on the time taken to present to seek help from services (Cereel & Campbell, 2008). It was reported that participants who had received an active postvention service presented for treatment at a crisis centre significantly sooner than those who had not received the service and had self-referred following the suicide of a family member. It was also reported that those who had received the active postvention service were more likely to attend support groups, and attended for longer. There were no demographic differences reported between the two groups, or differences in the levels of distress or impairment. It was suggested by the authors that seeking help sooner was an indication of a positive outcome, suggesting the effectiveness of an active postvention model.

A pilot study of a 12-week group therapy programme for children bereaved by suicide (Daigle & Labelle, 2012) found positive changes following the intervention on all measures, indicating an increase in emotional understanding, hope, and self-concept, and a reduction in grief reactions, depression, anxiety and maladaptive behaviour. There was no change reported for levels of anger. Change percentages of group means were presented in the paper, with no further statistical tests. Other limitations included a small sample size, lack of a control group, and one participant was under the recommended age for some of the measures used.

Barlow et al. (2010) reported that following a pilot of a four month peer support programme participants demonstrated significant improvements in levels of

despair, detachment and disorganisation with medium to large effect sizes reported. Other areas of grief reactions including panic behaviour, blame and anger and personal growth all showed improvements but did not meet statistical significance. Participants rated helpfulness and comfort of support highly, and stated that they felt this type of intervention was more helpful than group and family counselling. This study was limited by a lack of controls, as most participants were receiving more than one type of intervention, and an emergent sampling method may have biased the small sample.

Due to the variance in the literature, as well as the unique experience of suicide bereavement, it may be that traditional comparison studies using standardised measures alone may not provide enough information about what works. Whilst the RCT findings were not promising (de Groot et al., 2007; 2010), it should be noted that only four sessions were provided. It may also be expected that family members may still meet criteria for depression or complicated grief on a standardised measure after 12 months, and making comparisons between groups can be difficult owing to the variable nature of grief. Using sub-scales of measures may be helpful to provide further information on the complex emotional processes involved in suicide bereavement interventions. It may be that providing a multi-modal form of support, such as that described by Comans et al. (2013), or even the active postvention method of offering support at a very early stage following a suicide could be a useful way of increasing awareness of available interventions and providing timely and accessible support. Similarly a combination of professional and volunteer or peer-led support may be more appealing to family members seeking someone who they feel can really understand their experience. It may be more

helpful to consider what aspects of interventions participants find helpful, and whether there are factors that may influence an individual accessing a particular resource or intervention.

<insert table 1>

What do family members say about suicide bereavement interventions? Findings from qualitative studies and evaluation questionnaires:

'Help is at hand', the self-help booklet was evaluated in a questionnaire study (Hawton et al., 2012). The majority of participants were female and had been bereaved during the last six months. All participants bereaved by suicide reported finding the resource overall helpful or extremely helpful. Concerns were raised by participants about the availability of the resource, and 82% stated that they felt it would have been helpful to receive the resource within one month of a death.

In the pilot study of a peer support intervention reported by Barlow et al. (2010) participants and peer supporters were interviewed about their experiences of the intervention, and the contribution to their healing. A content analysis was used to extract themes. Peer supporters reported that the programme assisted in cognitive restructuring, connecting with others, reflecting on personal growth, increasing well-being and memorialising the deceased family member. They also reported a sense of satisfaction from helping others in a similar situation, and found that it assisted in their meaning making process as they felt able to give something back: "It evens things up. Helping another when possibly you were unable to help

[the deceased]" (Barlow et al., 2010, p.924). Participants reported feeling an increased sense of well-being after their meetings, and valued the chance to connect and share their emotions with another who they felt understood. Seeing someone at a later stage in the grieving process appeared to be particularly helpful, as they were able to act as an example of coping whilst maintaining a sense of memorialising their deceased relative: "Seeing it still so fresh [in the volunteer] was reassuring because you don't want to forget" (Barlow et al., 2010, p.924). Practical considerations were also important to participants, such as a willingness to adapt around their schedules, flexible and neutral meeting places, and access to telephone and email support.

Accessing support outside of normal service hours may be a particularly important aspect for people bereaved by suicide. Feigelman et al. (2008) explored participants' opinions of online peer support and 64% of the sample stated the main reason for using online support groups was the 24-hour availability of support. Privacy may also be important for some, as it was reported that stigmatisation was associated with increased distress in this sample. The three most valued aspects of online support group participation in this study were 'help to cope with pain and sadness', 'a safe place to discuss taboo topics' and 'sharing information and experiences'.

A qualitative evaluation of psycho-educational support groups for adults reported strong positive feedback from almost all participants about the group process, existence and facilitation. Helpful aspects included the group experience, talking extensively about the loss, generating hope, and sharing experiences with others. A main theme of 'feeling normal in the group' was revealed, which was contributed to by the information and guidance provided, as well as the group

structure. Themes of functional group experiences and personal change included permission, meaning making, reappraisal of cognitions around suicide and meaning-based coping processes, although there was some ambivalence around acceptance. A grounded theory model was developed which suggested that gaining insight, developing new narratives and schemas around the death and developing new relationships were desirable outcomes of the support group. It is possible that there may be a gender bias in this model as the sample only included one male participant.

A significant limitation of the research in this area is that little is known about those who drop out of interventions. Feigelman & Feigelman (2011b) interviewed participants who had withdrawn from support groups. It was reported that there were some differences in reasons for leaving depending on the duration of the membership of the group. For new members, common reasons for leaving included a mismatch between their level of need and the support available, the duration since the death, difficulties with the graphic detail in some discussions, the changing composition of open groups, and other practical reasons including finding other support networks. For long-term members, some stated that they no longer needed the support, and some experienced a mismatch between their own position in the bereavement journey and the extreme distress of those recently bereaved. Others stated a preference for suicide prevention work instead of attending groups, and some reported a move towards informal support with friends they had met in the groups. It was also reported that support groups and individual counselling may both act as facilitators for the other, and that people found them to be helpful at different times. These findings suggest that the experience of peer support groups may be very subjective, and that for some people it may not be appropriate at different

times for a range of different reasons. It should be noted that this study did not provide information on the method of qualitative analysis, therefore the validity of the findings may be questionable.

Trimble et al. (2012) reported on the postvention experiences of people who attended support groups, but had not accessed mental health services. A semi-structured qualitative questionnaire revealed themes around professional support included emotional expression and sharing, minimising stigma and knowledge of the impact of suicide, and subjectivity. These themes generally referred to support groups. Participants expressed a wish for professionals to understand the unique process of their experience. Reasons for not accessing professional support included a lack of understanding, fear of judgement or stigma, not feeling it is necessary, not thinking that professionals will understand their experience, not feeling ready, limited access to services, cost implications, and a need for better services. Whilst this sample may have been biased towards those who accessed support groups, it provides a helpful insight into some of the barriers that people may face when seeking professional support.

It is apparent from the qualitative findings reported here that the element of sharing the experience with others who understand is particularly significant in suicide bereavement interventions. Most studies reported the group element of interventions being helpful in terms of normalising and reducing the sense of isolation and stigma. The practicalities of interventions, such as having flexible 24-hour access to support were also reported to be helpful in more than one study. Two studies provide information about barriers to accessing support or reasons for withdrawing from interventions, which provides some helpful insights although

requires further attention. These findings are helpful to bear in mind when considering the range of interventions available, as it is likely that people's experiences and stage of their bereavement journey will influence the effectiveness of the interventions.

Discussion

The focus of this review was to determine what interventions for family members bereaved by suicide are described in the literature, how effective the interventions are, and what participants themselves say about their experience of engaging in them. There are a broad range of resources available, from self help and online support, community interventions, peer support, and professional led interventions. In terms of effectiveness of these interventions, five out of the six studies reporting pre and post measures reported improvements on a range of measures relating to emotional well-being. Interventions resulting in improvements included active postvention, peer support, community based crisis-intervention, group therapy for children, and family CBT for a high risk sub-group. Family CBT was not found to be effective in a general sample compared to controls. Qualitative studies reporting participants' opinions of suicide bereavement interventions were largely very positive, and suggested that having contact and sharing experiences with other people who had also been bereaved by suicide were important aspects of healing.

Whilst this review has provided an updated overview and summary of the research in this area, it is important to note that it is not possible to directly compare any of the studies due to the variance in interventions, study design and measures

used. Due to the limitations of the studies reviewed here in terms of sampling and methodology, only cautious conclusions may be drawn regarding the effectiveness of interventions for suicide bereavement. Only one study used an RCT design, and only two others used control groups. Therefore it is difficult to draw conclusions regarding whether suicide bereavement interventions are reliably more helpful than no intervention, or whether some are more helpful than others. Given these limitations, tentative conclusions can be drawn regarding peer support and multi-modal interventions. Previous reviews have not included participant opinions of suicide bereavement interventions. The qualitative findings reviewed here suggest that participants value peer support and a sense of shared experience. There was also information highlighted regarding barriers to accessing support which is important to take into account and rarely mentioned in this type of research.

Recommendations for research & practice

Although there may be increasing research into the range of suicide bereavement interventions, due to methodological limitations it is difficult to draw clear clinical implications. Also due to biases in sampling, it is unclear whether the effectiveness of certain interventions would generalise to other groups. It could be suggested that crisis intervention, community outreach interventions, or at least information packs available to people bereaved by suicide soon after a death may increase awareness of the support available, and by seeking help sooner people may reduce the complexity of their difficulties. Given the broad reaching and individual nature of suicide bereavement, it may be helpful to have a range of interventions at different levels of intensity. It was highlighted that timing may be an important

factor in determining whether an intervention may be suitable for an individual (Feigelman & Feigelman, 2011b). A multi-modal approach such as that described by Comans et al. (2013) is one example of providing a variety of types of support through one community intervention, which may enable bereaved family members to select the type of support they need at the time. Given the paucity of clear evidence around particular interventions, perhaps providing people with basic support, information and guidance may enable them to choose a mode of intervention that they feel is appropriate.

For future research, as echoed in previous reviews (Jordan & McMenemy, 2004; McDaid et al., 2008) methodologically sound studies with randomised controls, appropriate sample sizes, follow-up periods and adequate measures are required to build the evidence base for suicide bereavement interventions. Multiple outcome measures including quality of life measures and participant feedback on interventions would provide meaningful information for clinical implementation.

Given the technological advances of the last five years and the increased focus on online social interactions, further research exploring the effectiveness of online suicide bereavement resources and interventions would be helpful and may provide a means of cost-effective support. Introducing simple screening tools to assess symptoms of distress and user satisfaction to online forums would be one way of attempting to gather information on this, and could also help to signpost those most at-risk to other services.

Due to the lack of diversity in the samples of the studies reviewed, research into particular groups bereaved by suicide such as those from different cultural

backgrounds, men, and younger adults could be helpful in terms of informing whether there are differences in the bereavement experience and support needs. Based on the inclusion criteria only interventions aimed at family members were reviewed here, although there may also be a need to address the issue of emergency service and healthcare professionals who come into contact with families who are bereaved, both in terms of improving skills and awareness as well as considering the psychological impact of their work. This may contribute to attempts to counteract the wider impact of suicide bereavement in society.

Limitations of review

This review is limited by possible publication bias which may have led to an over-representation of studies reporting effective interventions. Due to this study being completed by a single reviewer there was no verification of accuracy of data extraction, and there was no structured quality assessment of the studies.

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Table 1: Summary of studies measuring the effectiveness of suicide bereavement interventions for children and adults

Date	Authors	N	Design	Type of resource	Measures	Results	Strengths & Limitations
2007	de Groot et al	122	RCT	Evaluation of 4 x sessions of manualised family cognitive behavioural grief therapy completed between 3-6 months of suicide death, compared to treatment as usual.	Baseline self-report questionnaire developed by authors including Eysenck Personality Questionnaire (EPQ), Pearlin Scale, Rosenberg Self Esteem Scale (R-SES), Inventory of Traumatic Grief, Centre for Epidemiological Studies Scale for Depression (CES-D), Paykel's suicidality items. At 13 month follow-up semi-structured interview to assess for depression & Traumatic Grief Evaluation of Response to Loss.	No significant difference between intervention and control group on complicated grief, depression or suicidal ideation at 13 month follow-up.	Randomisation stratified for age and sex and carried out independently. Control group. Standardised measures. Counselling sessions recorded for monitoring and supervision. Follow-up period. More than 50% of those approached refused to take part. Potential self-selection bias.
2008	Cerel & Campbell.	356	Comparison group.	All participant attended crisis centre. 150 had received active postvention (outreach service provided by survivors from time	Intake screening at crisis centre focussing on current & lifetime symptoms. Time taken to present to services recorded.	Active postvention group presented to services sooner and were more likely to attend support groups, and attended more sessions.	No differences between groups on individual symptoms or characteristics of suicide. Self-referred sample Retrospective comparison. No prospective data.

				of death), 206 received traditional passive postvention (self-referral to crisis centre).			Some differences between groups, APM decedent more likely to be male. Presenting to services viewed as positive indicator – unclear.
2010	Barlow, Waegemakers Schiff, Chugh, Rawlinson, Hides & Leith.	16	Pilot study – mixed methods.	4 month peer support programme – relatives of deceased paired with peer supporters (trained volunteers also bereaved by suicide). Funded by Canadian Mental Health Association.	Self-report questionnaires completed after each meeting, interviews after sessions & Hogan Grief Reaction Checklist (HGRC) completed pre & post programme completion.	Significant improvements in 3/6 domains on HGRC: despair, detachment & disorganisation. Mean ratings for helpfulness of support 4.4/5 & comfort 4.7/5. Participants rated peer support as more helpful than group and family counselling, and as helpful as individual counselling.	Standardised measure of grief reaction used. Pre & post measures & statistical tests. Mixed methods design provides detailed information for pilot evaluation. Views of peer supporters also represented. Emergent sampling, small sample size, limited representation of gender, age & kinship. No control group. No follow-up.
2010	de Groot, Neeleman, Van der Meer & Burger.	122	RCT follow-up.	Evaluation of 4 x sessions of manualised family cognitive behavioural grief therapy completed between 3-6 months of suicide death, comparing those scoring high or low on suicide	Baseline self-report questionnaire developed by authors including Eysenck Personality Questionnaire (EPQ), Pearlin Scale, Rosenberg Self Esteem Scale (R-SES), Inventory of Traumatic Grief, Centre for Epidemiological Studies Scale for Depression (CES-	22% of sample categorised as high suicide ideation. Risk of suicide ideation decreased in this group following therapy, and increased in the low suicide ideation group. No overall effect of therapy on suicidality. High suicide ideators	Data from controlled study using a general population sample. All types of kinship represented. Standardised measures used. Follow-up data provided. Sub-group analysis conducted post-hoc limits hypothesis testing. Small sub-group of suicide ideators so lower power. Reduction in suicide ideation

				ideation. Follow-up from 2007 RCT.	D), Paykel's suicidality items. At 13 month follow-up semi-structured interview to assess for depression & Traumatic Grief Evaluation of Response to Loss.	showed a significantly greater reduction in maladaptive grief reactions following therapy than low suicide ideators.	more likely in those with higher baseline scores. Replication of findings needed.
2012	Daigle & Labelle	8	Pilot study.	Evaluation of 12 session Group Therapy Programme for Children Bereaved by Suicide.	Self-report Grief scale constructed by authors, Bar-On Emotional Quotient Inventory-Youth Version, Beck Youth Inventory, Children's Hope Scale completed 2-3 weeks prior to programme and 1-2 weeks after completion.	Mean change percentages for all 4 measures indicated overall positive changes, except anger scale on BYI.	Group sessions observed & rated for adherence. Standardised measures used. Participants screened for PTSD. 1 participant was below recommended age for standardised measures. Broad age range (6-12yrs) & small sample size. Limited representation of kinship. No control group. Only descriptive group means reported, no significance testing. Programme not previously validated. Pilot study.
2013	Comans, Visser & Scuffman.	760	Matched controls.	Evaluation of cost-effectiveness of community-based crisis intervention programme for people bereaved by suicide.	Online self-report questionnaire including Kessler Psychological Distress Scale, World Health Organisation Health and Work Performance Questionnaire & European	Intervention group less likely to miss work, less contact with health professionals & more likely to continue engaging with activities of daily living. Cost utility	Large sample size. 4:1 matched controls based on time since bereavement and kinship to deceased. Standardised measures and cost analysis methods.

Quality of Life scale over a 1 year period.	analysis and quality adjusted life years indicated more positive results for those who received support from the service.	Self-selected voluntary sample. Differences between groups in terms of close kinship with deceased.
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Appendix A

Clinical Psychology Review: Guide for authors

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Section 3: Research Paper

**Professional experiences, responses and support following
patient suicide in adult mental health services in North Wales**

<Patient suicide in adult mental health services>

Rachel Newton & Dr Mike Jackson

Word count: 6958

Keywords: patient suicide, suicide survivor, mental health,

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Abstract

Objectives: To explore the experiences of patient suicide in mental health professionals.

Methods: The experience of 9 adult mental health professionals in two counties of North Wales was explored using semi-structured qualitative interviews.

Results: Interpretative Phenomenological Analysis revealed 6 themes: emotional impact on the self, being logical: making sense of suicide, impact in the workplace, unhelpful responses in the workplace, helpful responses and sources of support, and philosophy of mental health care.

Conclusions: All participants reported being affected by patient suicides at a personal and professional level. Peer support and contact with patient family were reported as helpful, whilst poor communication and a focus on formal and legal issues was unhelpful. Clinical implications for supporting professionals were explored.

Introduction

Suicide has received increasing research attention in the UK since the 1990's, (Appleby et al., 1999) and it is estimated that 90% of people who die by suicide have a mental health problem (Kapur, 2009). A great deal of research has been carried out to support the National Suicide Prevention Strategy in England (Robinson, Meehan & Appleby, 2002; Appleby et al, 2012), and it has been demonstrated that where mental health service recommendations have been implemented, a reduction in suicide rates followed (While et al., 2012). In Wales a five year national action plan is in place (WG, 2009) to address suicide and self-harm prevention, including aims to promote learning, research and improve information in this area.

The impact of suicide on those left behind is widely acknowledged (Clark, 2001; Hawton & Simkin, 2003), and certain factors may increase the impact, for example kinship to the deceased, quality of the relationship, and age of the deceased person. A qualitative study of the personal responses of people bereaved by the suicide of a young person highlighted themes of guilt, responsibility, and searching for reasons (Bell, Stanley, Mallon & Manthorpe, 2012). It is possible that relationships where there is a greater sense of responsibility for the person who dies, may have a greater impact in terms of guilt and blame. People often hold themselves responsible for not being able to prevent a suicide from occurring (Farberow, 1992).

A qualitative study (Chapple, Ziebland & Hawton, 2012) reported that family members' accounts of suicide included a sense of distancing themselves from blame

for the death, at times attributing responsibility to other factors. It has also been found that where a suicide has been expected, for example when there have been previous attempts, there is a greater sense of understanding in those who are bereaved, less preoccupation and less searching for explanations (Wojtkowiak, Wild & Egger, 2012). Searching for meaning is a common response to bereavement (Neimeyer, 2001), which can be a difficult process in the case of a suicide where there may be many questions left unanswered.

Mental health professionals work with individuals who experience significant mental health problems, and are thus at risk of experiencing suicide bereavement (Chemtob, Bauer, Hamada, Pelowski & Muraoka, 1989), and it has been suggested that patient suicide may be a leading cause of stress for these professionals (Ellis, Dickey & Jones, 1998). A study in England reported that 45% of Community Mental Health Team (CMHT) clinicians experienced long lasting professional effects of a patient suicide, and 40% experienced effects on their personal lives. Although it has been suggested that positive effects such as increased vigilance around risk assessment and better note-keeping occur as a result of patient suicide, in this study these effects were in the minority, and more clinicians reported negative effects such as increased anxiety at work and avoidance of high-risk client groups (Linke, Wojciak & Day, 2002). A survey of psychologists who experienced patient suicide reported emotional responses of guilt, anger, distress, and numbness, and almost half reported trauma symptoms that lasted 6 months (Chemtob, Hamada, Bauer, Torigoe & Kinney, 1988b). In a study of consultant psychiatrists in

Scotland, fifteen percent of respondents had considered taking early retirement as a result of a patient suicide (Alexander, Klein, Gray, Dewar & Eagles, 2000).

It has been suggested that professional's responses to a patient suicide can be influenced by a number of different factors, for example females are reported to be more significantly affected, and the number of years in the profession, number of previous patient suicides, and length of involvement with patient has also been suggested to play a role (Grad, Zavasnik & Groleger, 1997; Gulfi, Castelli Dransart, Heeb & Gutjahr, 2010; Wurst et al., 2010). Hodelet & Hughson (2001) suggested that those with the least professional training may be vulnerable to poor outcome following a patient suicide. Although this has not yet been explored with mental health professionals, it has been found that appropriate support lessens the emotional impact of suicide bereavement (Schneider, Grebner, Schnabel & Georgi, 2011).

The role of mental health professionals and duty of care towards the people they work with is associated with a degree of responsibility. Farberow (2005) suggested that this professional role brings with it additional difficult experiences such as feelings of failure, blame and self-doubt following a patient suicide, and highlighted a need for support. It has been suggested that mental health professionals may be hesitant to seek help due to concerns about burdening colleagues (Hodelet & Hughson, 2001). However Linke et al. (2002) reported that informal peer support and skilled supervision are helpful to clinicians following a patient suicide, in addition to dedicated reviews and careful handling of formal

enquiries. Contact with the patient's family has also been reported to be helpful (Rothes, Scheerder, Van Audenhove & Henriques, 2013). A study reviewing 505 patient suicides in the Netherlands suggested areas for improving practice including: communication and continuity of care, risk assessment, and involvement with patient's relatives (Huisman, Kerkhof & Robben, 2011). Valente and Saunders (2002) also highlighted the importance of the organisational structure and practitioners' views of the available support in response to patient suicide.

According to the most recent national statistics (Appleby et al, 2012), there were 70 patient suicides (categorised as having had contact with mental health services in the 12 months prior to death) in Wales in 2010, and 813 between 2000-2010. There have been calls for more research addressing the impact of patient suicide on professionals, and what support may be helpful to teams (Linke et al., 2002; Wallace, 2008).

This study aimed to contribute to current understanding and provide an in-depth exploration of the impact of patient suicide on professionals in a CMHT and the local organisational responses. A qualitative design allowed for detailed accounts of the experience of patient suicide, how it affects mental health professionals personally and professionally, and how the organisation responds.

Method

Participants

Community Mental Health Teams (CMHTs) in two counties of North Wales were approached to take part in the study. After completing a screening questionnaire nine participants consented to take part in qualitative interviews. The participant group comprised three community psychiatric nurses, two psychiatrists, two social workers, and two psychologists. The age range was 30-55 years, and the number of years experience in mental health ranged from two to twenty-eight years (median=16). Five females and four male professionals participated (with both genders being represented in each professional group).

Procedure

Ethical approval was obtained by the School of Psychology, Bangor University, and the NHS Research Ethics Committee. Managers of adult CMHTs in the Conwy and Denbighshire areas of North Wales were contacted and offered information about the study. The lead researcher attended three team meetings at different bases to provide further information about the research and distribute screening questionnaires. Approximately 12-15 adult mental health professionals attended each of the team meetings. The questionnaires included an opt-in form for participants to give their consent to be contacted regarding taking part in an interview about their experiences. Participants had the option of returning completed questionnaires at the meeting or using a freepost envelope.

To meet criteria for interviews participants had to have experienced a patient suicide where they had at least 5 clinical contacts with the patient. The patient could have been discharged for up to 12 months at the time of their death. Screening questionnaires were used to identify participants who met the criteria and had agreed to be contacted, and potential participants were contacted via email to confirm that they were still interested, and to arrange a suitable appointment. Consent forms were completed prior to the interviews, and all interviews were held at CMHT offices, between November 2013 and February 2014. Interviews lasted between 30-70 minutes.

Design

A screening questionnaire was developed based on Alexander et al. (2000) to gather descriptive information about professionals' experience of patient suicide; the results are not included here as the focus is on the qualitative aspect of the project. The questionnaire also provided an opportunity to opt in to take part in qualitative interviews. A semi-structured interview protocol was developed to address the research questions in more detail, focussing on the individual experience of the patient suicide, the personal and professional impact, the response from the organisation, and any support received (See appendix B). Participants were asked to focus on their most distressing experience of patient suicide if they had experienced more than one.

Interpretative Phenomenological Analysis (IPA) was used to analyse the transcripts, as the aim of the research was to explore the shared experience of

patient suicide in depth. IPA was felt to be the most appropriate analytic method for the subject matter because it allowed an in-depth exploration of the participant accounts of their experiences, whilst also acknowledging the perspective of the researcher as a mental health professional and how this may have influenced the interpretations. In the initial stage of analysis, interviews were transcribed by the researcher. Transcripts were explored and annotated, focussing on descriptive, linguistic, and conceptual comments on the data, along with reflective comments from the researcher. For each participant, these comprehensive comments were categorised and analysed to identify emergent themes, in an effort to capture the complexity of the experience in a simple and clear way. Three transcripts were selected at random by the research supervisor to triangulate responses with the lead researcher through comparison and detailed discussions. This enabled a level of confidence in the connection between the raw data and the interpretations that were made. Emergent themes were reviewed, involving a process of interpretation as attempts were made to make sense of the different elements of the individual experience. These were grouped according to the meaning that was assigned by the researcher. Individual theme tables were developed for each transcript; following a process of comparing and contrasting across emergent themes, revisiting transcripts, and abstraction of identified patterns these themes were organised into a master theme table, which demonstrates the superordinate themes.

Results

From the interviews, it was clear that patient suicide had a substantial effect on participants, although there was considerable variation in how they responded. All participants could recall in great detail being informed of the particular suicide, even in cases where they had experienced many patient suicides, reflecting the importance of the event. Participants had a desire to tell their story and that of the patient, and were especially keen to illustrate what they did to support the person before they died. Whilst participants clearly demonstrated that patient suicide had a significant impact on them, the majority stated that they felt able to cope and there was some resistance to seeking external personal support such as counselling. However the need for professional support was clearly stated, and there was a sense of participants feeling somewhat isolated and that the focus of managers was on professional liability rather than support. Participants appeared to deem themselves 'lucky' if they found themselves in a team with supportive colleagues and managers. Six superordinate themes are outlined with examples below.

<insert table 1 here>

Emotional impact on the self

Participants' accounts indicated significant initial and lasting emotional responses to a patient suicide, including shock, disbelief, sadness, anxiety, loss, anger, isolation and numbness.

P 9: "I was in tears, and I just, I couldn't go on, it was one of those days where...where I just, you know...I felt very very emotional, it wasn't just for a day"

It seemed that the impact extended to thinking about the patient over time, experiencing a strong emotional response when thinking about the patient now, and being reminded of the patient in different ways e.g. passing places associated with the person such as where they lived or worked, and anniversary effects. The following quote refers to a suicide that occurred almost eight years previously:

P 5: "I certainly think about him, I can picture him now, and erm I've got a really vivid image of him in that last session...and also, places that I associated with him...every time I pass that place I sort of think about the person"

The depth of the emotional impact of a suicide was related to the therapeutic relationship, longer involvement, and the professional's feelings towards the patient.

P 1: "because I had such a good relationship with her, I'd worked with her for a long time, and obviously you're bound to build up a relationship, and I feel quite emotional thinking about that"

Some participants felt that the nature of their role and the amount of direct contact with patients increased the impact of a suicide, compared to other professions who they felt may not develop the same depth of relationship.

P 3: "I do think that Psychology because they get to know people in-depth over a long period of time are perhaps more at risk of feeling a greater sense of loss, cos we don't have as many people on our caseload do we?"

Participants often made very positive attributions about the patient and spoke about them with fondness and sensitivity.

P 9: "for me it was, you know, a very precious patient, a being, to lose, and I don't think I will ever get used to losing somebody like that"

Professionals also described a sense of surprise and lost potential, patients were often described as having shown improvements or previous recovery from mental health problems, few had previously attempted suicide or voiced their intentions. Many were young adults whom professionals did not feel to be at risk of suicide. This unexpectedness and shock surrounding a suicide contributed to the emotional impact, adding a sense of tragedy and confusion.

P 4: "out of all the people you'd expect it, it wouldn't have been him...he was a lovely man...lovely couple...I knew he could get out of it I'd seen him, we'd sort of fixed it once, and we'd just do it again"

Being logical: Making sense of the suicide

A common initial response reported by participants was a process of rumination, participants questioned and blamed themselves and felt somewhat guilty for not having done more.

P 8: "you're just thinking back...what we talked about, should we have talked about more in-depth about medication...did we discharge him appropriately? Just everything, you know, just questions in my mind all the time"

Following a suicide, all participants described a process of trying to make sense of what happened. In doing this participants drew on their own views of suicide, their knowledge of the patient, and their ability to empathise with the mindset of the patient at the time of their death. For some participants this seemed to provide some comfort and acceptance, whereas for others they were left with unanswered questions.

*P6: "he was on a community treatment order, erm,
which he was desperately unhappy with....and I have
wondered somewhat whether that was relevant in why
he chose to do what he did, and I think it was clearly a
very angry destructive thing"*

Participants spoke of their role of supporting the patient, and most went into great detail about risk management plans and supportive interventions, and made comments about the limits of control of mental health professionals. In those cases where the risk was considered to be high, it appeared that increased support had been offered, but the patient had still gone on to end their life. Participants' focus on the support they had provided and the limits of their control was interpreted as a defensive way of establishing a boundary between their professional responsibilities, and the patients' right to choose to end their life, in order to reduce feelings of guilt and blame. It appeared that this dilemma between professional responsibility and the limits of control could lead to a sense of powerlessness in protecting patients, that 'we did everything we could', but it wasn't enough.

*P2: "we had the home treatment team involved, you
know everything we could possibly do, he'd been
admitted, nothing worked, and no matter what we
gave him, nothing seemed to matter"*

Impact in the workplace

Participants reported a range of ways in which a patient suicide had impacted on their professional practice, including a clear sense of increased caution and risk awareness. This ranged from an initial heightened awareness of suicide cues, to a long term understanding of risk factors such as hopelessness. Participants reported short term changes in practice such as avoiding discharging patients, or avoiding taking on suicidal patients. These short-term changes were often linked to their anxious emotional state and an urge to safeguard other patients, as well as themselves.

P4: "I felt that everybody that was talking about suicide was gonna go and kill themselves so that definitely affected me...but obviously it just lessened in intensity...I think I probably err on the side of caution now than I would have done before"

P3: "I did pull myself out of those type of cases just for a short while until I got myself re-grounded...helpful for me to know that I wasn't putting anybody else at risk of not hearing them"

For all participants, this immediate response of being averse to taking on suicidal patients or discharging patients decreased over time. In the long-term, some participants actively engaged in further training around working with high-risk

patients, which had a long-term impact on their practice in terms of improving their skill level and confidence. Participants spoke of what they had learned from their experience, and how they could incorporate that experience into helping other patients.

P8: "I think that it's made me stronger from an assessment point of view"

P3: "I'm not sure if I would have taken her on for long term therapy had it been today"

Participants spoke about offering support to other colleagues as a result of their experience, in some cases this was because they felt they didn't have this support, and in others it was acknowledged that this type of support was helpful for them, therefore they wanted to provide the same for others in their situation.

P7: "It's just giving them time to sort of reflect, talk it through...so for me when I offer supervision every month I'm very aware of, that that still may be ongoing, that process of enquiry hasn't finished, and I'll tend to bring it up in supervision"

Unhelpful responses in the workplace

Most participants reported feeling unsure about the formal process following a suicide, such as trust investigations, and that they were not given clear information or feedback about the outcomes of these processes. The usual process following a serious untoward incident is for clinical notes to be reviewed and further information gathered to determine whether appropriate steps were taken to assess and manage risk. This often cumulates in a report and a formal meeting to discuss what can be learned from the incident. Some participants were unsure whether investigations had been carried out, some had been involved but had not been informed of any outcomes and were unclear on what was supposed to happen. In some instances this lack of clarity referred to particular individuals such as managers, and in others it reflected on an overarching issue in the formal process.

P3: "notes have been taken and I was never informed of the outcome of that...you're left with it hanging over your head."

P4: "people don't really seem to know what's going on, it's just this big question mark, which I think is quite poor really"

One example of particularly poor communication involved a participant returning from annual leave and not being informed of a patient suicide by the team; they had sent out a missed appointment letter to the patient, and were then

informed of the death by the patients' family. It is likely that this lack of communication and clarity served to increase feelings of anxiety and isolation, and contributed to an already difficult situation.

P1: "it was almost like I had to find out myself what actually happened to her, you know, which I just found...pretty poor really"

Most participants reported finding some support from individuals in the workplace, which is discussed in a later theme. An unhelpful aspect of the more direct response to the suicide from managers, colleagues and other professionals was a focus on following protocol, and dealing with paperwork and formalities, and not acknowledging or validating the impact on the person. There was a sense of superficial support, perceived as 'ticking a box' and an inferred message that people should get on with their job. Participants appeared to feel neglected as they perceived that protecting against liability was prioritised over the consideration of their emotional well-being.

P7: "initially...your manager's very concerned about ensuring that things like that are done...so they're just concerned with the formality really...unless I guess you were showing that you were upset then they would obviously ask, but after a couple of days, not really"

P4: "It's like 'we'll support you'...but after that, there was nothing I suppose you're just expected to get back on with your work really...I was given cases in a hallway...and you just think 'actually you don't really know how this has affected me'"

Although participants reported an awareness of support services such as counselling, occupational health, and supervision, there were a number of issues raised about accessing this support in a timely manner. There was a sense of having to ask for support rather than it being offered, and barriers to this included an awareness of the demands of the service, worries about being perceived as not coping if they accessed counselling, and concerns around how appropriate the support would be if they did access it.

P2: "Sadly once or twice when I have gone to occupational health they just, don't know what to say, and you tend to have more answers than they do, maybe it's the nature of the job"

It was interesting to note that in a group of mental health professionals, only one had accessed counselling. There appeared to be some resistance to needing professional help, which may reflect some of the 'hardness' that was suggested to be

present among those who have worked in mental health for long periods of time. Some participants recalled being told by more experienced staff that they would get used to suicide, which they found unhelpful, and could have been a barrier to accessing further support.

P8: "I do think that the culture's definitely there...you get that response 'it happens, and you're going to have to develop your skills to accept it when it happens'"

A few participants reported not having management or clinical supervision until weeks after a patient suicide, and it was suggested by one that in some management supervision sessions a deceased patient would not be discussed as they would no longer be on the caseload. There were concerns raised about how specialised the support from Occupational Health services might be, and one participant considered Occupational Health as they felt they required support, but then decided against it as they felt it would result in them having to take time off, which would increase their workload in the long term.

P1: "I had supervision...general supervision, probably two or three weeks later...she said 'how are you feeling about it all?' and I said 'well you know we're sort of two or three weeks down the line now, (laughs) I've had to you know as they say pull yourself together...and get on with it'"

Helpful responses and sources of support

Participants reported using a range of personal coping strategies in response to a patient suicide, including focussing on their work with other patients, keeping active, putting things into perspective, and allowing themselves time to think about it. One participant accessed self-funded external counselling, and one participant stated that they coped by 'trying to forget'. It was noted that the only participant who accessed professional counselling was a clinical psychologist, which could reflect differences in professional training and the amount of focus on self-reflection and personal development. It was observed that those participants with social work or psychology training were more forthcoming when discussing coping strategies and their own well-being, compared to participants with psychiatric backgrounds.

P1: "I know what I need to do to keep myself well, both mentally and physically, and I do those things, to protect myself, because you have to when you work in mental health"

Peer support from colleagues was widely stated as helpful sources of support. A sense of having a shared experience, being able to talk informally and frequently in a safe environment seemed to be very important. There was a sense of having their experiences normalised and validated, as well as the reassurance that they weren't alone, and somebody was checking how they were doing. It was noted that

psychologists found clinical supervision to be more helpful than peer support from the wider team, whereas other professionals reported the opposite.

P7: "I think the support you tend to get is from other staff who may have experienced something similar, and that's sometimes helpful because...you just then know that you're not on your own"

Almost all of the participants reported that having contact with the patients' family after the suicide was a helpful experience. Only one participant had not had contact with the patients' family. Although it was generally acknowledged that there was no protocol for this and it may vary on a case by case basis due to different dynamics between patients, their families and mental health services, there was also a consideration of the importance of not simply 'cutting off' the support to the family following a suicide. In some cases a formal meeting was held with managers and professionals to offer families an opportunity to ask questions and be signposted for further support. In others participants attended funerals and had informal contact with families such as a phone call to express condolences.

P1: "I mean I went to her funeral, I contacted her son, I offered him support, which he very much appreciated, I went to her funeral, and I think that gave me closure"

It appeared that there was a sense of duty towards the family in some responses, as well as a fear of hostility or blame, which may have been driven by feelings of responsibility for the patient. It is possible that participants felt compelled to offer something to the family, as they may have felt that they could not help their loved one. The majority of patient families were very grateful for the support their loved one had received, and none responded with hostility or blame, which was a comfort for the participants, as well as a humbling experience. The process of participants being comforted in some instances by bereaved family members is an interesting reversal of role.

P8: "they said they didn't want me to feel that it was my fault, and they just wanted to thank us for the support we'd provided for him ... as soon as they walked in they gave me a hug and said 'I hope you're alright, don't think it's your fault'"

Philosophy of mental health care – role and responsibility

Throughout the interviews there were many references made to the wider contextual considerations around patient suicide. Participants spoke about the way that mental health services respond to people who express suicidal feelings, in terms of risk assessments and risk management plans, which give a sense of safety and security to professionals and the wider organisation. However this was coupled with an acknowledgement of the limitations of the professional role and responsibility,

and a sense of acceptance and inevitability that suicides will still happen in spite of prevention measures. There were some ideas expressed around people's right to choose to die, and where this might sit with suicide prevention schemes within mental health care. It is possible that acknowledging the paradox between wanting to prevent suicide and the patient's right to a choice created some feelings of unease.

*P2: "at the same time I do accept that people have
a right to kill themselves ...it's not against the law
it's nothing people aren't allowed to do...
all we can do is sort of do our analysis, we do risk
assessment...we can't wrap everyone up in cotton
wool and there's gonna be an acceptance... I mean
hopefully it won't happen, but one of these patients
is gonna die"*

There was a sense of tensions within mental health services, between different professional groups and the organisation. It was suggested that there was a contrast between the messages from the organisation around suicide prevention targets and the reduction in availability of inpatient beds and other services, with a sense of frustration of being stuck between patients who require more support than services can provide, and an organisation that sets targets which can't be met.

P2: "you know we've got less beds now than we had before...the trust on one hand are trying to say lets reduce suicides, lets give them more support...but at the same time things that have worked in the past are being reduced"

There were concerns expressed around a focus on targets and funding issues, leaving less time for supporting patients and for professionals to access support themselves, and a perception of a service operating on a 'skeleton' basis. It is possible that these tensions contributed to the sense of participants' feeling helpless and stuck in the middle of their patients and the organisation. It also seemed that participants felt somewhat powerless in a system that appears to be working against their philosophy of care, and it is possible that this may reflect the way that patients feel. The following quote questions the crisis-led approach of mental health services in preventing suicide:

P5: "If you just go too far towards safety ...you actually lose sight of the person's needs and the reason they might be feeling hopeless and helpless...we don't just want to be just trying to prevent suicide we want to help people to make their lives feel worthwhile and meaningful so they don't feel like they have to kill themselves...there seems to be more emphasis on prevention of doing things that make headline news"

Discussion

The experiences of nine CMHT professionals including community psychiatric nurses, social workers, psychologists, and psychiatrists were analysed using interpretative phenomenological analysis. Six superordinate themes relating to the experience of patient suicide emerged: emotional impact on the self, being logical: making sense of suicide, impact in the workplace, unhelpful responses in the workplace, helpful responses and sources of support, and philosophy of mental health care: role and responsibility.

The emotional impact of a patient suicide included sadness, shock, disbelief, and anger, which is consistent with previous research (Linke et al., 2002; Chemtob, 1988b). There also appeared to be certain factors associated with an increased emotional impact, such as length of involvement, therapeutic relationship and characteristics of the patient, in line with findings by Gulfi et al. (2010). The impact of some of the suicides in this sample was related to them being relatively unexpected, which resulted in a process of questioning and searching for meaning. This is supported by the findings of Wojtkowiak et al. (2012) who found a link between expected suicides and increased understanding in family members bereaved by suicide. In the context of mental health professionals, the difficulty in understanding the suicide was related to the seemingly low objective risk of the patients they were involved with, or signs of recovery that they had demonstrated, rather than a lack of insight into the persons' difficulties.

Similarities with findings from studies with family members included themes of responsibility and searching for reasons (Bell et al., 2012) as well as a sense of trying to distance themselves from blame (Chapple et al., 2012). This was apparent in the personal responses to patient suicide including stating all that had been done for the person, and pointing out the role of patient choice in terms of taking their own lives. Given the duty of care and common feeling of being responsible for patients in mental health care, it is likely that the dilemma between professional responsibility and patient choice is a common one. This links to moral and ethical issues related to suicide as a right and an act of free will, versus suicide as a sign of illness or an impulsive act that must be prevented. These rather taboo subjects were touched upon during interviews, and it was acknowledged that they are not commonly openly discussed in mental health services.

In terms of professional impact, there was a reported increase in anxiety and caution around decision-making, with some participants stating they had actively avoided certain tasks such as discharging patients or assessing suicidal patients. Similar issues were reported by Linke et al. (2002); almost half of respondents reported long lasting professional impact, the majority of which were deemed to be negative. In this sample there was evidence of some positive professional impact in terms of reflecting on the experiences, which may in turn improve practice. Some spoke about being motivated to increase their skills and engage in further training, and offer support to other professionals who had similar experiences. These experiences regarding increased reflection and a focus on improving clinical skills are interesting and have not been highlighted in previous research, although this may be a practical response following an initial period of increased anxiety and caution.

Given that participants expressed dissatisfaction with services such as Occupational Health due to concerns about whether it would meet their needs, and stated a preference for support from someone who has had a similar experience, peer support may be a valid option to explore.

Unhelpful responses were reported to come from individuals at work as well as the wider work organisation. This included a general sense of uncertainty around the formal processes that follow a patient suicide, and a lack of satisfaction regarding the communication around this. This is in support of the suggestion of Valente and Saunders (2001) around the importance of having a clear organisational structure in place. This also provides support for the recommendation made by Huisman et al. (2011) to improve communication around patient suicides both in terms of informing professionals of a suicide, and providing feedback on formal investigations. Where formal processes were followed, there was a sense of superficiality, and that protecting against liability was prioritised over the consideration of the impact of the suicide on the person. This may relate to an issue reported by Linke et al. (2002), that professionals felt uneasy about formal processes. If there is a lack of clarity and communication, combined with a perceived focus on fact-checking and a superficial sense of support, it is easy to see how professionals may feel isolated and to blame, and anxious about enquiry processes. Whilst formal processes are an important part of learning from patient suicides and ensuring that good practice is upheld, it is very important that these issues are dealt with sensitively, as suggested by Linke et al. (2002), and that they are part of a supportive process.

There were also issues around accessing professional and personal support where it was available, including a hesitance to ask managers for support if it was not offered, and concerns around the appropriateness and timing of the support. This is in line with Valente & Saunders (2001) point regarding the importance of taking into account professionals' views of available support. Those who were aware of occupational health were unsure of the suitability for their needs, or were concerned about being judged for requesting or accessing support, or having to wait a long time to be seen. There appeared to be a preference for support to be offered on an automatic basis rather than requested, with options for less formal support than face to face meetings, including telephone and online. The apparent resistance to accessing counselling was an interesting finding, and this is in direct contrast to aims of improving reflective practice and acknowledging the impact of the challenges of working with high risk patients (Holdsworth, Belshaw & Murray, 2001; Clouder & Sellars, 2004). It was noted that there were differences across professional groups in terms of their acknowledgement of the personal impact and desire to seek support which may reflect differences in training and approaches to supervision and staff support, for example psychologists spoke more positively about clinical supervision and reflective practice.

Peer support was widely reported to be a helpful response to patient suicide; this provides further support for Linke et al. (2002). In many cases support from colleagues and clinical supervision were the only forms of support deemed helpful by participants. It is acknowledged that this is likely to vary depending on relationships within a team, as many participants referred to very supportive colleagues, this appeared to be in contrast to the perception of the 'organisation' as being uncaring

and formalised, and there was a sense of team members coming together when they couldn't rely on other forms of support. The importance that was placed on peer support should be taken into account in light of recent ideas in some NHS trusts around moving away from traditional office bases and towards a 'hot-desking' mobile community team approach to improve efficiency (Duffin, 2011). This would be likely to dramatically reduce the access to good quality informal peer support, and may contribute to feelings of isolation. There was some suggestion of being unwilling to burden supervisors who were perceived to be very busy in some professional groups; Hodelet & Hughson (2001) reported that professionals may be unwilling to burden their colleagues to talk about their experiences. This is likely to be something that will vary depending on dynamics within teams and different systems for supervision; however it seems sensible that additional supervision is offered following a patient suicide, without the necessity of asking for it.

Contact with the family of the patient was reported to be helpful in terms of helping to understand the suicide, getting a sense of closure, and feeling a sense of satisfaction at being able to offer support to the family and receiving a positive response. This supports the findings of Rothes et al. (2013), although it was acknowledged by participants that the experiences of such contact may vary significantly depending on the individual family members. It was unclear what was expected of professionals in terms of family contact, and where the limits of this support might be. It may be good practice to have clear guidelines around contact with family members of patients following a suicide, and is possible that this could be helpful to both parties in terms of helping to make sense of what can be a hugely unsettling event.

The final theme emerging from the data concerned reflections on the philosophy of mental health care at its foundation. There appeared to be a paradox between ideas around suicide prevention and the perceived inevitability of suicide and peoples' right to choose to die. Tensions within mental health services and the NHS organisation were also referred to, such as a focus on targets and cost-cutting, and a reduction in services for prevention of suicide. These wider organisational factors are likely to provide a context for many of the other issues raised in this analysis, and are also important to bear in mind in terms of maintaining staff morale and optimism in a challenging area of work. These issues have not been highlighted directly in other research into patient suicide, and may be a result of the in depth discussions arising from the qualitative approach.

The findings from this study are supported by previous research in terms of the lasting personal and professional impact of patient suicide on mental health professionals. This study has also highlighted some specific issues around unhelpful responses which contribute to the difficulty of the experience, and may provide guidance for organisations to improve the support that is offered. Improving clarity and communication around the formal enquiry processes, and acknowledging the personal and professional impact it may have on individuals may be helpful. Guidelines for managers around steps to take and support available to professionals and families may help to increase awareness and promote better practice. A positive effect of increased reflection and a desire to improve practice was also reported by participants, which has not been reported in detail before. Promoting reflective practice along with peer support and clinical supervision may allow further

opportunity for learning and professional development. Broader issues around the philosophy of mental health care raised by this study may also provide a helpful context for further research or suggestions for service development.

This study was limited by the initial response rate, which meant that there was less opportunity to screen and select participants for interviews. A larger study could have included more CMHTs across North Wales to provide a broader representation of how patient suicide is dealt with within one large NHS health board. This may also have allowed for consideration of differences between professional groups. However, the aim was to represent the particular experiences of those who took part in the study, rather than generalise across a larger group.

Table 1: Themes following IPA analysis exploring mental health professionals' experience of patient suicide

Superordinate themes

Emotional impact on the self	Being logical: making sense of suicide
<i>Initial and lasting emotional responses</i>	<i>Questioning or blaming self</i>
<i>Role of therapeutic relationship</i>	<i>Trying to make sense of suicide</i>
<i>Patient factors – lost potential</i>	<i>We did everything we could – limits of control</i>
Impact in the workplace	Unhelpful responses in the workplace
<i>Increased caution and risk awareness</i>	<i>Uncertainty and poor communication</i>
<i>Reflecting on practice</i>	<i>Formality and superficiality – back to work</i>
<i>Supporting others</i>	<i>Barriers to accessing support</i>
Helpful responses and sources of support	Philosophy of mental health care – roles and responsibility
<i>Personal coping strategies</i>	<i>Risk assessment, prevention and the inevitability of suicide</i>
<i>Peer support and supervision</i>	<i>Professional and organisational tensions</i>
<i>Contact with patient's family</i>	

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Appendix B

Schedule for semi-structured interviews (V1 – 06/03/2013)

Start by reviewing information on page 1 of questionnaire:

Length of time working in mental health

- Work engagement/enjoyment
- Number of patient suicides – key professional in these cases?
- *Predictability of patient suicide?*
- *Preventability of patient suicide?*

Move on to discussing individual case of patient suicide:

- Tell me about this patient – length of involvement, engagement, therapeutic relationship?
- How long ago was it?
- Can you tell me about the time that you first heard that the patient had died? What happened next?
- What was your experience of the formal procedure following the death?
Refer to questionnaire for prompts
- How did this impact on you personally?
- How did you feel your role was perceived by others?
- What did you do to cope with this situation?
- What kind of support did you have during this time? Was this helpful?
Formal/informal, helpful/unhelpful? Refer to questionnaire responses – what about was helpful/unhelpful.
- Did this experience have any impact on you professionally? *Short term & long term, changes in practice etc.*
- What advice would you give someone in your position?

Appendix C: Archives of suicide research: Instructions for authors

Instructions for authors

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Abstract: Each article should be summarized in an abstract of no more than 120 words. Abstract should be separated into Objectives, Methods, Results, Conclusion. Avoid abbreviations, diagrams, and reference to the text.

Text: The contents of the text should adhere to the general structure of scientific papers: introduction, method, results, and discussion. If applicable, it should be made clear in the methods section that informed consent was obtained from subjects who participated in the study.

Illustrations: Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines: 300 dpi or higher; sized to fit on journal page; EPS, TIFF, or PSD format only; submitted as separate files, not embedded in text files.

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Section 4: Contributions to Theory and Clinical Practice

Suicide bereavement and patient suicide

Summary of thesis findings:

Following a literature review on available resources for family members bereaved by suicide, there was a range of helpful modes of support identified, ranging from self help and online support to structured peer support, and group and family interventions. Qualitative studies revealed that participants' opinions of interventions were generally very positive, and a particularly helpful aspect was sharing their experiences with others who understood. As the literature in this area is quite scarce, and those studies reviewed had many methodological limitations, it is apparent that there is a need for continued research into effective support for family members and friends affected by suicide.

A qualitative exploration of mental health professionals' experience of patient suicide and responses from the organisation revealed a number of themes, which are outlined in table 1. It was found that there was a significant emotional impact of the patient suicide, as well as a cognitive process of trying to make sense of the event, and changes to short and long-term practice. Unhelpful responses from within the organisation and forms of support were highlighted, along with philosophical issues around suicide and mental health care provision. These findings provided support for previous research, and highlighted the importance of the organisational response to patient suicide.

Table 1: Themes following IPA analysis of professionals' experience of patient suicide

Superordinate themes

Emotional impact on the self	Being logical: making sense of suicide
<i>Initial and lasting emotional responses</i>	<i>Questioning or blaming self</i>
<i>Role of therapeutic relationship</i>	<i>Trying to make sense of suicide</i>
<i>Patient factors – lost potential</i>	<i>We did everything we could – limits of control</i>
Impact in the workplace	Unhelpful responses in the workplace
<i>Increased caution and risk awareness</i>	<i>Uncertainty and poor communication</i>
<i>Reflecting on practice</i>	<i>Formality and superficiality – back to work</i>
<i>Supporting others</i>	<i>Barriers to accessing support</i>
Helpful responses and sources of support	Philosophy of mental health care – roles and responsibility
<i>Personal coping strategies</i>	<i>Risk assessment, prevention and the inevitability of suicide</i>
<i>Peer support and supervision</i>	<i>Professional and organisational tensions</i>
<i>Contact with patient's family</i>	

Implications for future research

There have been calls for an increase in research studies using a randomised control trial (RCT) methodology which may provide clearer findings about the effectiveness of interventions for people bereaved by suicide (McDaid et al., 2008; de Groot et al., 2010). RCT's are suggested for structured psychological interventions, such as group CBT or psychoeducation. Whilst there is a need for more controlled studies in this area, control groups and randomisation bring with

them some ethical issues of withholding a potentially helpful service from those in need. There are also practical considerations around using waiting list controls or treatment as usual; these participants may be likely to seek other forms of support during this time, as could treatment as usual participants. Also if a waiting list control group are to be offered the intervention at a later point in time, it would not be possible to provide follow-up data for the control group.

As Feigelman et al. (2008) reported, many family members who use one mode of supportive intervention often utilise others as well, such as online support groups, face to face support groups, and professional mental health input. Three of the six effective interventions reviewed were multi-modal and utilised a range of levels of support (Barlow et al., 2010; Cerel & Campbell, 2008; Comans et al., 2013). Controlling for the effects of other potential interventions such as advising participants against engaging in other interventions would be important, which would mean that the intervention being tested would have to appropriately meet the needs of the individuals by offering multi-modal support, to minimise risk to participants.

In any future research, gathering detailed data on participants' involvement in other services, including use of online and informal support, would be helpful and with a large enough participant group may allow for involvement in different types of intervention to be controlled for. Incorporating feedback from participants on how helpful they feel different aspects of interventions to be would also provide valuable information. Increased screening of participants for complicated grief, distress, and suicide risk, and larger numbers of participants in intervention effectiveness studies may allow for between group comparisons to explore who

might benefit most from these interventions. In-depth qualitative explorations in conjunction with wider quantitative studies could contribute meaningfully to the literature in this area and provide suggestions for service provision.

In the research paper a range of detailed experiences of patient suicide were highlighted by mental health professionals which may benefit from further exploration. For example it would be interesting to explore in more detail the role of the therapeutic relationship, and the patient factors such as severity of mental health problems, previous history of self harm or suicide attempts, and whether this may influence the impact of the suicide on the professional. A common experience for the professionals in this study was that their patients had not voiced their suicidal feelings to them before acting on them, which led to participants experiencing feelings of shock and questioning themselves. It would be interesting to explore a broader sample of professionals who may have had different experiences such as participants discussing their suicidal feelings prior to taking their life, and how this might affect the professional's response in terms of feelings of responsibility and the limits of their control.

Exploring individual differences in mental health professionals would provide further information about whether certain professionals may be more vulnerable to the impact of patient suicide. Research taking into account individual stress levels, burnout, attachment style and attributional styles may offer further insights into the processes involved in coping with the suicide of a patient. It was noted that whilst participants in this study reported experiencing lasting effects of a suicide, they all

felt that they had done all that they could for a patient and were confident that there would be no negative legal consequences. It is possible that professionals who had been most negatively affected by patient suicide may not have been able to take part in the research, due to being on sick leave, or may have been advised not to talk about their experiences due to ongoing investigations. Future research addressing professionals who may have had more challenging or complicated experiences where there were questions raised about practice or potential legal consequences would provide useful information on how these factors may increase the impact of a patient suicide, and what kind of support would be most useful in these cases. It is acknowledged that this type of research would be very sensitive and participants may be hesitant to discuss these types of cases whilst investigations may be ongoing; although a retrospective approach could provide a safer medium to explore these issues.

One of the ways this paper contributed to the literature was the findings around unhelpful responses and forms of support. Research exploring managers' views on patient suicide and their understanding of the formal processes and their role in supporting team members would provide a helpful additional perspective. It appeared from this study that certain professional groups such as psychologists valued clinical supervision more than nurses who received structured management supervision. A larger study including a range of professional groups would also allow for comparison between groups of professionals and managers, to explore whether there are any differing viewpoints or attitudes that influence the way that people respond to patient suicide.

This study highlighted the role of contact with patients' families in assisting professionals to cope with a patient suicide. This varied between individuals and participants were not following a particular protocol. Some invited family members to formal meetings; others offered informal support or attended funerals. Research with family members bereaved by suicide so far has not focussed on what family members expect of professionals who may have been involved with their loved one. Exploring what types of support family members would find helpful, and what they feel services should provide would contribute to this research base, and inform guidelines for services seeking to offer support to families.

Whilst there are obvious differences between the closeness of a family member and a mental health professional, it is apparent that there are a number of similarities in the emotional and cognitive responses to a suicide, such as shock, guilt, blame, and searching for meaning (Farberow, 1992). Therefore it is possible that supportive interventions which have been found to be effective with family members could be tested out with groups of professionals. As peer support was highly valued by family members in qualitative findings, and professionals in the research paper, further research exploring the effectiveness of peer support in mental health professionals would be interesting. A focussed qualitative exploration of formal and informal peer support across professional groups would provide useful information about what elements of peer support people find most helpful.

Theoretical implications

Findings from the literature review around preferences for peer support and an appreciation of group and multi-modal interventions are in line with bereavement theories around social network support. It is suggested that these types of support can enhance mastery and relieve distress, providing a buffer effect (Stroebe, Schut & Stroebe 2005). Whilst social network support usually refers to a person's existing social network, it is possible that peer support and multi-modal interventions after a suicide can replicate the type of support that friends and family may be unable to provide.

It was interesting to note that some of the themes around professional experiences of patient suicide relate to a dual-process model of grieving (Stroebe & Schut, 1999). Themes of emotional and cognitive impact may reflect a loss-oriented process, including grief and meaning making, whereas the impact in the workplace such as increased reflection, caution around decision making and supporting others reflected restoration oriented processes. This suggests an underlying grief process that takes place, regardless of the type of relationship with the deceased.

In the research paper there was a general sense of negativity around organisational processes that take place following a patient suicide, as well as a lack of clarity and communication. It is likely that on a broader scale this is linked with issues faced by the NHS such as cost-cutting, risk minimisation, and concerns around standards of care. Theories of positive psychology provide a framework for understanding how these wider organisational issues are likely to impact the experience of individual workers. The concept of a 'positive workplace' incorporates

three elements: positive deviance, virtuous practice, and affirmative bias (Cameron, 2009, cited in Lewis, 2011). Positive deviance involves an organisation maximising performance, rather than minimising errors. When this is lacking, there can be too much focus on preventing bad things from happening, at the expense of creating positive experiences. This was raised in the research paper in the sense that mental health care in the NHS is too focussed around 'preventing headline news', to give adequate attention to helping people improve their lives so that they are less likely to feel suicidal. Virtuous practice refers to being helpful, sharing information, and forgiving mistakes, and is related to trust, optimism, compassion and integrity. These practices, in particular sharing information, were reported by professionals as being lacking following a patient suicide, which contributed to their difficult experiences. Affirmative bias refers to emphasising strengths and possibilities rather than threats and weaknesses. It is important that this is taken into account when responding to serious incidents such as patient suicides, as it is common that in the face of negative events, people often fall back on simplistic and rigid responses to restore a sense of safety. Responses to professionals who experience a patient suicide are part of a wider process of organisational responses, which do not always utilise the most effective strategies.

Implications for clinical practice

The Welsh Government has an action plan for reducing suicide and self harm (WG, 2009) which aims to improve the support offered to people who are bereaved by suicide, by ensuring that support and counselling services are available. It is proposed that this should be provided by local NHS trusts in conjunction with local authorities and bereavement charities.

Interventions involving peer support were found to be helpful for family members bereaved by suicide, including face to face and online groups, and one to one support. In terms of clinical practice, at a local level in North Wales there are issues of a sparse population in a large geographical area, as well as Welsh language and cultural factors to consider when planning groups and other interventions. There is currently one suicide bereavement support group in North Wales which meets once a month, run by Survivors of Suicide Bereavement (SOBS), a charitable organisation. It is unlikely that this group is able to support all of those affected by suicide across North Wales. It is unclear what is currently in place in terms of NHS guidance on offering support to those affected by suicide, outside of third sector organisations. This was highlighted in a recent review (Pitman, Osborn, King & Erlangsen, 2014) which suggested a need to provide health and social care resources to facilitate input from NHS mental health services in this area.

Drawing on findings from the literature review, a peer mentor approach could be developed for family members bereaved by suicide (Barlow et al., 2010). This could enable individuals to be paired up with someone in their local area, to provide face to face support. Liaison between NHS mental health services and third sector organisations could provide additional support for those with increased

clinical need. A local online support group could also be developed, similar to that described by Feigelman et al. (2008), allowing people to connect with others without the requirement of travel or face to face involvement. Multi-modal peer support interventions were valued by participants, so offering out of hours contact via telephone or online with familiar people, in addition to the standard crisis contact lines would also be beneficial.

Although there may be no specific NHS services currently in place for people bereaved by suicide, it is important to bear in mind the high rates of depression and other mental health problems experienced by this group (Clark, 2001). These individuals are likely to present to mental health services for treatment for other difficulties, without their bereavement needs being taken into account. GPs and mental health professionals should have an awareness of the impact of suicide bereavement, in order to be able to offer appropriate support and guidance, and to assess and manage any associated risk. The 'Help is at Hand' (Hawton et al., 2012) self-help booklet has a section for professionals and a Welsh version is available, although incorporating information on suicide bereavement into suicide awareness training would also be beneficial in terms of professionals acknowledging the impact on family members, as well as the impact on themselves and other professionals.

As peer support was suggested to be a helpful form of support by professionals in the research paper, there is scope for developing a service for professionals affected by patient suicide, taking inspiration from peer support interventions offered to family members. Formalising this type of valuable support may give permission to professionals to seek support without concern about burdening a colleague. Professionals with experience of suicide in a range of

professions could be offered the opportunity to join a pool of peer mentors, who can be contacted by other professionals for advice and support. Encouraging effective clinical supervision and reflective practice across professional groups would also be helpful in terms of addressing the impact of patient suicide as well as other broader issues that arise from working in mental health services.

Another option for increasing support for professionals bereaved by suicide would involve automatic contact from occupational health services, in the form of a telephone screening appointment. This could involve a counsellor making a mandatory single contact with the professional, to offer them a chance to talk about their feelings, provide emotional support, and if necessary offer further input. It would be important that this service would be kept separate from other formal processes, and also that people were aware of the service and the aims to provide emotional support rather than provide answers or guidance around the formal processes.

As a result of the 2009 action plan a number of training packages have been rolled out to health professionals across Wales including the Applied Suicide Intervention Skills Training (Gould, Cross, Pisani, Munfakh & Kleinman, 2013). In addition to this a package for primary care services in the UK 'Connecting with People', has been rolled out across NHS services in North Wales and is currently under review (Cole-King & Lepping, 2010). These training packages are focussed on improving awareness and reducing the culture of blame and inevitability that can develop around suicide. It is possible that over time this may contribute to a more sensitive approach around managing patient suicides, and offering support to professionals. Incorporating training from bereavement organisations could expand

awareness around this issue and improve services for family members and professionals. Specific training for Occupational Health counsellors in these issues could also improve the confidence of professionals and potentially increase the rate of seeking support.

Due to the lack of certainty and clarity around formal enquiries following a patient suicide which participants in this study found unhelpful as it increased their sense of isolation and anxiety, clear guidelines around what is expected of professionals and managers following a patient suicide would be greatly beneficial. Suggestions that may be helpful based on the findings of this study would include:

- Information to be provided to professionals on the formal enquiry process.
- Professionals to be kept updated on the progress of investigations.
- Where professionals are absent at the time of a patient suicide, care to be taken to ensure that they are informed in a sensitive and timely manner, and that they are able to access patient information to enable them to contact the patients' family (if appropriate) when they return to work.
- Information regarding self-referral to counselling or advice services should be provided directly to professionals, rather than having to request information from managers.
- Clinical supervision and or a management meeting to be held at the earliest opportunity to allow time for the professional to discuss any concerns they may have and ask any questions.
- It should be acknowledged that depending on personal circumstances some individuals may be more vulnerable than others.

- Discussions around workload and caseload should consider whether the professional may require time to cope with the loss before working with other suicidal patients.
- Managers should check in at regular intervals with the key professionals involved, taking in to account that some may experience delayed effects.
- Professionals should be supported to contact families to express condolences, and to offer an opportunity for them to meet with professionals involved and discuss any issues. Any other contact e.g. attending funeral may be made on an individual basis.
- Managers should disclose patient suicides to the wider team in a sensitive manner, acknowledging the potential impact on the team, and inform other professionals of available supportive services.
- Following a completed investigation, any recommendations should be discussed with the professional involved, and disseminated to the wider team.

Personal reflections

Embarking on a research project focussing on suicide has been a challenging prospect in many ways. Initially what drew me to this subject area was the idea of exploring in more detail a topic which people tend to want to avoid. I find the subject of suicide profoundly sad in one sense, when I consider that people find themselves in desperate situations and can see no escape other than to take their own lives, as well as the grief and complex difficulties that are left behind with families and friends. When I think of it as an impulsive act I feel a sense of tragedy about what

could have been done for that person, if a random act of chance such as a phone call or the action of a stranger could have made a difference, as anecdotal evidence often states. I recall being struck by the reduction in suicide rates following certain actions such as changing paracetamol packaging, to installing gates at locations renowned for suicides. I felt that I knew where I stood on the subject of suicide: whilst I felt that it is ultimately a human right and an individual's choice to end their life, that is sometimes understandable given the circumstances, when people have mental health problems which may influence their capacity to make choices like this, it is our responsibility as professionals to protect people and prevent suicides.

In order to develop my understanding of suicide I read around the area and attended a Suicide Bereavement conference at the University of Manchester in September 2013. I found this conference to be hugely informative and was slightly surprised at the proportion of attendees and presenters who identified themselves as 'survivors of suicide'. As the majority of presenters began their talk by outlining their background and reasons for their interest in the area, I recall feeling a sense of being a fraud or some kind of voyeur for not having a personal experience to motivate my interest in researching this area. However, hearing the stories of people with first hand experience gave me more motivation and a sense that this research could really be helpful.

One of the most informative things I read during preparation for this research was 'Encounters with Suicide' (Graint, Haire, Biley & Stone) which is a collection of narratives around suicide and bereavement. I found this incredibly informative and also quite moving. In particular the stories of people's first hand experience of suicide bereavement touched me as they are not often heard, I found myself being

tempted to read more in my own time, although this could at times be a little overwhelming. I found I had to be aware quite early on of the potential second-hand impact of hearing tragic stories, and balance this out with reading about lighter subjects, or taking a break. Throughout the period of completing this research I have become more aware of suicide in the media than before, particularly after a presentation on the media coverage of the suicides of young people in Bridgend, and steps that have been taken to improve how this is dealt with. I have found this frustrating at times due to the unhelpful and sensationalist ways that these deaths are still presented in local news, such as a recent news story on the suicide of a young adolescent in Manchester which included a gallery of photos of the funeral and reported on the hundreds of attendees.

My experience of the actual research interviews was very interesting. This was my first piece of qualitative research, and I recall feeling quite nervous prior to my first interview. I was aware of the differences between a normal conversation, a typical interview that might take place in a mental health assessment context, and a semi-structured interview for IPA. I was also quite conscious of whether the questions I might ask would influence the participants and 'spoil' the analysis in some way. This led me to take a rather reserved approach to interviewing initially, as I was unsure whether acknowledging or validating a difficult experience would be interpreted as encouragement to focus on that aspect of the experience. I also found it quite difficult to suspend my clinical judgement and critical thinking during the interviews. The nature of the interviews is a different type of enquiry to that which I am most comfortable with as a clinician, and I was aware of urges to gather the

facts, create a chronology, and formulate and problem solve. I recall feeling that the participants were placing themselves in a relatively vulnerable position by opening up to me and telling their stories, whilst I was unable to give them anything in return. This was particularly notable when interviewing more senior clinicians, who would usually be in a position of authority and I would defer to.

When reading through transcripts to annotate for the initial stages of analysis I was aware of judgements or assumptions I made regarding participants' clinical practice, things that I would have done differently. I found it helpful to remind myself of the benefit of hindsight and objectivity, rather than assuming that I would have taken a different course of action. I did consider the ways that risk assessment was described in some interviews, and it struck me that there appeared to be a sense that if a patient did not describe having a clear plan or intent, then they were not felt to be at high risk of suicide. I was reminding of the Asking Difficult Questions training that we received, and how helpful this was in terms of considering subtle psychological and behavioural risk factors, and in pointing out that a lot of people don't wish to disclose their intentions to others. This led to me considering my own clinical practice, and recalling times where I may have had concerns about someone's suicidal feelings. I was able to recall the heightened anxiety that this results in, particularly at my level of training, and also the relief that can come from a patient reassuring you that they will not act on their thoughts. Reflecting on this encouraged a feeling of compassion for the participants who had experienced patient suicides.

At times I was very touched by certain stories, and recall sharing a participants' anger at the injustice of their experiences and sadness at the experiences of loss. I was also aware of my own expectations of participants, and I found those who were visibly touched and saddened by their experiences to be quite endearing. I was surprised by feelings of frustration with one participant who responded in an apparently flippant manner, however after discussing in supervision I was able to see the different aspects of patient suicides that affected people in different ways. I was aware that my perceptions of participants were influenced by the language that they used when describing their patients, the way that they spoke about mental health in general, and the level of detail they went into about patients. I found that even when discussing patients from up to fifteen years ago, participants recalled a great level of detail and seemed to want to tell the patients' story. I felt that this in some way reflected a level of care and respect. Anecdotally family members like to think that their loved ones are remembered by those who cared for them, and this made me feel that this was the case, and that the patients were being honoured in some way. Quite a few participants stated that they had chosen to take part in the research as they hoped that improvements could be made to the way that patient suicide is handled in the future. This often came out in debriefing discussions after interviews, and I felt quite proud to be involved in a project which might be able to contribute to improvements for my colleagues.

During some of the interviews I was aware of a conflict between a medical model and a biopsychosocial model of understanding mental health problems. I was unsure if there was some tension or defensiveness being expressed in the interviews

due to my role as a trainee clinical psychologist, as one participant referred to psychologists in a way that could have been perceived to have been sceptical, and another firmly aligned themselves with psychiatry colleagues. Also when interviewing psychologists, I was aware that there was an unspoken assumption that we had a shared understanding of mental health, and I wondered whether this may have influenced the accounts somewhat.

During the analytical process I recall some trepidation due to being new to IPA as an approach. I was aware of a desire to include everything that was said, and recall feeling quite attached to some of the transcripts. I felt that I could have written a full qualitative paper exploring one single transcript or a single theme. I was concerned about losing the individual narratives of the participants and patients, in order to pull together themes, and felt that everything I had heard was important, and that this should be reflected in some way. However I was also aware of the iterative process of IPA, and this enabled me to feel comforted somewhat that the general themes I would generate would be firmly rooted in the raw data. I recall hoping that the write-up would reflect a level of detail that participants would approve of, and I wondered what they would think about the quotes that I had chosen to illustrate themes. All participants asked to be sent a copy of the completed report, and consented to their quotes being published, although I am keen to hear their thoughts on the overall findings.

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Section 5: Ethics Appendix

Ethics Application to School of Psychology, Bangor University

Application for Ethical Approval

Project Title: Professional experiences, responses and support following patient suicide in adult mental health services in North Wales.

Principal investigator: Newton, Rachel Elizabeth

Other researchers: Jackson, Mike

Pre-screen Questions

Type of Project
D.Clin.Psy

What is the broad area of research
Clinical/Health

Funding body
Internally Funded

Type of application (check all that apply)
Study in the area of health and social care requiring sponsorship from BU

Proposed methodology (check all that apply)
Questionnaires and Interviews

Do you plan to include any of the following groups in your study?

If your research requires any of the following facilities MRI, TMS/ rCS, Neurology Panel, has the protocol been reviewed by the appropriate expert/safety panel?
Not applicable (the research does not require special safety panel approval)

Connection to Psychology, (i.e. why Psychology should sponsor the question)
Investigator is a student in Psychology (including the North Wales Clinical Psychology Programme)

Does the research involve NHS patients? (NB: If you are conducting research that requires NHS ethics approval make sure to consult the Psychology Guidelines as you may not need to complete all sections of the Psychology online application)

No

Further details: The research involves NHS staff, however due to the nature of the research question NHS ethical approval will be required and an IRAS application form has been completed and attached.

Has this proposal been reviewed by another Bangor University Ethics committee?

No

Part 1: Ethical Considerations

Will you describe the main experimental procedures to participants in advance, so that they are informed about what to expect?

Yes

Will you tell participants that their participation is voluntary?

Yes

Will you obtain written consent for participation?

Yes

If the research is observational, will you ask participants for their consent to being observed?

N/A

Will you tell participants that they may withdraw from the research at any time and for any reason?

Yes

With questionnaires, will you give participants the option of omitting questions they do not want to answer?

N/A

Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?

Yes

Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?

Yes

Will your project involve deliberately misleading participants in any way?

No

Will your project involve deliberately misleading participants in any way?

No

Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If "Yes", give details and state what you will tell them to do should they experience any problems (e.g., who they can contact for help)

Yes

Further details: Participants may find taking part in interviews an inconvenience due to busy lifestyles. Every effort will be taken to ensure that interviews are convenient for the participant in terms of timing and location. Participants may experience emotional distress when discussing patient suicides and their experiences following this. A sensitive approach to interviewing will be taken to ensure that this is minimised. Participants will be offered regular breaks during the interview if they become distressed. The lead researcher has experience of clinical interviews and therapy and will use these clinical skills during the interview. Participants may reveal personal information about themselves, patients or other professionals during the interview. BCUHB Confidentiality policy and the BPS code of conduct will be adhered to throughout the research process, and the recorded information will be anonymised at the point of transcription. This will be made clear to the participant prior to consenting. Participants may continue to experience emotional distress following the interview. Debriefing time will be offered at the end of the interview, and information or advice will be provided to participants should they wish to seek further support. Participants may reveal potential examples of malpractice or breach of professional conduct during the interview. If this occurs, the appropriate BCUHB policy would be followed. This will be made clear to the participants at the outset, and if any issues arise during the interview, this will be discussed with the participant at the time. (See attached information sheet)

Is there any realistic risk of any participants experiencing discomfort or risk to health, subsequent illness or injury that might require medical or psychological treatment as a result of the procedures?

No

*Does your project involve work with animals? If *Yes* please complete Part 2: B*

No

*Does your project involve payment to participants that differs from the normal rates? Is there significant concern that the level of payment you offer for this study will unduly influence participants to agree to procedures they may otherwise find unacceptable? If *Yes* please complete Part 2: B and explain in point 5 of the full protocol*

N/A

Further details: No payment will be offered to participants.

If your study involves children under 18 years of age have you made adequate provision for child protection issues in your protocol?

N/A

If your study involves people with learning difficulties have you made adequate provision to manage distress?

N/A

If your study involves participants covered by the Mental Capacity Act (i.e. adults over 16 years of age who lack the mental capacity to make specific decisions for themselves) do you have appropriate consent procedures in place? NB Some research involving participants who lack capacity will require review by an NHS REC. If you are unsure about whether this applies to your study, please contact the Ethics Administrator in the first instance

N/A

If your study involves patients have you made adequate provision to manage distress?

N/A

Does your study involve people in custody?

No

If your study involves participants recruited from one of the Neurology Patient Panels or the Psychiatry Patient Panel then has the protocol been reviewed by the appropriate expert/safety panel?

N/A

If your study includes physically vulnerable adults have you ensured that there will be a person trained in CPR and seizure management at hand at all times during testing?

N/A

Is there significant potential risk to investigator(s) of allegations being made against the investigator(s). (e.g., through work with vulnerable populations or context of research)?

N/A

Is there significant potential risk to the institution in any way? (e.g., controversy or potential for misuse of research findings.)

No

Further details: The research has been discussed with the Business Manager for the Mental Health and Learning Disabilities CPG within BCUHB, who has approved the methods and the proposed use of research findings.

Part 3: Risk Assessment

Is there significant potential risk to participants of adverse effects?

No

Is there significant potential risk to participants of distress?

Yes

Further details: See IRAS form sections A22-A23

Is there significant potential risk to participants for persisting or subsequent illness or injury that might require medical or psychological treatment?

No

Is there significant potential risk to investigator(s) of violence or other harm to the investigator(s) (e.g., through work with particular populations or through context of research)?

No

Is there significant potential risk to other members of staff or students at the institution? (e.g., reception or other staff required to deal with violent or vulnerable populations.)

No

Does the research involve the investigator(s) working under any of the following conditions: alone; away from the School; after-hours; or on weekends?

Yes

Further details: Interviews will be carried out at NHS sites during working hours only.

Does the experimental procedure involve touching participants?

No

Does the research involve disabled participants or children visiting the School?

No

Part 2: B

Brief background to the study

Further details: Mental health professionals are more likely than other healthcare workers to experience patient suicide. Burnout, stress and sickness rates are also increased in this professional group. Questionnaire studies and case studies have demonstrated that patient suicide may affect professionals personally and professionally, and factors influencing the impact have been suggested, including support received. The Welsh Government acknowledges the need for support for professionals following a patient suicide, although there is little information or evidence to say whether current practices are helpful or unhelpful. According to the most recent statistics there were 70 patient suicides (categorised as having had contact with mental health services in the 12 months prior to death) in Wales in 2010. There have been calls for more research addressing the impact of patient suicide on professionals. This is also outlined in the Welsh Government's 5-year action plan 'Talk to me: The National Action Plan to reduce suicide and self-harm in Wales 2009-2014'. Objective 4 of this action plan concerns managing the consequences of suicide and self-harm, and highlights the importance of supporting professionals bereaved by suicide. According to the action plan, this is to be provided in part by the health board in partnership with a number of other services. There is a need for an in-depth exploration of the experiences of mental health professionals following a patient suicide to inform future quantitative research and to potentially inform organisations about how best to support mental health professionals in these circumstances.

The hypotheses

Further details: This is a qualitative research design. The primary research question is: How does patient suicide affect mental health professionals? The secondary research question is: How are responses from others, organisational procedures and support experienced by those professionals following a patient suicide?

Participants: recruitment methods, age, gender, exclusion/inclusion criteria

Further details: Male and female participants, age 18-75. Inclusion criteria: - Participants are mental health professionals, e.g. nurse, social worker, psychiatrist, psychologist. - Participants have experienced what they believe to be a suicide of a patient for whom they were a key professional involved in their care, for example care coordinator, responsible clinician or therapist. - Participants had at least 5 clinical contacts with the patient. - The patient suicide must have taken place within 12 months of discharge from the team. Exclusion criteria: - No experience of patient suicide - Experience of patient suicide but not key professional involved in their care. - Experience of patient suicide but less than 5 clinical contacts with the patient. - Experience of patient suicide longer than 12 months after discharge. Recruitment method: Lead researcher will attend team meetings at participants' workplace to present questionnaires, explain process and distribute screening questionnaires. Participants will have the opportunity to opt in to be contacted for interviews on completion of the screening questionnaire, by providing their contact details. The lead researcher will then contact those who have agreed to be contacted to discuss informed consent and arrange interviews.

Research design

Further details: A qualitative design has been chosen for this study, using a semi-structured interview methodology. This method has been chosen as it provides a guide for the interviews to address the research question, whilst allowing the researcher to follow up any additional issues of interest raised by participants. This methodology is appropriate for the analysis method, Interpretative Phenomenological Analysis. Screening questionnaires will be used to select participants for interviews. Community mental health team managers will be contacted by telephone, letter or email and informed of the nature of the research project. This is planned to take place between March and June 2013. Permission will be requested to attend a team meeting to explain the nature of the study, answer any questions, and distribute screening questionnaires to all mental health professionals. The screening questionnaires will request information such as participant age, gender, profession, and number of patient suicides experienced. It will also request details of the experience of patient suicide and consequences, which will be used to screen participants for interviews. On completion of the questionnaire, participants will have the opportunity to opt-in to interviews to discuss their experiences in more detail. They consent to being contacted by completing their contact details and a preferred mode of contact for the main researcher. The questionnaires will be returned via postage paid envelopes to Bangor University. The main researcher will contact participants who opt-in and meet the inclusion criteria via their preferred mode of contact, explain the nature of the interviews, and arrange an appointment for an interview.

if the participant wishes to continue. This is planned to take place between June and December 2013. Interviews will be completed at the venue of the participants choice. At the appointment, participants will be given an information sheet outlining the areas of questions that will be covered in the interview, and a consent form to complete. In addition to the written consent, participants will also be requested to verbally consent to being audio-recorded. Interviews will last up to 1 hour, participants will have the opportunity to take breaks or withdraw from the research at any point during the interview. Data transcription and analysis will be ongoing during the interview period, although may continue until February 2014.

Procedures employed

Further details: Lead researcher will attend team meetings at participants' workplace to present questionnaires, explain process and distribute screening questionnaires. Participants will have the opportunity to opt in to be contacted for interviews on completion of the screening questionnaire, by providing their contact details. The lead researcher will then contact those who have agreed to be contacted to discuss informed consent and arrange interviews. Qualitative interviews will be carried out with mental health professionals.

Measures employed

Further details: See attached screening questionnaire and Interview protocol.

Qualifications of the investigators to use the measures (Where working with children or vulnerable adults, please include information on investigators' CRB disclosures here.)

Further details: Clinical interview skills.

Venue for investigation

Further details: NHS sites convenient to participants.

Estimated start date and duration of the study (N.B. If you know that the research is likely to continue for more than three years, please indicate this here).

Further details: Start 13/05/13, end 01/09/13

Data analysis

Further details: Data will be analysed using Interpretative Phenomenological Analysis (IPA), which is a method of analysis of qualitative data which aims to explore how a person in a particular context makes sense of a particular experience or phenomenon. In this case, it will be used to explore the phenomenon of patient suicide, and the participants' interpretations of this. Data will be manually coded, and patterns or themes will be generated from this. There may be broader themes, and sub-themes, which will be checked by the supervisor against the transcripts to ensure appropriate interpretation.

Potential offence/distress to participants

Further details: Participants may find taking part in interviews an inconvenience due to busy lifestyles. Every effort will be taken to ensure that interviews are convenient for the participant in terms of timing and location. Participants may experience emotional distress when discussing patient suicides and their experiences following this. A sensitive approach to interviewing will be taken to ensure that this is minimised. Participants will be offered regular breaks during the interview if they become distressed. The lead researcher has experience of clinical interviews and therapy and will use these clinical skills during the interview. Participants may reveal personal information about themselves, patients or other professionals during the interview. BCUHB Confidentiality policy and the BPS code of conduct will be adhered to throughout the research process, and the recorded information will be anonymised at the point of transcription. This will be made clear to the participant prior to consenting. Participants may continue to experience emotional distress following the interview. Debriefing time will be offered at the end of the interview, and information or advice will be provided to participants should they wish to seek further support. Participants may reveal potential examples of malpractice or breach of professional conduct during the interview. If this occurs, the appropriate BCUHB policy would be followed. This will be made clear to the participants at the outset, and if any issues arise during the interview, this will be discussed with the participant at the time. The lead researcher has experience of conducting clinical interviews and

psychological therapy, and discussing sensitive and upsetting issues. Care will be taken to ensure a sensitive and supportive approach to the interview topics. Participants will be offered breaks should they become upset. Participants may disclose potential incidents of malpractice or unprofessional behaviour. If this occurs it will be discussed with the participant and the research supervisor. If action is felt to be required, BCUHB policy will be followed. Participants may appreciate the opportunity to discuss their experiences with someone who is objective and who they are not involved with professionally. Raising awareness of the impact of patient suicide on professionals may be beneficial for participants. If the research informs clinical practice at a later date, this may be of benefit to participants.

Procedures to ensure confidentiality and data protection

Further details: Participants (NHS staff) will be asked to provide their age and profession on the screening questionnaire, but not their name or any other identifiable personal information. Those who wish to be contacted for interview will be required to provide their name and contact details to enable interviews to be arranged. Screening questionnaires and contact details will be stored in a secure filing cabinet, and will only be viewed by the researcher and supervisor, who are bound by confidentiality policy and professional code of conduct. Following interviews, transcripts will be coded and anonymised.

**How consent is to be obtained (see BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The University has its own Welsh translations facilities on extension 2036)*

Further details: Participants will be given an initial information sheet with the screening questionnaire, which will explain that consent to take part in the screening process and have their anonymised data used will be assumed by them submitting the questionnaire. A further information sheet will be enclosed at the end of the screening questionnaire, this will explain about the process of the interviews, how the information will be used, how to withdraw etc. Participants will provide consent to be contacted for follow-up interviews by completing their contact details and returning the questionnaire. At the point of contact for follow up interviews, the information sheet will be discussed again. Participants will provide written and verbal informed consent to take part in the interview, and to have their interview recorded, before starting the interview. In addition to this, at the end of the interview participants will be asked to consent to their interview data being used for analysis, and they will be reminded of the process for withdrawing their data from the study. For interviews, participants will be provided with information sheets at the initial contact when they complete the screening questionnaires. They will be contacted by phone or email after this, and given further information and the opportunity to ask questions and decide whether they want to go ahead and be interviewed. At the interview, this information sheet will be revisited. During and after the interview participants will have the right to withdraw at any time. As all participants will be employees of BCUHB, it is expected that they will be able to understand written or verbal information given in English. Information sheets and consent forms will be provided bilingually in English and Welsh, although it will be stipulated that verbal information must be given in English as the lead researcher does not speak Welsh. Information sheets and consent forms will be provided bilingually in English and Welsh, although it will be stipulated that verbal information must be given in English as the lead researcher does not speak Welsh. Informed consent will be recorded in writing.

Information for participants (provide actual consent forms and information sheets) including if appropriate, the summary of the study that will appear on SONA to inform participants about the study. N.B. This should be a brief factual description of the study and what participants will be required to do. Further details: See attached information sheets and consent forms.

Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)

Further details: N/A

Payment to: participants, investigators, departments/institutions

Further details: N/A

Equipment required and its availability

Further details: Interviews will be recorded using the lead researchers own equipment.

If students will be engaged a project involving children, vulnerable adults, one of the neurology patient panels or the psychiatric patient panel, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)

Further details: N/A

If students will be engaged in a project involving use of MRI or TMS, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)

Further details: N/A

What arrangements are you making to give feedback to participants? The responsibility is yours to provide it, not participants' to request it.

Further details: A summary of the findings will be disseminated through Community Mental Health Team managers following completion of the study.

Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.

Part 4: Research Insurance

Is the research to be conducted in the UK?

Yes

Research that is based solely upon certain typical methods or paradigms is less problematic from an insurance and risk perspective. Is your research based solely upon one or more of these methodologies? Standard behavioural methods such as questionnaires or interviews, computer-based reaction time measures, standardised tests, eye-tracking, picture-pointing, etc; Measurements of physiological processes such as EEG, MEG, MRI, EMG, heart-rate, GSR (not TMS or tCS as they involve more than simple 'measurement'); Collections of body secretions by non-invasive methods, venepuncture (taking of a blood sample), or asking participants to consume foods and/or nutrients (not including the use of drugs or other food supplements or caffeine).

Yes

Confirmation of Bangor University Liability Insurance

Hasilwood House
60 Bishopsgate
London EC2N 4AW
Tel: 020 7847 8670
Fax: 020 7847 8689



TO WHOM IT MAY CONCERN

9th July 2012

Dear Sir/Madam

**BANGOR UNIVERSITY
AND ALL ITS SUBSIDIARY COMPANIES**

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following covers are currently in place:-

1. EMPLOYERS' LIABILITY

Certificate No.	Y016458QBE0112A/026
Period of Cover	1 August 2012 to 31 July 2013
Limit of Indemnity	£25,000,000 any one event unlimited in the aggregate.
Includes	Indemnity to Principals
Cover provided by	QBE Insurance (Europe) Limited and Excess Insurers.

2. PUBLIC AND PRODUCTS LIABILITY

Certificate of Entry No.	UM026/95
Period of Cover	1 August 2012 to 31 July 2013
Includes	Indemnity to Principals
Limit Of Indemnity	£50,000,000 any one event and in the aggregate in respect of Products Liability and unlimited in the aggregate in respect of Public Liability.
Cover provided by	U.M. Association Limited and Excess Cover Providers led by QBE Insurance (Europe) Limited

If you have any queries in respect of the above details, please do not hesitate to contact us.

Yours faithfully

Susan Wilkinson
For U.M. Association Limited



U.M. Association Limited
Registered Office: Hasilwood House, 60 Bishopsgate, London, EC2N 4AW
Registered in England and Wales No. 2731799

Confirmation of School of Psychology Ethical Approval

Dear Rachel Elizabeth,

2013-9505 Professional experiences, responses and support following patient suicide in adult mental health services in North Wales.

Your research proposal number 2013-9505 has been reviewed by the School of Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Governance approval is granted for the study as it was explicitly described in the application and we are happy to confirm that this study is now covered by the University's indemnity policy.

If any new researchers join the study, or any changes are made to the way the study is funded, or changes that alter the risks associated with the study, then please submit an amendment form to the committee.

Yours sincerely

Everil McQuarrie

NHS Ethics Proposal: IRAS Form

NHS REC Form

Reference:
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IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Professional experiences of patient suicide in AMH services

1. Is your project research?

Yes No

2. Select one category from the list below:

- Clinical trial of an investigational medicinal product
- Clinical investigation or other study of a medical device
- Combined trial of an investigational medicinal product and an investigational medical device
- Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- Basic science study involving procedures with human participants
- Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- Study involving qualitative methods only
- Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- Study limited to working with data (specific project only)
- Research tissue bank
- Research database

If your work does not fit any of these categories, select the option below:

Other study

2a. Please answer the following question(s):

- a) Does the study involve the use of any ionising radiation? Yes No
- b) Will you be taking new human tissue samples (or other human biological samples)? Yes No
- c) Will you be using existing human tissue samples (or other human biological samples)? Yes No

3. In which countries of the UK will the research sites be located?(Tick all that apply)

- England
- Scotland
- Wales
- Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

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- England
 Scotland
 Wales
 Northern Ireland
 This study does not involve the NHS

4. Which review bodies are you applying to?

- NHS/HSC Research and Development offices
 Social Care Research Ethics Committee
 Research Ethics Committee
 National Information Governance Board for Health and Social Care (NIGB)
 National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

- Yes No

6. Do you plan to include any participants who are children?

- Yes No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

- Yes No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

- Yes No

9. Is the study or any part of it being undertaken as an educational project?

- Yes No

Please describe briefly the involvement of the student(s):
This study is being completed as part of the Doctorate of Clinical Psychology (DClinPsy) qualification. The main researcher is a trainee on the programme and will be conducting research under the supervision of Dr Mike Jackson.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

- Yes No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of

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its divisions, agencies or programs?

Yes No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

Yes No

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Integrated Research Application System
Application Form for Research involving qualitative methods only


Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Professional experiences of patient suicide in AMH services

Please complete these details after you have booked the REC application for review.

REC Name:
North Wales REC - West

REC Reference Number:
13/WA/0230

Submission date:
08/07/2013

PART A: Core study information
1. ADMINISTRATIVE DETAILS
A1. Full title of the research:

Professional experiences, responses and support following patient suicide in adult mental health services in North Wales.

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss Rachel		Newton
Address	2 Bryntirion Leeswood Mold		
Post Code	CH7 4SP		
E-mail	pspef8@bangor.ac.uk		
Telephone			
Fax			

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Give details of the educational course or degree for which this research is being undertaken:	
Name and level of course/ degree: Doctorate in Clinical Psychology (DClinPsy)	
Name of educational establishment: Bangor University	
Name and contact details of academic supervisor(s):	
Academic supervisor 1	
	Title Forename/Initials Surname Dr Mike Jackson
Address	Hergest Unit Ysbyty Gwynedd Bangor
Post Code	LL57 2PW
E-mail	mike.jackson@wales.nhs.uk
Telephone	
Fax	
Please state which academic supervisor(s) has responsibility for which student(s): Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.	
Student(s)	Academic supervisor(s)
Student 1 Miss Rachel Newton	<input checked="" type="checkbox"/> Dr Mike Jackson
A copy of a <u>current CV</u> for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.	

A2-2. Who will act as Chief Investigator for this study?

- Student
 Academic supervisor
 Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname Miss Rachel Newton
Post	Trainee Clinical Psychologist
Qualifications	MSc. Forensic Psychology BSc. Forensic Psychology
Employer	Bangor University / BCUHB
Work Address	NWCPP, School of Psychology Brigantia Building Bangor University, Bangor
Post Code	LL55 2AS

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Work E-mail pspef8@bangor.ac.uk
 * Personal E-mail
 Work Telephone
 * Personal Telephone/Mobile 07890856435
 Fax

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.
 A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.*

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

Title Forename/Initials Surname
 Mr Hefin Francis
 Address School of Psychology, Bangor University
 Brigantia Building, Penrallt Road
 Bangor
 Post Code LL57 2PW
 E-mail h.francis@bangor.ac.uk
 Telephone 01248388339
 Fax

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):
 Sponsor's/protocol number:
 Protocol Version:
 Protocol Date:
 Funder's reference number:
 Project website:

Additional reference number(s):

Ref.Number	Description	Reference Number
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Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

Yes No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

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A6-1. Summary of the study. Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.

This study aims to explore the professional experiences of patient suicide in adult mental health services through interviews with community mental health team staff, with a focus on organisational responses and support received. The data will be analysed using Interpretative Phenomenological Analysis which will generate themes from the responses representative of the lived experience of the participants.

A6-2. Summary of main issues. Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

*Participants will be asked to discuss a sensitive and emotional experience, and may become distressed during or after the interviews. Care will be taken throughout the interview to ensure the participant feels supported and information will be provided for further help seeking after the interview.

*Participants may give away patient identifying information by mistake during the interview. Confidentiality policy will be adhered to regarding patient identifying information, this will be anonymised at the point of transcription and only shared with the researcher's supervisor.

*Participants may reveal examples of potential malpractice, or unprofessional behaviour.

*Participants may reveal personal information about themselves during the interview. Confidentiality policy will be adhered to regarding personal information, this will be anonymised at the point of transcription and only shared with the researcher's supervisor.

*The researcher may be adversely affected by hearing the interviews. The researcher will be supervised and will also have the option of additional support via the personal and professional development counselling service offered to trainees at NWCPP.

A6-3. Proportionate review of REC application The initial project filter has identified that your study may be suitable for proportionate review by a REC sub-committee. Please consult the current guidance notes from NRES and indicate whether you wish to apply through the proportionate review service or, taking into account your answer to A6-2, you consider there are ethical issues that require consideration at a full REC meeting.

Yes - proportionate review No - review by full REC meeting

Further comments (optional):

Note: This question only applies to the REC application.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. Please tick all that apply:

- Case series/ case note review
- Case control
- Cohort observation
- Controlled trial without randomisation
- Cross-sectional study
- Database analysis
- Epidemiology
- Feasibility/ pilot study
- Laboratory study

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- Metanalysis
- Qualitative research
- Questionnaire, interview or observation study
- Randomised controlled trial
- Other (please specify)

A10. What is the principal research question/objective? Please put this in language comprehensible to a lay person.

How does patient suicide affect mental health professionals?

A11. What are the secondary research questions/objectives if applicable? Please put this in language comprehensible to a lay person.

How are responses from others, organisational procedures and support experienced by those professionals following a patient suicide?

A12. What is the scientific justification for the research? Please put this in language comprehensible to a lay person.

Mental health professionals are more likely than other healthcare workers to experience patient suicide. Burnout, stress and sickness rates are also increased in this professional group. Questionnaire studies and case studies have demonstrated that patient suicide may affect professionals personally and professionally, and factors influencing the impact have been suggested, including support received. The Welsh Government acknowledges the need for support for professionals following a patient suicide, although there is little information or evidence to say whether current practices are helpful or unhelpful. According to the most recent statistics there were 70 patient suicides (categorised as having had contact with mental health services in the 12 months prior to death) in Wales in 2010. There have been calls for more research addressing the impact of patient suicide on professionals. This is also outlined in the Welsh Government's 5-year action plan 'Talk to me: The National Action Plan to reduce suicide and self-harm in Wales 2009-2014'. Objective 4 of this action plan concerns managing the consequences of suicide and self-harm, and highlights the importance of supporting professionals bereaved by suicide. According to the action plan, this is to be provided in part by the health board in partnership with a number of other services. There is a need for an in-depth exploration of the experiences of mental health professionals following a patient suicide to inform future quantitative research and to potentially inform organisations about how best to support mental health professionals in these circumstances.

A13. Please summarise your design and methodology. It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.

A qualitative design has been chosen for this study, using a semi-structured interview methodology. This method has been chosen as it provides a guide for the interviews to address the research question, whilst allowing the researcher to follow up any additional issues of interest raised by participants. This methodology is appropriate for the analysis method, Interpretative Phenomenological Analysis. Screening questionnaires will be used to select participants for

interviews.

Community mental health team managers will be contacted by telephone, letter or email and informed of the nature of the research project. This is planned to take place in July 2013. Permission will be requested to attend a team meeting to explain the nature of the study, answer any questions, and distribute screening questionnaires to all mental health professionals. The screening questionnaires will request information such as participant age, gender, profession, and number of patient suicides experienced. It will also request details of the experience of patient suicide and consequences, which will be used to screen participants for interviews. On completion of the questionnaire, participants will have the opportunity to opt-in to interviews to discuss their experiences in more detail. They consent to being contacted by completing their contact details and a preferred mode of contact for the main researcher. The questionnaires will be returned via postage paid envelopes to Bangor University.

The main researcher will contact participants who opt-in and meet the inclusion criteria via their preferred mode of contact, explain the nature of the interviews, and arrange an appointment for an interview if the participant wishes to continue. This is planned to take place between August and December 2013. Interviews will be completed at the venue of the participants choice.

At the appointment, participants will be given an information sheet outlining the areas of questions that will be covered

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in the interview, and a consent form to complete. In addition to the written consent, participants will also be requested to verbally consent to being audio-recorded. Interviews will last up to 1 hour, participants will have the opportunity to take breaks or withdraw from the research at any point during the interview. Following the interview, participants will be able to withdraw at any time.

Data transcription and analysis will be ongoing during the interview period, although may continue until February 2014.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- Design of the research
 Management of the research
 Undertaking the research
 Analysis of results
 Dissemination of findings
 None of the above

Give details of involvement, or if none please justify the absence of involvement.

As the participants for the research are professionals, service users were not consulted regarding the design of the research. Findings will be submitted to a peer-reviewed journal which may be accessed by members of the public. Findings will also be disseminated to the teams involved in the research via email presentation, and possibly wider Community Mental Health Teams to increase awareness of the issues around professional experiences of patient suicide.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

- Participants are mental health professionals, e.g. nurse, social worker, psychiatrist, psychologist.
- Participants have experienced what they believe to be a suicide of a patient for whom they were a key professional involved in their care, for example care coordinator, responsible clinician or therapist.
- Participants had at least 5 clinical contacts with the patient.
- The patient suicide must have taken place within 12 months of discharge from the team.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

- No experience of patient suicide
- Experience of patient suicide but not key professional involved in their care.
- Experience of patient suicide but less than 5 clinical contacts with the patient.
- Experience of patient suicide longer than 12 months after discharge.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

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Intervention or procedure	1	2	3	4
Presenting research idea. Reading information sheets and discussing any issues raised.	1	N/A	15 minutes	Lead researcher will attend team meetings at participants' workplace to present questionnaires, explain process and distribute screening questionnaires.
Completing screening questionnaires.	1	N/A	15 minutes	Lead researcher will distribute questionnaires at team meeting and leave in pigeonholes in team office for those not at meeting. Participants complete questionnaires in their workplace or home.
Participants who opt in for interviews being contacted to arrange appointment.	1	N/A	15 minutes.	Lead researcher will contact participants by phone or email.
Full informed consent and interview.	1	N/A	60 minutes	Lead researcher will conduct interviews at a venue of the participants choice.

A21. How long do you expect each participant to be in the study in total?

From the point of completing screening questionnaires to completing interviews, a maximum of 8 months.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Participants may find taking part in interviews an inconvenience due to busy lifestyles. Every effort will be taken to ensure that interviews are convenient for the participant in terms of timing and location.

Participants may experience emotional distress when discussing patient suicides and their experiences following this. A sensitive approach to interviewing will be taken to ensure that this is minimised. Participants will be offered regular breaks during the interview if they become distressed. The lead researcher has experience of clinical interviews and therapy and will use these clinical skills during the interview.

Participants may reveal personal information about themselves, patients or other professionals during the interview. BCUHB Confidentiality policy and the BPS code of conduct will be adhered to throughout the research process, and the recorded information will be anonymised at the point of transcription. This will be made clear to the participant prior to consenting.

Participants may continue to experience emotional distress following the interview. Debriefing time will be offered at the end of the interview, and information or advice will be provided to participants should they wish to seek further support.

Participants may reveal potential examples of malpractice or breach of professional conduct during the interview. If this occurs, this will be discussed with the research supervisor and the appropriate BCUHB policy would be followed. This will be made clear to the participants at the outset, and if any issues arise during the interview, this will be discussed with the participant at the time.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

Yes No

If Yes, please give details of procedures in place to deal with these issues:

The lead researcher has experience of conducting clinical interviews and psychological therapy, and discussing sensitive and upsetting issues. Care will be taken to ensure a sensitive and supportive approach to the interview topics. Participants will be offered breaks should they become upset.

Participants may disclose potential incidents of malpractice or unprofessional behaviour. If this occurs it will be discussed with the participant and the research supervisor. If action is felt to be required, BCUHB policy will be followed.

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A24. What is the potential for benefit to research participants?

Participants may appreciate the opportunity to discuss their experiences with someone who is objective and who they are not involved with professionally.

Raising awareness of the impact of patient suicide on professionals may be beneficial for participants.

If the research informs clinical practice at a later date, this may be of benefit to participants.

A26. What are the potential risks for the researchers themselves? (if any)

As the researchers are also mental health professionals, they may relate to the experiences described by participants. Conducting interviews and transcribing and analysing qualitative data may result in the researchers experiencing emotional distress due to the experiences described by participants. Regular supervision meetings will be held during the interview and analysis period, which will include reflecting on the impact of the research on the researchers. The lead researcher will also have access to a Personal and Professional Development Counselling scheme offered by NWCPP, should any issues be raised that require further discussion.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).

Community Mental Health team managers will be contacted and the lead researcher will attend a team meeting to explain the nature of the research and answer any questions. The purposes of the questionnaire and the interviews will be outlined. Information sheets and screening questionnaires will be distributed at the meeting by the lead researcher to all professionals in the teams, and via pigeon holes in team offices for those absent from the meeting.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

Yes No

Please give details below:

Participants (NHS staff) will be asked to provide their age and profession on the screening questionnaire, but not their name or any other identifiable personal information. Those who wish to be contacted for interview will be required to provide their name and contact details to enable interviews to be arranged.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

Yes No

A27-5. Has prior consent been obtained or will it be obtained for access to identifiable personal information?

Yes No

If Yes, please give details below.

Participants (NHS staff) will provide their own personal contact details if they wish to opt-in to interviews.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

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 Yes No**A29. How and by whom will potential participants first be approached?**

Team managers will be contacted and the lead researcher will attend a team meeting to explain the nature of the research and distribute information sheets and screening questionnaires.

A30-1. Will you obtain informed consent from or on behalf of research participants? Yes No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Participants will be given an initial information sheet with the screening questionnaire, which will explain that consent to take part in the screening process and have their anonymised data used will be assumed by them submitting the questionnaire. A further information sheet will be enclosed at the end of the screening questionnaire, this will explain about the process of the interviews, how the information will be used, how to withdraw etc. Participants will provide consent to be contacted for follow-up interviews by completing their contact details and returning the questionnaire. At the point of contact for follow up interviews, the information sheet will be discussed again. Participants will provide written and verbal informed consent to take part in the interview, and to have their interview recorded, before starting the interview. In addition to this, at the end of the interview participants will be asked to consent to their interview data being used for analysis, and they will be reminded of the process for withdrawing their data from the study.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing? Yes No**A31. How long will you allow potential participants to decide whether or not to take part?**

For interviews, participants will be provided with information sheets at the initial contact when they complete the screening questionnaires. They will be contacted by phone or email after this, and given further information and the opportunity to ask questions and decide whether they want to go ahead and be interviewed. At the interview, this information sheet will be revisited. During and after the interview participants will have the right to withdraw at any time.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?(e.g. translation, use of interpreters)

As all participants will be employees of BCUHB, it is expected that they will be able to understand written or verbal information given in English. Information sheets and consent forms will be provided bilingually in English and Welsh, although it will be stipulated that verbal information must be given in English as the lead researcher does not speak Welsh.

A33-2. What arrangements will you make to comply with the principles of the Welsh Language Act in the provision of information to participants in Wales?

Information sheets and consent forms will be provided bilingually in English and Welsh, although it will be stipulated that verbal information must be given in English as the lead researcher does not speak Welsh.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the

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study? *Tick one option only.*

- The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- The participant would continue to be included in the study.
- Not applicable – informed consent will not be sought from any participants in this research.
- Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

*Further details:***CONFIDENTIALITY**

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study**A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?** *(Tick as appropriate)*

- Access to medical records by those outside the direct healthcare team
- Electronic transfer by magnetic or optical media, email or computer networks
- Sharing of personal data with other organisations
- Export of personal data outside the EEA
- Use of personal addresses, postcodes, faxes, emails or telephone numbers
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals
- Use of audio/visual recording devices
- Storage of personal data on any of the following:
- Manual files including X-rays
- NHS computers

- Home or other personal computers
- University computers
- Private company computers
- Laptop computers

*Further details:***A38. How will you ensure the confidentiality of personal data?** *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

BCUHB confidentiality policy will be followed regarding personal data. All audio data will be anonymised at the point of transcription, including information relating to the participant, other professionals and patients. Direct quotes may be used in a report, although care will be taken to remove all potential identifiable information, it may be important to report the participants' profession. This will be made clear to participants in the information sheet.

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A40. Who will have access to participants' personal data during the study? Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.

The questionnaire responses and interview transcripts will only be seen by the lead researcher and supervisor. The transcripts will be anonymised before being viewed by the supervisor. This will be made clear to participants in the information sheet prior to giving consent.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

- Less than 3 months
 3 – 6 months
 6 – 12 months
 12 months – 3 years
 Over 3 years

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

- Yes No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

- Yes No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

- Yes No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

- Yes No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

- Yes No

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Please give details, or justify if not registering the research.

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:

- Peer reviewed scientific journals
 Internal report
 Conference presentation
 Publication on website
 Other publication
 Submission to regulatory authorities
 Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
 No plans to report or disseminate the results
 Other (please specify)

A53. Will you inform participants of the results?

Yes No

Please give details of how you will inform participants or justify if not doing so.
 A summary of the findings will be disseminated through team managers following completion of the study.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? Tick as appropriate:

- Independent external review
 Review within a company
 Review within a multi-centre research group
 Review within the Chief Investigator's institution or host organisation
 Review within the research team

Review by educational supervisor

- Review by educational supervisor
 Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
 The research has been reviewed by the supervisor and the Research Director from NWCPP, Bangor University. It has also been dual reviewed by the School of Psychology ethics committee.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.

Total UK sample size: 10

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Total international sample size (including UK):
Total in European Economic Area:

Further details:
The sample size for the interviews will not exceed 10.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

For the method of analysis chosen (Interpretative Phenomenological Analysis) it is advised that 6-8 participants is sufficient to reach information "saturation".

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Data will be analysed using Interpretative Phenomenological Analysis (IPA), which is a method of analysis of qualitative data which aims to explore how a person in a particular context makes sense of a particular experience or phenomenon. In this case, it will be used to explore the phenomenon of patient suicide, and the participants' interpretations of this. Data will be manually coded, and patterns or themes will be generated from this. There may be broader themes, and sub-themes, which will be checked by the supervisor against the transcripts to ensure appropriate interpretation.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Dr	Mike	Jackson
Post	Consultant Clinical Psychologist		
Qualifications			
Employer	BCUHB		
Work Address	Hergest Unit, Ysbyty Gwynedd Bangor		
Post Code	LL57 2PW		
Telephone			
Fax			

Fax	
Mobile	
Work Email	mike.jackson@wales.nhs.uk

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status: NHS or HSC care organisation
 Academic
 Pharmaceutical industry

Commercial status: Non-Commercial

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Medical device industry
 Local Authority
 Other social care provider (including voluntary sector or private organisation)
 Other

If Other, please specify:

Contact person

Name of organisation Bangor University
 Given name Dr Charles
 Family name Leek
 Address School of Psychology, 43 College Road
 Town/city Bangor
 Post code LL57 2DG
 Country UNITED KINGDOM
 Telephone
 Fax
 E-mail

Is the sponsor based outside the UK?
 Yes No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

Funding secured from one or more funders
 External funding application to one or more funders in progress
 No application for external funding will be made

What type of research project is this?
 Standalone project

Project that is part of a programme grant
 Project that is part of a Centre grant
 Project that is part of a fellowship/ personal award/ research training award
 Other
 Other – please state:

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

Yes No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

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A68-1. Give details of the lead NHS R&D contact for this research:

	Title Forename/Initials Surname
	Dr Rossela Roberts
Organisation	BCUHB
Address	Cinical Governance Officer Ysbyty Gwynedd Bangor
Post Code	
Work Email	rossela.roberts@wales.nhs.uk
Telephone	
Fax	
Mobile	

Details can be obtained from the NHS R&D Forum website: <http://www.rdforum.nhs.uk>

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/08/2013
 Planned end date: 01/09/2014
 Total duration:
 Years: 1 Months: 1 Days: 1

A71-2. Where will the research take place? (Tick as appropriate)

England
 Scotland
 Wales
 Northern Ireland
 Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?
 Yes No

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:

NHS organisations in England
 NHS organisations in Wales 1
 NHS organisations in Scotland
 HSC organisations in Northern Ireland
 GP practices in England
 GP practices in Wales
 GP practices in Scotland
 GP practices in Northern Ireland
 Social care organisations
 Phase 1 trial units

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- Prison establishments
 Probation areas
 Independent hospitals
 Educational establishments
 Independent research units
 Other (give details)

Total UK sites in study: 1

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- NHS indemnity scheme will apply (NHS sponsors only)
 Other insurance or indemnity arrangements will apply (give details below)

The University has appropriate insurance for research projects.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- NHS indemnity scheme will apply (protocol authors with NHS contracts only)
 Other insurance or indemnity arrangements will apply (give details below)

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
 Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

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Please enclose a copy of relevant documents.

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- NHS indemnity scheme will apply (NHS sponsors only)
 Other insurance or indemnity arrangements will apply (give details below)

The University has appropriate insurance for research projects.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- NHS indemnity scheme will apply (protocol authors with NHS contracts only)
 Other insurance or indemnity arrangements will apply (give details below)

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
 Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

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PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.

Research site		Investigator/ Collaborator/ Contact	
Institution name	BCUHB	Title	Dr
Department name	Adult Mental Health Services	First name/ Initials	Mike
Street address	Ysbyty Gwynedd (Base)	Surname	Jackson
Town/city	Bangor		
Post Code			

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PART D: Declarations**D1. Declaration by Chief Investigator**

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
 - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
 - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
 - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
 - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response

to requests made under the Acts except where statutory exemptions apply.

- May be sent by email to REC members.

10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication(Not applicable for R&D Forms)

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

Chief Investigator

Sponsor

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D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

This section was signed electronically by Mr Hefin Francis on 05/07/2013 08:54.

Job Title/Post: School Manager for Psychology

Organisation: Bangor University

Email: h.francis@bangor.ac.uk

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D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.
2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.
3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.
4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Mike Jackson on 05/07/2013 12:46.

Job Title/Post: Clinical Psychologist
Organisation: BCUHB
Email: mike.jackson@wales.nhs.uk

**North Wales Research Ethics Committee – West : Letter of favourable
opinion with additional conditions**

Part of the research infrastructure for Wales funded by the National Institute for Social Care and Health Research, Welsh Government.
Yn rhan o seilwaith ymchwil Cymru a arlarri'r gan y Selyddiad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd, Llywodraeth Cymru



**Pwyllgor Moeleg Ymchwil Gogledd Cymru - Y Drillewin
North Wales Research Ethics Committee - West**

Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Clinical Academic Office
Bangor, Gwynedd
LL57 2PW

Telephone/ Facsimile: 01248 - 384.877
Email: Rossela.Roberts@wales.nhs.uk
Website : www.nres.nhs.uk

Miss Rachel Newton
Trainee Clinical Psychologist
NWCPP, School of Psychology
Bangor University,
Brigantia Building, Penrallt Road
Bangor, LL55 2AS

pspefs@bangor.ac.uk

22 July 2013

Dear Miss Newton,

Study title: Professional experiences, responses and support following patient suicide in adult mental health services in North Wales.
REC reference: 13/WAJ0230
IRAS project ID: 125772

The Research Ethics Committee reviewed the above application at the meeting held on 18 July 2013.

The Committee wishes to thank you and Dr Jackson for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Coordinator, Dr Rossela Roberts, rossela.roberts@wales.nhs.uk

Ethical opinion

Ethical issues raised, resolved or noted in preliminary discussion

A query was raised regarding the need for ethical review for this project. Under paragraph 2.3.13 of Governance Arrangements for Research Ethics Committees (2010), review by a REC is not normally required for research involving healthcare staff recruited as research participants by virtue of their professional role.

It was noted that the sponsor advised that this should be treated as a research project and would require REC review, exceptionally, because it raises significant ethical issues and has potential to generate incidental findings with ethical implications.



Cynbellr Cydweithradiad Gwyddor Iechyd Academaidd y Selyddiad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd gan Fwrdd Addysgu Iechyd Powys
The National Institute for Social Care and Health Research Academic Health Science Collaboration is hosted by Powys Teaching Health Board



Ethical Issues raised by the Committee in private discussion, together with responses given by you and Dr Jackson when invited into the meeting

The Chairman welcomed you and introduced the Committee members and the observer. The Chairman explained that the observer will have no input in the ethical review or the decision making process and gave you the opportunity to raise an objection to the observer being present for the review of this application.

You did not raise an objection to the observer being present.

The following issues were discussed:

Social or scientific value; purpose and need; scientific design and conduct of the study

The Committee considered whether the objectives, design, methodology, and the conduct of the study are appropriately described in the protocol.

A query was raised in relation to the feasibility of the study and the likelihood of having enough participants to answer the research question.

You clarified that the study was scoped in the Clinical Psychology Programme and a number of potential participants showed interest.

Dr Jackson clarified that the sample for this qualitative study is based on published data; it is not possible to establish how many participants would be eligible to participate but in his professional experience there would be sufficient Community Mental Health Team members of staff who have experienced patient suicide.

The Committee concluded that the research design and the proposed analysis are suitable for answering the research question.

No further ethical issues were raised in relation to the scientific value and conduct of the study.

Independent review

The Committee discussed whether the study has been independently peer reviewed and whether the review is in scale of the research and risks involved.

The Committee concluded that the review of the project by Bangor University's School of Psychology Research Governance and Ethics Committee is sufficient evidence of peer-review for this type of project.

No further ethical issues were raised regarding the peer-review.

Recruitment arrangements; fair participant selection

The Committee was satisfied that the selection of potential participants has taken into account their clinical role and sufficient details are provided in the protocol and the application form regarding the inclusion and exclusion criteria. The Committee raised no further issues.

Favourable risk benefit ratio; anticipated benefits/risks for research participants

The Committee discussed the anticipated benefits and potential risks to participants and was satisfied that you have suitably identified the risks and benefits and highlighted them in the information given to potential participants.

No further ethical issues were raised in relation to the risk/benefit for research participant.

Care and protection of research participants; respect for participants' welfare and dignity; data protection and confidentiality

The Committee discussed the information governance aspects of the study, where and for how long will data be stored, and clarified who will have access to the data.

No further ethical issues were raised in relation to data protection.

Informed Consent process; adequacy and completeness of Participant Information

The Committee noted that written informed consent is taken as part of a process - with participants having adequate time to consider the information, and opportunity to ask questions.

The information is clear as to what the participant consents, and there is no inducement or coercion.

The Committee agreed that the procedures described in the protocol have been addressed in the information sheet, but felt that some minor corrections are needed to clarify the complaints mechanism and aspects of confidentiality.

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Suitability of the applicant and facilities

The Committee discussed the suitability of the applicant and concluded that you are sufficiently qualified and adequately supervised to carry out this research.

General comments/ missing information/ typographical errors/ application errors/ suitability of the study summary

The summary of the study as it appears in section A6-1 of the REC application form was deemed to be an accurate description of the study and suitable for publication on the NRES website.

The Chairman thanked you and Dr Jackson for your availability to speak to this submission and gave you an opportunity to ask questions.

You did not raise any issues.

The Chairman confirmed that the Committee will deliberate and will be in touch shortly.

On the basis of the information provided, the Committee was satisfied with the following aspects of the research:

- Social or scientific value; purpose and need
- Scientific design and conduct of the study
- Independent review
- Recruitment arrangements; fair participant selection
- Favourable risk benefit ratio; anticipated benefits/risks for research participants
- Care and protection of research participants; respect for participants' welfare and dignity; data protection and confidentiality
- Informed Consent process
- Suitability of the applicant and facilities
- Suitability of the study summary

The Committee identified issues with the following aspects of the research:

- Adequacy and completeness of Participant Information

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

The favourable opinion is subject to the following conditions being met prior to the start of the study:**The Committee requested that the following amendments are to be made to the Participant Information Sheets and Consent Form:**

1. In Participant Information Sheet 1 the paragraph "What does the study entail" and Participant Information Sheet 2 the paragraph "What if I change my mind" need to clarify that a decision to not take part in the project or withdraw at a later date will not affect their employment rights.

13WA/0230

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2. In Participant Information Sheet 2 the first sentence of paragraph "What will happen to the information I provide in the questionnaire" needs to be re-phrased to ensure participants that all their data (not only their contact details) will be kept confidential.
3. The Participant Information Sheet 2 needs to incorporate a paragraph giving contact details for potential complaints
4. In the Consent Form , paragraph 2 needs to clarify that a decision to withdraw will not prejudice their legal or employment rights.
5. The amended Participant Information Sheets and Consent Form need translating and the Welsh language version made available to participants.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers.

The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.r4forum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations. It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
REC application (submission 125772/473540/1/67)		08 July 2013
Protocol	1	03 June 2013
Participant Information Sheet: 1	1	06 March 2013
Participant Information Sheet: 2	1	06 March 2013
Participant Consent Form	1	06 March 2013
Interview Schedules/Topic Guides	1	06 March 2013
Questionnaire	1	06 March 2013
Evidence of Insurance or Indemnity		09 July 2012
Investigator CV		04 July 2013
Other: Academic Supervisor CV		

(end of list)

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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

No declarations of interest were made in relation to this application.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical reviewReporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

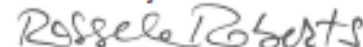
Further information is available at National Research Ethics Service website > After Review

13/WA/0230	Please quote this number on all correspondence
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We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Mr Derek James Crawford, MBChB, FRCS
Chair

E-mail: rosalea.roberts@wales.nhs.uk

Enclosure: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

13/WA/0230

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Copy:

Sponsor: Dr. Charles Leek,
c/o: Mr Hefin Francis
School of Psychology, Bangor University
Adellad Brigantia, Penrallt Road
Bangor, Gwynedd, LL57 2AS h.francis@bangor.ac.uk

Academic Supervisor: Dr Mike Jackson
Consultant Clinical Psychologist
Hergest Unit, Ysbyty Gwynedd
Betsi Cadwaladr University Health Board
Bangor, LL57 2AS mike.jackson@wales.nhs.uk

R&D Office: Mr Sion Lewis
Clinical Academic Office
Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Bangor, LL57 2PW sion.lewis@wales.nhs.uk

file copy

North Wales Research Ethics Committee West
Attendance at Committee meeting on 18 July 2013

Committee Members

Name	Profession	Capacity	Present
Dr. Karen Addy	Clinical Psychologist	Expert	Yes
Dr. Swapna Alexander	Consultant Physician	Expert	Yes
Ms Valerie Barcoft	Volunteer Worker	Lay +	Yes
Mrs. Kathryn Chester	Research Nurse	Expert	Yes
Dr. Christine Clark	Consultant Obstetrician & Gynaecologist	Expert	Yes
Mr. Derek James Crawford	Consultant Surgeon (Chairman)	Expert	Yes
Mrs. Gwen Dale-Jones	Retired Personal Assistant	Lay +	Yes
Mr. Hywel Lloyd Davies	Solicitor (Alternate Vice-Chairman)	Lay +	Yes
Ms. Gillian Jones	Student	Lay +	Yes
Dr. Mark Lord	Consultant Pathologist	Expert	Yes
Dr. Neil McKenzie	Retired Physicist	Lay +	Yes
Dr. Jason Walker	Consultant Anaesthetist	Expert	Yes
Dr. Philip Wayman White	General Practitioner (Vice-Chairman)	Expert	Yes

Deputy Members

Name	Profession	Capacity	Present
Dr. Michael Cronin	Consultant Paediatrician (deputy to Dr. Clark)	Expert	No

In attendance

Name	Position (or reason for attending)
Dr. Rossela Roberts	Clinical Governance Officer / Committee Coordinator

Observer

Name	Position (or reason for attending)
Ms Sydna Ann Williams	Retired Lecturer / Prospective Lay member of the REC

North Wales Research Ethics Committee – West: Acknowledgement of documents in compliance with additional conditions

Part of the research Infrastructure for Wales funded by the National Institute for Social Care and Health Research, Welsh Government.
Yn rhan o seilwaith ymchwil Cymru a arlannir gan y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cynddelbasol ac Iechyd, Llywodraeth Cymru



Pwyllgor Moeseg Ymchwil Gogledd Cymru - Y Orllewin
North Wales Research Ethics Committee - West

Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Clinical Academic Office
Bangor, Gwynedd
LL57 2PW

Telephone/ Facsimile: 01248 - 384.877
Email: Rosie.Roberts@wales.nhs.uk
Website : www.nres.nhs.uk

Miss Rachel Newton
Trainee Clinical Psychologist
NWCPP, School of Psychology
Bangor University,
Brigantia Building, Penrallt Road
Bangor, LL55 2AS

pspef8@bangor.ac.uk

23 July 2013

Dear Miss Newton,

Study title: Professional experiences, responses and support following patient suicide in adult mental health services in North Wales.
REC reference: 13/WAJ/0230
IRAS project ID: 125772

Thank you for your letter of 23 July 2013.
I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 22 July 2013.

Documents received

The documents received were as follows:

Document	Version	Date
Participant Consent Form	2	23 July 2013
Participant Information Sheet: part 1	2	23 July 2013
Participant Information Sheet: part 2	2	23 July 2013

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
REC application (submission 125772/473540/1/67)		08 July 2013
Protocol	1	03 June 2013
Participant Information Sheet: part 1	2	23 July 2013
Participant Information Sheet: part 2	2	23 July 2013
Participant Consent Form	2	23 July 2013
Interview Schedules/Topic Guides	1	06 March 2013
Questionnaire	1	06 March 2013
Evidence of Insurance or indemnity		09 July 2012
Investigator CV		04 July 2013
Other: Academic Supervisor CV		

(end of list)



Cyswllir Cydwethriadol Gwyddor Iechyd Academaidd y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cynddelbasol ac Iechyd gan Fwrdd Addysgu Iechyd Powys
The National Institute for Social Care and Health Research Academic Health Science
Collaboration is hosted by Powys Teaching Health Board



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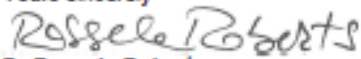
Page 2 of 2

You should ensure that the sponsor has a copy of the final documentation for the study.

It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/WA/0230	Please quote this number on all correspondence
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Yours sincerely


Dr Rossela Roberts
Committee Co-ordinator

E-mail: rossela.roberts@wales.nhs.uk

Copy:

Sponsor: Dr. Charles Leek,
c/o: Mr Hefin Francis
School of Psychology, Bangor University
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Academic Supervisor: Dr Mike Jackson
Consultant Clinical Psychologist
Hergest Unit, Ysbyty Gwynedd
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Bangor, LL57 2AS mike.jackson@wales.nhs.uk

R&D Office: Mr Sion Lewis
Clinical Academic Office
Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Bangor, LL57 2PW sion.lewis@wales.nhs.uk

Confirmation of Research and Development approval



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Panel Arolygu Mewnol Y&D - Y Gorllewin R&D Internal Review Panel - West

Betsi Cadwaladr University Health Board
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Miss Rachel Newton
Trainee Clinical Psychologist
Bangor University/BCUHB
NWCPP, School of Psychology
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pspef8@bangor.ac.uk

Chairman/Cadeirydd - Dr. Mike C Jackson, CPsychol, DClinPsych, DPhil
Email: rossela.roberts@wales.nhs.uk
wendy.scrase@wales.nhs.uk
slon.lewis@wales.nhs.uk
Tel/Fax: 01248 384 877

5 August 2013

Dear Miss Newton

Re: Confirmation that R&D governance checks are complete / R&D approval granted

Study Title	Professional experiences, responses and support following patient suicide in adult mental health services in North Wales
IRAS reference	125772
REC reference	13/WA/0230

Thank you for submitting your R&D application and supporting documents.

The above study was eligible for Proportionate Review and was reviewed by the R&D Manager and Chairman of the Internal Review Panel West.

The Committee is satisfied with the scientific validity of the project, the risk assessment, the review of the NHS cost and resource implications and all other research management issues pertaining to the revised application.

The documents reviewed and approved are listed below:

Document:	Version	Date
R&D Form – 125772/477191/14/58	-	11/07/2013
SSI Form – 125772/473183/6/839/193789/276031	-	04/07/2013
R&D Checklist	-	-
SSI Checklist	-	-
Proposal	1	03/06/2013
Information sheet 1	2	23/07/2013
Information sheet 2	2	23/07/2013
Consent Form	2	23/07/2013
Guide for Interviews	1	06/03/2013
Questionnaire	1	06/03/2013
SL2 Acknowledgement of a valid application 13-WA-0230 (Newton)	-	08/07/2013
SL5 Favourable opinion with additional conditions 13-WA-0230 (Newton)	-	22/07/2013
SL44 Acknowledgement of documents in compliance with additional conditions 13-WA-0230 (Newton)	-	23/07/2013
Insurance Letter 2012-2013	-	09/07/2012
CV – CI - R Newton	-	-
CV – Dr M Jackson	-	-

All research conducted at the Betsi Cadwaladr University Health Board sites must comply with the Research Governance Framework for Health and Social Care in Wales (2009).

An electronic link to this document is provided on the BCUHB R&D WebPages. Alternatively, you may obtain a paper copy of this document via the R&D Office.

Attached you will find a set of approval conditions outlining your responsibilities during the course of this research. Failure to comply with the approval conditions will result in the withdrawal of the approval to conduct this research in the Betsi Cadwaladr University Health Board.

If your study is adopted onto the NISCHR Clinical Research Portfolio (CRP), it will be a condition of this NHS research permission, that the Chief Investigator will be required to regularly upload recruitment data onto the portfolio database.

To apply for adoption onto the NISCHR CRP, please go to:

<http://www.wales.nhs.uk/sites3/page.cfm?orgId=580&pid=31979>.

Once adopted, NISCHR CRP studies may be eligible for additional support through the NISCHR Clinical Research Centre. Further information can be found

at: <http://www.wales.nhs.uk/sites3/page.cfm?orgId=580&pid=28571> and/or from your NHS R&D office colleagues.

To upload recruitment data, please follow this link:

http://www.cmcc.nlhr.ac.uk/about_us/processes/portfolio/p_recruitment.

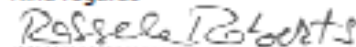
Uploading recruitment data will enable NISCHR to monitor research activity within NHS organizations, leading to NHS R&D allocations which are activity driven. Uploading of recruitment data will be monitored by your colleagues in the R&D office.

If you need any support in uploading this data, please contact wendy.scrase2@wales.nhs.uk or sion.lewis@wales.nhs.uk

If you would like further information on any other points covered by this letter please do not hesitate to contact me.

On behalf of the Committee, may I take this opportunity to wish you every success with your research.

Kind regards



Dr. Mike C Jackson
Associate Director of R&D
Chairman IRP-West

P

Copy to:	Sponsor:	Mr H. Francis School of Psychology Brigantia Building Bangor University Bangor LL55 2AS h.francis@bangor.ac.uk
	Lead Sponsor:	Dr Charles Leek School of Psychology Bangor University 43 College Road Bangor LL57 2DG e.c.leek@bangor.ac.uk
	Academic Supervisor:	Dr Mike Jackson Hergest Unit Ysbyty Gwynedd Bangor LL57 2PW mike.jackson@wales.nhs.uk

Letter to CMHT managers

Dear (Name)

I am a second year Trainee Clinical Psychologist at Bangor University and BCUHB. I am conducting a research project on the experience of mental health professionals when their patients commit suicide, under the supervision of Dr Mike Jackson (Consultant Clinical Psychologist)

I am interested in speaking to community mental health professionals who have experienced patient suicide. The focus of the study is on how this impacts on people professionally and personally, and what responses or support they may have found helpful or unhelpful. The Welsh Government have stated that they aim to improve support for professionals affected by patient suicide, but little is known about how this should best be put into practice.

The aim of the study is NOT to review professional practice or individual cases. The focus will be on understanding more about the experiences of people who have worked clinically with patients who have died by suicide. Please see the attached participant information sheets, questionnaire and interview guides for more details.

Of course this is a very sensitive subject to research, and every effort has been made to ensure that this will be done in a compassionate manner. The study has been approved by two ethics committees from the School of Psychology at Bangor University, and the NHS Local Research Ethics committee, as well as R&D review. The study has also been discussed with Hilary Owen (Business Manager for MH & LD CPG) who has offered her support.

The study will entail a short screening questionnaire, following which staff members can opt in to be contacted for follow-up interviews. These may take between 20 minutes to an hour, and will be arranged at a time and location convenient to the participant.

I would like to attend a team meeting to present the background and rationale for my study, offer staff the opportunity to take part and to distribute screening questionnaires. This will take between 10-15 minutes. I would appreciate it if you could send me some dates of team meetings in the near future.

Please feel free to contact me if you would like to discuss this further.

Rachel Newton
Trainee Clinical Psychologist

Information sheets: English



PARTICIPANT INFORMATION SHEET 1 (V.2 - 23/07/2013)

Title of Project: Professional experiences and support following patient suicide in adult mental health services.

Name of researcher: Rachel Newton (Trainee Clinical Psychologist) supervised by Dr Mike Jackson (Consultant Clinical Psychologist)

We would like to invite all Community Mental Health Team professionals to take part in our research. This research is part of Rachel's DClInPsy qualification at Bangor University. Before you decide, it is important that you understand why the research is being done and what it will involve. This information sheet is a summary of the explanation that will be given by the researcher. You will have an opportunity to ask any questions before agreeing to take part in the study. This should take about 10 minutes.

What is the study about?

Mental health professionals are more likely than other healthcare workers to experience patient suicide. The Welsh Government published a 5 year action plan to reduce suicide and self-harm. Objective 4 of this plan includes the following:

"improve the care and support offered to people who are bereaved by suicide and to professionals who are affected by the aftermath of suicide ensuring that peoples' emotional psychological and spiritual needs are met" (WAG, 2009).

This study aims to explore current practice in relation to this action plan, as more information is needed to understand what is helpful or unhelpful to professionals following a patient suicide.

We are interested in your experiences of patient suicide, in particular how this has impacted on you personally and professionally, and what responses or support you found helpful or unhelpful. This is not about reviewing your professional practice.

For the purposes of this study we use the term 'patient suicide' to refer to a person who you were directly clinically involved with and who you believe to have ended their own life. This may have occurred up to 12 months after being discharged from services.

What does the study entail?

This is a voluntary study and you are free to opt out. Your employment rights will not be affected should you opt out or choose to withdraw later. The study is in two stages, a short questionnaire and an interview. The next page will explain in detail about the questionnaire. If you decide to complete the questionnaire, at the end you will find a second information sheet with details about the interview.

It is important to consider that this study focuses on a sensitive and potentially emotional topic which can be difficult to talk about. Every effort has been made to ensure that this study approaches these issues sensitively and supportively; however you are encouraged to take care of yourself and to consider the emotional impact of taking part.

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by North Wales Research Ethics Committee, and the School of Psychology at Bangor University. If you are unhappy with any aspect of this study or would like to make a complaint, please see the final paragraph of Information Sheet 2.

PARTICIPANT INFORMATION SHEET 1 (V.2 – 23/07/2013)

INFORMATION ABOUT THE QUESTIONNAIRE

What am I expected to do?

The questionnaire takes less than 10 minutes to complete. Part 1 asks for information about your professional role and whether you have experienced a patient suicide. The completed questionnaires can be returned in the envelope provided.

You can complete part 1 even if you have not experienced a patient suicide. If you have, and you are happy to share the information, you can complete part 2, which asks about what happened after the patient suicide. At this stage, the questionnaires are anonymous and can be returned in the envelope provided.

After completing the questionnaire, you can decide whether you would be happy to talk about your experiences in more detail (See information sheet 2). This would involve giving your name and contact details, so your responses would no longer be anonymous to the researcher. Your contact details will be kept confidential.

What will happen to the information I provide in the questionnaire?

If you only complete the questionnaire and do not opt in to the interview, your information will be anonymous to the researcher and will be reported as group statistics.

The completed anonymous questionnaires will only be seen by the researchers. They will be kept in a secure filing cabinet in a locked office with limited access. They will be kept for up to 5 years as the study may be published. After this time they will be destroyed by the researchers.

A summary of the findings of the study will be distributed to the teams who take part.

What if I change my mind?

If you change your mind at any point during the completion of the questionnaire, you can simply not return it. However once you have returned an anonymous questionnaire it is not possible to withdraw from the study. Information about withdrawing after opting in for interviews is explained in Information Sheet 2.

How do I consent?

If you are happy to continue, please complete the questionnaire. Your consent to the information being used is assumed when you return the completed questionnaire.

Thank you for your time.

If you would like to continue, please turn over to start the questionnaire.



PARTICIPANT INFORMATION SHEET 2 (V.2 - 23/07/2013)

Thank you for considering taking part in a follow up interview for this study. The purpose of the follow up interview is to get detailed information about the experience of patient suicide, the personal and professional impact, and what responses or support you found helpful or unhelpful. The interview will expand on the areas covered in the questionnaire. Before you decide, it is important that you understand what this will involve. This information sheet is in addition to the explanation given by the researcher, and you are encouraged to ask any questions if you are unsure of anything.

What am I expected to do?

You will be asked to give your contact details (name, email or contact number) to the researcher. This does not mean that you have consented to be interviewed. The researcher will contact you after a week to check if you would still like to be involved, and to answer any further questions that you may have. If you still want to continue, an appointment will be arranged at a time and location convenient for you. At this appointment this information will be presented to you again, and you will be asked to sign a form if you wish to consent to take part. The interview will last between 20 minutes to an hour. The interview will be audio-recorded. This is essential for this type of qualitative research and avoids excessive note-taking which can distract from the interview process.

What will happen to the information that I provide?

All of your information will be treated with strict confidentiality, and contact details will be destroyed following the interview. Any personal information will be stored in a locked filing cabinet, separate from interview data.

The audio recording will be saved on an encrypted password protected safe-stick, and transcribed (typed-up) by the lead researcher as soon as possible. Nobody else will listen to the recording. As the interview is typed up it will be anonymised, and any personal information that you provide will be edited out. This includes personal information about other people that would allow them to be identified. The anonymised transcripts of your interview will only be seen by the lead researcher and supervisor for the purposes of analysis. The data will be coded, analysed and organised into themes. This will involve grouping data from a number of participants. When the study is written up, it is common to use direct quotes from interviews to provide examples of themes in the data. The quotes will have all identifying features removed. You will have the opportunity to consent to direct quotes being used from your interview.

The report of the study will be submitted to Bangor University for marking and all anonymised interview transcripts will be included. As the study may be published, this information including audio recordings will be kept for up to 5 years. It will be kept in a secure filing cabinet and electronic devices will be password protected.

The researcher, supervisor, and University examiners are all bound by the rules of confidentiality. A summary of the findings will be sent out to all teams who take part in the study via team managers.

What if I change my mind?

You will have lots of opportunities to change your mind and opt out of the interview before it starts. During the interview you will be able to stop at any time and withdraw from the study. At the end of the interview, you will be asked again if you are happy to have your interview included in the study. At any time after the interview, you will be able to contact the lead researcher and withdraw your interview from the study without having to give a reason. Your employment rights will not be affected by withdrawing from the study.

What if I don't want to talk about something?

We are aware that this is a sensitive topic to discuss, and you will not be asked to talk about anything that you are not comfortable with. The researcher is a Trainee Clinical Psychologist with experience of interviewing people and talking about difficult and emotive topics, and every effort will be made to make you feel comfortable and supported. You will be able to stop the interview at any time should you become upset or distressed. It is also possible that issues may come up around professional practice. You are advised that although the interviews are confidential, any disclosures of serious breaches of professional codes of conduct will have to be acted upon. If this happens, this will be discussed with you at the time, and the research supervisor may be consulted in the first instance.

Can I do the interview in Welsh?

Unfortunately it is not possible to conduct interviews in Welsh.

How do I consent?

You can consent to being contacted about an interview by completing your contact details on the slip enclosed and returning it to your questionnaire. Alternatively you can email the researcher, Rachel Newton at pspef8@bangor.ac.uk. After an interview has been arranged, the formal consent process will take place and you will complete and sign a form.

What if I'm not happy with something?

If you are unhappy with any aspect of this study please email Rachel Newton (pspef8@bangor.ac.uk) or Mike Jackson (mike.jackson@wales.nhs.uk).

If you remain unhappy and wish to make a formal complaint, please contact the BCUHB concerns team ConcernsTeam.bcu@wales.nhs.uk or (01248) 384194.

Thank you for your interest in this research study, your time is greatly appreciated. If you have any further questions please contact the researcher or supervisor.

Please return the questionnaire in the envelope provided, and if you wish to be contacted about the follow up interview, please complete your contact details on the slip over the page.

Information Sheets: Cymraeg



TAFLEN WYBODAETH I GYFRANOGWYR 1 (F.2 - 23/07/2013)

<u>Teitl y Project:</u>	Profiadau proffesiynol a chefnogaeth yn dilyn hunanladdiad gan gleifion mewn gwasanaethau Iechyd Meddwl Oedolion
<u>Enw'r ymchwilydd:</u>	Rachel Newton (Seicolegydd Clinigol dan Hyfforddiant) dan oruchwyliaeth Dr Mike Jackson, Seicolegydd Clinigol Ymgynghorol

Hoffem wahodd holl weithwyr proffesiynol y Tîm Iechyd Meddwl Cymunedol i gymryd rhan yn ein hymchwil. Mae'r ymchwil hon yn rhan o gymhwyster DClinPsy Rachel ym Mhrifysgol Bangor. Cyn i chi benderfynu, mae'n bwysig eich bod yn deall pam mae'r ymchwil yn cael ei gwneud a'r hyn bydd yn ei olygu. Mae'r daflen wybodaeth hon yn grynodedb o'r eglurhad a roddir gan yr ymchwilydd. Cewch gyfle i ofyn unrhyw gwestiynau cyn cytuno i gymryd rhan yn yr astudiaeth. Dylai hyn gymryd tua 10 munud.

Beth yw diben yr astudiaeth?

Mae gweithwyr proffesiynol iechyd meddwl yn fwy tebygol na gweithwyr eraill ym maes gofal iechyd o gael profiad o hunanladdiad gan gleifion. Cyhoeddodd Llywodraeth Cymru gynllun gweithredu 5-mlunedd gyda'r bwriad o leihau achosion o hunanladdiad a hunan-niweidio. Mae amcan 4 o'r cynllun hwn yn cynnwys y canlynol:

“gwella'r gofal a'r gefnogaeth a gynigir i bobl sydd wedi colli rhywun o ganlyniad i hunanladdiad, ac i weithwyr proffesiynol y mae canlyniadau hunanladdiad yn effeithio arnynt, gan sicrhau bod anghenion emosiynol, seicolegol ac ysbrydol pobl yn cael eu diwallu” (LIC, 2009).

Bwriad yr astudiaeth hon yw archwilio'r arfer cyfredol yng nghyswllt y cynllun gweithredu hwn, am fod angen mwy o wybodaeth i ddeall yr hyn sy'n fuddiol neu'n ddi-fudd i weithwyr proffesiynol yn dilyn hunanladdiad gan glaf.

Mae gennym ddiddordeb yn eich profiadau chi o achosion o hunanladdiad gan gleifion, yr effaith a gafodd hynny, yn bersonol ac yn broffesiynol, arnoch chi, a pha ymatebion neu gefnogaeth a gawsoch yn fuddiol neu'n ddi-fudd. Nid oes a wnelo hyn ddim ag adolygu eich ymarfer proffesiynol.

At ddibenion yr astudiaeth hon, rydym yn defnyddio'r term 'hunanladdiad gan glaf' i gyfeirio at rywun yr oeddech yn ymwneud yn uniongyrchol ag ef/hi yn glinigol, ac sydd, yn ôl eich barn chi, wedi'i (l)ladd ei hun. Efallai y bydd hyn wedi digwydd hyd at 12 mis ar ôl rhyddhau'r claf o wasanaethau.

Beth y mae'r astudiaeth yn ei olygu?

Astudiaeth wirfoddol yw hon, ac mae gennych hawl i roi'r gorau iddi. Os penderfynwch dynnu'n ôl o'r astudiaeth neu'n dewis rhoi'r gorau iddi'n ddiweddarach, ni fydd hynny'n effeithio ar eich hawliau o ran cyflogaeth. Dwy ran sydd i'r astudiaeth, holiadur byr a

chyfweliad. Ar y dudalen nesaf, cewch eglurhad manwl ynglŷn â'r holiadur. Os penderfynwch lenwi'r holiadur, ar y diwedd, cewch ail daflen wybodaeth, ac arni fanylion am y cyfweliad.

Mae'n bwysig sylweddoli bod yr astudiaeth hon yn canolbwyntio ar bwnc sensitif a allai ysgogi teimladau cryf a allai fod yn anodd eu trafod. Ymdrechwyd i'r eithaf i sicrhau bod yr astudiaeth hon yn ymdrin â'r materion hyn mewn modd sensitif a chynhaliol; fodd bynnag, rydym yn eich annog i ofalu amdanoch eich hun ac i ystyried yr effaith a gaiff cyfranogi ar eich teimladau.

Mae'r holl ymchwil yn y GIG yn cael ei hystyried gan grŵp annibynnol o bobl, o'r enw Pwyllgor Moeseg Ymchwil, er mwyn amddiffyn eich buddiannau. Mae'r astudiaeth hon wedi'i hadolygu ac wedi cael dyfarniad ffafriol gan Bwyllgor Moeseg Ymchwil Lleol Gogledd Cymru a chan Ysgol Seicoleg Prifysgol Bangor. Os byddwch yn anhapus ynglŷn ag unrhyw agwedd ar yr astudiaeth hon, neu os hoffech wneud cwyn, darllenwch baragraff olaf Taflen Wybodaeth 2.

TAFLEN WYBODAETH I GYFRANOGWYR 1 (F.2 - 23/07/2013)

GWYBODAETH YNGLŷN Â'R HOLIADUR

Beth y disgwylir imi ei wneud?

Bydd yr holiadur yn cymryd llai na 10 munud i'w llenwi. Mae Rhan 1 yn gofyn am wybodaeth ynglŷn â'ch rôl broffesiynol, a ph'un a oes gennych brofiad neu beidio o glaf yn cyflawni hunanladdiad. Ar ôl eu llenwi, gellwch anfon holiaduron yn ôl yn yr amlen a ddarparwyd.

Gellwch lenwi Rhan 1 hyd yn oed os nad oes gennych brofiad o glaf yn cyflawni hunanladdiad. Os oes gennych brofiad, ac os ydych yn fodlon rhannu'r wybodaeth, gellwch lenwi rhan 2, sy'n holi ynglŷn â'r hyn a ddigwyddodd ar ôl hunanladdiad y claf. Yn y fan hon, mae'r holiaduron yn ddi-enw, a gellwch eu hanfon yn ôl yn yr amlen a ddarparwyd.

Ar ôl llenwi'r holiadur, gellwch benderfynu a fyddech yn fodlon trafod eich profiadau yn fwy manwl (darllenwch daflen wybodaeth 2). Byddai hyn yn gofyn i am ichi roi eich enw a'ch manylion cyswllt, fel na fyddai eich ymateb mwyach yn ddi-enw i'r ymchwilydd. Cedwir eich manylion cyswllt yn gyfrinachol.

Beth fydd yn digwydd i'r wybodaeth a roddaf yn yr holiadur?

Os na lenwch ond yr holiadur, heb ddewis cael cyfweliad, bydd eich gwybodaeth yn ddi-enw i'r ymchwilydd, ac nid adroddir arni fel ystadegau grŵp.

Dim ond yr ymchwilwyr a gaiff weld yr holiaduron di-enw wedi'u llenwi. Cedwir hwy mewn cabinet ffeilio diogel mewn swyddfa dan glo, a mynediad cyfyngedig yn unig. Cedwir hwy am hyd at 5 mlynedd, oherwydd y posibilrwydd o gyhoeddi'r astudiaeth. Ar ôl y cyfnod hwn, bydd yr ymchwilwyr yn eu dinistrio.

Bydd y timau sy'n cymryd rhan yn cael crynodeb o ganfyddiadau'r astudiaeth.

Beth os byddaf yn newid fy meddwl?

Os newidiwch eich meddwl ar unrhyw adeg tra byddwch yn llenwi'r holiadur, y cwbl sydd i'w wneud yw peidio â'i anfon yn ôl. Fodd bynnag, unwaith y byddwch wedi anfon holiadur di-enw yn ôl, ni fydd modd ichi dynnu'n ôl o'r astudiaeth. Mae gwybodaeth am dynnu'n ôl ar ôl dewis cael cyfweliad i'w gweld ar Daflen Wybodaeth 2.

Sut u dylwn gydsynio?

Os ydych yn fodlon parhau, llenwch yr holiadur os gwelwch yn dda. Cymerwn yn ganiataol eich bod yn caniatáu i'r wybodaeth gael ei defnyddio pan anfonwch yr holiadur yn ôl, wedi'i lenwi.

Diolch am roi o'ch amser.

Os hoffech barhau, trowch drosodd i gychwyn ar yr holiadur.



TAFLEN WYBODAETH I GYFRANOGWYR 2 (F.2 – 23/07/2013)

Diolch i chi am ystyried cymryd rhan mewn cyfweiliad dilynol ar gyfer yr astudiaeth hon.

Diben y cyfweiliad dilynol yw cael gwybodaeth fanwl am y profiad a geir yn achos hunanladdiad gan gleifion, yr effaith a gaiff hynny, yn bersonol ac yn broffesiynol, a phymatebion neu gefnogaeth a gawsoch yn fuddiol neu'n ddi-fudd. Bydd y cyfweiliad yn ehangu ar y meysydd a gafodd sylw yn yr holiadur.

Cyn i chi benderfynu, mae'n bwysig eich bod yn deall yr hyn bydd yn ei olygu. Mae'r daflen wybodaeth hon ar ben yr eglurhad a gawsoch gan yr ymchwilydd, ac rydym yn eich annog i ofyn cwestiynau os ydych chi'n ansicr ynghylch unrhyw beth.

Beth y disgwylir imi ei wneud?

Gofynnir i chi roi eich manylion cyswllt (enw, e-bost neu rif cyswllt) i'r ymchwilydd. Nid yw hyn yn golygu eich bod wedi cydsynio i gael cyfweiliad.

Bydd yr ymchwilydd yn cysylltu â chi ymhenn wythnos, i wirio a ydych yn dal yn awyddus i gymryd rhan, ac i ateb unrhyw gwestiynau eraill a fo gennych. Os ydych yn dal yn awyddus i barhau, trefnir apwyntiad ar adeg ac mewn lleoliad sy'n gyfleus i chi. Yn yr apwyntiad hwn, cewch weld y wybodaeth hon unwaith eto, a gofynnir ichi lofnodi ffurflen os ydych am gydsynio i gymryd rhan. Bydd y cyfweiliad yn cymryd rhwng 20 ac awr. Caiff y cyfweiliad ei recordio ar dâp sain. Mae hyn yn hanfodol ar gyfer y math hwn o ymchwil ansoddol, ac yn osgoi cymryd gormod o nodiadau, a all dynnu oddi wrth y drefn gyfweiliad.

Beth fydd yn digwydd i'r wybodaeth a roddaf?

Byddwn yn trin yr holl wybodaeth a rowch yn llwyr gyfrinachol, ac yn dinistrio eich manylion cyswllt ar ôl y cyfweiliad. Byddwn yn cadw unrhyw wybodaeth bersonol mewn cwpwrdd ffeilio dan glo, ac ar wahân i ddata cyfweiliadau.

Cyn gynted ag y bo modd, bydd y prif ymchwilydd yn cadw'r recordiad sain ar ffon ddiogel, wedi'i hamgryptio a'i gwarchod gan gyfrinair, ac yn ei drawsgrifio (ei deipio). Ni fydd neb arall yn gwrandao ar y recordiad. Wrth i'r wybodaeth gael ei theipio, sicheir ei bod yn ddi-enw, a dilëir unrhyw wybodaeth bersonol a rowch. Mae hyn yn cynnwys gwybodaeth bersonol am bobl eraill a fyddai'n arwain at eu hadnabod. Y prif ymchwilydd a'r goruchwyliwr fydd yr unig rai i weld trawsgrifiadau di-enw eich cyfweiliad, a hynny at ddiben y dadansoddiad. Caiff y data eu codio, eu dadansoddi a'u trefnu yn ôl themâu. Bydd hyn yn golygu grwpio data gan nifer o gyfranogwyr. Pan ysgrifennir ar yr astudiaeth, mae'n arferol defnyddio dyfyniadau uniongyrchol o gyfweiliadau er mwyn darparu enghreifftiau o themâu yn y data. Dilëir o'r dyfyniadau unrhyw nodweddion a allai arwain at adnabod unigolion. Cewch gyfle i gydsynio inni ddefnyddio dyfyniadau uniongyrchol o'ch cyfweiliad.

Cyflwynir adroddiad yr astudiaeth i Brifysgol Bangor i'w farcio, a chynhwysir yr holl drawsgrifiadau di-enw o gyfweiliadau. Oherwydd y posibilrwydd o gyhoeddi'r astudiaeth, cedwir y wybodaeth hon, yn cynnwys recordiadau sain, am hyd at 5 mlynedd. Cedwir hi mewn cabinet ffeilio diogel, a bydd dyfeisiau electronig wedi'u gwarchod trwy gyfrinair. Mae'r ymchwilydd, y goruchwyliwr ac arholwyr y Brifysgol i gyd wedi'u rhwymo gan reolau cyfrinachedd. Bydd yr holl dimau sy'n cymryd rhan yn yr astudiaeth yn cael, trwy reolwyr timau, grynodedb o'r astudiaeth.

Beth os byddaf yn newid fy meddwl?

Cewch lawer o gyfleoedd i newid eich meddwl ac i dynnu allan o'r cyfweiliad cyn iddo gychwyn. Yn ystod y cyfweiliad, byddwch yn gallu rhoi'r gorau iddi ar unrhyw adeg a thynnu'n ôl o'r astudiaeth. Ar ddiwedd y cyfweiliad, gofynnir ichi unwaith eto a ydych yn fodlon inni gynnwys eich cyfweiliad yn yr astudiaeth. Ar unrhyw adeg ar ôl y cyfweiliad, bydd gennych hawl i gysylltu â'r prif ymchwilydd a thynnu'ch cyfweiliad o'r astudiaeth heb orfod rhoi rheswm. Os penderfynwch dynnu'n ôl o'r astudiaeth ni fydd hynny'n effeithio ar eich hawliau o ran cyflogaeth.

Beth os na fyddaf am siarad am rywbeth?

Rydym yn gwybod bod hwn yn bwnc sensitif i'w drafod, ac ni ofynnir ichi drafod dim na fyddwch yn gyffyrddus yn ei gylch. Mae'r ymchwilydd yn Seicolegydd Clinigol dan Hyfforddiant a chanddi brofiad o gyfweild â phobl a thrafod pynciau anodd ac emosiynol, a byddwn yn ymdrechu i'r eithaf i wneud ichi deimlo'n gyffyrddus a chynaledig. Byddwch yn gallu rhoi'r gorau i'r cyfweiliad ar unrhyw adeg os byddwch yn teimlo'n ofidus. Mae'n bosibl hefyd y bydd materion o bwys yn codi sy'n gysylltiedig ag ymarfer proffesiynol. Er bod y cyfweiliadau'n gyfrinachol, rydym yn eich rhybuddio y bydd yn rhaid gweithredu ar unrhyw achosion difrifol a ddatgelir o dorri codau ymddygiad proffesiynol. Os bydd hyn yn digwydd, byddwn yn trafod y mater â chi ar y pryd, ac mae'n bosibl yr ymgynghorir â goruchwyliwr yr ymchwil yn y lle cyntaf.

A gaf y cyfweiliad yn Gymraeg?

Yn anffodus, nid oes modd cynnal cyfweiliadau yn Gymraeg.

Sut u dylwn gydsynio?

Gellwch gydsynio i rywun gysylltu â chi ynglŷn â chyfweiliad trwy nodi eich manylion cyswllt ar y bonyn amgaeedig a'i anfon yn ôl gyda'ch holiadur. Fel arall, gellwch anfon e-bost at yr ymchwilydd, Rachel Newton, ar pspef8@bangor.ac.uk. Ar ôl i gyfweiliad gael ei drefnu, dilynir y drefn gydsynio ffurfiol, a byddwch yn llenwi a llofnodi ffurflen.

Beth os nad ydw i'n hapus ynglŷn â rhywbeth?

Os byddwch yn anhapus ynglŷn ag unrhyw agwedd ar yr astudiaeth hon, anfonwch e-bost at Rachel Newton (pspef8@bangor.ac.uk) neu Mike Jackson (mike.jackson@wales.nhs.uk).

Os byddwch yn parhau'n anhapus ac am wneud cwyn swyddogol, cysylltwch â thîm Bwrdd Iechyd Prifysgol Betsi Cadwaladr sy'n ymdrin â phryderon: ConcernsTeam.bcu@wales.nhs.uk neu (01248) 384194.

Diolch i chi am eich diddordeb yn yr astudiaeth ymchwil hon; rydym yn werthfawrogol iawn o'ch amser. Os oes gennych unrhyw gwestiynau eraill, cysylltwch â'r ymchwilydd neu'r goruchwyliwr.

Anfonwch yr holiadur yn ôl yn yr amlen a ddarparwyd, ac os ydych am i rywun gysylltu â chi ynglŷn â'r cyfweiliad dilynol, rhowch eich manylion cyswllt ar y bonyn dros y ddalen.

Consent form: English

CONSENT FORM (V2 – 23/07/2013)

Title of Project: Professional responses and support following patient suicide in AMH services.

Name of Researcher: Rachel Newton under supervision of Dr Mike Jackson

Please initial all
boxes

1. I confirm that I have read and understand Information Sheets 1 & 2 dated July 2013 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and this decision will not affect my legal or employment rights.
3. I give permission for my interview to be audio recorded, and understand that the recordings will be stored securely by the researchers for a maximum of 5 years.
4. I give permission for the possibility of verbatim quotations being published, which will not contain any personal identifiable information.
5. I understand that the interviewer will be bound by confidentiality policy, and that any issues raised that may require a breach of confidentiality, will be discussed with me first.
6. I agree to take part in the above study.

<hr/>	<hr/>	<hr/>
Name of Participant	Date	Signature

<hr/>	<hr/>	<hr/>
Name of Person taking consent.	Date	Signature



FFURFLEN GYDSYNIO (F2 – 23/07/2013)

Teitl y Project: Ymatebion proffesiynol a chefnogaeth yn dilyn hunanladdiad gan gleifion mewn gwasanaethau Iechyd Meddwl Oedolion

Enw'r Ymchwilydd: Rachel Newton dan oruchwyliaeth Dr Mike Jackson

Rhowch lythrennau
blaen
eich enw yn yr holl
focsys

1. Cadarnhaf fy mod wedi darllen a deall Taflenni Gwybodaeth 1 a 2, dyddiedig Gorffennaf 2013 (fersiwn 2), yng nghyswllt yr astudiaeth uchod. Rydw i wedi cael cyfle i ystyried y wybodaeth a gofyn cwestiynau ac wedi cael atebion boddhaol.
2. Deallaf fy mod yn cymryd rhan yn wirfoddol ac y gallaf dynnu'n ôl ar unrhyw adeg, heb roi rheswm, ac na fydd y penderfyniad hwnnw'n effeithio ar fy hawliau cyfreithiol nac o ran fy nghyflogaeth.
3. Rhoddaf ganiatâd i'm cyfweliad gael ei recordio ar dâp sain, a deallaf y bydd yr ymchwilwyr yn cadw'r recordiadau'n ddiogel am uchafswm o 5 mlynedd.
4. Rhoddaf ganiatâd ar gyfer cyhoeddi dyfyniadau, air am air, na fyddant yn cynnwys unrhyw wybodaeth bersonol a allai arwain at fy adnabod.
5. Deallaf y bydd y cyfwelydd wedi'i rhwymo gan bolisi ar gyfrinachedd, ac y trafodir â mi gyntaf unrhyw faterion a godir pe bai unrhyw bosibilrwydd iddynt ofyn am dorri cyfrinachedd.
6. Cytunaf i gymryd rhan yn yr astudiaeth uchod.

 Enw'r Cyfranogwr

 Dyddiad

 Llofnod

 Enw'r Unigolyn
yn cymryd cydsyniad.

 Dyddiad

 Llofnod

Screening questionnaire

Part 1: Personal details

Although this questionnaire is confidential, to give us an idea of the background of those who have kindly agreed to help, we ask you to complete the following.

Please respond to all items by completing the appropriate boxes:

1. Age (in years)

2. Gender:

Male

Female

3. Number of years working in mental health:

4. Your profession:

Psychiatry

Nursing

Social Work

Psychology

5. During your career how many patient suicides have you experienced?

If you have not experienced a patient suicide, please return the questionnaire in the envelope provided, you do not have to complete the rest of the questionnaire.

Otherwise, please proceed onto section 2.....

Part 2: Your experience of patient suicide

In this section we would like to ask you about the *most distressing* case of a patient committing suicide whilst under your care. By *most distressing*, we mean in terms of the impact on you personally and professionally.

In relation to that particular patient suicide, please answer the following:

Patient details and characteristics of suicide:

6. What was the patient's age:

Under 18 18-30 31-40 41-50 51-60 61-70 Over 70

7. What was the patient's gender:

Male Female

8. If the patient had a mental health diagnosis at the time, please state in the box:

9. Had the patient previously engaged in deliberate self-harm or attempted suicide?

Yes No

10. Were you clinically involved with the patient's care at the time of the suicide?

Yes No

If 'Yes', please estimate the extent of your involvement

Approx. number of contacts: Approx. length of involvement:

11. What was the status of the patient at the time of the suicide?

Inpatient Day-patient Out-patient Discharged

14. Below is a list of individuals that may play a role in your coming to terms with a patient suicide. Please tick one box next to each item to indicate how helpful you found the individual(s). Please respond to all items. Some of the items may not apply to you, if this is so, please tick 'not applicable'.

	<i>Not applicable</i>	<i>Very helpful</i>	<i>Helpful</i>	<i>Neutral</i>	<i>Unhelpful</i>	<i>Very unhelpful</i>
Clergyman/ spiritual leader	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your own family/ partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your own friend(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient's family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient's friend(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your own GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your own team colleague(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your supervisor / manager						
Other mental health professionals						
Union representatives						

Please continue onto the final page of the questionnaire...

If you have any additional comments to make relating to patient suicide, we would be pleased to hear them – please write them in the box below:

Thank you for taking the time to complete this questionnaire.

Would you like to talk more about your experience?

For the main part of this research we are looking for people who are willing to be interviewed about their experience of patient suicide, the organisational response and support received from others.

It is hoped that this research may raise awareness of the impact of patient suicide on mental health professionals, and responses from organisations that may be helpful or unhelpful.

If you are interested in talking more about your experiences, please read information sheet 2 on the next page.

If you would like any further information before returning the questionnaire, or are unhappy with any aspect of this study please email Rachel Newton (pspef8@bangor.ac.uk) or Mike Jackson (mike.jackson@wales.nhs.uk).

If you remain unhappy and wish to make a formal complaint, please contact the BCUHB concerns team ConcernsTeam.bcu@wales.nhs.uk or (01248) 384194.

If completing this questionnaire has left you feeling like you might need some extra emotional support, here is a list of organisations and services that you may find useful:

BCUHB confidential service for staff health and well-being (**).

Survivors of Bereavement by Suicide www.uk-sobs.org.uk 0844 561 6855
Cruse Bereavement Care Helpline 0844 477 9400 (Mon-Fri 9.30am to 5pm)

I would like to be contacted for interview.

(Please complete your details):

Name:

Email address:

Contact telephone number:

Preferred mode of contact:

Section 6: General Appendix

Extract from transcript

Research Interview: 8

Social Worker, M. 2 yrs exp – 1 suicide.

I: Okay so if we just start by talking about your experience of working in mental health, how have you found it so far?

P: er, I've worked in health now about I think, 2 years, I think it's probably one of the most, err, risk orientated sectors within adult care, and I suppose we're dealing with people that are feeling quite negative a lot of the time, err, I probably, a third of my caseload is around people that are depressed, at a low point, and we are dealing with people that are feeling that they wanna end things or maybe not planning it but they've got thoughts of it, so, it can be quite demanding, erm, situation to be in all the time.

I: Do you find it quite easy to stay engaged with your work in spite of the demands?

P: Yeah I mean it's quite a, it's err, it's hard but it's quite rewarding when you see someone that has been feeling quite low turn things round and they're no longer feeling like that. It can be, quite stressful at times, when everything you do, I wouldn't say throw it back in your face but whatever you do doesn't seem to work they don't wanna engage, and you kind of think there's nothing more you can do, but you have to look on the positive side even when every avenue has been explored is there something else that I could have done previously in a better way, cos I think people, it's like everything, every single case whether it's the same symptoms, same diagnosis, the way they respond to medication or psychological therapies can be different.

I: Okay. And on the questionnaire it says you've had one patient suicide in your career is that still the same?

P: Yeah, yeah.

I: So in a little bit we're going to go on to discuss that in a bit more detail. I was just wondering whether you had any thoughts about how much we can predict patient suicide, and if then whether we can prevent it? Or to what extent?

P: Err, I'd like to say we can, but I think on the other hand, I think it's quite hard to predict, if they're gonna do it, erm, if they, if they've tried it once, and they continue to try, I think the law of averages says it's gonna happen. I've worked with about a handful of clients that have tried, and we've just increased the kind of support that we're providing for them, so it was if we're seeing them weekly, we'd see them probably twice, three times a week to begin with, we'd increase the support and the support outside of working hours, which does reduce the possibility, but unfortunately we can't, even if we think it's gonna happen, we can't cover every avenue, unless we put them actually in hospital, or 24hour care like a residential

placement or something like that. Luckily everyone I've worked with has had either a loved one, be it a son, daughter or a wife that's been there to support them, so they've been able to manage them during parts of the time when I haven't been able or the CMHT has been closed, I've given numbers of relevant contacts outside, so it does help, but I don't think we can completely predict its gonna happen, cos if we could, there'd be no suicides.

I: Yeah, fair point. So, now if we just talk about the particular case, do you want to start just by telling me a bit about the person?

P: Yeah, he was a young lad, err, early twenties, he had just come into services, he'd been quite, as he put it 'disturbed' with voices and things, erm for about 2 years, err, kind of negative thoughts going through his head and voices, err, basically telling him to kill himself, there's no point in living, everything like that. He was listening to quite heavy metal, and he was kind of, the words he was hearing, and the music, were having a massive effect on his mental health. He came in here, we assessed him, and he err, luckily he didn't go into hospital, we treated him out of hospital, and he responded really well to medication, err, everything kind of reduced, we were seeing him, we had home treatment to begin with seeing him weekly, then I took over after about a month or 6 weeks and we continued quite regular visits, to a point where I think we got to about 5 months or just over, and he was going back to work, err, the consultant was quite impressed with his progress, his parents were really impressed with the way he turned things round, err, so we discharged him not long after that, err, and I think it was 3 weeks maybe a month, and err, he committed suicide.

I: A month after discharge that was?

P: A month after discharge yeah, he was err, the family came in after the discharge err after the err suicide, and err things came out that they'd realised like they'd found his medication that he hadn't been taking, they didn't know about it, err, and things started to pan out that there were signs there but they didn't think at the time, they just thought, 'oh he'll be alright' and then when they found the medication wasn't being taken, they assumed that all the voices that he was hearing and the negative aspect had probably come back to the surface, and err, he couldn't live with it anymore.

I: Okay, do you mind if we just go back a little bit just to what your relationship was like with him?

P: yeah course you can yeah, it was really good, err, he was very, to begin when we first assessed he was quite difficult, but we have to take into account he was quite unwell at the same time, err, but during the weeks that went by, we just started talking about general things, what he did outside of the house, relationships, how he was with his family, just general stuff really, rather than just talking about, you know 'are you taking your medication are you hearing voices?', trying to get to, you know the outside of those kind of things. So yeah I would say it was a good relationship

yeah, I was quite fond of him actually, because not only was he responding to the medication and engaging really well, err, he was quite positive about things he wanted to get his own place, wanted a car, wanted a change of career, he saw things beyond the present day, which I thought was really good. And his family were very much on board as well so, I would say I had quite a good relationship with the whole family, err, dad worked away so I didn't see much of dad, but his mum was quite concerned, bit overprotective at first, because she was quite reluctant about him taking medication, and have the stigma of mental health, and possibly going to the (inpatient) unit as well, so bit of an issue there, but after a month or so she was totally on board because she saw the change in him.

I: And did you see him quite frequently when you were involved?

P: yeah, I saw him when we first engaged I saw him on the Friday, contacted him again on the Monday, and then home treatment took over and what we do when home treatment take over, is we leave them do their interventions and weekly or daily monitoring with them, and then we do the transfer of care, and then to begin with I was visiting him weekly, and then we took it to fortnightly, and towards the end it was three-weekly monthly, or I just phoned him, because he was doing really well, and a lot of the things we were talking about wasn't about his actual mental health or his progress, it was just chitchat how two young lads would really talk, err, which wouldn't have happened when he first came in, I think it was in January just after the new year when he first came in, he wouldn't have sat down and talked like that because he was making no sense whatsoever.

I: Okay, erm, and how long did you say this was ago, was it last year, towards the end of last year?

P: Yeah last year

I: Can you just tell me a bit about how you first heard that he'd died, what it was like?

P: Err I was, I was going up to a visit just to the top of the town here, and I got a mobile phone call from the staff here, we knew someone had committed suicide on, I think it was a Monday or Tuesday, we knew someone had committed suicide, we weren't sure of who it was, we had no names, err and the management here were looking round and some of the workers were looking round to see who it was, and when it came in they phoned me when I had to go visit a client, and they err, just advised me to come back to the office, I asked why and one of the nurses said 'I'll explain to him' and at first err, I was a bit shook up really, cos it was my err, I'd not experienced it before. I've worked with older people and I've worked with people that are terminally ill, and you kind of expect, at some point that's gonna happen cos you know, you don't expect that a young lad who was doing so well to, commit suicide, so yeah it was a bit of a shock, err, I was, I was probably shocked for a couple of days to be honest with you, yeah totally like stunned yeah, I was a bit

apprehensive to assess anyone, I didn't really wanna get involved in anything acute, cos I didn't think I was in the right frame of mind.

I: So did you come back and then you were told?

P: I came back and err, a couple of my colleagues sat me down and said 'are you alright do you want to go home?' and I just felt that going home wouldn't have been appropriate, so I just continued working, office-bound for a couple of days, I did go and visit some people but it was more err just routine visits that I visit people so it was just checking how they are rather than assessing anyone that could have been suicidal or in a negative kind of way. And that was, I was probably feeling like that, really bad for a couple of days, and I was a bit tearful at one point I'll be honest with you, err, but then err the parents came in to see me on the Friday and we had a, they requested to come and see me, and they explained that it wasn't my fault, don't worry about it, which I thought was brave of them, but quite an emotional meeting.

I: Did you find that helpful? To have that contact with his parents?

P: Err, I think it brought everything that I was feeling at the beginning of the week, really straight back on me really, the weekend was quite difficult, err cos it kept going through my head, err, but his mother and father were really good, they basically said 'there was nothing more that you could have done' and they agreed at the point of discharge that it was the most positive way to go, and they said you know 'you got him back on his feet', and I did explain to them you know it's a two-way street, it wasn't just me, he was doing it as well, he'd got back on his feet he'd got back to work and all that, but, you kind of flicking back, for the kind of, over the coming weeks I was like flicking back and forwards in my mind thinking 'what could I have done different?' and the parents said 'nothing more you could have done' and a lot of my colleagues said 'okay you can run it through your head til you're blue in the face, if he was gonna do it he was gonna do it'.

I: Did you, I know you said that the meeting with the parents kind of brought everything up for you so it was quite emotional, did you find it made you feel better in any way?

P: When they first phoned I thought they were coming to have a go, I wasn't quite sure because it's not very much the thing to, well from my experience here it's not been the thing to do is you know, when your son's passed away is to phone up the team that's been supporting him for the past 6 months and have a meeting, you know normally they just wanna get their things sorted, but you know I was here my manager was here, even the consultant was in here as well because they wanted to ask any questions we wanted to be able to answer them, and I would say, we were all borderline crying, it was err, but I think it came clear from our view that they weren't coming to argue with us they were coming to thank us really, err and I think they wanted to do that cos they didn't want us, they said they didn't want me to feel

that it was my fault, and they just wanted to thank us for the support we'd provided for him during that difficult period at the beginning of the year

I: That's really nice

P: yeah it is yeah, it's just, I'll probably never see that again, if I'm honest with you, yeah, I mean, mum and dad really, really emotional, they were probably, I would say we were in this room for about 45 minutes an hour, err, and we offered them a chance if there's anything they wanted to ask, and there was nothing to ask about what we provided them with, they felt that we provided above and beyond, but they just said that they never saw it coming.

I: And I suppose that was quite soon after the death as well, that was the same week?

P: Same week yeah, same week it was, yeah, we found out on the Wednesday, they came to see us on the Friday last thing, err, and they were here, and as soon as they walked in they gave me a hug and said 'I hope you're alright, don't think it's your fault'

I: and you said that the weekend after that was quite difficult, that it was still on your mind and you were quite upset about it, do you remember how long that affect lasted? That initial kind of feeling?

P: err, it was really bad over the weekend, I just remember sitting there, err watching TV or even reading and you're not really concentrating, you're just thinking back, at certain times when I'd been to see the client, what we talked about, should we have talked about more indepth about medication, should we have looked at that, err did we discharge him appropriately? Just everything, you know, just questions in my mind all the time, even when I came back in the following week, I was assessing people but I was being very cautious about anything really I was like 'oh I'm not sure if i...' a colleague was saying it was time to discharge someone I was like 'I'm not discharging anyone' and it was like that I would say for about a month I was reluctant to discharge anyone, I just didn't feel that...I just couldn't do it, I dunno whether it was just part of the err, the processing the shock, or whether it was just err, I just wasn't willing to take the risk.

I: Did you find, you mentioned kind of avoiding assessing clients that are really quite unwell, did you avoid that for a similar period of time?

P: Err, yeah I avoided it for about a couple of weeks, and then I was on mental health act duty, so I had no choice you had to, but even during those assessments I was err, I was cautious, and I was making sure that, just again I was just questioning myself.

Extract from Individual theme table**Interview 8**

Patient story		
Young man, hearing voices, negative thoughts. External factors having impact on mental health.	2	“he was a young lad, err, early twenties, he had just come into services, he’d been quite, as he put it ‘disturbed’ with voices and things, erm for about 2 years, err, kind of negative thoughts going through his head and voices, err, basically telling him to kill himself, there’s no point in living, everything like that. He was listening to quite heavy metal, and he was kind of, the words he was hearing, and the music, were having a massive effect on his mental health”
Treatment with medication – regular weekly visits – made progress, returned to work, ‘turned things around’. Discharged from service. Died a month later.	2	“luckily he didn’t go into hospital, we treated him out of hospital, and he responded really well to medication, err, everything kind of reduced, we were seeing him, we had home treatment to begin with seeing him weekly, then I took over after about a month or 6 weeks and we continued quite regular visits, to a point where I think we got to about 5 months or just over, and he was going back to work, err, the consultant was quite impressed with his progress, his parents were really impressed with the way he turned things round, err, so we discharged him not long after that, err, and I think it was 3 weeks maybe a month, and err, he committed suicide.”
Good relationship with patient. Initial difficulties, improved over time. Interest beyond symptoms, seeing as whole person. Fond of him. Felt patient was positive about future.	3	“it was really good, err, he was very, to begin when we first assessed he was quite difficult, but we have to take into account he was quite unwell at the same time, err, but during the weeks that went by, we just started talking about general things, what he did outside of the house, relationships, how he was with his family, just general stuff really, rather than just talking about, you know ‘are you taking your medication are you hearing voices?’, trying to get to, you know the outside of those kind of things. So yeah I would say it was a good relationship yeah, I was quite fond of him actually, because not only was he responding to the medication and engaging really well, err, he was quite positive about things he wanted to get his own place, wanted a car, wanted a change of career, he saw things beyond the present day, which I thought was really good”
Family on board with	3	“his family were very much on board as well so, I would say I had quite a good relationship with the whole

<p>treatment – good relationships.</p> <p>Weekly involvement, reducing over time due to improvements. Engaging with him as a person.</p>	3-4	<p>family”</p> <p>“to begin with I was visiting him weekly, and then we took it to fortnightly, and towards the end it was three-weekly monthly, or I just phoned him, because he was doing really well, and a lot of the things we were talking about wasn’t about his actual mental health or his progress, it was just chitchat how two young lads would really talk, err, which wouldn’t have happened when he first came in.”</p>
Being informed of a suicide		
<p>Team aware of a local suicide but not sure who. Colleague phoned when on the way to a visit, advised to return to the office. Shook up. First experience.</p>	4	<p>“I got a mobile phone call from the staff here, we knew someone had committed suicide on, I think it was a Monday or Tuesday, we knew someone had committed suicide, we weren’t sure of who it was, we had no names, err and the management here were looking round and some of the workers were looking round to see who it was, and when it came in they phoned me when I had to go visit a client, and they err, just advised me to come back to the office, I asked why and one of the nurses said ‘I’ll explain to him’ and at first err, I was a bit shook up really, cos it was my err, I’d not experienced it before.”</p>
Contact with patient’s family after death		
<p>More information received from family after death – patient had stopped taking medication.</p> <p>Trying to understand patients’ point of view.</p>	2-3	<p>“The family came in after the discharge err after the err suicide, and err things came out that they’d realised like they’d found his medication that he hadn’t been taking, they didn’t know about it, err, and things started to pan out that there were signs there but they didn’t think at the time, they just thought, ‘oh he’ll be alright’ and then when they found the medication wasn’t being taken, they assumed that all the voices that he was hearing and the negative aspect had probably come back to the surface, and err, he couldn’t live with it anymore.”</p>
<p>Parents requested contact – reassured not his fault. Emotional meeting.</p>	4-5	<p>“the parents came in to see me on the Friday and we had a, they requested to come and see me, and they explained that it wasn’t my fault, don’t worry about it, which I thought was brave of them, but quite an emotional meeting...I think it brought everything that I was feeling at the beginning of the week, really</p>

<p>Initial anxiety around family contact – not a common occurrence. Arranged meeting with other professionals. Chance to ask questions. Emotional meeting – on verge of tears. Family wanted to thank team, didn't want him to feel responsible. Parents didn't see it coming.</p> <p>Parents comforting professional. Supportive.</p> <p>Meeting parents difficult but helpful. Able to fill in gaps about what happened, clarity, closure.</p>	<p>5-6</p> <p>6</p> <p>16</p>	<p>straight back on me really...but his mother and father were really good, they basically said 'there was nothing more that you could have done' and they agreed at the point of discharge that it was the most positive way to go, and they said you know 'you got him back on his feet'"</p> <p>"When they first phoned I thought they were coming to have a go, I wasn't quite sure because it's not very much the thing to, well from my experience here it's not been the thing to do is you know, when your son's passed away is to phone up the team that's been supporting him for the past 6 months and have a meeting...but you know I was here my manager was here, even the consultant was in here as well because they wanted to ask any questions we wanted to be able to answer them, and I would say, we were all borderline crying, it was err, but I think it came clear from our view that they weren't coming to argue with us they were coming to thank us really, err and I think they wanted to do that cos they didn't want us, they said they didn't want me to feel that it was my fault, and they just wanted to thank us for the support we'd provided for him during that difficult period at the beginning of the year... it's just, I'll probably never see that again, if I'm honest with you, yeah, I mean, mum and dad really, really emotional, they were...we offered them a chance if there's anything they wanted to ask...they felt that we provided above and beyond, but they just said that they never saw it coming."</p> <p>"as soon as they walked in they gave me a hug and said 'I hope you're alright, don't think it's your fault'"</p> <p>"it was difficult but it was nice to be able to speak...they contacted us, err, and it was, it was brave of them, I dunno if I could do it if I was in their situation, but it was brave of them and I think it gave us, everyone, especially myself and the consultant, to basically have a chat with them and them to explain what had happened...you know from the point of discharge to the point of his death what had happened, and it gave us some clarity... I think it was a nice point for closure, err, but, cos obviously it was so raw at that point it was still err, but like I say you probably, I'll be very shocked if that ever happens again, where a parent or anyone comes in and wants to talk to you"</p>
<p>Formal process</p>		
<p>Strange process – check file</p>	<p>7</p>	<p>"Erm, after he'd died err, it's kind of a strange thing, you kind of, as an employee, you aren't discussed</p>

<p>first, checking practice. Annoyed. Deal with formalities first. Then check how you are.</p>		<p>but the first thing they do is they take the file, and they check that everything you've done is correct, and they kind of check your practice first which makes you feel a bit annoyed, err, because err, you'd assume that they'd be checking your practice anyway if they're that concerned, but, err but they check the file see if it's all up-to-date, then they seal it and send it off. And then they ask how you're doing, rather than the other way round, which I found really weird,"</p>
<p>Independent reviewer discusses case. Feedback given on the day. Helpful. Not pleasant process – feel on trial, justifying actions. Pragmatic, has to be done. Process quite quick.</p>	7-8	<p>"the formalities you send the file down to Cardiff, you wait about, how long did I wait, probably waited about 4-6 weeks, and then they come and interview they have an independent reviewer that comes to discuss the case with you, and you go through all that, and I think the only, err, good think about all of them he looked through the file, and he goes 'I don't think there's anything more you could have done, the consultant had seen, you'd seen, you had regular contact, he was taking his medication, he was socially engaging outside of (the CMHT) so he was doing everything else he was seeing friends, his parents were happy' so yeah that was, that was good to know...he gave me that feedback there yeah, he gave me that feedback. You do feel like you're on trial, even though he's there just to discuss things, err it's just not a pleasant feeling because you have to justify what you've done. But I understand that it has to be done as well.... yeah it was quite quick yeah, and it's just basically a phone call 'are you available next week? Well we'll come next week'"</p>
<p>End of formal process – no further feedback, file returned.</p>	9	<p>"that's it, trust investigation and err, that was it, you don't get any feedback, well there was verbal feedback on the day but that's it they just basically, the file comes back to you, and you just basically update all the records to say that he's deceased really"</p>
<p>Discussed briefly in team meeting.</p>	12	<p>"there wasn't a review of practice, we discussed it in a team meeting briefly, just to say that the notes had gone off, there's gonna be a thing, it's more to do with the protocol, err, no one really reflected, err, the consultant said she was gonna do a report for the coroner,"</p>
Service response		
<p>Colleagues offered chance to go home, didn't feel appropriate.</p>	4	<p>"I came back and err, a couple of my colleagues sat me down and said 'are you alright do you want to go home?' and I just felt that going home wouldn't have been appropriate"</p>

<p>Manager unaware until afternoon. Showed concern, offered time off, time to talk, counselling. Acknowledged first time is difficult. Stated it as inevitability – out of teams control. Balance between validation and reassurance?</p>	7	<p>“unfortunately our manager here works over 2 sites, so she didn’t come in til probably the back end of the afternoon, so she was unaware of the situation, and err then I went in to see her about something and she was quite err, she was quite good she basically said ‘how you doing?’ and I said ‘I’m fine’ and she said ‘not about that, I’ve only just heard whats happened earlier in the week, I didn’t know it was one of your clients, you know if you want time off or anything like that just let me know, you know we’re here if you want to talk’, we had a bit of a chat and she asked ‘if you want to have any counselling or anything like that’ she goes ‘cos it’s your first time, it is a shock’ and she basically said ‘it’ll happen again, it is part and parcel of mental health services, people do this and it’s out of your control’. Err, still hard to take on board though cos you still think but, it’s hard to explain to her but I could have done anything different, and she goes ‘you could probably go back again and do everything differently, and it’d still happen, that it just how it is”</p>
<p>Offered referral to occupational health – felt it was just shock. Management only involved initially – main concern if review had been completed.</p>	9	<p>“That was basically my manager saying ‘I can refer you over to occupational health if you want to’, I didn’t feel the need to, I just felt that it was just a shock and everything, that was kind of still really in me, and that was just something that would go with time. I would say after the first week err management didn’t really bother me again really, all they really cared about was ‘has the review been done’ and that’s all they ever contacted you to know.”</p>
<p>Management could be more sensitive & understanding. Offer private time to discuss, check up over time. Sense that initial contact and offer of support is enough – box ticking. Comparison with other teams, discussing patient deaths in supervision.</p>	10	<p>“I think maybe, management could be, a bit more understanding or delicate about the situation, I had that discussion with my manager in front of err, a deputy manager and someone else in the room, so you’d have thought they’d have took you to one side had a chat with you, and maybe just come to check up, you know have a chat a couple of weeks later, how things are kind of thing, because sometimes when you go through that ordeal, it’s not a day later, or a week later, it’s a couple of weeks later, you know how are you feeling now, but it’s kind of ‘well it’s happened now, I’ve checked with him he didn’t want counselling he says he’s alright, leave him to it’, that kind of shocked me, cos I’ve worked in other teams where, you know, older patients and terminally ill people have died and you’ve got more support, management will ask you in supervision like a month later you know ‘how are you feeling after that ordeal how are you doing you know”</p>

<p>Importance of offering support – particularly for new professionals. Supervision. Occupational health – unsure how long referral process would take. Support needs to be timely.</p>	14	<p>“I think it’s really important that if anyone else especially if you’ve only been working in the team about a year and a half and it happens, then it’s important to talk about it, and use supervision...So yeah I suppose talking yeah, I mean if it is that bad, if you do feel it’s for you then I would say yeah occupational health speak to counselling, how long that would take, I don’t know. That would have been my other thing if I had got referred over to occupation health, how long would it have taken? Would it have taken a week, would it have been a couple of weeks? I don’t know... cos if they’re putting a referral through, are they gonna get back to you a month later when all that, feeling of negative and everything was in your mind, and ‘how do you feel now’ well it was a month ago...I don’t know from a trust point of view how much support outside of the team would have actually been offered, in a timely manner.”</p>
<p>Timely support – not being left alone. Extending same courtesy to professionals as patient and family.</p>	16	<p>“I mean I was sat at my desk when it happened, for about 3, maybe 4 hours before any manager actually acknowledged that it had happened, and they all knew about it, but no-one came to me, they said ‘we’re just busy making phone calls to make sure the file is appropriately done and everything’ and you just think surely a 10 minute ‘how you doing’ kind of chat would have been appropriate, but maybe that’s just me, you don’t know, but you know like you say people have feelings, just the same as you know the parents were in shock, and err, they err, they came in here and we gave them a consultation basically.”</p>
<p>Staff need to know what’s available. Professionals can get forgotten in the process. Support offered to patients not extended to professionals – irony.</p>	15	<p>“just for staff to know what the protocol is... I kind of think that the employees get forgotten in it all, they just think that you should be able to deal with this, part of your profession, and that’s one thing that I think came out quite clearly, you know you’ll hear ‘oh I had that, and I had that’ and you think, yeah but where actually is, apart from colleagues, where is the support?... so because the tables have turned kind of way and we’ve experienced some kind of, like a client that’s committed suicide, that there would be... some level of support that would get us through, err, that kind of difficult period.”</p>
<p>Suggestions for online or phone support – importance of confidential support –</p>	15	<p>“could be on the intranet or something where they say, ‘if you’ve experienced this, contact us, have a chat with us’ if you wanna do it in work or even outside of work, cos I do think it’s a bit inappropriate, I’m just gonna make a phone call, and I share a phone with someone next to me, I’m just gonna have a chat</p>

<p>flexibility to enable accessing support outside of workplace. Reluctance to have face to face counseling.</p> <p>Balancing acceptance & support. Self-referral process rather than having to go through manager. Anonymous support.</p>	17	<p>about how I'm feeling...So yeah I think there should be something outside of working hours, or be able to say 'I'll be in a bit later, just going to make a few phone calls at home to speak to someone about how I'm feeling, I don't need a face to face consultation with a counsellor'"</p> <p>"suicide does happen in mental health unfortunately, we have to kind of deal with it to a degree but I just think that across all health trusts and social services there should be a better network for support. Cos everything seems to go, you have to go to your manager to go there, there should be a point where you can just be given a number to contact, you can have a chat with them see what you think, I think that would be a positive outcome really."</p>
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Emotional impact on the self	Page
<p><i>Initial and lasting emotional responses:</i></p> <p>P 7: "it is grief, but it's also shock...and just sort of disbelief"</p> <p>P 3: "I was quite surprised...I was quite traumatised by it"</p> <p>P 4: "I thought about him for weeks...it was definitely on my mind a lot...and it made me feel sad for, for a good number of weeks"</p> <p>P 8: "I was probably shocked for a couple of days to be honest with you...really bad for a couple of days, and I was a bit tearful at one point"</p> <p>P 9: "I was in tears, and I just, I couldn't go on, it was one of those days where...where I just, you know...I felt very very emotional, it wasn't just for a day"</p> <p>P 5: "I certainly think about him, I can picture him now, and erm I've got a really vivid image of him in that last session...and also, places that I associated with him...every time I pass that place I sort of think about the person"</p> <p>P 7: "Christmas time I usually will...think 'gosh this time of year'...'that little boy...wonder what he's doing"</p> <p>P 2: "I mean I'm a different person in work, I think your emotions do become very blunted...every so often the emotional side comes into it"</p> <p>P 6: "I guess...thinking back I kind of felt numbed by it really...it was something that was on my mind a lot during that two weeks away"</p> <p>P 1: "I feel quite emotional now, thinking about it...it's not until you sit down, and reflect on it, that I feel that emotion"</p>	<p>14</p> <p>4</p> <p>12</p> <p>4</p> <p>4</p> <p>9</p> <p>12</p> <p>14</p> <p>4</p> <p>8</p>
<p><i>Role of therapeutic relationship:</i></p> <p>P 3: "It wasn't an easy thing, and I think it was because I'd seen her for so long, had I not...the intensity of the therapeutic relationship wouldn't have been there in the same way"</p> <p>P 1: "because I had such a good relationship with her, I'd worked with her for a long time, and obviously you're bound to build up a relationship, and I feel quite emotional thinking about that"</p> <p>P 5: "you know I kind of see people trying to do their best and trying to cope"</p>	<p>4</p> <p>12</p> <p>11-12</p>

<p>their best based on what they've learnt about themselves and about the world in general...we do get in a lot closer and consequently the impact is probably gonna be greater"</p>	
<p>P 9: "for me it was, you know, a very precious patient, a being, to lose, and I don't think I will ever get used to losing somebody like that"</p>	11
<p>P 8: "it was a good relationship yeah, I was quite fond of him actually...he saw things beyond the present day, which I thought was really good"</p>	3
<p>P2: "Every so often the emotional side comes into it, there are going to be patients that are like one I've had now for what ten years and there's high risks and she may kill herself one day, so there are some that are gonna hit you harder than the others"</p>	14
<p><i>Patient factors – lost potential:</i></p>	
<p>P 4: "out of all the people you'd expect it, it wouldn't have been him...he was a lovely man...lovely couple...I knew he could get out if it I'd seen him, we'd sort of fixed it once, and we'd just do it again"</p>	3
<p>P 5: "even though I realised he was going through an incredibly difficult time...it really shocked me that he had taken his life...it felt, that he would get through it, and you know if he gave himself a little time he would recover and regain some of the lost ground"</p>	4
<p>P 6: "I suppose from a personal level the ones that tend to have affected me more...young people, violent methods, and unpredictable...it's about you know the tragedy in the sense of, these people probably would have got better"</p>	9
<p>P 3: "the fact that we'd been working so hard at keeping her alive and she still chose to do it, yeah, it was that"</p>	4
<p>P1: "I felt that my client really was making progress and would have I felt, carried on"</p>	9
<p>P 7: "I think her baby must have been about 6 months old...so for me it was just horrendous, knowing all of that"</p>	5
<p>P2: "things could have been resolved you know"</p>	8
<p>P8: "I think if it was to happen again, depending on the circumstance...a similar kind of thing where you know the person was doing really well and it</p>	10

<p>all happened again, I don't think I'd be able to prepare myself for that either"</p> <p>P9: "they were in the process of moving, they sold their house, they were moving to be closer to the daughters so there were positive things going on for him, why? You know, why did he do that?"</p>	8
<p>Being logical: making sense of the suicide</p>	
<p><i>Questioning/blaming self</i></p>	
<p>P 4: "there's a mixture of feelings then you worry about whether you've done everything right"</p>	5
<p>P 5: "I guess there's always doubts, 'have I done enough?...and risk factors 'did I miss something did I not pick up on something?' so there's always those sort of soul-searching questions"</p>	7
<p>P 8: "you're just thinking back, at certain times when I'd been to see the client, what we talked about, should we have talked about more in-depth about medication...did we discharge him appropriately? Just everything, you know, just questions in my mind all the time"</p>	6
<p>P 9: "I found myself...ruminating, ruminating on is, the treatment, whether I did the right thing to up his medication at that point, whether it could have, you know, altered things, and whether I would do the same with other patients, so judging my own treatment"</p>	7-8
<p>P6: "you go through that process you know, could we have done anything different, could we have prevented it"</p>	5
<p><i>Trying to make sense of suicide</i></p>	
<p>P 3: "I accepted it as, understandable given the severity of her despair for so long"</p>	4
<p>P 9: "was he so good at planning this and made sure that his wife was accompanied you know had friends around when this happened so that she won't be on her own, but that he always had it in mind but never revealed it to anyone."</p>	8
<p>P 8: "when they found the medication wasn't being taken, they assumed that all the voices that he was hearing and the negative aspect had probably come back to the surface, and err, he couldn't live with it anymore"</p>	2-3
<p>P 2: "the door was left ajar, so ...we're left in the situation of was it intentional? Was he hoping the ambulance service would get there in time?"</p>	3

<p>He knew what time the home treatment team would visit him, it appeared more planned.”</p> <p>P4: “I suppose I did reflect on how bad he must have been feeling, and right leading up to...I mean, you’ve got to be feeling pretty bad to do that haven’t you? And how his mind must have been working at that time...it was still shocking to imagine him thinking like that, and him actually going through with it and doing it, erm so I thought about that for a while”</p> <p>P6: “he was on a community treatment order, erm, which he was desperately unhappy with....and I have wondered somewhat whether that was relevant in why he chose to do what he did, and I think it was clearly a very angry destructive thing”</p>	<p>12-13</p> <p>2</p>
<p><i>We did everything we could – limits of control</i></p>	
<p>P1: “I felt that I had done everything that I could do professionally for that lady, erm, it wasn’t in my control, she made a choice, and that’s what we do”</p>	<p>11</p>
<p>P7: “we’d all planned that she was to go home for Christmas for 4 days and everybody was quite positive about that, an that the support we’d put in place...support workers to visit, all the things were put in place, that I was just shocked really...even after a long period on an acute ward, that, that still happened”</p>	<p>5</p>
<p>P4: “you know I did do everything I could do, and I think that I did have the right things, obviously in hindsight we probably should have put him in hospital, then he might not have...but at the time he wasn’t presenting as needing hospital admission...the consultant saw him and the home treatment team saw him, and nobody felt that he needed to be in hospital”</p>	<p>15</p>
<p>P2: “we had the home treatment team involved, you know everything we could possibly do, he’d been admitted, nothing worked, and no matter what we gave him, nothing seemed to matter”</p>	<p>3</p>
<p>P3: “she was very careful in her plans and she had always told me that when she was going to do it the next time she wouldn’t survive, and clearly she didn’t, and she wouldn’t have let me know anyway when she was going to do it”</p>	<p>3</p>
<p>P8: “I didn’t agree to discharge for another 6 weeks, to make sure...just to see if there was any sign of relapse, err, so even holding it a bit longer there was no signs, so it just proves that you can’t predict it at all”</p>	<p>11</p>

<p>P9: "I altered slightly his medication...the home treatment team as well as myself we offered whether we could do anything to help him as well as asking whether he wanted to be admitted, they felt that it was not necessary, and that they had support and that they would make contact more with home treatment team who would still have access to admitting him over the weekend if he needed"</p>	<p>2</p>
<p>Impact in the workplace</p>	
<p><i>Increased caution and risk awareness</i></p>	
<p>P 1: "I guess it made me a little bit more aware of you know how unpredictable people can be, and are"</p>	<p>11</p>
<p>P7: "I remember feeling...constantly being, checking my notes, checking that everything's fine...and that all things are in place, before annual leave say for instance...I think I'm still quite vigilant really to ensuring that communication is constant"</p>	<p>12</p>
<p>P4: "I felt that everybody that was talking about suicide was gonna go and kill themselves so that definitely affected me...but obviously it just lessened in intensity...I think I probably err on the side of caution now than I would have done before"</p>	<p>19</p>
<p>P2: "I'm aware now, the importance of things, talking about risk, talking about capacity at the time, and making sure you say if you've had a conversation with people, write it down"</p>	<p>7</p>
<p>P3: "I did pull myself out of those type of cases just for a short while until I got myself re-grounded...helpful for me to know that I wasn't putting anybody else at risk of not hearing them"</p>	<p>6</p>
<p>P5: "It just sensitised me to risk...it certainly made me more aware of potential risk factors...it sort of propelled me to be thinking far more about risk and ensuring that the person was safe to be working in a therapy way"</p>	<p>13</p>
<p>P8: "I would say for about a month I was reluctant to discharge anyone, I just didn't feel that...I just couldn't do it... I was cautious, and I was making sure that, just again I was just questioning myself all the time"</p>	<p>6-7</p>
<p>P9: "it might have increased temporarily...it always a risk that you take with patients when they are talking about suicide...whilst I felt I had to pay attention more initially there was that extra vigilance, erm, I don't think that is sustained"</p>	<p>12</p>

Word Count Statement

Thesis Component	Word Count
Title	7
Thesis Abstract	237
Literature Review	6988
Literature Review Table	854
Literature Review References	728
Empirical Paper	6962
Empirical Paper Table	128
Empirical Paper References	739
Contributions to Theory and Clinical Practice	4821
Contributions to Theory and Clinical Practice references	341
<u>Word count excluding tables, figures, reference lists and appendices</u>	<u>19,011</u>
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General appendix

Extract from interview transcript	2785
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Extract from master theme table	1620

Appendices including figures, tables and reference lists,**excluding ethics appendix** **11,665****Total Word Count****30,676**

