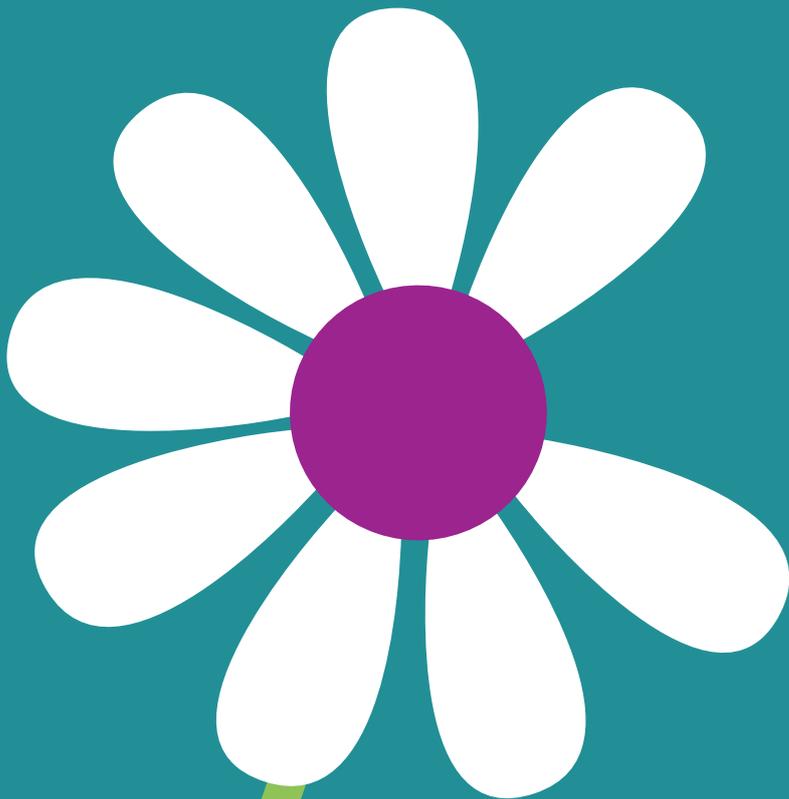


If a patient dies by suicide: A Resource for Psychiatrists



Endorsed by:



**RC
PSYCH**
ROYAL COLLEGE OF
PSYCHIATRISTS



CENTRE
FOR
SUICIDE
RESEARCH

This booklet and the survey that informed it were produced at the University of Oxford Centre for Suicide Research by a multidisciplinary group of clinicians and researchers, all of whom have experienced deaths of patients by suicide during their careers. This group was led by Professor Keith Hawton and included: Fiona Brand, Alison Croft, Dr Rachel Gibbons, Dr Anne Carbonnier, Karen Lascelles, Melsina Makaza, Dr Gerti Stegen and Dr Gislene Wolfart.



Introduction

This guide was developed following a survey of psychiatrists who had experienced the death of a patient by suicide (Gibbons et al. 2019), from a review of the limited research literature in this area and from personal experiences. It is aimed at psychiatrists of all levels, from trainees to experienced consultants. Its purpose is to provide information about a difficult topic that psychiatrists often avoid discussing, to reduce a sense of isolation, and to help psychiatrists cope at what is likely to be a very difficult time. Quotes from psychiatrists who have experienced the death of a patient by suicide and have contributed to the survey are used to illustrate personal experiences.

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Some facts about suicide

Most individuals who die by suicide in the UK are not in contact with mental health services at the time of their deaths. Between a quarter and a third are in current psychiatric care or had been in the 12 months before their deaths. Prediction of suicide is notoriously difficult, with most patients who die by suicide having been assessed as at low risk at their final service contact, even when this has occurred shortly before death. There are, however, times of particular risk, including the two-week period following discharge from psychiatric inpatient care and also the first few weeks following a hospital presentation for self-harm. While there is evidence that strategies to prevent suicide at the general population level can be effective, and psychiatric services probably prevent numerous suicides (although this is more difficult to demonstrate), identification of patients who are at greater risk than others is extremely difficult. The unpredictability of suicide is one of the factors that makes such deaths of patients under the care of mental health services so challenging for all those involved.

Emotional responses reported by psychiatrists following the death of a patient by suicide

The majority of psychiatrists will experience the death of a patient by suicide at some point in their career. Many will experience this more than once (Alexander et al. 2000, Gibbons et al. 2019). A significant number will experience the death of a patient by suicide whilst in training (Courtney et al. 2001). Each death is different and affects psychiatrists in individual ways, but the aftermath can be very distressing. In the survey that informed this guide (Gibbons et al. 2019) some psychiatrists reported coping relatively well, but others were significantly affected in their emotional wellbeing, their functioning at work, and their personal lives. The loss of a life is a highly significant event and those occurring in a professional context are no different (Gitlin 1999). In one study, 53% of psychiatrists reported stress levels in the weeks following a suicide comparable to those found in studies of people seeking treatment after the death of a parent (Chemtob 1988).

Most psychiatrists responding to the survey experienced a wide range of intense emotions. Some suffered severe distress. For most, these feelings passed within a few weeks, but for others the impact continued for a long time and some of these thought they met criteria for clinical depression or other mental health conditions, whether they sought medical help or not.

The feelings reported included:

- Sadness
- Anxiety
- Guilt
- Shame
- Anger

Many of the psychiatrists also reported:

- Feeling responsible for the death
- Fear that they had made a mistake that had contributed to the death
- Feeling blamed by others for the death

These feelings of responsibility are frequently reported after the death of a patient by suicide. From the survey, some female psychiatrists reported this more acutely than their male colleagues. These feelings are often not rational but can seem very real at the time. Suicide is complex and multifactorial. The psychological pathways involved in someone deciding to take their life are poorly understood. Therefore, suicide may leave uncertainty, which can result in a clinician assuming an unjustified level of responsibility, often at great personal cost.

The following are quotes from psychiatrists in the survey who shared their emotional responses after a patient's suicide:

'Sadness primarily. Also shame, worried about what colleagues would think about my practice.'

'Remembering the interview over and over, trying to search for things I have missed. Remembering his face... made me remember previous relevant traumatic events.'

'Like being deeply wounded. ...The feeling of something good having been destroyed... Guilt, sadness, shock, anger, injustice...'

'Shame, guilt, it kept me awake at night. It affected subsequent career choices. It affected my capacity to work.'

Understandably, because of the nature of these feelings, some psychiatrists reported withdrawing from their colleagues, fearing their negative judgement. However, isolation can make these feelings worse rather than better. It is important to remember that other psychiatrists have faced similar situations and that you are not alone.

'It helped knowing that some of my colleagues had been through it, that I was not the only one to feel the shame and guilt'

Almost all of the psychiatrists who responded to the survey said that the death of a patient had changed their clinical practice. Some felt that this had improved their sensitivity and awareness of risk and also made them more self-aware.

‘Ongoing thoughtfulness about patient contact - made me more vigilant and risk conscious’.

‘Ongoing concern that although I believe that I can make a valuable contribution, I feel ineffectual in changing systems that I recognise as being ineffective and fragmented.... I regret that I am not more robust, but I am also now more realistic about my own limitations’.

Many psychiatrists in the survey reported that the effects had been very detrimental in terms of their clinical practice.

‘I was unable to progress in my career as it affected my confidence and self-esteem a great deal and I lost faith in my job and the NHS for a long time’

About a third of those responding to the survey had considered a career change or had actually changed their career path as a result.

How to look after yourself

It is to be expected that the death of a patient by suicide will have some impact on you. This impact can vary from psychiatrist to psychiatrist, and between one death and another. Whatever the impact on you, it is important to recognise that you may need to do things a bit differently in the period after the death for your own health and wellbeing. The following strategies may be helpful.

The first few days

There are often many demands on psychiatrists in the immediate aftermath of a patient's death by suicide. You are likely to have urgent duties to carry out as well as your normal ones. You will be better able to perform these tasks if you pay attention to your own welfare.

- **Connect with the people around you.** Withdrawing from others, at work and at home, puts you at risk of increasing your sense of isolation and will give you more time to ruminate in an unhelpful manner. Evidence about support after traumatic events indicates that those who fare best tend to be those who are able to connect with their natural support systems, such as family, friends, colleagues and communities. Talk to members of your family that you trust, or friends, colleagues or a mentor who can accompany you emotionally and offer you support. Many psychiatrists find it helpful to talk confidentially to a colleague who has been through similar experiences, or other clinicians involved in caring for the patient who has died.
- **Soothe yourself.** It helps to know what enables you to relax and, importantly, to do it. Be kind to yourself; self-criticism and impatience won't help you feel better. Treat yourself as you would treat a good friend or your patients. Try to have patience regarding your own difficulties. Some people might like to use relaxation, mindfulness or gentle exercise as healthy coping mechanisms.

- **Look after your emotional health.** Expressing emotions is a normal part of processing distressing experiences. You may observe that you feel tearful, easily upset and irritable with your partner or family. You may have experiences similar to a grief reaction. Consider if these emotions interfere with your ability to carry out your clinical duties. Psychiatrists have reported that it was helpful to read articles, papers or books related to suicide and other clinicians' experiences in similar situations. These include a paper by a psychiatrist (Gitlin, 1999) that recounts his personal experience following the suicide of one of his patients, and a book called '*Working in the Dark*' by Campbell and Hale (2017) who theorise about the nature of suicide and why it can leave such distress in those that survive, including clinicians. (These resources are referenced at the end of this booklet).
- **Look after your physical health.** Have some structure to your day (particularly if you need time off work to recover), including activity and rest times. Sleep, eat regular meals, stay hydrated and keep physically active. Do not drink alcohol excessively, 'self-medicate' or 'overdo it' (sport, work, other activities). Keeping a healthy day-to-day routine will help reduce tiredness and emotional exhaustion.
- **Seek help.** Many people will be willing to help you themselves or to help you find other suitable support or resources. Most of the psychiatrists in the survey found that talking to colleagues or family members was very beneficial. The main thing is to ask people. You should not feel obliged to talk about what has happened, but avoiding doing so can sometimes be unhelpful. Some workplaces will offer formal or informal opportunities following a patient's death to talk through the events. Going for a walk with a friend, or some similar activity, might be an invaluable distraction if you are feeling preoccupied and unable to stop thinking about the death.
- **Consider making temporary adjustments to your working patterns.** Most psychiatrists in the survey reported they continued working, perhaps finding it useful to maintain regular life structure through work where support from colleagues could be more easily accessed. However, it may be helpful taking

some time away from work to recover and you should consider if a temporary adjustment to your clinical duties is desirable. A referral to Occupational Health might help put necessary measures in place if you need ongoing adjustment to your work pattern to support your recovery and to deliver safe patient care.

‘My mentor was my closest and strongest support until I went off sick. ... Occupational Health was very helpful’



Many of the psychiatrists in the survey found that talking to colleagues or family members was very beneficial.

Keeping a healthy day-to-day routine will help reduce tiredness and emotional exhaustion.

The medium and longer term

Individuals recover at their own pace and this is influenced by many factors. If you are still having difficulties several weeks or months on, or only begin to have difficulty at a later stage, this is not unusual and not something to just struggle on with. You may benefit from some additional support. There are many options for accessing support, but the first step is to recognise that you might need this and to let someone else know.

Signs that this may apply to you include the following:

- Frequent intrusive thoughts about, or images of, the events around the suicide
- Nightmares and disturbed sleep
- Being more irritable, tearful or anxious
- Avoiding people or situations that remind you of the suicide, or where you may need to make difficult clinical decisions
- Taking longer than usual over work tasks, doubting your judgement or having difficulty concentrating
- Low mood
- Poor motivation
- Avoiding social contact
- Thinking about leaving psychiatry or medicine altogether

‘I feel it’s something I’ll have to carry forever. ...One thought I had at the time (and still have) is that if I had another suicide then I’d resign and do something else with my life’

It is well recognised that many psychiatrists find it difficult to admit they are in emotional difficulty. Concerns about confidentiality and not understanding the support structures available are key obstacles to seeking help. You may find it easier to speak to someone outside of your workplace initially. This may be a friend or relative, although your GP may also be a good starting point.

‘A CPD group for psychiatrists affected by suicide organised in a neighbouring Trust really helped’

Other sources of help mentioned by the psychiatrists in the survey are listed towards the end of this booklet.

Seeking more formal professional help. A few psychiatrists experienced significant mental health difficulties following a patient's death by suicide, including depression, anxiety and PTSD. Remember that counselling or therapy is an option if you prefer to speak to someone independent. Some Deaneries or Occupational Health departments offer this, or you can access the Practitioner Health Programme, national helplines or private therapy (see the section on resources at the end of this booklet). There are effective treatments out there and most psychiatrists who access this sort of help find it beneficial.

'Therapy is what helped me process the trauma and guilt and manage to return to work. I would have left my job and the Trust otherwise, with hindsight'



Psychiatrists can find a reflective group helpful.

What might help to prepare for the experience of death of a patient by suicide

Training

The following are different opportunities to learn about what to expect:

- **Workshops and other sources of information.** Trusts and medical indemnity organisations run workshops on legal processes and have articles about how to write a statement for the coroner or prepare for an inquest.
- **Other psychiatrists.** Some psychiatrists are willing to share their experience at academic meetings. If one of your colleagues has been involved in the care of a patient who died by suicide, it may be informative for you (and supportive for them) to shadow them when they present their statement to the coroner at the inquest. In this way you learn about the process when not directly involved.
- **Learn about local processes.** It can be very helpful to find out about how your organisation responds to a death by suicide, and to get involved in these processes. Familiarise yourself with your organisation's serious incident policy. Participating in an investigation of a death of a patient by suicide can be a good way of learning about the processes. This might include becoming an investigator or attending the panel or group where recent serious incidents reports are reviewed.
- **Conferences.** There are national and regional conferences focused on suicide and its prevention.
- **Literature.** As doctors, we often learn by reviewing the available literature. A few key references are included at the end of this booklet.

The formal processes following a patient's death by suicide

The police

As part of the initial investigation the police and coroner gather information about the person who has died. If they have left a note or message, the police or coroner's office may need to take it away. The police need to make sure that no-one else was involved in the person's death.

The Inquest and the Coroner

In England and Wales, sudden and unexplained deaths are reported to the coroner, who is an independent judicial officer (usually a lawyer or a doctor). A coroner must hold an inquest where, after investigation, they consider that the cause of death was unnatural or is unexplained (suicide is considered an unnatural death) or (even if the cause of death is natural) the death occurred in state detention (typically, in prison or detained under the Mental Health Act). The main inquest hearing should normally take place within six months from the death being reported. However, some cases are more complex and the wait can be considerably longer, occasionally years. If a death appears to be due to suicide the coroner generally requests a post-mortem. If the post-mortem examination establishes that the cause of death is unlikely to be suicide, a coroner may decide that further investigation is unnecessary.

The inquest is not a trial and its role is not to apportion blame. The role of the inquest is to discover the facts about:

- Who has died
- How they died
- When and where the death happened

The aim is to provide a verdict so that the death can be officially registered.

There are occasions where a death is internally investigated as a probable suicide by a mental health organisation before the inquest, only to find out after coronial inquiry that the death occurred in a different way and/or receives a verdict other than suicide.

Common inquest verdicts include:

- **Suicide.** These verdicts used to be based on the coroner being sure a person intended to take their own life. However, since 2018 this has changed to a probabilistic verdict, i.e. based on a coroner assessing the likelihood of suicide.
- **Natural Causes.**
- **Open (death due to undetermined cause).** When doubt remains as to how the death occurred.
- **Accidental.**
- **Misadventure.** Almost the same as accidental but where the person died as a result of actions by themselves or others that went wrong or had unintended consequences.
- **Narrative.** Where the coroner feels the other conclusions are not right for these circumstances and sets out his or her understanding of the facts. Narrative verdicts have become increasingly common. Unless suicidal intention is clearly indicated in the narrative, the death is often classified by the Office for National Statistics as 'accidental'.

The conclusion of the coroner can come as a surprise. Some people believe very strongly that the person who has died took their own life, and are then confused or distressed when the verdict is 'open' or 'accidental'. A narrative verdict may feel inconclusive.

Being a witness at an inquest

If you were directly involved in the patient's care, the coroner is likely to request

a statement from you via your Trust's legal department. The coroner may also ask you to attend the inquest as a witness. Families sometimes have their own legal representative at the inquest, so that they have someone who can guide them through the process, give them advice and ask questions.

Your Trust's legal department will usually act as your link with the coroner and will provide legal advice and support if you are asked to write a statement and/or are called as a witness for the inquest. The following information should be included in your statement:

- The patient's demographics including their name, date of birth and address
- Your qualifications
- How you became involved in the patient's care
- A timeline of the patient's care, mental state and progress while they were being treated by you and your team
- A brief concluding summary

Your professional indemnity insurance organisation can provide you with advice about your statement. You may find it useful to read previous statements to the coroner from colleagues who have been in your position in the past.

'Two colleagues reviewed my statement to the Coroner which helped immensely. My medical indemnity organisation made a lot of recommendations too which reassured me, then the Trust legal department gave me a brief article and template and made some amendment in my final draft, at the end of the process. The Trust lawyer prepared me for the inquest itself which was a huge help as I knew that he would be there and would make the final remark'

Sometimes during the inquest the coroner can become concerned about an aspect of care provided to the person who has died. In this case they may make a Prevention of Future Deaths report. The Organisation must respond within 56 days, stating what action it has taken over the area of concern. These reports are sent to the Chief Coroner and published electronically.

Your Trust's legal department can provide you with a guide to the inquest process. See also St John-Smith et al. (2009) (referenced at the end of this booklet).

Internal investigations within the Trust

There will be an internal investigation within the Trust.

- This investigation **is not** to determine, or comment on, the cause of the death; this is the coroner's role.
- It **is** an opportunity to look at the pathway of care provided to the patient and whether anything can be learned from an examination of this. The aim is to identify both good practice and areas for development, and make recommendations that can improve future care of other patients.
- These processes **are** about rational fact-based organisational learning and not to provide emotional support for the clinicians involved.

A member of the mental health service's team investigating the incident makes contact with the family and asks for their views to be added to the investigation.

Additional formal processes when a child under 18 years dies

When a child under 18 dies by suicide a process is automatically started to check every aspect of what has happened.

- This is the responsibility of the Child Death Overview Panel (CDOP). Their inquiry runs alongside the inquest, and its aim is to protect other children and young people. The CDOP reports to the Local Safeguarding Children Board, and both work with the coroner to share information.
- The Local Safeguarding Children Board includes a Rapid Response function, which is a comprehensive and multi-agency review of all unexpected child deaths. Professionals involved in this process provide initial support to the family and help to inform the subsequent CDOP review process. The aims of the CDOP are to classify the cause of death, identify modifiable factors, decide on preventability of death, and to consider whether to make recommendations and to whom they should be addressed.

Psychiatrists' experience of the formal processes

The formal enquiry processes ensuing from the death of a patient by suicide can be experienced as challenging, particularly if you feel vulnerable.

The survey indicated that psychiatrists can find inquests and internal investigations helpful or unhelpful depending on the attitude of the coroner, the investigators and the mental health organisations. If these processes were experienced as hostile or persecutory, the psychiatrists said it was harder to recover emotionally; if they were experienced as understanding and compassionate, it was reparative for them.

“The suicide was upsetting, however the aftermath, the serious incident investigation and attending the Coroner’s Court were very traumatic for me. It made me feel very upset, sad, angry and it felt like people were out to blame me and the services.”

- Remember, whatever you might be thinking or feeling, or however the investigation is conducted, the general aim is to find out what happened and not to blame you.
- It is often helpful to have a supportive colleague accompany you to inquiries (and inquests).



The formal enquiry process can be a very challenging experience.

How to support the family and friends of the deceased

The majority of psychiatrists who participated in the survey wished that they had been able to access help in communicating with the family and friends of the deceased. They also wished they had known about resources to offer them. This section seeks to address some of these issues.

- If an individual died while an in-patient or whilst under the care of a community team, then mental health services usually offer support to the relatives. You may feel that you want to contact the family yourself immediately after the death. Think about this and take advice. Contact with the family is very important, even if it solicits anger or rejection, but this is not your role alone, you are part of a service. A senior clinician, manager, or member of staff who worked with the patient may be better placed to meet them, particularly if you are feeling overwhelmed.
- It is important to be sensitive to how the family may perceive contact with the professionals who were caring for their relative. Offering contact early on is crucial; however families may not be able to take this up at this point. They may find contact with you and/or the service intrusive or provocative. It is a good idea to discuss and make a plan with experienced colleagues and your manager. Make sure that you are acting as part of a service and in the best interests of the family - and yourself. Some psychiatrists and families report contact as very helpful and reparative. However, this is not true in every case and doesn't need to happen in the immediate aftermath of the death. Empathy with the pain of loss is the key. Below is a quote on this issue from a father whose son died by suicide.

“It was several months before I would have been able to think through my son’s death... and then further years before I could place this in a perspective that allowed for the unknowability, the limits to intervention, and allowed agency of some kind to my son in his own death. There was a time when finding others responsible was important in preserving the integrity of my son..., finding causes in myself and others who did not keep him safe. It might help professionals to place the anger or blame they may experience from families in the context of the process of grief they (the families) are going through. The point is that families’ engagement with professionals in the early period may be shaped by their need for a narrative of the suicide with which they can live, driven by their need for emotional survival. Narratives of blame serve to protect a family’s relationship with the one they love and have lost.”

- A particular comprehensive resource that may be helpful for the family and friends is *Help is at Hand*. This and other resources are listed at the end of this booklet.



Several psychiatrists who participated in the survey wished that they had been able to access help in communicating with the family and friends of the deceased.

Psychiatrists' suggestions about resources and activities that they found helpful, or wished they had access to, following the death of a patient by suicide

In order of frequency, these included:

- A senior clinician who understands the impact of suicide and is able to offer confidential advice and support.
- Support for the formal processes following a patient's suicide.
- A confidential reflective practice group or space to process the effects of deaths of patients by suicide.
- A personal one-to-one review of the events surrounding the death.
- Information, training and workshops:
 - From clinicians who have experienced a death of a patient by suicide
 - Workshops to share experiences
 - Information about the processes following patients' death by suicide
 - Support for the community (including schools)
- Support with communicating and/or meeting the family/friends of the patient who has died.
- Information about support available for family and friends (e.g. *Help is at Hand*).
- Organised peer support.
- Counselling and therapy.

Concluding remarks

Having a patient die by suicide may well be one of the most challenging and painful experiences you will face in your professional career. You are not alone - many of your colleagues have been through a similar experience, often more than once. The emotional pain will generally ease with time. Make sure you look after yourself and do not underestimate the care you might need. Psychiatrists find it notoriously difficult to attend to their own emotional needs, but this is the best thing you can do for yourself, your team, your family and your patients.

It is also important not to collude with the idea that you or someone else is to blame for this death. Blame implies that the responsibility lies with one person only. This is clearly not the case and denies the complex reality of suicide and the diverse nature of responsibility. Whilst we may have some responsibility for an aspect of the care provided, or not provided, to assume too much responsibility for an act we often cannot understand, and the uncertainty of which cannot be resolved, is not reasonable. It is our role as psychiatrists to maintain engagement with reality and, in this way, to help others in this challenging task, as well as helping ourselves.

This booklet was written based on information from a survey of psychiatrists and on clinical and research experience by a multidisciplinary group of professionals, all of whom had themselves experienced loss of a patient to suicide. By sharing this information our aim is to support psychiatrists at all stages of their career, to reduce isolation and to recommend helpful resources. We hope that you will find this booklet useful and will share it with anyone you think may benefit from it.

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Resources and further reading for psychiatrists

Online

- **Clinicians as Survivors of Suicide.** Located on the website of the American Association of Suicidology. The Clinician Survivors Task Force provides a postvention web resource and opportunity for linking for clinicians who had lost a patient to suicide.
[READ MORE](#)
- **Helping Residents Cope with Patient Suicide.** Produced by the American Psychiatric Association to support doctors in training who have had the death of a patient from suicide.
[READ MORE](#)
- **Finding the Words: How to support someone who has been bereaved and affected by suicide.** Provides useful simple advice for how to speak to someone who has been bereaved by suicide. Helpful for family and friends of those who have suffered bereavement and also for clinicians. There is a leaflet that can be downloaded.
[READ MORE](#)
- **Healthtalkonline. Bereavement by Suicide.** Thematically arranged clips of interviews with bereaved individuals to show impacts of bereavement by suicide and ways of coping.
[READ MORE](#)
- **Royal College of Psychiatrists Leaflet: Post-Traumatic Stress Disorder.** Online information on Post Traumatic Stress disorder that can be downloaded, detailing symptoms, treatment and links to sites providing further help.
[READ MORE](#)
- **Suicide Bereavement UK.** Specialises in suicide bereavement research, providing consultancy on postvention and delivering evidence-based suicide bereavement training.
[READ MORE](#)
- **Support After Suicide.** A special interest group of The National Suicide Prevention Alliance which campaigns for the development of services and support of those bereaved by suicide. The website provides helpful online information and details of local and national support services.
[READ MORE](#)

Sources of support for psychiatrists

- **BMA Counselling and Peer Support for Doctors and Medical Students.**

24/7 helpline, individual counselling and doctors' advisory service (peer support). Free telephone support for all doctors and medical students.

[READ MORE](#)

Tel: 0330 123 1245

- **DocHealth.** Independent psychotherapeutic consultation service for doctors. Based in London but available to all doctors in the UK. Fees payable.

[READ MORE](#)

Tel: 020 7383 6533

- **Improving Access to Psychological Therapy services (IAPT).** Primary care mental health services in England offering a range of evidence-based treatments for common mental health problems via telephone, online and face-to-face services. Accept self-referral. Search IAPT for your local service contact information.

- **NHS Practitioner Health Programme.** Confidential NHS treatment service for doctors working in England with mental health or addictions problems. A 24/7 crisis text service is also provided. Free.

[READ MORE](#)

Tel: 020 3049 4505

- **Private therapy.**

- **BABCP.** Accredited CBT therapists:

[READ MORE](#)

- **UKCP.** Accredited psychotherapists and counsellors:

[READ MORE](#)

- **Free online CBT resources.**

Computer-based self-help for everyone.

- **Living life to the full:**

[READ MORE](#)

- **Mood juice:**

[READ MORE](#)

- **Support Service, Royal College of Psychiatrists.** Confidential support and advice service for psychiatrists at all stages of their career. Free.

[READ MORE](#)

Tel: 020 7245 0412

- **Sick Doctors' Trust.** Helpline for Psychiatrists with drug or alcohol issues. Free.

[READ MORE](#)

Tel: 0370 444 5163

Resources for family and friends

- **Help is at Hand.** Very useful and widely used resource to provide important information and support for relatives and friends after a death by suicide. There is a downloadable booklet that is a first line resource used by many Mental Health Trusts and community services.

[READ MORE](#)

- **The Listening Place.** Offers free face-to-face support 7 days a week between 9am and 9pm for those experiencing suicidality. Self-referral by email or phone.

[READ MORE](#)

- **Healthtalkonline: Bereavement by Suicide.** Thematically arranged clips of interviews with bereaved individuals to show impacts of bereavement by suicide and ways of coping.

[READ MORE](#)

- **A Special Scar: The Experiences of People Bereaved by Suicide.** Alison Wertheimer (2013). Routledge: Abingdon. Book with very sensitive accounts of experiences of bereaved individuals, which psychiatrists will also find informative.

Support agencies for family and friends

- **Cruse Bereavement Care.** A confidential bereavement service.

[READ MORE](#)

Tel: 0808 808 1677

- **Survivors of Bereavement by Suicide (SOBS).** Offering emotional help and support to those bereaved by suicide.

[READ MORE](#)

Tel: 0300 111 5065

- **The Compassionate Friends.** Charitable organisation supporting bereaved parents and their families after a child dies.

[READ MORE](#)

Tel: 0845 123 2304

- **Samaritans.** Provision of 24/7 listening service for people who are struggling to cope, depressed or suicidal.

[READ MORE](#)

Email: jo@samaritans.org

Tel: 116 123

- **The Way Foundation.** Supporting young widowed men and women as they adjust to life after the death of their partner.

[READ MORE](#)

Tel: 01332 869 222

- **Winston's Wish.** A national grief support programme for bereaved children.

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Tel: 08452 03 04 05

This booklet was written based on information from a survey of psychiatrists and on clinical and research experience by a multidisciplinary group of professionals, all of whom had themselves experienced deaths of patients by suicide. The aim of sharing this information is to support psychiatrists at all stages of their career, to reduce isolation and to recommend helpful resources for those psychiatrists who have this experience. We hope that you will find this booklet useful and will share it with anyone you think may benefit from it.

Developed by a Team working at Oxford University Centre for Suicide Research
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