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**Review Article**

# Walking the Line: Supporting Professionals Working with Patients Experiencing Suicidal Ideation

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**Abstract:** Working with patients who experience suicidal ideation is a challenging role for mental health professionals. Whilst services ensure that patients are rightfully protected from avoidable harm and moral injury, it appears that staff are not given the same consideration. Existing models of trauma informed care may be readily adapted to include a both staff and patients since it's principles apply beyond mental health services to all services and beyond patients to all those involved in healthcare.

**Keywords:** Staff support, working with suicidal patients, avoidable harm, risk assessment.

## INTRODUCTION

Suicide is an urgent and complex public health issue the world over. Global suicide rates equal 1.4% of deaths worldwide (Brådvik, 2018).

Suicide has historically been related to mental illness and whilst mental illness itself does not lead to suicide, symptoms of mental illness do result in an increase an individual's vulnerability to suicidal ideation, planning action. For every individual who dies by suicide there are many more people who attempt suicide and /or live with suicidal ideation, this with no accurate statistics available given that a good part of those may be unknown/ unrecorded (Akkas and Corr, 2022).

Whilst mental-health issues are accepted as contributing factors to suicidal ideation and action, there is little information around the relationship between physical ill-health and suicidal ideation/ suicide. However available research suggests there is a clear association.

For staff working with patients experiencing suicidal ideation (PESI), procedures and protocols around risk assessment are advised as part of all treatment plans, be they part of the mental health or physical health service.

The introduction of trauma focused care has played a great part in protecting patients from both moral injury and avoidable harm in their interactions with healthcare. However, whilst our health services work hard towards managing patient distress and risk around suicide/suicidal ideation, there is little guidance available in supporting staff who manage this patient group. Our clinical experience tells us that the role creates distressing emotions such as stress, fear, avoidance resulting in implementation of risk assessments as burdensome (Jahn *et al*., 2022).

So whilst we work to reduce patient harm, little consideration is given to harmful and distressing experiences that staff may face in their role/ facilitating patient care. This is not to suggest patient care impedes staff care nor is it to imply that policy is ill-intended towards staff, but it is of note that concepts of concern and safety are rather restricted to patients with and little awareness that the same concerns may apply to staff.

This paper aims to explore current challenges facing staff in managing suicidal patients across acute and acute mental and physical health setting and aims to highlight points across the spectrum where they are vulnerable to moral injury and avoidable harm and concludes that trauma focused care is equally applicable to staff.

N.B. The paper focuses on the experiences of staff managing risk under suicidal ideation as opposed to experiences of staff post suicide, accepting the link between both. Whilst the research here is limited, studies include the experiences of all staff working with this patient group, that is, medics, nurses ,psychologists, trainees and social workers.

**Prevalence**

Available statistics focus on suicide and as such we can assume the existing levels of suicidal ideation and related PESI presenting within services.

***Suicide and mental illness***

According to the Office of National Statistics (2021) UK statistics for 2020 show, 6248 people took their own lives: 5224 in England and Wales, 805 in Scotland and 219 in Northern Ireland as a result of mental illness. However, this is likely to be an underrepresentation due to limitations of the database not accounting for undiagnosed or untreated mental health issues (Akkas and Corr, 2022).

Suicide rates in the UK varied according to gender with women being at greater risk than men but adults between 45-49 in general being at greater risk of suicide.

Mental health diagnoses such as depression, mood disorders, bi-polar, schizophrenia, substances use and psychosis are known to be the most relevant risk factors, with anxiety, personality /eating/trauma -related disorders also contributing to overall risk. Aside from formal diagnoses, one in five adults considered to have experienced some form of suicidal ideation during their lifetime (Mental Health UK website, 2022).

A number of groups present with higher prevalence of mental health problems and as such present with an increased risk of suicide (as distinct from gender differences above which were actual suicides). These include members of black and minority ethnic groups, carers, homeless people as well people who have experienced domestic violence, those living with learning difficulties as well as those individuals who identify as LGBTIQ (Mental Health Foundation website, 2022).

***Suicide and physical illness***

Whilst there is commonly understood that suicide occurs in the context of mental illness, there is growing evidence to suggest that physical ill-health can also impact on the patient's vulnerability/risk of suicide, even after adjusting for mental illness and related risk factors.

As with mental illness, Onyeka, (2020) concluded that the relationship was not causal. Rather, the risk was influenced by the impact of the health issues upon quality of life, daily activities and functioning. The relationship between activity limitation and suicide was most pronounced at younger ages (18-34).

Ahmedani (2022) found that nearly all physical health conditions increased risk of suicide and multiple physical health conditions increase that risk substantially. Researchers found that 17 physical health conditions, ailments such as back pain, diabetes, and heart disease, were associated with an increased risk of suicide. Two of the conditions -- sleep disorders and HIV/AIDS -- represented a greater than twofold increase, while traumatic brain injury made individuals nine times more likely to die by suicide (Science Daily, 2022).

The ONS (2021) carried out an analysis on the rates of suicide in patients with a diagnosis of: chronic ischaemic heart conditions, low survival cancer and COPD.

It was found that a diagnosis or first treatment of the above conditions was associated with an increased rate of death due to suicide when compared to a control group. It is also found that one year post diagnosis for low survival cancers suicide and COPD, the rates were 2.4 times higher than suicide rates for matched controls. One year post diagnosis the situation remained for COPD and for chronic ischaemic heart conditions suicide rates was nearly 2 times higher than for matched controls.

Treharne (2000) found that in considering the association between depression - progressive physical (neurological) illness - highlighted the importance of considering depression as a sign of risk. He carried out a study with patients suffering from rheumatoid arthritis - as the most prevalent chronic inflammatory musculoskeletal disease that

has been associated with several negative psychological outcomes, including depression. Results indicated significant findings , showing that almost 11% of hospital outpatients with rheumatoid arthritis (13 out of 123) experienced suicidal ideation. Furthermore, patients with longstanding disease (of more than four years' duration) were more likely to report suicidal ideation (12%) than those with early rheumatoid arthritis (of less than two years' duration) (7%). He found that even when considering moderating factors of age and sex as well as length of illness, it was depression ( detected by use of the HADS) that was the most accurate predictor of suicidal ideation.

In both physical and mental illness, the increased vulnerability to action suicidal ideation is influenced by factors such as a history of suicide, substance abuse, intoxication, access to firearms, a series of chronic mental illness, history of trauma or abuse, prolonged stress and recent tragedy or loss (Mental Health Foundation website, 2022).

**Trauma informed care**

The trauma focused model has more recently been offered as helpful framework to facilitate patient care. It aims to support patients from entry into and exit from services. The aim is to recognise , understand and empathise with the patient's experience of *the impact of trauma*. More specifically, the model aims to nurtures a culture of compassion and kindness and to avoid re-traumatising people by paying attention to the signs and symptoms of trauma and the variety of ways this may present (Hereford and Worcester NHS Trust website, 2022).

This involves consideration of the principles of trauma informed care which include, safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice and cultural/historical/ gender issue.

As such, trauma informed care (should)/does not restrict itself to clinical interventions but lends itself to the healthcare system as a whole; Patient contact with services, overall service delivery, treatment plans and discharge all aim to offer an interaction with services centred upon an intention effort to reduce moral injury and avoidable harm.

Given that the model has been borne from Trauma, what is of interest is that the principles, whilst rightfully applied to patient care, fail to acknowledge the parallel distress of those staff members caused directly by their role, none more so than who work with PESI. The experiences of moral injury and avoidable harm also apply equally but are seemingly overlooked.

**Experiences of clinicians working with suicidal patients**

Patient death by suicide is understandably one of the greatest fears for mental health practitioners hence detecting and managing suicidal ideation bears a significant clinical and emotional burden. Research suggests that suicide training, procedures and protocols, whilst core to the role, do not necessarily reduce the related emotional dis/ stress of the role. Rather experiences of staff is moderated by a number of external clinical and personal factors.

***Clinical and personal challenges to working with PWSI***

We might assume familiarity and a clear structure around risk assessment and procedures reduces stress of managing suicidal patients. However, research suggests that in and of themselves this does not significantly reduce negative experiences of managing PESI for staff. Moderating factors here include; quality and level of practical training, adherence to principles of training, levels of experience and time spent with PESI, professional hierarchies and accountability as well as personal experiences of friends who have died by suicide as well as the experiences of relatives. The research studies that the afore-mentioned factors influence *confidence* in implementing risk assessments which in turn may mitigate some distress.

It is of course important o note that part of working with PESI would inherently involve some degree of distress, but research does point to the more avoidable harm and moral injury staff may expereince in the role

Jahn *et al*., (2016) reported that patient suicide is the main fear reported by mental health practitioners. They explored factors behind this fear examining the relationships between suicide-focused training, professional experience, fear of suicide-related outcomes, comfort with and skills in working with suicidal patients, and knowledge of suicide risk and protective factors. They found that regarding suicide training - staff who felt their training was sufficient reported a significantly lower fear of patient suicide as well as reporting significantly greater comfort and skills in working with this group as did greater knowledge of suicide risk and protective factors.

However, when exploring experiences of working with suicidal patients, staff did not report significantly different fear of patient death by suicide or patient suicide attempt than practitioners who did not work with suicidal patients.

The study suggests that whilst training is helpful in process, it does not guarantee a reduction in emotional responses to fears of professionals.

Dundas (2020) carried out a thematic analysis of professionals' descriptions of suicide-related situations and identified four themes: Unreachable patients, choosing between therapy and security, therapist's boundaries and empathy with death-wishes As with Jahn et al ( 2016), results suggested that experience of working with suicidal patients did not necessarily equate with a decrease in distress and also that years of experience and frequency of contact with suicidal patients correlated only weakly with perceived difficulty.

Rousch *et al*., (2017) highlighted that in spite of *reported use* evidenced-based practices, there appears to be variability in implementation and application. They found that one third of mental health professionals did not ask every patient about current or previous suicidal thoughts or behaviours. However, comfort in working with suicidal patients and related assessment procedures, *but not fear of outcome,* resulted in increased likelihood of conducting evidence-based suicide risk assessments at first appointments .

In the context of individual confidence in knowledge and experiences of working with suicidal patients Ramberg and Wasserman (2013) found differences in personal attitudes between psychiatrists and nurses moderated not only by procedural awareness but also supervision. They found that 35% assistant nurses, 43% of the nurses and 74% of the psychiatrists believed that that they were sufficiently trained for the work with 75% of the assistant nurses, 72% of the nurses and 34% of the psychiatrists receiving supervision in their work. In spite of these figures nursing staff felt that that they lacked training and uncertainty in their work in comparison to psychiatrists. They raised the issue *of context of application,* since often staff were required to rely on individual skills in emergency situations.

Hunter (2015) in exploring experiences of medical trainees, found that personal experiences with suicide were associated with increased stigmatizing attitudes, while specific education appeared to mitigate these negative feelings. Results suggested that high levels of personal suicidal experiences in clinical trainees' histories which affected attitudes towards patients. Hunter (2015) concluded that specific education may increase students' preparedness and comfort in working with this vulnerable clinical population.

The research challenges many of our assumptions about equipping staff with skills to manage risk assessment is an adequate way to manage -application / assessment anxiety' for the professional. , since we see this is not enough to reduce or remove distress. The issue then becomes one of developing a skill-base centring on *confidence of application of skills* as well as the skills themselves ( Mitchell, 2022).

Overall recommendations included improved supervisions for staff but again focused on those staff who had issues around training and confidence less managing subjective experiences of working with this population (Vedana, 2017 and Wheeler, 2010).

Meichenbaum (2005) makes the point that the validation of fear as part of this work may go some way so normalising emotional responses as compassionate rather than fear of consequences.

Whilst familiarity with suicide and risk assessment is fundamental, negative experiences of implementation have also been associated with numerous personality factors and individual differences. These include subjective views on suicide as a form of managing distress, avoidance of exploration versus fear of outcome / potential suicide and related fear of blame as well as over identification of patient emotions in the context of subjective life experiences.

Sethi and Shipra (2005) assessed the attitudes of clinicians working in the emergency room. These clinicians show attitudes of avoidance, rejection, hostility, anxiety and fear, and inadequacy. They also considered the act of suicide as manipulative and unlawful. Again, these results may contextualise the research by Rousch *et al*., (2017), in that what is reported as being applied in terms of protocols may well be influenced by the value placed on the overall intention of suicide by the professional.

Of note is that the above factors all exist in the wider contexts of mounting pressures upon healthcare staff, arguably, in turn increasing susceptibility to be influenced by the above (Scupham and Goss 2020).

What we can conclude form the above studies is that future training needs to consider not only the emotional expereince of working with PESI but also the behavioural impact of this on completing risk assessment procedures.

***A note around stratification of risk and accuracy of prediction***

Currently, there is an ongoing debate and review as to the accuracy and true value of existing risk assessment procedures in the context of prediction. Clinical studies show that overall ,there appears to be a lack of consistency in approaches to risk and that most people who die by suicide were rated as low risk during assessment, suggesting that risk tools have poor predictive value. Accepting that there is ideation may not lead to action, ideation is the identifying factor when reporting risk levels. This points to the levels of responsibility staff assessing risk may expereince as the results here imply that there is a recognisable danger of not being able to identify vulnerable people (Hawton, 2022, Beale, 2022, Meichenbaum 2005).

Whilst NHSE have taken measures to work with external bodies, such as coroners, to improve and raise awareness of the interface between the teams and impact of post suicide investigations upon staff, the management of the unhealthy emotion appears to be considered part of the role with little consideration of the effect on staff and their work (Beale, 2022).

Working with PESI in the absence of a more accurate tool means that the procedures can not only feel a formality for clinicians, again, contextualising Rousch et al, (2021) in their finding that reported assessment does always mean consistent application) but also leaves staff feeling they are exposed to avoidable harm by a procedure that itself acknowledges it is not accurate. The implication of staff awareness of these issues undoubtedly has a practical and emotional. impact on not only not only implementation but also confidence in risk assessment protocols.

This points to the need for improved frameworks incorporating all aspects of risk of suicide beyond ideation alone. This itself may reduce fear and reduce emotional barriers to clinical implementation and application.

## CONCLUSION

Working with PESI is a personal and professional challenge and has been associated both mental and physical health problems. Management of PESI is not always a core part of staff training outside mental health settings and even within, the challenges remain. Whilst services ensure through models such as trauma focused care that patients are rightfully protected from avoidable harm and moral injury, it appears that staff are not given the same consideration. The support for staff in these settings has centred largely on practical and professional suicide management training and working with external bodies to manage practical reduction of fear of application of procedures. However, what is omitted is the management of the very emotional distress that research has shown, directly impacts on applications and implementation of professional training.

Models of trauma informed care may be readily adapted to include all people involved in healthcare services both staff and PESI alike since neither do not exist in isolation to the other. Its principles apply beyond mental health services to all services and beyond patients to all those involved in healthcare.

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