

**A STUDY OF UNTIMELY SUDDEN DEATHS  
AND PEOPLE WHO TOOK THEIR LIVES  
WHILE IN THE CARE OF DONEGAL MENTAL HEALTH SERVICES**

***Summary***

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## **CONTENTS**

- Background
- Aim of study
- Research findings relating to the deceased
- Research findings relating to the needs of mental health service users
- Meeting the needs of bereaved family members
- Responses to family concerns
- On-going and future practice
- Recommendations and actions

**The research was funded by the National Office of Suicide Prevention (NOSP).**

**This research would not have been possible without the co-operation and involvement of bereaved family members who generously gave their time to discuss often sensitive issues surrounding the death of a family member. For this, we express our sincere gratitude and thanks.**

## **Background**

This report was commissioned by the Donegal Mental Health Service (DMHS) and funded by the National Office for Suicide Prevention (NOSP). As part of a unique, on-going programme of research being undertaken by the National Suicide Research Foundation (NSRF), it examined sudden unexpected deaths and those who took their own lives while in the care of the Donegal Mental Health Service between October 2011 and May 2015. The research was approved by the Clinical Director of Psychiatric Services who sought to gain insight into the increasing number of sudden unexpected deaths of its users while in the care of the mental health service, including people who took their lives. The research was approved by the Letterkenny Hospital Ethics Committee

The objectives of this research are in line with key strategic goals and actions of the new National Strategy to Reduce Suicide in Ireland, *Connecting for Life*, 2015-2020.

- Developing a uniform procedure to respond to suicidal behaviour across mental health services.
- Implementing a system of services review based on incidents of suicide and suicidal behaviour within HSE mental health services and developing a responsive practice model.
- Improving the uniformity and effectiveness of support services for families bereaved by suicide

## **Aim of study**

The principle aim of this research was to identify those factors associated with sudden unexpected deaths and people who took their lives, which would assist DMHS in the future care and treatment of service users at risk. Data was gathered using the Suicide Support and Information System-Psychological Autopsy Model, SSIS-PAM (Arensman et al, 2012, 2013). A key component of the SSIS-PAM is its capacity to collect information from multiple sources to corroborate the clinical history of the deceased while also reaching out to family members who may need support in the aftermath of such a tragic event. All cases were examined to determine common risk factors and investigate potential patterns among those who used mental health services prior to their death. Data was collected from sources including medical records, close family members or friends, coroner's records and post-mortem reports, and healthcare professionals. In addition to the altruistic benefits of participation, it offered the opportunity to discuss personal feelings of loss and experiences of service interaction in a confidential setting with the benefit of psychological support. The multi-source element of the SSIS-PAM also provided a valuable opportunity to cross-reference and subsequently confirm information pertaining to the service use and treatment of the deceased, as well as the experiences reported by family members.

### **Research findings relating to the deceased**

- A total of 34 deaths were included in the study and 24 family informant interviews took place. With the approval of next-of-kin, General Practitioners were also contacted for additional information relating to the deceased. This information was then analysed along with information obtained from medical records and coronial files.
- Younger men up to 41 years old were overrepresented among those who had died by suicide or sudden unexpected death.
- Almost half of the cases being examined were known to abuse both drugs and alcohol prior to death while one fifth had abusive or dependent issues with a single substance.
- History of self-harm was known in three quarters of the deceased, with over half having a previous medically recorded episode of self-harm in the 12 months prior to death.
- The vast majority of cases had at least one psychiatric in-patient admission, with multiple admissions being more common among the middle-aged group.
- Nine deaths occurred during the first two months of discharge from the psychiatric unit.
- Psychiatric diagnosis was confirmed in all 34 cases, with the majority also having a secondary diagnosis. Depression and substance abuse were most frequently reported in both categories

### **Research findings relating to the needs of mental health service users**

The majority of the deceased were being prescribed medication for mental illness preceding death. However, over three quarters of these were described as non-compliant, particularly in those cases where substance abuse or dependence was diagnosed. Many mental disorders cause cognitive disruption including problems with memory, highlighting the vulnerability of this group with regard to the effects of disrupted psychiatric medication. More than half (53%) of those who died suddenly or with a presumed cause of suicide, had family members with known mental health issues, the most common of which were depression and substance abuse. More than half of the deceased had experienced childhood trauma, including physical and sexual abuse. It is well known that the mental health of caregivers in childhood is a key indicator of subsequent adult well-being and resilience.

### **Meeting the needs of bereaved family members**

Among bereaved family members, men reported more often symptoms of depression following the death of a loved one while bereaved women more often experienced symptoms associated with higher levels of anxiety. This has consequences for both the direct and wider family members, and underscores the urgency of access to appropriate aftercare.

Lack of information and the issue of client confidentiality were at the core of concerns reported by more almost two thirds of family members. The need for enhanced communication between staff and next-of-kin was highlighted as essential to ensure adherence to aftercare arrangements for the client.

### **Responses to family concerns**

Concerns from family members about issues such as disclosure of suicide risk, lack of support, failure to be made aware of the legal process and the perceived staff's dismissal of family information during acute crises, underlines the need to effectively and sensitively communicate the formal clinical structure and routine of the inpatient centre by:

- Providing training in communicating with families as an important feature of introductory training for clinical staff.
- Improving clinical skills in recognising the value of further information provided by family members during the care-planning and treatment of a service user, and providing support for family members on a continuous basis.
- Ensuring that families and service users are aware of mental health service procedures through development of an information pack explaining treatment, policy and legal process for both family members and service users.
- Ensuring that clinical staff is informed about appropriate procedures of disclosure of risk to family members and others by including this as a core module of both introductory and on-going training.

The research revealed a lack of consistency, and in some cases, inappropriate responses towards families following a suicide or sudden death. Reports of significant family concerns about weaknesses in communication highlights the need to:

- Put in place a formal acknowledgement of the tragic event from the mental health service that includes information about local support services.
- Make a link with the local Suicide Bereavement Liaison Officer and ensure communication from DMHS to find out the needs of family members after the loss of a family member.

## **On-going and future practice**

High response rates, positive feedback and rich data collection have influenced the decision to roll out the current SSIS-PAM in four further counties with the potential for national implementation. Prior to publication, a number of recommendations are already being processed, with the overarching aim of improving services and reducing the number of premature sudden deaths and suicides in Ireland. One of these recommendations is the development of a treatment trajectory/service pathway for every service user presenting with current or a previous history of suicidal behaviour which will provide a comprehensive case summary. This allows examination of the service provision and uptake by individual cases, and identifies episodes of disengagement both by the service user and services.

In addition, as a result of the current research, DMHS now has a 'real-time' database of information on socio-demographic, psychosocial and psychiatric risk factors associated with the deaths of those in their care through untimely events or suicide. This database provides current rates of such events and is unconstrained by national figures from the Central Statistics Office, which can take up to two years to be confirmed due to the legal process involved. This database will be rigorously maintained and available to assist in the identification of changing trends at the level of the DMHS, the community and wider level.

## **Recommendations and actions**

The following recommendations and actions were generated following detailed examination of information gathered through the multi-source methodology of the SSIS-PAM conducted by the National Suicide Research Foundation. Cross-referencing of recorded clinical data and family interviews has provided a unique opportunity to address areas such as best practice and staff training needs, while also giving a voice to family members in County Donegal who have experienced first-hand the complexities of caring for those with mental health issues while navigating the challenges of mental health care provision.

### **Recommendation**

#### *Rationale*

Examination of current risk assessment procedures has highlighted a need for on-going staff training to advance understanding of the complexities of suicidal behaviour. Risk will almost certainly change throughout treatment and must be regularly reviewed. Therefore, it is recommended to:

1. Improve clinical practice to increase understanding about client suicide and self-harm risk that is mindful of gender, age and other factors which may influence risk of premature death.
2. Prioritise uniformity of good practice through on-going training and supervision in suicide and self-harm risk assessment. Implementation at both induction stage and regular intervals thereafter for all staff.

## **Actions**

(a) As part of staff induction, provide evidence-based training on assessment and management of clients with (potential) risk of self-harm and suicide across **all** sections of DMHS, including Consultants and NCHDs.

(b) Following induction, provision of a programme of regular training for **all** clinical staff. Identify training needs and communication skills in the in-patient centre to maintain a high level of knowledge of suicidal behaviour and related mental health problems.

(c) Review current administrative procedures of risk assessment and management of clients at risk. Establish an on-going auditing process to ensure continuity of clinical recording, risk assessment and management plans.

(d) Ensure protected supervision time for **all** staff involved in suicide risk assessment.

## **Recommendation**

### *Rationale*

Family members perceived procedures with regard to disclosure, legal process, patient autonomy and staff hierarchy as a barrier to effective treatment. Communication was inhibited in some cases where language was 'too technical' or English was not the primary spoken language of staff members. In addition, some family members felt that valuable collateral information they offered to staff was dismissed by the clinical team. Therefore, it is recommended to:

3. Foster communication and engagement with family members of service users with regard to the formal clinical structures and routine of in-patient psychiatric care.

## **Actions**

(a) Provide training in communicating with families as an important feature of induction For **all** clinical staff including NCHDs, and as a core component of subsequent training.

(b) Up skill **all** clinical staff members to recognise the value of collateral information provided by family members and provide on-going appropriate support.

(c) Ensure family members and service users are aware that they can request extra staff support in clinical consultations.

(d) Ensure family members are aware of MHS procedures through development of an information pack addressing treatment, policy and legal processes.

(e) Be informed by best practice models with regard to disclosure of risk to family members and/or others. Incorporate as a core component of staff training.

## **Recommendation**

### *Rationale*

Reported contact with family members following bereavement was variable and highlighted shortcomings in communication and signposting to qualified and specialised bereavement support services. These findings underline the need to:

4. Improve the service response to family members following the death of a service user.

### **Actions**

(a) In addition to the informal contact with family members currently made by staff following a tragic death, establish a formal acknowledgement of the tragic event from the mental health service, including signposts to available support services in their area.

(b) Ensure an appropriately timed telephone call from DMHS to ascertain the needs of family members as they come to terms with their loss.

(c) Promote collaboration with the local Suicide Bereavement Liaison Officer to streamline provision of information and support.

## **Recommendation**

### *Rationale*

Overall, journalistic reporting was mindful of the effect over-sensationalised reports can have on family members, as well as the community. However, between 10% and 30% of the media articles failed to comply with the media guidelines. These findings underline the need to:

5. Improve media reporting of suicide, in particular in relation to avoiding reporting of specific details and personal information.

### **Actions**

(a) In keeping with objectives of *Connecting for Life Donegal*, reinforce on-going implementation of and adherence to the media guidelines for reporting of suicide through regular briefings.

(b) Work with local media to organise an annual meeting to promote the Media Guidelines for Reporting on Suicide

6. Implement, monitor and evaluate the SSIS PAM under the remit of the new National Strategy for Suicide Prevention, *Connecting for Life, 2015-2020* and local suicide prevention plans such as *Connecting for Life Donegal*.

### **Action**

(a) Sustain the SSIS-PAM in County Donegal, with plans for further implementation in other areas of CHO1 (Cavan, Monaghan, Sligo and Leitrim) as vital to good governance and reducing the number of sudden untimely deaths, especially suicides, among users of mental health services.



## Further Information

If you or someone you care for is experiencing mental health difficulties, the following are services that you can contact.

### Hospital Emergency Services

#### Letterkenny University Hospital Emergency Department

Call (074) 91 23595

Hours: 24 Hours, 7 days a week

### Your own Doctor

You can make an appointment with your local GP during office hours, Monday- Friday.

During evenings, nights or weekends you can contact an out of hours GP service.

#### Now Doc

Call 1850 400 911

Hours: 6pm- 8am, 7 days a week

### Listening Services

Non-judgemental, confidential support is available 24/7 on the following free phone services.

#### Samaritans

Call 116 123 Hours: 24 Hours, 7 days a week

Email: [jo@samaritans.org](mailto:jo@samaritans.org)

#### Childline

Call 1800 66 66 66 Hours: 24 Hours, 7 days a week

Text TALK to 50101 Hours: 10am-4am, 7 days a week

Webchat at [www.childline.ie](http://www.childline.ie) Hours: 10am-4pm, 7 days a week

[www.mentalhealth.ie](http://www.mentalhealth.ie): An online support and information service