RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

CR239

Supporting staff following a patient-perpetrated homicide (PPH)

A prevention and postvention framework

June 2024

COLLEGE REPORT

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Purpose of this guidance

> **In the aftermath of a patient homicide, we are all victims.**

– Healthcare staff at the RCPsych conference held on this subject in October 2022

When a homicide is perpetrated by a psychiatric patient – a Patient-Perpetrated Homicide (PPH) – it can have a profound effect on the clinicians who have been involved in their care. Two research surveys in the UK (Mezey et al, 2020 and Hussain et al, 2023) have reported intense emotional experiences such as guilt, sadness, feelings of persecution and distress associated with internal investigations and court proceedings where staff can feel blamed by the media, their organisations and colleagues. This can result in significant mental health problems, personal and professional isolation, and in some cases, leaving the mental health profession altogether. Poor treatment of colleagues following these events impacts widely on the profession and reduces the desire of those in training to enter psychiatry.

> **It was harrowing, horrible, the worst experience of my life.**

– Mezey et al, 2020

Staff support following PPH varies widely across organisations, but it is very minimal in general. Currently there are no national guidelines for organisations that employ mental health clinicians for the provision of pastoral care of their staff, both before these events to help in preparation (prevention), or to aid recovery (postvention).

When organisations provide effective support to their staff, this can mitigate the damaging personal and clinical effects, enhance resilience, and facilitate realistic reflection leading to post traumatic growth. Early evidence for this relates to staff support following the death of a patient by suicide and demonstrates the effectiveness of organisations that use them consistently (Tamworth et al, 2022, Barajas et al, 2019; Gutin, 2019; Leaune et al, 2020; Kinman and Torry, 2020). We suggest that similar support programmes should exist for clinicians involved in patient-related homicide (PPH).

Recommendations in this document are based on recent research studies (Mezey et al, 2020, Hussain et al, 2023), feedback from clinicians who attended the first international conference on the effect of homicide on clinicians (RCPsych October 2022),

focus groups, and other feedback that includes personal reports and presentations at support groups. Quotes in this document are from these sources.

This guidance has been written by the Royal College of Psychiatrists' Working Group on the Effect of Suicide and Homicide on Clinicians (ESHC). It outlines best practice recommendations for mental health and training organisations for both supportive operational strategies, and the pastoral care of staff, following a patient-related homicide (PPH). It is aimed at the organisational board, senior clinical leadership including medical and nursing directors, organisational leads for suicide and homicide, and more broadly to all clinicians.

The document provides guidelines for professionals working in mental health however we hope they can also be of use in other professional environments where homicide is a work-related experience. We suggest that members of the Board will need to value, endorse, and support the ethos of this guidance for the recommendations to be successfully integrated within their organisations.

Aims

> It happened 18 years ago... but I still remember clearly how it made me feel.

– Mezey et al, 2020

- **To recommend best practice interventions**
    - To mitigate the impact on mental health professionals of PPH, improve the sustainability of mental health services and increase staff wellbeing, progression with training, resilience, and retention.
    - To assist mental health and training organisations in their legal obligation of duty of care for their employees.
- **To increase awareness of the impact on professionals of patient-perpetrated homicide (PPH)**
    - To encourage transparent and open dialogue about the impact on staff of PPH.
    - To facilitate training to include preparation for the emotional effects and the processes that follow PPH.
- **To help challenge the destructive fantasies of 'omniscience' and 'omnipotence' that society holds of psychiatrists**
    - To change the perception that psychiatrists are to blame for the death of a patient following a PPH.
    - To encourage a reality-based understanding of the psychiatrist's role that draws those in training towards this rewarding profession rather than pushing them away from it.
- **To support cultural transformation**
    - From one where an individual clinician can feel isolated and personally blamed following a death, to a systemic understanding about the lack of certainty and complexity regarding the aetiology of PPH, and its consequences on staff.
    - To provide support for working with the media after these events.

- **To improve the quality of patient care**
    - By helping staff feel less anxious working with high-risk patients and in this way maintain their capacity to think clearly and creatively, and provide high-quality, safe, care.
- **To increase the possibility of truly learning from these tragic events**
    - Learning takes time, space for reflection and freedom from persecution, and is impeded by anxiety generated by the current response to a PPH.
- **To encourage organisations to develop local processes, for the benefit of all staff, in the event that a patient under their care commits a PPH**

Executive summary of recommendations

1. **Organisational pastoral lead role**
2. **Pastoral support provided by senior management**
3. **Support for the processes following the homicide**
4. **Buddy systems and other individual support**
5. **Group psychological support**
6. **Communication with families of both perpetrator and victim**
7. **Resource availability**

Summary of research

There is marked paucity of research in the area of the impact of patient-related homicide on clinicians. This summary is primarily based on Mezey et al (2020) and Hussain et al (2023).

- **Most mental health professionals will experience a patient-related homicide at least once in their career (Botelho and Gonclaves, 2016)**
  - There is currently no data on patient-related homicides for clinicians in training.
- **Patient-related homicide has significant emotional and clinical impact on clinicians, including:**
  - loss of confidence in professional skills and the ability to accurately assess risk, leading to anxiety about making clinical decisions
  - feelings of depression, anxiety, guilt and responsibility, shame, and self-doubt
  - professional and personal isolation, including experiences of scapegoating, are common
  - negative impact on relationships with other members of staff.

> It felt like a personal bereavement but more complicated. I "coped" well in my own view at the time but in fact it was appalling beyond words… it has been life-changing for me and contributed to an eventual decision to go part-time and then take early retirement

> It made me feel unable to trust colleagues who tried to shift blame from themselves.

- **Impact of the homicide on the clinician's mental/physical health**
  - A significant number of psychiatrists reported a negative impact on their health – stress, anxiety, depression, and sleep disturbance were the most common issues.
  - An important minority of respondents reported the PPH had long-term negative consequences for their clinical practice, health, or personal life.

> **Even now if my mobile phone goes off if I'm at home, relaxing with the children/family . . . my heart misses a beat . . . in case someone telling me that a patient has killed . . . committed suicide . . . or escaped.**

- **Impact of the homicide on the clinician's personal life**
  - Personal relationships were reported to be negatively affected in over 30% of clinicians consulted.

> **It changed who I am. I am scarred by the experience, and it caused me to distance myself from my husband to protect him from the details of events. This has never been healed.**

- **Experience of organisational processes can have an adverse impact**
  - The formal processes following the homicide were usually experienced as distressing, unfairly blaming of individuals and rarely constructive.
  - Only a quarter of respondents reported they had at least some understanding of the legal processes likely to be involved.
  - 14% reported legal processes to be psychologically damaging to them, with the most common complaint being that they were unfairly blaming of individual clinicians.
  - Disciplinary and/or being reported to the GMC occur for a small number. Those reported to the GMC were not sanctioned.
  - Formal inquiries often resulted in individuals or teams being judged harshly in what they referred to as 'hindsight bias'.

> **I learned the meaning of the term Kafka-esque . . . being prosecuted for something but you don't know what, and... things around you keep changing in an inexplicable way.**

- **Psychiatrists' experience of exposure in the media**
    - Most patient-related homicides (94%) were reported in the local media and also appeared in the national press (50%), with clinicians (13%) being named in media articles.
- **Psychiatrists' experience of support offered by organisations**
    - Two thirds of respondents said they had received no support at all from the organisation.

> **"The internal inquiry blamed everyone and was poorly managed. The interview was very traumatic . . . a panel of eight people, arguing with each other . . . I physically collapsed afterwards . . . I had no solicitor, no support."**

- **Psychiatrists' views on support that should be offered**
    - Being offered support and information by a consultant with expertise in managing such incidents.
    - Receiving information about the formal processes that may follow.
    - Support from the RCPsych including a dedicated webpage with information about what to expect following a patient-perpetrated homicide.
    - A support group.
    - Signposting to resources to access further help.
    - Publishing guidelines for employing organisations about the support they should provide.
- **The response of the employers of mental health clinicians matters**
    - If clinicians experience the mental health and training organisations as supportive this reduces the traumatic impact.
    - If clinicians experience the mental health and training organisations as unsupportive it can increase the traumatic impact and recovery becomes problematic.
    - Poor support results in clinicians leaving the team, organisation, or profession.
    - Workplace stress in healthcare organisations affects quality of care for patients as well as doctors' own health (West and Markiewicz , 2016; West and Coia, 2019).

- **Mental health staff may need to be encouraged to attend to their own wellbeing after these events**
  - Few respondents in the surveys took time off work following the homicide, with most reporting that their heavy workload and lack of adequate cover arrangements precluded this.
  - Clinicians find it difficult to acknowledge their vulnerability and may benefit from temporary adaptations to facilitate recovery. These adaptations may include compassionate leave.

Recommendations in detail

1. Appointment of an Organisational Pastoral Homicide and Suicide Lead role

The working group recommends that each mental health organisation appoint an Organisational Pastoral Homicide and Suicide Lead role. This should be a senior clinician. This clinician needs protected time within their job plan for:

- leading employing organisations to develop internal written resources describing local processes, people to contact, etc; this includes advice for clinicians and managers but also for executive and non-executive directors (ED's and NED's) whose experience and expertise may not extend to such a scenario
- leading, overseeing and supervising the organisational response in the pastoral care of clinicians experiencing a PPH
- preparing the staff and organisation for these events
- supporting staff and families through the formal processes that follow a PPH
- signposting to resources for staff and families
- advocating for clinicians and families after critical events within the organisation.

NHS England has recommended the appointment of Wellbeing Guardians for all NHS organisations, executive board members who have responsibility for staff wellbeing. The homicide pastoral lead may link with this person.

2. Pastoral support provided by senior management

> **My team, manager, clinical director, and CEO were utterly amazing. CEO called me to check in. Team looked after me. Manager called ahead to a meeting I was chairing to make sure they looked after me.**

Compassionate leadership to support staff following an incident such as patient-related homicide is highly recommended.

- **Break the news thoughtfully**
  - How the news about a PPH is imparted influences the emotional impact of the death and is therefore very important. Timing is crucial so that the news is not received from an untrained source.
  - Consider all staff members who have been involved in the patient's care, however peripherally. These may be clinicians and non-clinical staff who are not currently part of a team, have left, or have come across the patient while on call/duty.
- **Be kind**
  - Support adjustments to work demands, including managing clinical work, and giving compassionate leave as appropriate.
  - Send thoughtful and kind letters/emails to those clinicians and teams affected.
  - Help teams and team members find ways to be more supportive after the sharing of news.
- **Intervene on behalf of the clinician if there are any professional sanctions following the incident**
  - The specific reasons for homicide are very unlikely to be known. Avoid drawing any conclusions that an individual professional's input had a role in the death. These assumptions are likely to be erroneous, and any action taken based on these assumptions is unnecessarily blaming and harmful. Instead encourage thoughtful reflection and compassion.
  - Advise clinicians to contact support services to receive advice or support early on if this might be helpful. For example, psychiatrists can contact the Royal College of Psychiatrists' Psychiatrist Support Service (PSS) and/or Practitioner Health (PH) (England and Scotland). NHS Wales operates a service called 'Canopi' that offers various levels of support for social and health care staff in Wales. https://canopi.nhs.wales
  - Any inquiries regarding referrals for immediate professional sanctions, such as a referral to the GMC, NMC or HCPC need to be carefully reviewed, and intervention on behalf of the clinician by the employing organisation strongly considered.
- **Be aware of the different support needs of different clinicians**
  - There is no ideal support that suits everyone as both clinicians and non-clinicians vary in what they want and need.
  - Some clinicians will need to be able to access support at different times,

depending on their circumstances. In some cases, this might need to be very soon after the incident. Being able to respond to the need for urgent support is important and having a named person whom the clinician can call upon is helpful.

3. Support for the processes following PPH

a. Serious incident investigation (SI) and internal organisation investigations

  - ○ It should also always be remembered that the offender in this case is the patient who is alleged to have killed, rather than the doctor or clinician who was looking after them.
  - ○ The purpose of the investigation is to look at the standard of care provided and NOT to speculate about the likely causes of the PPH which cannot be determined at this stage.
  - ○ Organisations need to be aware of the uncertainty and anxiety resulting from a PPH that can lead to confusion and disturbance in organisational functioning and scapegoating behaviours.
  - ○ The individual clinicians involved in SI's may themselves be highly anxious and going through a grieving process following any loss. Organisations need to be mindful about disenfranchised grief (Doka 1990).
  - ○ Investigators should be well-trained and supervised to ensure that the formal processes do not become persecutory.

- **Avoid individual clinician responsibility and encourage systemic recommendations and reflections**
  - ○ Avoid using words such as 'fault' and 'blame' within formal processes and reports.
  - ○ Investigators can feel that they have failed if they do not comment on causation and generate recommendations.
  - ○ Investigators should be trained to avoid language that inflates imperfections. For example, minor problems in areas such as note taking can be identified as serious 'failures', and lead to unhelpful or unrealistic recommendations. This results in meaningless actions that are hard to put into practice, have additional detrimental emotional impact on bereaved families, and can result in little systemic and organisational learning.
  - ○ It is important that investigators highlight good practice where this is found, to ensure a balanced report is produced.

b. Support during legal processes, e.g., coroners' inquests, criminal court, domestic homicide reviews, Fatal Accident Inquiries (in Scotland)

- It is vital that clinicians are able to prepare thoroughly for the legal processes that follow. Information about these and any related matters should be shared by the organisation with the clinicians as soon as is appropriate and in a supportive and non-threatening manner.

- Employing organisations should provide adequate time and resource for psychiatrists to write the reports, seek advice, and amend the reports as needed. This should include dedicated administrative support and time out of routine clinical duties to do so. It is important to note that the majority of PPH occur in acute psychiatric settings. Psychiatrists may not be trained or experienced in legal processes, the language for writing legal reports or trained to give evidence in court. They may therefore need training and support in these areas.

- Clinicians should be encouraged to seek advice from their employer's legal services and Medical Defence Unions.

- Clinicians should be accompanied by supportive colleagues, and legal representation whenever needed in coroner's court, criminal courts and at inquests.

- Mental Health organisations should consider training from clinicians who have lived experience as a previous witness to guide colleagues on how to prepare as a witness (See 4. 'Mentoring from a consultant or mental health professional with lived experience (Buddy system)' below).

- Employers should encourage a thoughtful return to work after the inquest or attendance at criminal court.

    - For example, the clinician can have the rest of day off as supported leave.

    - The clinician will be given the opportunity to reflect the following day with a supervisor/manager/buddy/service lead before starting usual duties.

c. Dealing with Media

- Clinicians are not trained to deal with media attention: being named in newspapers, on television and in social media can be a persecutory and overwhelming experience. This will likely place significant additional stress on the clinician. Organisations need to give clinicians clear, unequivocal advice about dealing with the media. Dealing with the media - The MDU

4. Mentoring from a consultant or mental health professional with lived experience ('buddy system')

- 'Buddy systems' are starting to develop in different organisations. These systems mean that clinicians who have experienced a PPH are put in touch with colleagues in a different part of the mental health organisation who have been through similar experiences in the past. The 'buddy' can give collegiate support and information, helping to guide the clinician through the processes that follow the death.

5. Group psychological support

- There should be reflective spaces embedded within the structure of the team and organisation where the PPH can be processed (see Appendix 3).

- **A separate reflective group specifically to process the effects of patient-related homicide and suicide**

  - Some clinicians responding to research surveys (Gibbons 2019, Croft 2022) wanted a safe, confidential space specifically designed for reflecting on deaths by suicide and PPH within the organisation. Several organisations have such groups running successfully. These groups tend to run on a monthly or bi-monthly basis and cover the whole mental health organisation. Facilitation is an important consideration when planning these groups. The current groups are facilitated by clinicians with training in psychotherapy and vary in whether they are internal or external to the organisation. A model for the group is described in Appendix 3. In some organisations, facilitation of suicide groups is being written into the job descriptions of new consultant medical psychotherapists.

6. Communication with relatives and loved ones of perpetrators and victims

- **The responsibility for planning communication with families rests with the organisation's leadership, who require time and space to determine the best approach**

  - PPH is a rare event and is likely to propel the organisation into unfamiliar territory regarding communication with bereaved relatives of both the perpetrator and victim. It is imperative that the organisation's leadership assumes responsibility for navigating this situation, with compassion and care for all involved. With the police primarily handling family communications initially, it is vital for the organisation and its clinicians to exercise restraint and not take on too much responsibility too soon. This approach

is crucial to reduce potential distress for the families and avoid interfering with police procedures. To aid in managing this emotional turmoil and potential harm, we recommend the organisation appoint a Family Liaison Officer or someone in a similar role to facilitate the process.

- **Family Liaison Officer (FLO), FLO service or similar**
  - FLO's are increasing in number nationally as their value to mental health organisations becomes clear. These services can provide effective support and help bridge the gap that can arise between the organisation, the treating team, and the family and friends in the aftermath of a death.

7. Training on the effects of PPH on clinicians and the processes that follow

- **Encourage training institutions to have a major role in mentoring and pastoral care**
  This subject is now in the national curriculum for psychiatrists, but not in that of other professional groups.

- **At induction**
  - Details of what to do after incidents such as a PPH should be an integral part of induction for trainees and new starters to the organisation.
  - Formalised training as part of induction: This should include open, supportive, and frank discussions of suicide/PPH and the potential impacts and mitigation measures.

- **As a matter of course**
  - Regular teaching sessions on the effects of suicide/PPH should be an integral part of local teaching programmes and mandatory training sessions.
  - Clinicians should be encouraged to attend an inquest and serious incident review as part of training.

- **We propose that there should be regular and accessible workshops on:**
  - The effect of patient suicide and homicide on clinicians.
  - Lived experience – there should be opportunities for clinicians to talk openly and share their experience of both recent and historical patient deaths, without fear of judgment or censure, as this develops the understanding that clinicians experiencing death by suicide and homicide is part of the shared experience of working within mental health.

    - The internal and external inquiry processes.
    - Working with families.
    - Inviting those with lived experience.

- **Teaching and training should include workshops on legal processes such as:**
    - attending inquests and coroner's court
    - writing reports
    - appearance in criminal courts.

  The organisations solicitors and clinicians with lived experience should be involved in this training.

- **Trainees**
    - Mental health trainees, doctors, nurses, social workers, and allied health professionals are likely to experience one or more PPH during their professional careers. It is very important that their training and curriculum routinely includes the important topics of the effect of homicide and suicide on clinicians. We propose that this topic should also be included in medical student training as these events are not exclusive to psychiatry and will particularly involve GPs.

  Find more information on providing pastoral support to trainees involved in serious incidents here: https://www.nwpgmd.nhs.uk/sites/default/files/Guidance on Providing Pastoral Support to a Trainee involved in a Serious Incident - 021115.pdf

Appendix 1

Resources and further reading for all mental health professionals

- The webpage If a patient commits homicide on the RCPsych website contains information and resources to help support psychiatrists in the event of a PPH.

- The webpage If a patient dies by suicide on the RCPsych website has many resources including videos of clinicians and families talking about their experience following a death by suicide.

- NHS England Mental Health and Wellbeing Hubs provide rapid access to assessment and local evidence-based mental health. The hub offer is confidential and free of charge for all health and social care staff.

- NHS Scotland Wellbeing Hub

- Canopi offers free and confidential mental health support for NHS and social care staff across Wales.

- **Free online CBT resources**
  Computer based self-help for everyone:
  - **Living life to the full:**
    https://llttf.com/
  - **Mood juice:**
    https://www.moodjuice.scot.nhs.uk/

- **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: https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-traumatic-stress-disorder

- **Private therapy**
  - **BABCP accredited CBT therapists:**
    http://www.cbtregisteruk.com/
  - **UKCP accredited psychotherapists and counsellors:**
    https://www.psychotherapy.org.uk

- **Samaritans**
  Charity aimed at listening to people who are angry, depressed, and suicidal at any time – night or day.

  Website: https://www.samaritans.org/
  Email: jo@samaritans.org
  Tel: 116 123

- **BMA Counselling**
  24/7 helpline, individual counselling, and Doctors Advisor Service (peer support). Free telephone support for all qualified doctors and medical students.

  Website: http://www.bma.org.uk/advice/work-life-support/your-wellbeing/bma-counselling-and-doctor-advisor-service
  Tel: 0330 123 1245

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

  Website: http://www.dochealth.org.uk
  Tel: 020 7383 6533

- **NHS Practitioner Health Programme**
  Free confidential NHS treatment service for Healthcare Professionals working in England with mental health or addictions problems.

  Website: https://php.nhs.uk/
  Tel: 020 3049 4505

- **Workforce Specialist Service**
  Free, confidential NHS mental health service for regulated health and social care professionals working in Scotland. Self-referral.

  Website: https://wellbeinghub.scot/the-workforce-specialist-service-wss/

- **Royal College of Psychiatry Psychiatrists Support Service (PSS)**
  Free confidential support and advice service for psychiatrists at all stages of their career.

  Website: https://www.rcpsych.ac.uk/members/supporting-you/psychiatrists-support-service
  Tel: 020 7245 0412

- **Sick Psychiatrists Trust**
  Free helpline for psychiatrists with drug or alcohol issues.

  Website: http://sick-doctors-trust.co.uk/
  Tel: 0370 444 5163

- **Cavell Nurses Trust Helpline**
  For nurses, midwives, and healthcare assistants, both working and retired.

  Website: https://www.cavellnursestrust.org/
  Tel: 01527 595 999

- **Health Education and Improvement Wales (HEIW)** have produced a Mental Wellbeing in the Workplace Policy that highlights expectations and appropriate training and further resources.

- **Health Education and Improvement Wales (HEIW) Wellbeing Hub**
  Website: https://heiw.nhs.wales/support/colleague-health-and-wellbeing/

Appendix 2

Support agencies for family and friends

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

  Website: https://www.cruse.org.uk/
  Tel: 0808 808 1677

- **Scottish Association of Mental Health**
  Scotland's national mental health charity offer a range of mental health support and services.

  Postal address: Brunswick House, 51 Wilson Street, Glasgow, 1 1UZ
  Website: www.samh.org.uk
  Email: info@samh.org.uk
  Tel: 0141 530 1000

- **2 wish upon a star**
  Bereavement support for families who have suddenly and traumatically lost a child or young person aged 25 years and under. This service has been extended to provide support to professionals from any field.

- **The Compassionate Friends**
  Charitable organisation supporting bereaved parents and their families after an 'out-of-order' death (or child loss).

  Website: www.tcf.org.uk
  Tel: 0845 123 2304

- **Samaritans**
  Charity aimed at listening to people who are angry, depressed, and suicidal any time – night or day.

  Website: https://www.samaritans.org/
  Email: jo@samaritans.org
  Tel: 116 123

- **The Way Foundation**
  Supporting young, widowed men and women under 51 years of age as they adjust to life after the death of their partner.

  Website: https://www.widowedandyoung.org.uk/
  Tel: 01332 869 222

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

  Website: https://www.winstonswish.org/
  Tel: 08452 03 04 05

Appendix 3

Model for a group for reflecting of deaths by PPH and/or suicide

- **Frequency:** Monthly or bi-monthly
- **Duration:** 60–90 mins
- **Number of cases discussed:** 1
- **Type of case:** PPH and suicide
- **Facilitator or convener:** Usually two; one of whom has psychotherapy training and one who has lived experience.
- **Boundaries:** Same time and same place on each occasion if possible.
- **Style:** Often similar to Balint group.
- **Core membership:** Around four core members who commit to attend frequently. It is advisable to start with a pilot group to establish the core members. The core members should have their lived experience of losing patients to suicide or of PPH which can be the starting point for their own reflection.
- **Attendance:** Clinicians who have had a PPH or a patient death by suicide either ask to attend or are invited if a colleague is aware they have just had a death. They may come once to tell their story, or more frequently. They can also stay in the longer term and join the group. Quite often individuals can come once after the death and then again at the time of the coroner's court.

Functioning or process

1. When a new member (e.g., Dr X) joins after they lose a patient to suicide, they are first given space to share their story, without notes, while the rest of the group listen. This may take them between 10–20 mins. They are allowed to talk without any interruption. This is without notes, allowing any emotional responses to be shared.
2. Dr X is asked to sit back and listen to the group discuss what they have heard for around 20 mins. The group members share their thoughts and associations to Dr X's story.

3. Dr X is then asked to re-join the group and feedback their thoughts. They are then allowed more time, around 10 mins, to continue the narrative. They are then asked to sit back again.
4. The group again discuss the further material for around 20 mins.
5. Dr X is asked back into the group, to feed back.
6. Further discussion is as a group.

References

Barajas A, Binder A, Hale C (2019) Postvention Program for Clinicians after Loss of a Patient to Suicide. *Uniformed Services University.*

Botelho M and Goncalves RA (2016) Why do people kill? A critical review of the literature on factors associated with homicide. *Aggression and violent behavior*, **26**: 9–15.

Bultema JK (1994) Healing process for the multidisciplinary team: Recovering post-inpatient suicide. *Journal of Psychosocial Nursing and Mental Health Services*.

Croft A, Lascelles K, Brand F, Carbonnier A, Gibbons R, Wolfart G and Hawton K (2023) Effects of patient deaths by suicide on clinicians working in mental health: A survey. *International journal of mental health nursing*, **32(1)**: 245–76.

Doka KJ (1999) Disenfranchised grief. *Bereavement care*, **18(3)**: 37–39.

Figueroa S and Dalack GW (2013) Exploring the impact of suicide on clinicians: a multidisciplinary retreat model. *Journal of Psychiatric Practice®*, **19(1)**: 72–77.

Gibbons R, Brand F, Carbonnier A, Croft A, Lascelles K, Wolfart G, and Hawton K (2019) Effects of patient suicide on psychiatrists: Survey of experiences and support required. *BJPsych Bulletin*, **43(5)**: 236–41. doi:10.1192/bjb.2019.26

Gutin NJ (2019) Losing a patient to suicide: What we know. *Current Psychiatry*, **18**: 15–32.

Hussain Q, Killaspy H, McPherson P and Gibbons R (2023) Experiences and support needs of consultant psychiatrists following a patient-perpetrated homicide. *BJPsych Bulletin*, 1–7.

Kinman G, Torry R (2020) Responding to the death by suicide of a colleague in Primary Care: A postvention framework. *Supporting Occupational Health and Wellbeing Professionals (SOM).* Available at: https://www.som.org.uk/responding-death-suicide-colleague-primary-care-postvention-framework. [Accessed: 09 August 2022].

Leaune E, Cuvillier B, Vieux M, Pacaut-Troncin M, Chalancon B, Perez AF, Haesebaert J, Chauliac N, Poulet E and Durif-Bruckert C (2020) The SUPPORT-S protocol study: a postvention program for professionals after patient or user suicide. *Frontiers in psychology*, **11**: 805.

Mezey G, Rowe R and Adshead G (2021) Impact of homicide by a psychiatric patient on forensic psychiatrists: national survey. *BJPsych Bulletin*, **45(3)**: 183–89.

Supporting Occupational Health and Wellbeing Professionals (SOM) (2024) Available at: https://www.som.org.uk [Accessed: 29 May 2024].

Tamworth M, Killaspy H, Billings J, Gibbons R (2022) Psychiatrists' Experience of a Peer Support Group for Reflecting on Patient Suicide and Homicide: A Qualitative Study. *International Journal of Environmental Research and Public Health*, **19(21)**: 14507. doi:10.3390/ijerph192114507

West M and Coia D (2019) Caring for doctors, caring for patients. *General Medical Council*.

West MA and Markiewicz L (2016) Effective team working in health care. *The Oxford handbook of health care management*, 231–54