Correspondence

Suicide: Don't wait for the publicity

DEAR SIRS

Several times recently people who have just had an in-patient suicide have asked me what to do,* and whether the College recommends any procedure. It might be a good idea if the College, possibly through the Public Policy Committee, did publish a recommended scheme of audit for suicide, or a medical inquest. In the meanwhile may I offer some suggestions?

A medical inquest is not to decide if it was suicide, or if anyone is to blame. Starting from the facts that a patient of the hospital has killed himself/herself by a specific method at a specific place, time and date, it has a psychological function and a teaching function. By bringing people together to talk about their roles in the common work of the hospital it is a morale-builder. By drawing together all those who cared for the dead person it allows mourning, and the staff will feel better. By examining together the sequence of events which ended in the death, people can learn whether they collectively or individually needed more knowledge or a different procedure.

Not all in-patient suicides are avoidable, but some are. I have known of visitors or fellow-patients who brought in razors or drugs and gave them to a person known to the staff to be at risk. I have known of a ward where the number of disturbed patients was quite out of balance with the few staff on duty. I have known of failures of communication between staff members or with the world outside the hospital, some due to unsatisfactory procedures, others to secretarial misapprehensions or telephonic inadequacies. The medical inquest is to see whether the hospital and community services are working as efficiently as they might and, if not, to try to improve them.

This inquest takes place at two levels, or in two parts. In the first, all the team involved in the care of the dead person meet together to establish the details of the events which ended in the death. In the second part the professional managers of the hospital and external services—consultants, nursing officers, administration, perhaps social work leader—consider the details, and compare them with those of other recent suicides to see if any changes in practice are needed.

The first part requires the attendance of consultant and nursing officer, the ward charge nurses of all shifts, the junior doctor(s) of the team, possibly the patient's GP, social workers and psychologist (where involved in care), nurses who knew the patient, any secretaries who do the team's clerical work, and possibly the hospital engineer or other specialist. Basically they look at three things:

1. The assessments of suicidal risk at admission to hospital and just prior to suicide made by medical and nursing members: was full knowledge of the patient's history obtained, and was it known to all staff? (With hindsight, would it have been better if someone had obtained additional history, or if there were better communications between staff at some points—how?; or if some staff were more informed of up-to-date knowledge about suicide—a training matter?)
2. How did the patient get to the (unobserved) place where the suicidal act was made? This may mean looking at how a patient went missing or was granted leave, or the degree and quality of nursing observation on the ward at the time. Sometimes there are delays in carrying out procedures, or they are found to be unworkable in part. Again, hindsight is valuable in reviewing what happened and how it could have been avoided in ideal circumstances.
3. How was the particular method of suicide available to the patient at that time—e.g. jumping down stair wells or out of open upstairs windows, hanging from lavatory chains, acquiring knives or stocks of tablets? (Patients often have preferred methods of sicide. A patient of mine in South London went to Victoria and caught a train to Brighton, in order to throw herself into the sea and drown there. Denying her a railway ticket (by holding her money) during the time she felt particularly suicidal might have prevented this.)

The second part of the medical inquest is concerned with the death as it affects the whole hospital, and possibly community services. Admissions policies, disposition of nursing staff, training of staff, hospital procedures for different emergencies, harmony between psychiatric and general wards, co-operation with GPs, social services and voluntary agencies may all need to be considered.

These suggestions are full, but of course need modification to suit different types of psychiatric unit, and possibly different types of suicide. They are made because a breadth of inquiry is likely to be useful if medical audit is to improve service to the patient and to the community and help staff to overcome their feelings of guilt and failure.

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*Perhaps arising from papers in the *Bulletin*, January 1983, **7**, 2–4; and in the *Journal*, November 1984, **145**, 460–3.

Mental handicap and the Mental Health Act

DEAR SIRS

I also share the concern of Dr T. Hari Singh about the provisions of the Mental Health Act as they relate to mentally handicapped people (*Bulletin*, January 1985, **9**, 14).

It is right that the intention of the legislation was to protect the 'rights' of mentally handicapped people but, leaving aside the question of what 'rights' actually means, I think the Act was trying to do something more complicated than that. The substitution of the term 'mental impairment' for 'subnormality' was an attempt to remove most mentally handicapped people from the long-term compulsory hospital admission sections of the Mental Health Act. Underlying this move was the feeling that the legislation concerning the care of mentally

handicapped people was inappropriately placed with that for people suffering from mental illness. The intention of the Act was to provide that only mentally handicapped people whose condition was associated with 'abnormally aggressive or seriously irresponsible conduct' would remain liable to admission under Sections 3, 37, 47 and 48. In general terms, all mentally handicapped people remain liable to admission to hospital under the shorter term sections, in particular Section 4 and Section 2. This was a very messy way of half achieving the underlying objects, but at the time the legislators thought this was the only option open to them.

The use of guardianship in relation to mentally handicapped people is another issue. I have looked through the debates of the Special Standing Committee in the House of Commons and I can find no mention of any consideration of the limitation of this power to 'mentally impaired' and 'severely impaired' people. My own recollection is that it never occurred to any of those involved in the passage of the Mental Health Act to query its application to only that group of mentally handicapped people.

I agree with Dr Singh that consideration must be given to those problems. My own view is that there seems little evidence for the need to extend the long-term detention sections of the Act to all mentally handicapped people and that as far as guardianship is concerned there is an urgent need for hard evidence as to whether the powers actually possessed by the guardian would be useful and appropriate in many circumstances where they are inapplicable at the moment. The 'rights' to which Dr Singh referred must mean not only the rights to protection but also the rights to take risks that all of us regard as an ordinary part of our life. What we really need is an entirely separate legislation which can be tailored to particular needs of mentally handicapped people.

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Psychiatry of mental handicap services

DEAR SIRS

Recently D. A. Spencer argued in your columns that Divisions of Psychiatry should be watchful to preserve the roles of consultants of mental handicap services in those places where it is proposed to adopt a service model based on principles of 'normalization' (*Bulletin*, January 1985, **9**, 14).

The City of Sheffield is, as far as I can discover, the only place where there is a published strategy to transfer the care of intellectually impaired people from the health service to the local authority. It must be made clear that Sheffield plans do not envisage anything other than a continuing and active role for the consultant psychiatrist. Indeed, she is a very committed and active member of the Joint Team of Officers that has the responsibility of translating the strategy into actuality. The longer this Team works at its task, the more convinced we become that if the opportunities of intellectually impaired people are to be maximized, the combined skills of all those professional groups currently working in the mental handicap services will be required in abundance. Our aim is not to offload such patients from a hard-pressed service, but to enable all intellectually retarded people in this city to play a full part in its life.

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Physical activity for the mentally handicapped: A unit of learning

DEAR SIRS

Physical activity is important in the development and maintenance of good physical health and mental well being. Such activities are especially important to the mentally handicapped where development of physical movement and co-ordination helps create activity, invigorates and improves the quality of life. The feelings of well being and of achievement also improves self-esteem and the socialization of the handicapped and aids integration not only between themselves but also with the community.

The term physical activities should be interpreted widely and include any physical activities that aid the mentally handicapped to develop their full potential and acquire maximum independence and use of their leisure time.

Within the hospital service many units have developed active programmes, not only of traditional activities but also of adventure-type projects such as rock climbing, potholing, sailing, etc, as well as local and regional sports days. National and international olympics have been held successfully.

Everyone caring for the handicapped needs to have knowledge of the resources available in the community, locally and nationally. In particular, nurses should have some knowledge of how physical achievement can enhance the quality of life for mentally handicapped persons, and be equipped with some of the necessary skills needed to provide relevant physical activities.

Towards this end a unit of learning for staff caring for children and adults with mental handicap has been devised by Barbara Norris, Lecturer in Physical Education, University of East Anglia, working as a part-time member of staff of the Disabled Living Foundation. The unit of learning has been approved by the English National Board for Nursing, Midwifery and Health Visiting. The learning unit is intended to provide 40 hours' tuition during the three-year nurse training. Its syllabus includes: (i) the concept of an active life style, with relevance to the division of work and recreation in the life of a mentally handicapped person; (ii) movement as an integral part of child development and growth; (iii) physical activities as a stimulator for language development; (iv) the physiological benefits arising from regular physical activity; (v) the resources available in the community. Practical work includes activities based on music, ways of promoting large body movement in water therapy and swimming.