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5-7-2016

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Recommended Citation

johnson, amanda l., "Assessing Factors Related to Clinicians' Attitudes Towards Suicide Prevention" (2016). *Master's Theses*. 937.
https://opencommons.uconn.edu/gs_theses/937

Assessing Factors Related to Clinicians' Attitudes Towards Suicide Prevention

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A Thesis

Submitted in Partial Fulfillment of the

Requirements for the Degree of Master of Public Health

University of Connecticut

2016

2016

APPROVAL PAGE

Master of Public Health Thesis

Assessing Factors Related to Clinicians' Attitudes Towards Suicide Prevention

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2016

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I.   Introduction

Mental health clinicians are inevitably impacted by the loss of a patient to suicide. While a clinician-patient relationship is professional in nature, it is common for clinicians to experience feelings similar to what would be felt if a personal friend or family member took their own life by means of suicide. Research has shown that in the wake of a patient's death by suicide, clinicians experience the stages of grief as would be expected with any traumatic loss (Veilleux, 2011). Clinicians also report an impact on their professional practice that includes self doubt about professional competence and fear of legal reprimand.

Mental health professionals are often looked at as clinicians who are ultimately responsible for "healing" their patients. As a result, in addition to feelings of grief, clinicians may have feelings of guilt and shame from the loss of a patient to suicide. Mental health professionals often feel a level of personal responsibility in preventing harm to their patients inproviding psychotherapy or psychiatric medication. However, mental health treatment, like most treatments for physical illnesses, are not necessarily effective in curing the disease at hand, and therefore subject to negative outcomes for the patient.

A "survivor" by definition is"any and all people, both close and distant, whoexperience the pain of a suicidal death"(Veilleux, 2011). Clinicians are considered survivors of suicide and are therefore not exempt from feelings of bereavement as a result of the loss of the patient. Therefore, after losing a patient to suicide, it is important that clinicians are offered the services, resources, training, and personal empathy that are routinely offered to other survivors, such as the family and friends of the individual who took his or her life.Clinicians should receive the

care and support necessary to foster a healthy grieving process and restore personal and professional functioning.

II.   <u>Background</u>

The incidence of suicide in the United States has been on the rise in the past decade with more than 39,000 people taking their own lives each year (CDC, 2015).In 2007, 34,000 people died by suicide in the United States (SAMSHA, 2012). In 2013, 41,149 people died by suicide in the United States (CDC, 2015). Of those affected by major depressive disorder, a leading cause of suicidality, it is estimated that about one half receive professional mental health treatment (Jiaquan, Sherry. Murphy, Kenneth, Kochanek, Brigham, Bastian, 2016).

Almost 35 million adults age 18 and over received mental health services in 2013. Average use of mental health services reported between 2002 and 2011, ranged from 12.8-13.8% indicating that the use of mental health services in the United States is rising.(SAMSHA, 2014). Because the number of deaths by suicide are increasing, as well as the rates of individuals receiving mental health services, it is becoming increasingly likely that a mental health clinician will experience the loss of a patient to suicide at some point during their career.

Numerous factors have been associated with risk for suicide. Family history of suicide, previous suicide attempts, history of mental health disorders, impulsivity or aggression, isolation, withdrawal from normal activities, and barriers to accessing mental health treatment (National Council for Community Behavioral Healthcare, 2012). Several populations have been specifically identified as being more "at risk" for suicide than the general population. These subpopulations include:white males age 65 and older, veterans and military personnel, Alaskan natives/Native American Indians, lesbian/gay/bisexual/transgender/questioning youth, and those individuals suffering from serious mental illness (Hogan, 2010). Protective factors include:

access to and use of effective clinical care for mental health and substance abuse related concerns, support from one's family and community, problem-solving skills, and religious and cultural beliefs that discourage suicidal behaviors (CDC, 2015).

Throughout their professional career about half of psychiatrists and one quarter of psychologists will lose a patient to suicide (Hendin, Haas, Maltsberger, Szanto, &Rabinowicz, 2014). Those clinicians who are younger in age and have less experience in the field are at heightened risk for experiencing distress and prolonged grief in the wake of losing a patient to suicide (Henden et. al., 2014). Suicide prevention training has been shown to affect distress levels of clinicians who have lost a patient to suicide. Severe distress was reported by over half of therapists who were still in training in comparison to one-third of therapists who had completed training in response to losing a patient to suicide (Henden et. al., 2014).

The Effects of Losing a Patient to Suicide

Clinician responses to the loss of a patient to suicide are often grouped in two categories: personal(i.e. impact on life outside of work) and professional (i.e.impact on clinical practice.) Studies have shown that personal responses of a clinician to the death of a patient to suicide closely resembles bereavement experienced by personal friends or family members who have lost the individual (Veilleux, 2011). Since many clinicians work with patients for significant durations, investing a great deal of time in learning about the patient while providing support and hope for healing, a natural reaction to learning that a patient has completed suicide includes feelings of shock, disbelief, denial, sadness, grief, anger, and sometimes internal thoughts of suicide (Veilleux, 2011). Research by Hendin et. al. (2014) assessed reactions from 34 clinicians who had previously lost previously lost a patient to suicide. It was found that 38.2%, or 13 clinicians of the 34 clinicians, reported feeling severe levels of grief, shock, guilt, inadequacy,

anger, shame, anxiety, and depression in response to losing a patient to suicide (Henden et. al., 2014).Clinicians reported four main factors that contributed to level of distress experienced following the loss of a patient to suicide. These four factors include; failure to hospitalize a suicidal patient, regret or question surrounding a treatment decision, negative reactions from the institution or agency in which they practice, and lastly, fear of legal retaliation (Hendin et. al., 2014). It is important to remember that the grieving process and related symptoms are different for all people and that labeling or judging an individual, especially during early bereavement, may be damaging or harmful for the individual (Zisook& Shear, 2009).Participants reported long term strainfrom losing a patient to suicide on both personal and professional aspects of their life, even when the relationship was relatively short and the interactions minimal (Veilleux, 2011). This suggests that, length of professional relationship is may not be a factor in predicting how impacted a clinician will be after losing a patient to suicide.

Licensed mental health clinicians legally carry a certain degree of accountability in ensuring the safety of their patients. Clinicians must remain vigilant in identifying patients at risk for self harm and take appropriate measures to ensure that the patient is protected from carrying out acts of self destruction. If a court of law finds a clinician guilty of failing to take action in protecting a patient who expresses or demonstrates risk of harm to self, the clinician can be held liable for malpractice (Berman, 2006). Legal accountability leads to not only increased guilt and shame regarding professional competence, but leads to fear of legal retaliation from family or caregivers of the individual who took his or her life (Veilleux, 2011). Research also shows that clinicians may become hypervigilant in clinical assessment, as well as more likely to either refer at risk patients to a colleague, or avoid patient contact in general (Seguin, Bordeleau, Drouin, Castelli-Dransart, & Glasson, 2014).

Interventions and programs to support clinicians who have lost a patient to suicide are few. Research has shown peer to peer support to be an evidence-based practice, and is now emerging as an intervention for care providers in the healthcare setting (Daniels, Grant, Filson, Powell, Fricks, &Goodale,2009).The peer to peer model focuses on providing support and developing coping skills. Four components to to the peer support approach include the exchange of resources, self-appraisal, building life skills, and identity transformation (Vayshenker, Mulay, Gonzales,West, Brown &Yanos, 2016). Peer support is used in a wide range of settings with populations of varying needs. One study of 93 patients diagnosed with cancer who participated in a peer support program found that participants reported feeling a sense of community, unconditional acceptance, and valuable knowledge of the disease and its treatment(Ussher., Kirsten, Butow, & Sandoval, 2006). Participants reported feeling increased empowerment and increased feelings of control over their diagnosis and interactions with others.Another study of mothers who recently lost their infants shortly after childbirth reported that support from peers had greater effects than support from health care providers. (Nikkola, Kaunonen, &Aho, 2013).Ninety-seven percent (97%) of the mothers noted continued contact with peers as especially helpful in coping with the loss of their child

There are a couple of interventions that have incorporated peer supports as an intervention for clinicians who have suffered the loss of a patient to suicide. The American Association of Suicidology (2014) facilitates a Clinician Survivor Task Force that provides a list of clinician contacts who can provide consultation, support, and education to fellow clinicians who experience the loss of a patient to suicide on a national level. However, it is uncertain how many clinicians use this service. A study was done to determine the effects of peer support for

health care professionals who work with terminally ill children. Peer support was offered to nurses and physicians who interacted with the patients and their families in order to foster healthy grieving and stress management. It was found that a greater level of participation in the peer support group was associated with better self reported scores for perceived health and grief management (Keene, Hutton, Hall, & Rushton, 2010).

Zero Suicide Approach

Zero Suicide is an approach to suicide prevention in health and behavioral heath care systems that is currently being incorporated throughout the United States to organizations on a voluntary basis.In Connecticut, the Zero Suicideapproach, introduced by the Connecticut Suicide Advisory Board in partnership with the Institute of Living, provides a framework for health and behavioral healthcare settings for the purpose of preventing suicide. The core principal of the Zero Suicide approach is the aspiration that suicide is preventable. This approach seeks to eliminate the potential for patients at risk for suicide to "fall between the cracks" as a result of an inconsistent or distracted health care system. The systematic framework for the Zero Suicide approach seeks to eliminate missed opportunities in identifying and treating patients at risk for suicide. The Zero Suicide approach has seven fundamental components. The first, "Leadership Leading to Cultural Transformation," requires that organizational leadership must believe in and promote the idea that suicide is an unacceptable outcome. Six other competencies include: training a competent workforce, systematically identifying those at risk for suicide, engaging those at risk for suicide, incorporating evidence-based treatment, fostering smooth care after acute care is received transition, and apply a quality improvement approach to practice assessment (Goldstein Grumet, 2015)

The idea that suicide is preventable is a controversial idea that has received resistance from many clinicians. It is argued that the idea of "zero" suicides ultimately sets clinicians up for failure in their practice by setting the standard for patients lost to suicide to zero. For example, during Grand Rounds on October 1, 2015 at Hartford Hospital's Institute of Living, clinicians openly expressed their frustrations and disagreement with the initiative, arguing that it promotes an unrealistic goal, rather than an aspiration. According to one clinician, "zero suicide is a delusion."

Clinicians' pessimism about not only eliminating suicide, but decreasing suicide rates as well, leads many clinicians to avoid involvement with suicide prevention efforts. However, studies on systems-based suicide prevention programs have shown that a substantial decrease in patient suicide rates is possible. Agencies and organizations that have targeted clinician attitudes have effectively implemented such programs in the workplace (Covington & Hogan, 2011). Fostering a culture shift within the agency or organization providing mental health services has proven effective in significantly reducing suicide rates in long term studies with the Henry Ford Health Care System and Air Force suicide prevention efforts (Covington & Hogan, 2011). Using the Zero Suicide framework, the rate of suicide among patients receiving behavioral health care in the Henry Ford Health Care System declined by 75% between 2000 and 2005. In 2000, Henry Ford Health Care experienced 89 deaths from suicide per every 100,000 patients; after implementation of the Zero Suicide framework, Henry Ford saw a rate of 22 patient suicides per every 100,000 patients between 2002 and 2005. The Henry Ford Health Care system went on to experience 1.5 years of no patient suicides amongst its members receiving behavioral health care (McCarthy, Mueller, & Wrenn, 2009). Key components of the Zero Suicide framework that strengthened care given and aided in the effort to reduce suicide rates in the Henry Ford Health

Care System include: drop-in group medication appointments, same day access to care, and email notifications to remind patients of appointments (Covington, 2012).

The Air Force Suicide Prevention Program implemented a similar approach in 1996. This program implemented a systematic approach to suicide prevention that emphasized leadership involvement. Other components of the program involved increased awareness of mental health resources and services, professional training in suicide prevention, developing a surveillance system to track intentional and unintentional deaths, creating a behavioral health survey for personnel, creating trauma-stress response teams, creating methods for early identification of at risk personnel, improving treatment interventions, and promoting help seeking behavior. Overall, the rate of patients at risk for suicide was reduced by one-third (USDHHS, 2012). The rate of suicide in the Air Force decreased from 15.8 suicides per 100,000 airmen, since its implementation in 1996, to 6 per 100,000 airmen in 2002 (WHO, 2010).

Purpose of the Study

The purpose of this research is to assess factors related to clinicians' attitudes toward suicide prevention. This research was initiated in response to resistance seen from clinicians in accepting the Zero Suicide approach within health care organizations in Connecticut. Results from this research will be communicated to the Connecticut Suicide Advisory Board, and will go on to inform statewide interventions targeted at reducing clinician apprehension towards accepting suicide as preventable.

In order to effectively integrate and incorporate suicide prevention efforts, such as Zero Suicide,clinicians must support and believe in the efficacy of the practice. Clinicians are often the first line of defense for patients in addressing, alleviating, and hopefully eliminating suicidality. A common reaction to losing a patient to suicide is self doubt in one's professional

competence, which could go on to negatively impact interactions with other patients and effectiveness in practice. If clinicians doubt the effectiveness of their practice, it will inevitably influence patients, who may suffer as a result.

Clinicians who lose a patient to suicide must be acknowledged as survivors who are in need of services and resources to aid their grieving process. Clinicians often internalize responsibility for preventing the loss of a patient to suicide and therefore grief may be more severe than if a patient were to die from a different cause of unexpected death (Covington & Hogan, 2011). Preventative measures should be considered to help prepare clinicians for this loss and provide an accessible resource for support in coping with feelings associated with the loss. Avoidance behavior has been identified in clinicians who are ambivalent about the idea that suicide is preventable. These clinicians have missed opportunities to effectively reduce suicide risk by strengthening protective factors and promoting resilience (Covington & Hogan, 2011). It is important to assess clinician attitudes toward suicide prevention because such attitudes maygo on to compromise clinical practice.

III.   Survey Design

A cross sectional web-based study of clinicians was conducted to measure clinicians' attitudes towards suicide prevention and to examine factors that may affect those attitudes. A 13-item survey was designed to be completed in under 10 minutes by the survey participant (See Appendix). The survey was made available for a 3-week time period from March 4th, 2016 through 25 March 2016. The anonymous survey was administered online through Survey Monkey. It was determined that an online survey would be the most the feasible means of reaching the greatest number of cliniciansin a relatively short time period. Research methods using the world wide web has significantly increased in recent years because this method is

convenient, relatively inexpensive in comparison to other research methods, and produces instantaneous data (Tolstikova,&Chartier, 2009).

The survey was designed to be concise and relatively brief in order to encourage participation. The survey began by gathering information pertaining to the clinician's background including: clinical field of specialty;type of agency;patient population served; years of clinical experience; average length of professional relationships with clients;and receipt of training related to patient suicide. Questions related to type of agency and type of clients allowed clinicians to provide multiple answers. One question asked directly about whether or not the clinician had lost a patient to suicide. This was followed by asking whether the participant believes suicide is preventable, and then to what extent he or she feels clinicians are responsible for the death of a patient to suicide. Clinicians were asked whether or not they would be willing to participate in peer support following the loss of a patient to suicide and whether or not he or she would be willing to participate in a peer support program for fellow clinicians who have lost a patient to suicide. A final text box at the conclusion of the survey allowed the participants an opportunity to share any additional ideas or comments they might have pertaining to suicide prevention. A copy of the survey is located in the Appendix.

Clinicians were invited to participate in the survey through three main avenues. The survey link was distributed through theList Serve of the Connecticut Suicide Advisory Board, which is coalition facilitated jointly by the Connecticut Department of Mental Health and Addiction Services (DMHAS) and the Connecticut Department of Children and Families (DCF). The Connecticut Suicide Advisory Board is a network of diverse advocates, educators, and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, and response. The listserv for this group consists of about 250 individuals from

over 100 different mental health and related agencies in the state (Duarte, 2015). The survey was also distributed through the listserv of the Connecticut Clearinghouse, a statewide resource center for mental health, substance abuse, and wellness related topics (Connecticut Clearinghouse, 2016). Additionally, the researcher made personal connections with former professional contacts with a clinical license to participate in the survey. The survey was approved through the University of Connecticut Health Center Institutional Review Board.

Analysis

Data was exported from Survey Monkey to a Statistical Package for the Social Sciences (SPSS) data file for analysis. Four hypotheses were identified to test the correlation between specific factors surveyed. These hypotheses were intended to highlight strengths and challenges within the population pertaining to attitudes about suicide prevention and identify areas that could be targeted in future initiatives to support mental health clinicians in Connecticut.

Research has shown that feelings of guilt, inadequacy, anxiety, and depression impact clinicians after losing a patient to suicide. It was hypothesized that as a result of these feelings, those clinicians that have lost a patient to suicide are more likely to think that suicide is not preventable. Suicide prevention training helps clinicians to better understand the circumstances surrounding suicide, as well as feel more comfortable in treating patients at risk for suicide (USDHHS, 2012). This should help reduce shame associated with losing a patient to suicide and help to normalize feelings in response to the loss of the patient. Therefore, it was hypothesized that those who have not participated in suicide prevention training are less likely to believe that suicide is preventable. In addition, it was hypothesized that those who had participated in suicide prevention training would be more open to participating in peer support. Research shows that when clinicians experience pessimism towards practice efficacy and reducing suicides their

clinical practice is negatively impacted (Covington & Hogan, 2011). Therefore, it was further hypothesized that those clinicians who believe suicide is preventable would be more likely to state that they would participate in peer support following the loss of a patient to suicide.

Cross tabulations of study variables were used to examine the relationships described above. Chi square tests were computed to determine the strength of association in these cross tabulations. When considering the association between having lost a patient to suicide and belief that suicide is preventable, answer categories "no" and "unsure" were grouped into one category for each variable comparison as both answers express some degree of doubt. Statistical significance was determined by identifying whether or not the P value for the chi-square test was under .05.

IV.   Results

One hundred and four individuals participated in the survey. Eight of these individuals did not complete the survey. For this reason, the number of people answering each question varied. Of those who responded to the survey, 73%% identified as licensed clinicians (e.g. Licensed Therapists, Psychologists, and Psychiatrists.)Twenty-nine percent of respondentsidentified as "Other." Most of the occupational specialties reported in "Other" included responses such as Licensed Marriage and Family Therapist, and Licensed Professional Counselor. Five individuals reported occupational specialties that did not appear to meet criteria for the target population. These specialties included a nurse, occupational therapist, advocate, spiritual leader, and blogger/radio host. Because the number who did not meet the survey participation criteria was small, it was determined that the data would not be significantly impacted by their results and therefore their responses were included in the data analysis. Also, a few respondents selected more than one response category.

Table 1. Clinical Field

Type	Percent
Psychiatrists	2
Psychologists	8
Licensed Clinical Social Workers	51
Licensed Therapists	12
Other	29

n=102

Of those who responded, 62% had been practicing for over ten years, 20% had been practicing as a clinician for 6-10 years, and 13% had been practicing for 1-5 years. Only 4% reported practicing for less than one year.

Table 2. Length of Time in Practice

Years	Percent
Less than 1	4
1-5	13
6-10	20
11-15	20
16 or greater	42

n=100

Thirty-one percent of respondents reported that they had not participated in suicide prevention training outside of coursework provided to them in their academic training. Sixteen participants identified the type of training they had received. These included Applied Suicide Intervention Skills Training (ASIST)(n=5), Question, Persuade, Refer (QPR) training (n=6), and Continuing Education Units (CEU) training (n=3).

Thirty-four percent (34%) of clinicians reported being a survivor of patient/client suicide. Sevenpercent (7%) of participants were unsure whether or not a patient or client had gone on to

die by suicide. Clinicians might be unsure because patients at risk for suicide often receive services from other treatment facilities or terminate services.

Table 3. Clinician Report of Patient/Client Suicide

Survivor	Percent
Yes	34
No	59
Unsure	7

n=99

The majority (83%) of clinicians surveyedreported that they believe suicide is preventable; the remaining18% either did not believe suicide is preventable or were unsure. More than half (57%)felt that clinicians had a moderate level of responsibility in preventing a patient from attempting suicide and 24% felt clinicians held a high level of responsibility in preventing a patient from attempting suicide.

Table 4. Extent to Which Clinicians Are Responsible for Preventing Patient Suicide

Extent of Responsibility	Percentage
High	24
Moderate	57
Minimal	18
None	2

n=97

An overwhelming majority (93%) of cliniciansreported they believe the peer to peer model could help them cope with the loss of losing a patient to suicide while only five percent were unsure (Table 5).

Table 5. Clinician Belief That Peer to Peer Support Would Help in the Wake of Losing a Patient to Suicide

Belief	Percentage
Yes	93
No	2
Unsure	5

n=96

As the data in Table 6 shows, two-thirds of clinicians reported that they would be willing to participate in peer to peer support for fellow clinicians who had lost a patient or client to suicide. One-fourth reported they were unsure about participating in peer to peer support for fellow clinicians who have lost a patient to suicide.

Table 6. Clinician Willingness to Participate in Peer to Peer Support for Clinicians Who Lost a Patient or Client to Suicide

Willingness	Percentage
Yes	67
No	8
Unsure	25

n=96

It was hypothesized that clinicians who had lost a patient to suicide would be more likely to believe that suicide is not preventable. More than one-fourth (26.5%) of those clinicians surveyed who are survivors of client/patient suicide either did not believe suicide is preventable or were unsure (Table7). Among those clinicians who either had not lost a patient to suicide or were unsure about whether or not they had lost a patient to suicide, 12.5% reported that they either disagreed with or were unsure of whether or not suicide is preventable. A 14% difference was seen between those who had lost a patient to suicide and those who had not or were unsure

about having had a loss in believing that suicide is preventable. Although this association failed to achieve statistical significance in this sample (p=.082), it is possible that a statistically significant difference would have been found with a larger sample size.

Table 7. Belief That Suicide is Preventable by Survivorship of Patient/Client Suicide

		Believe Suicide is Preventable		
Survivor of Patient Suicide		Yes	No/Unsure	Total
	Yes	73.5%	26.5%	100.0%
	No/Unsure	87.5%	12.5%	100.0%
Total		82.7%	17.3%	100.0%

p=.082

It was hypothesized that clinicians who had participated in suicide prevention training would be more likely to believe that suicide is preventable. It was found that 80.6% of clinicians who participated in suicide prevention training reported that they believed suicide is preventable compared to 87.1% of those who did not. The lack of statistical association between these two variables supports that suicide prevention training does not appear to have an effect on clinician's attitude toward the idea that suicide is preventable.

Table 8. Belief that Suicide is Preventable by Participation in Suicide Prevention Training

		Believe Suicide is Preventable		
Participated in Suicide Prevention Training		Yes	No/Unsure	Total
	Yes	80.6%	19.4%	100.0%
	No/Unsure	87.1%	12.9%	100.0%
Total		82.7%	17.3%	100.0%

n=.429

It was further hypothesized that clinicians who had participated in suicide prevention training would be more likely to report that they feel peer to peer support would help in coping with the loss of a patient to suicide. As the data in Table 9 shows, 92.5% of clinicians who had participated in suicide prevention training would be in favor of peer to peer support in the wake of losing a patient to suicide. Similarly,over 93.1% who did not receive suicide prevention

training, were open to peer support. Clearly, suicide prevention training did not have a significant influence on attitude towards peer support.

Table 9. Openness to Peer to Peer Model by Participation in Suicide Prevention Training

Participated in Suicide Prevention Training	Openness to Peer to Peer Model		
	Yes	No/Unsure	Total
Yes	92.5%	7.5%	100.0%
No/Unsure	93.1%	6.9%	100.0%
Total	92.7%	7.3%	100.0%

p=.922

Finally, it was hypothesized that those who believe suicide is preventable are more likely to be in favor of peer to peer support in the wake of losing a patient to suicide. The results showed that there was no difference in clinician attitudes toward peer to peer supportamong these two groups (Table 10). Believing that suicide is preventable or not does not significantly impact openness to receiving support from colleagues.

Table 10. Openness to Peer to Peer Support by Clinician Belief that Suicide is Preventable

Believe Suicide is Preventable	Openness to Peer to Peer Model		
	Yes	No/Unsure	Total
Yes	92.4%	7.6%	100.0%
No/Unsure	93.8%	6.3%	100.0%
Total	92.6%	7.4%	100.0%

p=.851

The final question of the survey gave clinicians an opportunity to provide thoughts and comments pertaining to suicide prevention. Twenty-five individuals commented in this section on a variety of different topics. One clinician noted that a barrier for participating in peer support was the humiliation and responsibility he or she felt in response to losing a patient to suicide. The clinician commented; "I hope I would have the strength to participate (in peer support). Honestly, I am not sure that I do." One clinician reported that

"…sometimes the illness is so severe and the treatment so ineffective that at times, it is almost better that they have passed on…" Other clinicians expressed similar attitudes. One went on to say;

> It is essential to understand that as clinicians we have limited ability to affect whether someone will attempt suicide. We can provide resources, we can assess that they need to be in-patient and/or that they need to be in intensive outpatient (programs), we can try to keep these clients connected, ask them to please allow us to create a team for their health such as a psychotherapist, a psychiatrist, and their medical doctor, but many times clients will not follow through on the treatment plan that we provide them. We have little ability to compel them to follow the clinically appropriate treatment plans that we provide.

V.   Discussion

The purpose of this research was to assess different factors related to clinician attitude towards suicide prevention. Clinician have expressed apprehension in response to the recent implementation of the Zero Suicide program in Connecticut. Thishas sparked conversation within the Connecticut Suicide Advisory Board about needed intervention to support these clinicians. This survey was intended to provide some insight on clinician attitudes towards suicide prevention, as well as clinician support towards peer support for clinicians who have lost a patient to suicide, peer support.

A response rate for this survey cannot be ascertained for several reasons.First, I was unable to determine how many unique individuals were contacted about participation. The CTSAB ListServ used to recruit survey participantshas over 250 recipients and the CT Clearinghouse ListServ has about 3,000 recipients. Second, while these two ListServ's reach a large amount of individuals, not all are clinicians' who meet eligibility criteria. Third, there is potential for overlap of clinicians' who are recipients of both the ListServ's. With an unknown response rate and small sample size, the usefulness of the data is quite limited.

About one-third (34%) of clinicians reported that they are a survivor of patient suicide, which is consistent with the literature. The loss of a patient to suicide in Connecticut may reflect rates on a national level. Eighty percent (80%) of surveyed clinicians reported that they believe suicide is preventable. This leaves one in five who either disagree with, or are unsure about, the idea that suicide is preventable. This finding highlights a need to work further with this population to change their attitudes about the possibilities of suicide prevention. Several surveyed clinicians described their struggle to accept the idea that suicide is preventable in the concluding open-ended question.

Several clinicians also expressed concern and frustration over clinician responsibility in preventing the death of a patient to suicide, as well as ambivalence towards peer support. Many of these individuals may be suffering from feelings of distress such as guilt, shame, and inadequacy, as described in the literature. This apprehension indicates that some professionals may not feel comfortable in reaching out for help or support in times of need. These comments also highlight a need for more education and awareness with clinicians in practicing self care and having help seeking behavior. As peer support becomes more utilized by clinicians, confiding with colleagues and processing feelings related to practice with peers who may have experienced similar feelings will become more normalized.

This research shows that most (80%) of respondents feel clinicians have a moderate or high level of responsibility in preventing a patient from dying by suicide and 24% of surveyed clinicians feel clinicians have a high level of responsibility in preventing a patient from dying by suicide. This finding suggests that 80% of surveyed clinicians internalize the clinical outcome for their patient or client and indicates an area for intervention. Trainings to

educate and relieve feelings of personal shame or guilt over patient or client clinical outcome should be considered for the future.

Nine in ten clinicians surveyed reported that they would be open to peer support following the loss of a patient to suicide. This finding is important because peer support can be applied to a wide variety of needs and situations. Having a peer support network for clinicians can be utilized to support clinicians who have lost a patient to suicide as well as clinicians struggling with the stress of trying to prevent suicide with severely depressed patients. Peer support can also be used with clinicians with other personal stressors or transitions,including coping with serious illness or grief associated with divorce. Considering the high level of interest expressed, peer support should be looked at as a potential intervention for this population.

A smaller percentage (67%) of the clinicians reported that they would be willing to participate in a peer support program following the loss of a patient to suicide. Twenty-five percent (25%) of clinicians were unsure about willingness to participate.This difference may be due to a variety of different factors. Clinicians may be apprehensive in committing time during a busy work day to provide peer support in addition to other job related tasks. Perhaps clinicians are concerned about vicarious trauma in hearingstories of life lost as a result of suicide. An additional reason might be that clinicians are concerned about feeling vulnerable to re-experiencing feelings related to trauma, shame,or survivor guilt, as described in the quote from the preceding section, that were experienced when they lost a patient to suicide. Further research should be done to determine factors related to willingness to participate in peer support in comparison to willingness to facilitate peer support for clinicians who lose a patient to suicide.

Of the four hypothesis tested, noneshowed statistical significance. Clinicians who lost a patient to suicide were less likely to believe that suicide is preventable, but the p valueexceeded the .05 criterion for statistical significance. If the sample size had been larger, it s possible that some level of association may be detected between the experience of losing a patient to suicide and perception of suicide preventability.

Half(50%) of the survey participants were Licensed Clinical Social Workers which may impact data analysis. Clinicians who practice social work may have different patient/client interactions than other specialties such as in psychiatry. Varying specialties may have preconceived attitudes towards treating patients at risk for suicide, as well as suicide prevention and peer support. Different specialties also have different foundations, training, and guiding theories that shape practice, which align with their respective specialty. For example, psychiatrists may be more likely to view patients using the medical model with an emphasis on psychopharmacology, whereas social workers may use models that emphasize the whole person in the context of their environment to guide their practice, such as the social ecological model.

VI.   Limitations

Several limitations should be considered in the analysis of this research. While the sample size was large enough to reliably analyze the data and draw conclusions based on the respondents who participated in the survey, it is not possible to estimate the response rate. It is unknown how many licensed mental health clinicians were reached by the ListServs used to recruit participants. More than half of survey participants identified as Licensed Clinical Social Workers. The results from this survey may be most generalizable to Licensed Clinical Social Worker's than other clinical specialties.

Participants recruited from the Connecticut Suicide Advisory Board ListServ are voluntarily involved with suicide prevention efforts, and therefore it can be implied to some degree are predisposed to believe suicide is preventable. These survey participants have some level of investment in mental health and wellness related topics, including suicide prevention. Those survey participants recruited from personal outreach are affiliated with academia and may be more likely to have had training related to suicide prevention, as well as provide education to students for patients or clients at risk for suicide.

Because the survey was voluntary, individuals who may not feel strongly about suicide prevention, either favorably or unfavorably, may not have chosen to participate. Likewise, individuals who have a strong negative emotional reaction to the topic of patient suicide may have avoided responding to the survey upon seeing the email subject line. This may be a result of personal survivor guilt from having lost a patient before. Although responses were anonymous, because the topic of suicide and the idea that suicide is preventable is sensitive in nature, participants may have altered truthful answers based on what they felt was socially acceptable, and therefore created skewed data based on response bias. Therefore, potential for skewed data exists as a result of the sample of clinicians responding to the survey.

The sample population for this survey was predominantly licensed mental health clinicians in the State of Connecticut, with the exception of those few individuals who participated and did not meet clinical criteria. Because of the small population size, results from this survey cannot be generalized to the broader population of clinicians.

Need for Further Research

Findings from this research indicate areas for further consideration and research. Clinicians who are survivors of patient/client suicide should be surveyed to gain a better,

more in-depth understanding of their experience. Factors such as level of grief experienced,as well as supervisor or organizational culture should be assessed. Pilot peer support programs for clinicians who lose a patient to suicide should be initiated and evaluated to determine clinician response.

The majority of clinicians surveyed indicated that they felt a moderate or high level of responsibility in preventing suicide with their patients/clients. Further research should be done to evaluate internalization of client outcomes and identify opportunities for training or interventions to minimize vicarious trauma and counter transference in professional relationships. It may be appropriate to categorize clinicians into groups based on type of training experienced, level of acuity in the treated population, or type of clinical specialty, to assess trends in subpopulation attitudes or beliefs.Clinical specialties and agencies vary in practice and approach. More research should be done that looks at each professional field as a separate entity. Research should be done to assess the relationship between clinical field and attitude towards the idea that suicide is preventable.

Suicide is the worst outcome for a patient/client, clinician, and healthcare system. Therefore, it is a topic that is sensitive in nature for those clinicians affected by the loss of a patient to suicide. As a result, biases could have impacted results. Bias in survey participation could have occurred because participation was voluntary, and therefore personal investment of some sort probed survey participants to participate. Further research should be done to reach a more representative clinician sampleto eliminate this potential for bias.

Professional organizations, such as the National Association for Social Workers, and practice settings, such as hospitals or residential treatment facilities, should initiate, more in-depth research to gain a more thorough understanding of mental health needs for clinicians.

Programs and initiatives can then be targeted to address those needs and strengthen skills such as self care and help seeking behavior, that are instrumental with professionals in fields that care for others.

VII. Conclusion

Research was conducted to gain a better understanding of factors related to clinicians' attitudes towards suicide prevention. This research was initiated to inform the CTSAB in the implementation of the Zero Suicide approach by investigating apprehension expressed by clinicians in participatingin suicide prevention initiatives. An online survey was conducted to measure clinicians' attitudes towards suicide prevention, and to examine various factors that may affect those attitudes. The findings of the study will be presented to CTSAB to help direct development and implementation of the Zero Suicide approach.

The response to the survey suggests that clinicians have an emotional reaction to the topic of suicide prevention. The majority of clinicians supported the idea that suicide is preventable, and almost 80% of clinicians indicated that they believe clinicians have a moderate or high level of responsibility in preventing their patients from dying by suicide. This indicates that clinicians may internalize the clinical outcome of their patients that may impact their work with other clients. This is an area for future investigation. A marginal relationship was found between losing a patient and belief that suicide is preventable, indicating that this may be a subpopulation of clinicians who would benefit from targeted interventions, such as peer to peer supports. The vast majority (93%) of clinicians were open to peer support, indicating an intervention that health care and behavioral healthcare settings can integrate into practice to support clinicians who have lost a patient to suicide.

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Appendix