Fact Sheet:
Organizational Approaches to Address Suicide Risk in Providers and Staff

ACU Association of Clinicians for the Underserved

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The Crisis of Provider & Staff Suicide

Introduction

Healthcare professionals—whether providers or healthcare team members—are healers, working to improve the health of others. However, all too often, they deprioritize or sacrifice their own wellbeing to do so. This and other factors such as stigma and institutional barriers have led providers and healthcare team members alike to exhibit significantly higher rates of risk for suicide. Organizations have unique opportunities to support their providers and staff by incorporating systemic suicide prevention practices. This fact sheet introduces the issue of suicide risk in healthcare professionals and provides recommendations for organizations to develop a systemic response to reduce suicide risk among their teams.

A Longstanding Issue

Suicide rates have generally risen each year in the U.S. over the past 20 years, and healthcare professionals are no exception to this trend. For nearly 150 years, it has been known that physicians have an increased propensity to die by suicide.[1] Male physicians are 1.4 times more likely to die by suicide than the general male population, and female physicians are 2.27 times more likely to die by suicide than the female population.[2] Studies differ in their estimates of the scope of physician suicide: one recent analysis estimated that 119 physicians die by suicide each year, while another found that **approximately 300 physicians die by suicide each year—nearly one a day.**[3] Both, however, emphasized that because deaths by suicide often go unreported, the true rate is almost certainly higher.

> ***"[One study] found that approximately 300 physicians die by suicide each year—nearly one a day."***

Suicide risk and depression in providers are significant issues. An estimated 7% of physicians have thoughts of taking their life each year, [4] and among medical residents, 20% meet criteria for

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1 Bucknill JC, Tuke, DH, eds. (1874.) *A Manual of Psychological Medicine, containing the Lunacy Laws, the Nosology, the Ætiology, Statistics, Description, Diagnosis, Pathology, and Treatment of Insanity*3rd Edition. London: J & A. Churchill: 806.

2 Schernhammer, E. S., & Colditz, G. A. (2004). Suicide Rates Among Physicians: A Quantitative and Gender Assessment (Meta-Analysis). American Journal of Psychiatry AJP, 161(12), 2295-2302.

3 Center, C., Davis, M., Detre, T., Ford, D. E., Hansbrough, W., Hendin, H., Laszlo, J., Litts, D.A., Mann, J., Mansky, P.A., Michels, R., Miles, S.H., Proujansky, R., Reynolds, C.F. 3rd, Silverman, M. M. (2003). Confronting Depression and Suicide in Physicians. *JAMA* 289(23), 3161.

4 Shanafelt, T D, Drybye, L N, et al. (2021). Suicidal Ideation and Attitudes Regarding Help Seeking in US Physicians Relative to the Working Population. *Mayo Clinic Proceedings* 96(8): 2067-2080.

depression and 74% for burnout.[5] Furthermore, a meta-analysis of 54 studies found a 16% increase in depressive symptoms during the first year of residency, across all specialties and countries of training, with symptoms increasing over time.[6] For many, these issues begin even prior to practice. 27% of medical students exhibit depressive symptoms[7] which worsened year-over-year in medical school.[8] Part of the issue is both cultural and professional: "From medical school on, physicians are taught there is no room for error and . . . trained to put patients first—often to their own detriment."[9]

Similar issues have been found in nurse practitioners (NPs) and physician assistants (PAs), which are increasingly overtaking physicians as principle providers of primary care, particularly in federally qualified health centers.[10] While not as much work has been done to study suicide risk specifically in these providers, data shows that many rural physician assistants (PAs) evidence feelings of high to moderate emotional exhaustion and burnout[11] , and PA students report high levels of emotional exhaustion and burnout while in training.[12] As part of the broader workforce of providers, female physician assistants and nurse practitioners also share significantly elevated rates of suicide when compared to general women of working age.[13]As NPs and PAs

5 Kalmoe, M C, Chapman, M B, et al. (2019). "Physician Suicide: A Call to Action." *Missouri Medicine* 116(3): 211-216.

6 Mata D. A., Ramos M. A., et al. (2015). Prevalence of Depression and Depressive Symptoms Among Resident Physicians: A Systematic Review and Meta-analysis. *JAMA* 314(22):2373-83.

7 Ibid.

8 Schwenk, T. L., Davis, L., and Wimsatt, L. A. (2010). "Depression, Stigma, and Suicidal Ideation in Medical Students." *JAMA* 304(11): 1181-90.

9 Kalmoe, M. C., Chapman, M. B., et al. (2019). *Missouri Medicine* 116(3) : 212.

10 Mark, B. A., & Patel, E. (2019). "Nurse Practitioner Scope of Practice: What Do We Know and Where Do We Go?" *Western Journal of Nursing Research* 41(4), 483–487.

11 Benson, M. A., Peterson, T. et al. (2016). "Burnout in Rural Physician Assistants: An Initial Study." *The Journal of Physician Assistant Education* 27(2): 81-83.

12 Johnson, A. K., Blackstone, S. R., et al. (2020) "Assessing Burnout and Interest in Wellness Programs in Physician Assistant Students." *The Journal of Physician Assistant Education* 31(2): 56-62.

13 Peterson, C., Sussel, A., et al. (2020). "Suicide Rates by Industry and Occupation – National Violent Death Reporting System, 32 States, 2016." *Morbidity and Mortality Weekly Report* 69(3): 57-62.

become ever larger components of the primary care provider workforce,[14] it is essential to better understand the factors involved in their heightened levels of burnout and suicide risk.

Nor is this issue limited solely to providers. Nurses are the largest component of the U.S. healthcare workforce, and they and other healthcare team members are likely to experience burnout, are less likely to seek help, and occupy a unique and sometimes difficult position on the front lines between patient care and providers. It is, perhaps, unsurprising, that nurses, too, are at significantly higher risk of suicide than the general population,[15] and female nurses, particularly, are more likely to die by suicide than women in the general population.[16] Furthermore, nurses experience depressive symptoms at rates twice as high as individuals in other professions,[17] and they also face significantly higher rates of suicidal ideation than other workers.[18]

"Many providers and team members simply forego treatment [for suicidal ideation], leading to sometimes devastating results.."

Nevertheless, many healthcare professionals do not seek care for depression or suicide risk. Indeed, 35% of physicians who reported suicidal ideation in one study stated that they would not likely seek help,[19] and only 16% of medical students with depression sought treatment.[20]The professional culture of providers and other healthcare professionals often emphasizes stoicism and lack of regard for self-care, and stigma against mental illness is pervasive in the medical community,[21] leading many physicians to decline to seek help for fear of professional repercussions. Furthermore, 25% of physicians have no primary care provider,[22] depriving them of crucial opportunities for suicide prevention such as interventions or behavioral health referrals. As such, many providers and team members simply forego treatment, leading to sometimes devastating results.

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14 Kleinpell, R. M., Hudspeth, R., Scordo, K. A., & Magdic, K. (2012). "Defining NP Scope of Practice and Associated Regulations: Focus on Acute Care." *Journal of the American Academy of Nurse Practitioners* 24(1): 11–18.

15 Davis, M A, Cher, B A, et al. (2021). "Association of US Nurse and Physician Occupation with Risk of Suicide." *JAMA Psychiatry* 78(6): 651-658.

16 Davidson, J E, Proudfoot, J, et al. (2020). "A Longitudinal Analysis of Nurse Suicide in the United States (2005-2016) with Recommendations for Action." *WORLDviews on Evidence-Based Nursing: Linking Evidence to Action* 17(1): 6-15.

17 Brandford AA, Reed DB. (2016). "Depression in Registered Nurses: A State of the Science." Workplace Health & Safety 64(10): 488-511.

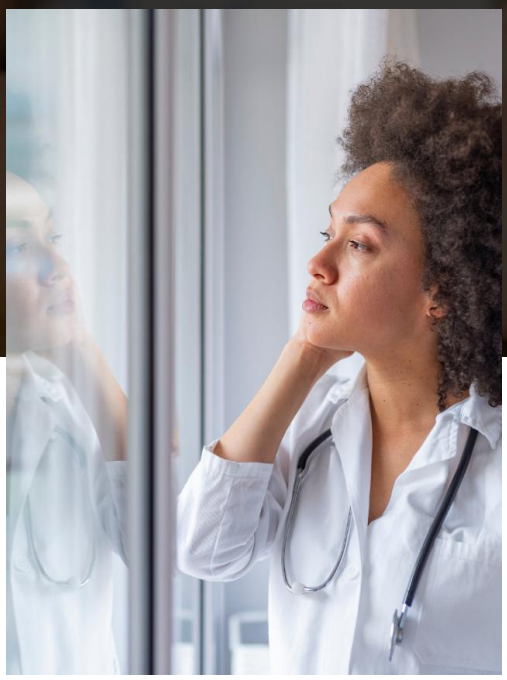
18 Kelsey, E A, West, C P, et al. (2021). "Suicidal Ideation and Attitudes Toward Help Seeking in U.S. Nurses Relative to the General Working Population." *American Journal of Nursing* 121(11): 24-36.

19 Mata DA, Ramos MA, et al. (2015).

20 Rotenstein, L S, Ramos, M A, et al. (2016). "Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students: A Systematic Review and Meta-Analysis." *JAMA* 316(21): 2214-2236.

21 Kalmoe, M C, Chapman, M B, et al. (2019).

22 Center, C., Davis, M., et al. (2003). "Confronting Depression and Suicide in Physicians: A Consensus Statement." *JAMA* 289(23): 3161–3166.



How Organizations can Take Action

In addition to the incalculable human costs of deaths by suicide, suicide and suicide attempts cost the U.S. $95.3 billion each year in medical and lost productivity expenses, and investments in medical, counseling, and linkage services would result in an estimate 6:1 benefit-to-cost ratio.[23] For these and other reasons—including improving quality of care and lessening the chance of medical errors—it is crucial that organizations incorporate suicide prevention practices to support their providers and staff.

The best response to suicide prevention and postvention is a comprehensive one planned before incidences occur. However, many institutions do not implement these practices until forced to confront a death by suicide, and organizations often do not include training on Suicide Safer Care practices for providers or staff. The following is a quick list of steps that institutions can take for suicide prevention and postvention in their workforce.

Assess What Steps, If Any, Your Organization Takes to Support Staff and Providers and Reduce and Address Suicide Risk

The best way to start is by honestly assessing your organization and how it incorporates suicide prevention, if at all, in its practices. Some key questions include:

- Does your organization include training on Suicide Safer Care for providers and staff?
- Does your institution train managers in how to respond and address suicide risk in employees?
- Are Zero Suicide principles included in Human Resources practices?
- Is your Employee Assistance Program trained in evidence-based suicide prevention?
- Does my organization effectively integrate with other local behavioral health services, community resources, or other support systems?

An in-depth organizational assessment guide, the Zero Suicide Organizational Self-Study, offers further support to help your organization conduct a full analysis of your institution's strengths and weakness regarding knowledge and implementation of Suicide Safer Care.

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23 Shepard, D.S., Gurewich, D., et al. (2016). "Suicide and Suicidal Attempts in the United States: Costs and Policy Implications." *Suicide and Life-Threatening Behavior* 46(3): 352-362.

Understand the Impact of Social Determinants of Health and How They May Affect Mental Health and Suicide Risk

In addition to assessing where your organization stands in terms of suicide prevention, it is also important to understand trends in your provider and staffs' profession, as well as the impact of significant stressors such as burnout or fatigue exacerbated by the COVID-19 pandemic. Nearly 50% of all healthcare workers reported significant psychological distress during COVID-19,[24] and the effects of the COVID-19 pandemic on mental health may linger or even increase long after the pandemic itself begins to subside.[25]

- **Relevant Webinar:** Caring for the Healers Part II: Preventing Suicide Among Providers and Staff: Offers Suicide Safer Care techniques to support providers and staff with organizational approaches to address suicide risk and prevent suicide.

Other helpful resources are available from ACU's Suicide Safer Care and Zero Suicide Institute.

Train Managers to Understand Warning Signs and Put Response Systems in Place

Managers can play significant roles in creating holistic cultures of care at their workplaces, and that includes supporting the mental health of their employees. To ensure that they can take advantage of these opportunities, managers should know what to do through established systems.[26]

Recognize Warning Signs

Supervisors are well-positioned to notice if employees are struggling or exhibit warning signs. Whether via self-disclosure from staff, information or concern from other staff, social media posts, or simple observation from supervisors, it is critical to recognize potential evidence of suicide risk.

Warning Signs

If a provider or staff member talks about:

- Feeling hopeless or trapped
- Having no reason to live
- Being a burden to others
- Experiencing unbearable pain
- Suicide

If an employee describes or shows feelings of:

- Depression or loss of interest
- Aggression or impulsivity
- Humiliation
- Sudden sense of peacefulness

24 Young, K. P., Kolcz, D. L., et al. 2020. "Health care workers' mental health and quality of life during COVID-19: Results from a mid-pandemic, national survey." *Psychiatric Services* 72(2): 122-128.

25 Banerjee, D., Kosagisharaf, J. R., and Rao, T.S. S. 2021. "'The dual pandemic' of suicide and COVID-19: A biopsychosocial narrative of risks and prevention." *Psychiatry Research* 295.

26 Little, V., & Stoll, B. (2020). "Caring for the Healers: Preventing Suicide Among Providers." Association of Clinicians for the Underserved. Retrieved from https://clinicians.org/caring-for-the-healers-preventing-suicide-among-providers-wednesday-may-6-300-pm-et/.

If the following conditions or behaviors exist:

- Looking for a way to end their lives, such as searching online for methods
- Visiting or calling others to say goodbye
- Displaying severe emotional pain.
- Withdrawing or isolating from others
- Speaking of sleeping too much or too little
- Mentioning a family history of suicide or previous attempts of their own
- Local suicide epidemic

Make Sure You Know What Help Is Available

As previously discussed, many providers and healthcare team members avoid seeking help for fear of professional repercussions. For physicians especially, real or imagined fears that their medical license could be jeopardized by seeking mental healthcare is a significant barrier to care. [27] As such, it is crucial for employers to offer explicit answers to common questions on confidentiality, cost, and other considerations in employee assistance. Consider the following questions and be able to provide explicit answers:[28]

- "Will my employer have access to my counseling records?"
- "Will a diagnosis hinder my chances for a promotion?"
- "What will this cost?"
- "Who will know if I use the employee assistance services provided by my workplace?"
- "What does counseling involve and what should I expect?"

It is also crucial to understand both the services that your organization provides and what employees understand about them. Consider also what community support systems exist and to take steps to make providers and staff aware of them, from local behavioral health assistance services to national helplines such as the **988 Lifeline**.

Act Quickly to Intervene

There is no "foolproof" way for managers to know that a provider or healthcare team member may be thinking of ending their lives. However, once they become aware of threats of suicide or notice appreciable warning signs, they should act quickly to approach and address the issue with the employee with concern, support, and understanding. Each of these factors can help impact their willingness to receive professional help. Simple steps include:

- **Reach out to the person.** Meet with them privately, ask how they're doing, and give them space and time to share their thoughts while listening without judgment.

- Mention that you have noticed changes in their behavior or became aware of their potential intentions. **Ask them if they've experienced thoughts of ending their life.**

- Show concern without asking about personal problems or offering advice. Instead, **let them know that there is help for their problem with appropriate support.** Mention that you are not equipped to help them, but that they do have access to Employee Assistance Programs (EAP) and/or licensed counselors who are trained experts.

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27 Hendin, H., Reynolds, C. et al. (2007). "Licensing and Physician Mental Health: Problems and Possibilities." *Journal of Medical Regulation* 93(2): 6-11.

28 Little, V., and Stoll, B. (2020).

- **Get them to agree to accept help from an EAP Counselor and to not hurt themselves.**
- Mention that you will protect their privacy, but don't promise confidentiality: instead, say you will share information only if necessary to protect their safety.[29]

Cultivate a Culture of Physical and Mental Wellness for Employees

Organizations are responsible for creating supportive, flexible workspaces that emphasize provider and staff wellness and self-care. In addition to offering essential benefits such as generous Paid Time Off and holidays, consider investing in wellness resources such as access to a 24/7 Employee Assistance Program, memberships in wellness activities such as gyms, and other "life" benefits such as onsite food or dry-cleaning services.

Also important is creating a professional work environment that honors employee wellness: allow opportunities for individuals to decompress, effectively communicate with employees via easily accessible intranet landing pages, offer training or community service opportunities, and take time to cultivate a welcoming environment for staff.[30] It is also crucial for organizations to support and acknowledge how other factors in provider and healthcare team members' lives impact them as well as their patients by creating responsive environments for their complex needs.

29 Ibid.

30 Little, V., and Stoll, B. (2020).

Take Effective Steps for Postvention After Deaths by Suicide

Effective suicide postvention—activities that reduce risk and promote healing after deaths by suicide—can be as important as effective suicide prevention.[31] Survivors of others' deaths by suicide have elevated risks of developing complicated grief and depression, post-traumatic stress disorder, and suicide risk,[32] even when compared to individuals experiencing other sudden bereavements.[33] Deaths by suicide of providers or healthcare teams can have ripple effects throughout healthcare organizations, affecting not only survivors such as family members, friends, patients, and colleagues, but also the entire workforce and community—especially if no direct measures were previously taken for Suicide Safer Care. Postvention initiatives should take a comprehensive, *compassionate* approach to acknowledge and respond to the emotional needs of employees in the aftermath, accomplishing one or more of the three aims identified by the Survivors of Suicide Loss Task Force's National Guidelines:

- "To facilitate the healing of individuals from the grief and distress of suicide loss."
- "To mitigate other negative effects of exposure to suicide."

"To prevent suicide among people who are at high risk after exposure to suicide." [34]

Organizations should create a postvention plan before incidents occur, and these should involve but necessarily be limited to being prepared to monitor and assist colleagues, patients, and other survivors of healthcare team members' deaths by suicide, who may be at elevated risk for suicide themselves, to offer effective staff support via providing opportunities for individual and group assistance, and to provide opportunities both for active outreach to survivors and for self-referral. Transparent, compassionate communication—both to survivors within an institution and to patients, media outlets, and the broader community—is also key.[35]

- **Relevant Resource:** Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines: Developed by the Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention, this report outlines key principles for planning to address individual and community needs, provide immediate and long-term support, tailor responses to the unique needs of suicide loss survivors, and more.
- **Relevant Resource:** A Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of Suicide: This guide from the National Alliance for Suicide Prevention provides workplace leaders with action steps for suicide postvention both for immediate and long-term responses.

31 Norton, K. "Postvention as Prevention." (2015). Suicide Prevention Resource Center. "Director's Corner Blog." Retrieved from https://www.sprc.org/news/postvention-prevention.

32 Young, I. T., Iglewicz, A. et al. (2012). "Suicide Bereavement and Complicated Grief." *Dialogues in Clinical Neuroscience* 14(2): 177-186.

33 Levi-Belz, Y., & Gilo, T. (2020). "Emotional Distress Among Suicide Survivors: The Moderating Role of Self-Forgiveness." *Frontiers in Psychiatry* 11(341): 1-8. https://doi.org/10.3389/fpsyt.2020.00341.

34 Survivors of Suicide Loss Task Force. (2015). "Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines." Washington, DC: National Action Alliance for Suicide Prevention. Retrieved from http://www.sprc.org/resources-programs/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines

35 Little, V., & Stoll, B. (2020).