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Postvention Program for Clinicians after Loss of a Patient to Suicide

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Abstract

Estimates suggest that up to 82% of mental health providers will lose a patient to suicide during their career. Suicide postvention, which includes interventions to address the needs and recovery of bereaved survivors is usually focused on family and friends of the deceased. These postvention efforts generally neglect to support clinicians, who often experience significant personal and professional distress after a patient dies by suicide. Many clinicians who work with military populations report the standard of care review process feels more punitive than constructive, and perpetuates suicide stigma while hindering clinician resilience. The distress associated with patient suicide contributes directly to decreased physical and emotional health of military clinicians, who are already at an elevated risk for emotional exhaustion, burnout, and compassion fatigue. Postvention programs for clinicians are vital to reduce the psychological impact of suicide. The purpose of this project was to assess the perceived need for clinician-focused suicide postvention guidelines for primary care and mental health providers at an Air Force military treatment facility (MTF).

Keywords: patient death, suicide by patient, military, provider, coping, support

Introduction

Staggering statistics highlight the tragic prevalence of suicide. Approximately 45,000 people died by suicide in the United States in 2016, which equates to one suicide death every 12 minutes (CDC, 2017). From 1999 to 2016, suicide rates rose in almost every state, with more than half of states reporting an alarming increase of more than 30% (CDC, 2018). While there has been substantial focus on suicide prevention and awareness programs in recent years, much less attention has been paid to the importance of suicide *post*vention. Postvention was first defined as interventions to address the care of bereaved survivors of suicide (Schneidman, 1972). To date, the vast majority of suicide postvention efforts have focused on family and friends of the deceased, without much thought given to the patient's healthcare providers (Gulliver et al., 2016). This project aimed to assess the need for clinician-focused suicide postvention guidelines at David Grant USAF Medical Center.

Significance of the Problem

Despite the unfortunate frequency of suicide, most behavioral health training programs fail to provide adequate education and preparation for coping with it, leaving many clinicians feeling overwhelmed and unprepared for the event (Prabhakar et al., 2013; Ellis & Patel, 2012; Tsai et al., 2012). Estimates suggest that 51-82% of psychiatric providers and about 25% of counselors, social workers, and psychologists will lose a patient to suicide during their career (Kelleher, Kelleher, & Grad, 2014; Veilleuz & Bilsky, 2016). In 2016, 275 military service members died by suicide—a rate of one every 32 hours (U.S. Department of Defense [DoD], 2017). In the 90 days preceding their deaths, 58.5 % engaged in some form of care through the Military Health System (DoD, 2017). Ultimately, these statistics highlight the likelihood that military clinicians will encounter patient suicide at some point during their careers. In the

aftermath of patient suicide, clinicians consistently report profound sadness, guilt, shame, self-doubt, and anxiety about potential litigation. Many impacted clinicians report changes in their clinical practice, such as hypervigilance to record keeping, increased hospitalizations of patients, avoidance of suicidal patients, or leaving their career entirely (Ellis & Patel, 2012).

A comprehensive literature search yielded 69 articles for review (Appendix A). Key search terms included variations of "suicide by patients," "client suicide," "coping with client death," "aftermath of suicide," "impact of suicide on clinicians," and "suicide postvention." Of the 69 articles; there were 11 duplicates, leaving 58 relevant studies. Initial review of these articles sought reactions of healthcare providers to patient suicide or insight on postvention strategies, which brought the total down to 31. Literature that focused solely on the death of mental health providers by suicide or providing postvention to family members was excluded. After a full-text review by all three project team members, eight additional articles were eliminated because they focused on terminally ill patients or hospice care. The 23 remaining articles provided the basis for this project proposal (Appendix B). These articles were appraised for their level of evidence, quality, and consistency using The Johns Hopkins Nursing Quality of Evidence Appraisal (Johns Hopkins University, 2007).

Several themes emerged around clinicians' experiences after patient suicide, including severe emotional distress, lack of support from colleagues or institutions, anxiety about potential litigation, and self-doubt when caring for suicidal patients (Gulfi et al., 2016; Dransart et al., 2015; Figueroa & Dalack, 2015; Kelleher, Kelleher & Grad, 2014; Draper et al., 2014; Prabhakar et al., 2013; Ellis &Patel, 2012; Jadhav, Chandra & Saranga, 2011; Landers, O'Brien, & Phelan, 2010; Gaffney et al., 2009; Welton & Blackman, 2006). In one qualitative study, the authors compared 211 clinicians who had patients die by suicide to 92 clinicians whose patients died by

other means such as injuries, accidents, or medical conditions. The authors determined that suicide deaths were significantly more likely than other sudden deaths to impact a clinician's professional practice and personal life. Amongst the findings of the study, the researchers noted that clinicians of suicide deaths were more likely to have past personal experience as a survivor of suicide (Draper, Kolves, Diego de Leo, & Snowdon, 2014). Moreover, in a study by Wurst et al. (2013), 227 therapists who had lost a patient to suicide completed a questionnaire. The results indicated that 39.6% of the therapists experienced severe distress after patient suicide, with shock, sadness, and guilt reported as the most common emotions.

Throughout the literature, researchers reported low availability and utilization rates of suicide postvention tools. For example, in one qualitative study, the authors administered a postvention survey to 90 psychiatrists at the Group for the Advancement of Psychiatry (GAP) conference. Notably, only 9% of the psychiatrists reported using a postvention strategy or having a postvention protocol in place at their institutions (Erlich et al., 2017). However, current evidence demonstrates that postvention programs are highly effective for organizations that use them consistently. Additionally, postvention programs with the best outcomes use structured procedures and follow up with survivors to actively engage them during periods of care transition (Erlich et al., 2017). In an article by Lerner et al. (2012), the authors reported that an annual half-day workshop on patient suicide and postvention procedures yielded significant increases in knowledge and confidence among psychiatry residents. Another article outlined the development of an effective postvention program by military psychiatry residents. Elements of the program included a notification process of the suicide occurrence, a case review, and facilitated emotional support. The results of this program demonstrated that residents took

comfort in simply knowing that a postvention process exists for them (Cazares, Santiago, Moulton, Moran, & Tsai, 2015).

A theme highlighted within the literature was the significant need for clinician support after the loss of a patient to suicide. A survey of 97 Air Force mental health providers found that almost 50% did not feel supported by their squadron in the aftermath of patient suicide (Welton & Blackman, 2006). In two other studies of healthcare providers who experienced patient suicide, 47% of providers who needed postvention help reported they had not received enough support and 39% reported they were not supported at all (Draper, Kõlves, De Leo, & Snowdon, 2014; Gaffney et al., 2008). A study of the impact on psychiatrists and trainees found that in spite of their reported distress, 27% of respondents were unable to ask for help (Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004). In a later study, only 19% of chief residents reported feeling prepared to manage the aftermath of a patient's suicide (Lerner, Brooks, McNiel, Cramer, & Haller, 2012. According to a recent RAND report on postvention for the DoD, there is a lack of evidence on how to best approach clinician-focused postvention (Ramchand et al., 2015). Overall, the evidence supports the need for healthcare organizations to prepare for the aftermath of patient suicide through training and implementation of clinician-focused postvention guidelines (Ellis & Patel, 2012).

The Defense Strategy for Suicide Prevention (DSSP) report was published by DoD in December 2015. It is based upon the 13 goals and 60 objectives outlined by the 2012 National Strategy for Suicide Prevention (NSSP), which was published by the Department of Health and Human Services, Office of the U.S. Surgeon General. The DSSP was developed in collaboration with the DoD Components and services with the intent of meeting their unique needs. However, as evidenced by the DoD Suicide Prevention Strategic Coverage Map 4.0 (Appendix E),

attempting to assimilate that many suicide prevention-related programs creates quite a complicated strategy. The DSSP was intended to link existing DoD suicide prevention programs to the goals of the NSSP, and includes programs across all components and branches of service.

Postvention is included in the DSSP, under NSSP Goal #10: "Provide care and support to individuals affected by suicide deaths and attempts to promote healing, and implement community strategies to prevent further suicides;" Objective #10.5 D: "Provide health care providers, first responders, and other with care and support when a patient dies under their care by suicide." Objective #10.5 D is then detailed as follows:

> The DoD will ensure Military Health care clinicians, first responders, emergency personnel, and other medical professionals who lose a patient to suicide are provided with support to deal with the emotional aftermath of this traumatic event. DoD support to these providers should address trauma and grief reactions and potential suicide risk among healthcare providers. Mechanisms for review of such deaths should avoid blaming the provider. Instead, the goal should be to respond to the provider's need for support and help the provider respond to patients who may be at risk for suicide in the future. (DoD, 2015, p.29)

Underneath Objective #10.5 D, there are 17 programs listed from all military services and components that should theoretically meet this need. However, an analysis of each service's programs revealed inconsistency and variance in approaches to postvention.

The Air Force published its Guide for Suicide Risk Assessment, Management, and Treatment in 2014. Although it includes postvention efforts for surviving families and units, nearly all references to surviving clinicians focus on investigations or hint at potential punitive actions. The only mention offering support for a surviving clinician is vague and informal: "In

cases where you find yourself treating a colleague who has lost a patient to suicide, offer the opportunity to talk through his or her actions, if desired." (U.S. Department of the Air Force, 2014, p. 86)

Similarly, Air Force Instruction (AFI) 90-505, Suicide Prevention Program, only includes one short paragraph on postvention and doesn't refer to the needs of clinicians at all:

> Suicide impacts coworkers, families, and friends. Offering support early is associated with help-seeking behavior and resilience. Post-suicide responses will be managed by unit leaders. The unit leaders will support affected personnel through the grieving process by consulting with chaplains, mental health, and Directors of Psychological Health, as needed. (p. 19)

One mental health provider familiar with this project brought up AFI 44-153, Disaster Mental Health (DMH) Response, as a possible resource for clinician postvention. However, the only reference that might be applied to postvention is rather vague and non-specific to clinicians:

> 2.5.4. Following an all-hazard incident, individuals can seek up to four one-on-one meetings with any member of the DMH team…2.5.4.1 One-on-one meetings are for the purpose of education and consultation, not for medical assessment or treatment (p. 7).

In 2012, the Army worked to integrate the NSSP objectives into its 2020 Army Strategy for Suicide Prevention (ASSP). Under goal #8, Postvention, the ASSP included objective #8.4:

> Clinicians, first responders, emergency personnel, and possibly commanders and first-line supervisors who lose a patient to suicide should be provided with support to deal with the emotional aftermath of this traumatic event. Such support should address trauma and grief reactions and potential suicide risk among caregivers. Mechanisms for review of such deaths should avoid blaming the caregiver. Instead, the goal should be to respond to the

> caregiver's need for support, and help the provider respond to patients who may be at risk for suicide in the future. (p. 53).

Underneath this objective, the ASSP established a short term goal to publish a Comprehensive Behavioral Health Service Line OPORD, and a long term goal to develop a care provider support program through said OPORD. However, a review of the Army's current Suicide Prevention Program did not yield any reference to a provider support program or suicide postvention for providers (U.S. Department of the Army, 2015).

The Navy's 2018 Suicide Prevention Handbook refers to OPNAV Instruction 1720.4A, Suicide Prevention Program (2009). Although the Handbook does include a section on postvention to guide commanders in supporting their sailors, neither document contains any information or instruction on postvention for clinicians.

Review of the service's policies reveal that the DoD recognizes the legitimacy of postvention as a necessary component of suicide prevention. However, the policies lack consistency and fail to address the unique needs of clinicians following patient suicide.

Clinical Question

PICO Question

In healthcare providers at David Grant USAF Medical Center, how does education on the impact of patient suicide affect the perceived need for clinician-focused postvention guidelines?

Focus Areas & Goals

The anticipated impact of this project was multi-faceted. Based on the evidence found in the literature review, the short-term goal of this project was to deliver an educational program to clinical staff at David Grant USAF Medical Center (DGMC) about common emotional and professional reactions clinicians experience following the death of a patient by suicide.

Increasing awareness about the personal and professional impact of patient suicide on healthcare providers served as a primary goal. The focus was on the perceived need for clinician-focused postvention guidelines, which were assessed through a needs assessment survey after the presentation. A second aim was that a needs assessment within a Military Health System (MHS) treatment facility could serve as the potential first step to further research on a standardized postvention program. While evidence supports the need for specific postvention programs for clinicians, there is a lack of research to support the effectiveness any single postvention protocol. If this needs assessment supported the need for such guidelines, a long-term goal was for a clinician-focused postvention program to be developed, piloted, reviewed, and ultimately implemented at all treatment facilities across the MHS. The ultimate goal was to foster a culture within the MHS that prepares and supports clinicians in the unfortunate event of patient suicide.

Relevance to Military Nursing

Considering the increasing critical shortage of mental health professionals, postvention guidelines for clinicians may be helpful to reduce the psychological and public health impact of suicide (U.S. DHHS 2016; Andriessen & Krysinska, 2012). Military mental health providers are at increased risk for emotional exhaustion and compassion fatigue, with burnout rates ranging up to 67% (Stearns, Shoji & Benight, 2018; Kok et al., 2016; Lester et al., 2015). Research suggests that given the negative effects of burnout, the DoD should take steps to address occupation-specific stressors—especially catastrophic events like patient suicide (Kok et al., 2016). Combined with an already elevated risk of burnout, military mental health providers' likelihood of encountering patient suicide may necessitate supportive interventions such as postvention guidelines.

As outlined in the DSSP, the DoD has an aspirational goal to eliminate the occurrence of suicide among military personnel. A key component of this objective includes suicide prevention programs. Suicide postvention for clinicians falls within a continuum as tertiary prevention (Erlich et al, 2017). The DSSP also emphasizes the role of education and the use of evidence-based practice in the delivery of suicide prevention efforts (U.S. Department of Defense, 2015). The doctorally-prepared nurse functions as an educator and translator of evidence-based research to clinical practice (American Association of Colleges of Nursing [AACN], 2006). Military nurses aid in the delivery of suicide prevention by educating patients, families, communities and other clinicians on suicide risk factors and interventions. Nurses also use skill in evidenced-based practice to disseminate best practices discovered through research. This needs assessment fulfills both the nursing role of educator and translator of evidence. Delivery of this needs assessment is foundational to further research and improvement in suicide prevention efforts. The current era of transition under the Defense Health Agency provides an opportune time to pilot a standardized clinician-focused postvention program.

Organizing Framework

This project was guided by the Evidence-Based Decision Making (EBDM) Model, which was developed by DiCenso, Cullum, Ciliska, and Guyatt (Melnyk & Fineout-Overholt, 2011). While traditional evidence-based practice (EBP) is based on a triad of research, clinical expertise, and patient preference, the EBDM model also considers dynamic variables such as local healthcare resources and the patient's unique circumstances and clinical presentation. In the context of suicide postvention for clinicians, there is an interesting dichotomy in that the affected clinician may also transition into a "patient role." The additional variables included in the EBDM model are well-suited to examining complex phenomena such as the loss of a patient to suicide.

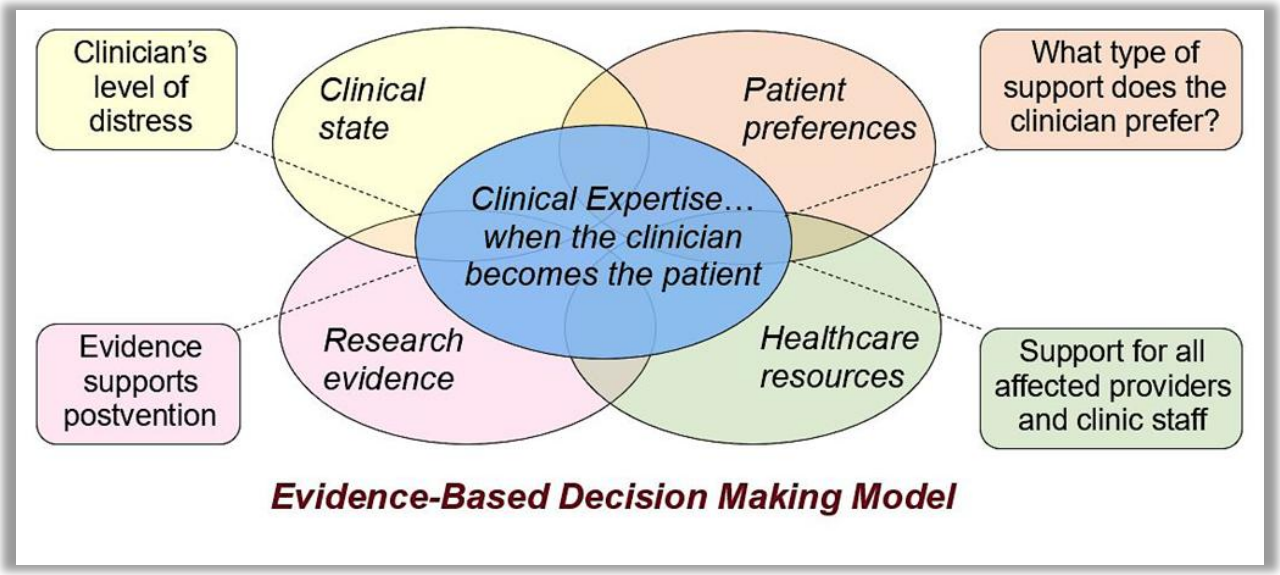

Figure 1. Evidence based decision-making model.

Project Design

General Approach

Utilizing evidence from current literature, a 15-minute PowerPoint presentation was created to educate clinicians on suicide postvention. The presentation defined suicide postvention, described the potential impact of patient suicide on clinicians, briefly reviewed the literature, outlined current Air Force guidance on postvention, and identified potential elements of a clinician-focused suicide postvention program. After each presentation, a needs assessment survey was distributed, completed, and collected from the audience. The survey assessed the providers' previous experience with patient suicide, methods of support utilized, and the perceived need for clinician-specific postvention efforts. Responses to the needs assessment survey were analyzed to compare local clinicians' perceived need for suicide postvention guidelines to the evidence found in the literature.

Setting

This project was conducted at David Grant USAF Medical Center at Travis AFB, California. DGMC is the largest Air Force MTF in the United States, serving more than 500,000 DoD and VA eligible beneficiaries. DGMC provides 84 inpatient beds and is one of two inpatient mental health facilities in the Air Force Medical Service. The 60th Aeromedical Staging Flight (ASF) is one of only three in the United States, responsible for providing care for wounded warriors traveling via the aeromedical evacuation system. It is the only Air Force-bedded ASF on the west coast, serving as the aeromedical staging point for the Pacific theater (DMGC, 2014). The medical center also boasts one of the largest Air Force mental health clinics with 27 active-duty and civilian providers. Additionally, DGMC includes family medicine residency and family health clinics with three embedded behavioral health providers. As the Air Force's largest MTF, protocols implemented at DGMC could have far-reaching impact across the MHS and DoD.

The population targeted for this needs assessment included credentialed health care providers from the Mental Health Clinic, the Family Health Clinic, and the Family Medicine Residency Clinic. Each of the family practice clinics sees an average of 34,000 patients annually. These clinics were chosen as the platform for this needs assessment because their clinicians provide care to a high volume of patients seen at DGMC. Additionally, completing the needs-assessment in these clinics provided responses from both primary care and mental health providers. This was important to assess the perceived need and applicability of healthcare professionals outside of mental health. Primary care providers also experience the aftermath of patient death by suicide. Researchers noted that a clinician's specialty had little implication on the professional and personal impacts of patient suicide (Draper et al., 2014).

Procedural Steps

After reviewing the literature, evaluating the evidence, and creating the presentation, the authors created a needs assessment survey to be filled out by each clinician who attended any of three sessions (Appendix C). The survey was anonymous but included demographic information such as profession/specialty, workplace, and years in practice. The needs assessment included questions about previous training in suicide postvention and perceived competence in managing the aftermath of patient suicide. It delineated between providers who have experienced the suicide of a patient and those who have not, facilitating answers from both personal and hypothetical experiences. Next, the survey utilized a Likert scale to identify what type of postvention interventions the audience found helpful. Finally, the survey solicited additional feedback on the concept of a suicide postvention program for clinicians. A biostatistician and qualitative methods subject matter expert (SME) assisted with the analysis of survey responses.

The results of the needs assessment were presented to stakeholders at DGMC, including the commanders of each clinic where the postvention presentations were held as well as senior administrators of the hospital. The authors' final step was to assimilate the findings of this needs assessment with existing literature to propose suicide postvention guidelines that could be further developed and evaluated in a future pilot study. The project results and the postvention guidelines were further disseminated via both oral and poster presentations to the student body, faculty, and guests at Uniformed Services University's annual Research Week.

HIPAA Concerns

There were no privacy concerns related to this project, as it did not utilize any patient records or personal identifying information. After receiving project approval from Uniformed Services University's Vice-President for Research, an EBP project summary application was

submitted to DGMC's Clinical Investigation Facility for IRB approval. This EBP project was granted IRB exemption (Appendix H).

Project Results

Postvention Needs Assessment

A postvention needs assessment adapted from Rothes et al. (2013) gauged the basic demographics of the audience, audience members' contact with suicidal patients, reactions to patient suicide, utilization of support services available, and the perceived need for clinician-specific postvention interventions. The needs assessment was broken up into three main sections with the option for additional comments at the end. The full needs assessment is available in Appendix C.

Characteristics of Participants

The first part of section one of the needs assessment focused on the characteristics of the participants, which are listed in Table 1. Forty-two providers from three separate clinics (Mental Health Clinic, Family Health Clinic, and Family Medicine Residency Clinic) participated in the needs assessment. The majority of the participants' area of practice was Family Medicine (67%) and most participants were physicians (45%). Additionally, most had 0-5 years of clinical practice (62%). One-third of the participants worked in the Mental Health Clinic.

Table 1. *Characteristics of Participants*

Characteristics	*n (%)*
Area of Practice	
Mental Health	14 (33.33%)
Family Medicine	28 (66.67%)
Professional Group	
Physician	19 (45.24%)
Nurse Practitioner	2 (4.76%)
Physician Assistant	3 (7.14%)
Psychiatrist	1 (2.38%)
Psychologist	5 (11.90%)
Social Worker	9 (21.43%)
Medical Student	3 (7.14%)
Years in Practice	
0-5 Years	26 (61.90%)
6-10 Years	6 (14.29%)
11-15 Years	4 (9.52%)
16-20 Years	4 (9.52%)
Over 20 Years	2 (4.76%)
Workplace	
Mental Health Clinic	14 (33.33%)
Family Health Clinic	7 (16.67%)
Family Medicine Residency	21 (50.00%)

Previous Training and Reactions to Postvention Presentation

The second portion of section one of the needs assessment determined whether participants had previous postvention training, garnered their reactions to the presentation, and asked whether or not they believed a clinician-focused postvention program would be beneficial. Table 2 summarizes the responses in this section. Thirty-six participants (86%) reported they never had previous postvention training. The six individuals (14%) who had previous postvention training reported various formats, including: pre-deployment briefings, training through the Department of Veterans Affairs (VA), and lectures during medical school. Most clinicians reported that they felt either somewhat capable (48%) or very capable (43%) providing care for suicidal patients. Finally, forty clinicians (95%) reported a clinician-focused postvention program would be helpful.

Table 2. *Previous Postvention Training, Perceived Capability in Caring for Suicidal Patients, and Reactions to the Postvention Presentation*

Responses	*n (%)*
Have you had previous training on managing the aftermath of a patient suicide (postvention)?	
Yes	6 (14.29%)
No	36 (85.71%)
To what extent do you feel capable of caring for suicidal patients?	
Not Capable	4 (9.52%)
Somewhat Capable	20 (47.62%)
Very Capable	18 (42.86%)
Based on the information presented today, do you think a clinician-focused postvention program would be helpful?	
Yes	40 (95.24%)
No	2 (4.76%)

Table 3 summarizes the categories, meanings, and exemplary quotes the authors organized utilizing conventional content analysis. Thirty-seven participants answered question number eight from section one: "*Based on the information today, do you think a clinician-focused postvention program would be helpful? Why or why not?"* Thirty-five participants (95%) indicated that clinician-focused postvention would be beneficial. Two participants (5%) did not feel clinician-focused postvention would be helpful. The most common meanings elicited from the responses in support of clinician-focused postvention included: helping providers (68%), providing resources (19%), and fear of punitive action (8%). The two meanings from the comments that did not support clinician-focused postvention included perceived lack of time (3%) and one statement that postvention would be ineffective (3%).

Table 3. *Summary of Meanings and Exemplary Quotes from Section 1, Question 8: "Based on the information today, do you think a clinician-focused postvention program would be helpful? Why or why not?"*

Category: Postvention would be beneficial	
Meanings	*Exemplary Quotes from Providers*
Helping Providers	"Help prepare providers in the case of suicide and prevent provider burnout." "There is a clinical and corporate need. It will likely reduce burnout and enhance/maintain productivity and readiness." "Providers are often forgotten. A postvention program allows the space to check in, check back, and process." "Suicide is a frequent occurrence. As such, providers are constantly stressed, either directly or indirectly (offering help to others). There should be a process to ensure providers themselves are cared for."
Fear of Punitive Action	"We lose patients often and the aftermath feels administrative rather than therapeutic." "There is a lot of feelings to work through and due to punitive focus on investigation, the fear factor takes the primary role." "Especially since I've become active duty Air Force, I've noticed a lot of fear around active duty patients dying by suicide. Though I haven't experienced a loss of a patient [to suicide] yet, I have noticed some hypervigilance in my note taking/documentation and recommendations for inpatient psychiatric hospitalization when I'm on night call."
Providing Resources	"It would be helpful to know what resources are available for people impacted by suicide before the suicide takes place. This way in the event of a [patient] suicide we know where to send people." "Were I to have a patient to complete suicide, I would want support, access to resources, and guidance afterward." "It would be helpful to give much needed resources to clinicians to be able to take time and to be able to grieve the loss of a patient appropriately."
Category: Postvention would NOT be beneficial	
Meanings	*Exemplary Quotes from Providers*
Ineffective	"Institutional and standardized mental health interventions that I have observed in medical school and residency used to prevent burnout have been ineffective. The only successful interventions I have seen were the simple conversations and acts of kindness that were taken by colleagues and friends."
Not Enough Time	"There is not enough time to organize a group like that to meet with a physician who is trying to see a full clinic load. Additionally, many of us see a large number of patients in our empanelment, so we likely wouldn't even know the patient."

Providers Who Have Not Had a Patient Die by Suicide

Unlike section one, which was filled out by all participants, the second section of the needs assessment was only completed by participants who had not experienced a patient suicide in their career. Thirty of the participating providers (71%) had not had a patient die by suicide in their career. The majority of clinicians reported that if they were to have a patient die by suicide, they anticipated feeling sadness (100%), guilt (73%), self-doubt (80%), anxiety (77%), fear (53%), disbelief (50%), and shame (47%). Fewer participants expected feelings of relief (10%), indifference (17%), irritability (27%), or anger (40%).

Utilizing a Likert scale, participants rated the extent to which various interventions might be helpful if they were to have a patient die by suicide in the future. Their choices on a five-point Likert scale ranged from not helpful to most helpful. Most of the clinicians reported that supervisor leadership/support would be very helpful or most helpful (80%). Talking to colleagues was also regarded as very helpful or most helpful by the participants (83%). Talking to friends and family was considered very helpful (33%). Professional counseling was also considered very helpful (47%). Reviewing the case with the clinical team was deemed very helpful (43%), as was time off work (33%). Temporary reassignment was deemed not helpful at all or slightly helpful (67%). Contact with the patient's family was considered slightly helpful (57%). A 30-day grace period before the standard of care (SOC) review was rated as helpful by most of the clinicians (43%). Finally, annual refresher training was considered not helpful at all or slightly helpful by the majority (53%).

Providers Who Have Had a Patient Die by Suicide

The third section of the needs assessment was completed only by clinicians who had experienced a patient suicide during their career as a healthcare provider. Twelve providers (29%) reported losing a patient to suicide. The majority reported that when they had a patient die

by suicide, they experienced feelings of sadness (75%), guilt (83%), self-doubt (83%), anger (58%), anxiety (50%), fear (42%) and disbelief (42%). Fewer participants reported feelings of relief (0%), indifference (0%), irritability (33%), or shame (33%). Most providers reported that these symptoms lasted 0-6 months (67%).

These clinicians were also asked how the suicide affected their clinical practice. Nine participants (75%) reported spending increased time record keeping. Two providers (17%) increased patient admissions/hospitalizations. Three providers (25%) increased patient referrals to Mental Health. Two providers (17%) reported an increase in prescribing antidepressants. Two providers (17%) sought further training on suicide. Two providers (17%) reported avoiding suicidal patients. All of these providers (100%) denied avoiding their peers. Finally, five providers (42%) reported a loss of motivation. The majority of providers (58%) reported the changes in their clinical practice lasted for over a year.

In this section of the needs assessment, providers were also asked to what extent they felt supported by their unit/organization after a patient suicide. Seven providers (58%) reported feeling not supported or somewhat supported. Six participants (50%) answered the “why or why not” portion of question number five. Two of these individuals stated that they felt supported by their leadership while the remaining four reported not feeling supported (67%). Common themes of not feeling supported included: unaware of notification process or that the patient had died by suicide, feeling punitive actions rather than support, and lack of expertise for support. Table 4 summarizes the categories, meanings, and exemplary quotes organized utilizing conventional content analysis.

Table 4. *Summary of Meanings and Exemplary Quotes from Section 3, Question 5: "Did you feel supported by your unit/organization? Why or why not?"*

Category: Not Supported	
Meanings	*Exemplary Quotes from Providers*
Unaware	"The only way I found out about the suicide was scrolling on Facebook. Even now, I was never formally notified by anyone in my command." "It wasn't ever brought up by my leadership."
Lack of Expertise	"My MAJCOM consultant was supportive, however he had no specific training."
Punitive	"Felt the punitive, finger pointing aspect of the investigation only."
Category: Supported	
Meanings	*Exemplary Quotes from Providers*
Did Not Seek Support	"I did not ask for support."
Supported	"Discussed case with colleagues/supervisor, was allowed to go home that day."

Utilizing a Likert scale, the providers rated to what extent various interventions were utilized and whether they were helpful. The choices were: did not utilize, slightly helpful, helpful, very helpful, and most helpful. The majority of clinicians reported that supervisor leadership/support was not utilized (33%) or was helpful (33%). Talking to colleagues was also regarded as helpful by most of the participants (33%). Talking to friends and family was evenly reported as not utilized (25%), slightly helpful (25%) or helpful (25%). Professional counseling was also not utilized by the majority (92%). Reviewing the case with the clinical team was most often not utilized (58%), as was time off work (83%). Temporary reassignment was usually not utilized (83%), nor was contact with the patient's family (92%). The majority of clinicians (92%) were not offered a 30-day grace period before the initiation of the standard of care (SOC) review.

Additional Comments

The additional comments section was the final portion of the needs assessment and was to be filled out by all participants. Of the 42 participants, nine (21%) answered the additional comments portion of the needs assessment. Figure 2 summarizes the exemplary quotes from this section. All comments suggested that a postvention protocol could be beneficial. Other themes that emerged included: desiring follow-up regarding the results of this need assessment, effectively utilizing clinician-focused postvention protocol, and appeal for a postvention response team.

"If you have any additional comments on experiencing a patient's suicide or regarding the presented material, please use the section below to share those with us."
"In addition to notifying PCM/providers. A 'team' reaching out to the providers for postvention care would be helpful/welcome."
"I'm interested in learning more regarding the results of this study and effectiveness of postvention programs."
"Postvention and support for providers is so needed, especially establishing protocol. I've noticed often times colleagues want to support each other when an event happens, but they feel uncomfortable and not sure how."
"I have seen co-workers deal with a blaming approach struggle greatly and [one] was discharged from the military after an alcohol related incident."
"I believe if you do this work long enough [healthcare] the odds are 80-100% of having a patient complete suicide."

Figure 2. Summary of exemplary quotes.

Analysis of Results

A DGMC biostatistician assisted the authors with the quantitative portion of data analysis, utilizing STATA software version 14.2 (College Station, TX). Descriptive statistics (frequencies and percentages) were used to summarize the responses from the 42 participants. A local SME on qualitative data guided the authors' efforts in using conventional content analysis to organize and identify meanings within the qualitative responses.

The results of this needs assessment mirrored the literature in that the 30 participants (71%) who had not had a patient die by suicide reported that leadership and supervisor support, professional counseling, reviewing the case with the clinical team, time off of work, and talking with colleagues would be very helpful or most helpful. However, of the 12 participants (29%) who had had a patient die by suicide, many did not utilize those services. One major take away from this needs assessment is a vast discrepancy between what clinicians would find helpful compared to what is actually offered/available. Additionally, this needs assessment revealed that 95% of providers with various clinical backgrounds believed a clinician-focused postvention program would be beneficial.

Practice & Policy Implications

The results of this needs assessment highlight the need for organized clinician support in the aftermath of patient suicide. When a clinician experiences an adverse patient outcome such as suicide, they often experience a sense of bereavement with unique emotional and professional implications. Ensuring that the experience of patient loss to suicide is acknowledged and met with support aligns with the MHS quadruple aims of better care, better health, lower cost, and improved readiness. Providing support to military clinicians enables them to provide the best care to millions of beneficiaries within the MHS.

Findings from this needs assessment can be utilized to improve accessibility, quality, and consistency in the support offered to clinicians. Support provided through the use of a standardized suicide postvention program may potentially improve job satisfaction while decreasing the risk for burnout among providers. A standardized suicide postvention program also has potential to increase readiness by providing opportunities for clinicians to learn from the unfortunate event of patient suicide. As highlighted previously, DSSP Objective #10.5 D

emphasized the need for postvention programs. However, the DoD has yet to implement such a program.

In light of the lack of any standardized postvention program among all DoD Components and services, DoD-wide policy change is needed. In our current era of transition under the Defense Health Agency, the time is right to pilot a clinician-focused postvention program. This would be the first step toward meeting the postvention objectives outlined in the DSSP.

Future Directions for Research and Practice

Project Limitations

This postvention needs assessment generated valuable data about the perceived need and utility of a clinician-focused suicide postvention program. However, the results must be considered in the context of several limitations. Limitations included sample size, reliance on self-reported data, and lack of prior research studies about postvention for clinicians.

The limited sample size (n=42) and population makes generalization of the findings to other populations difficult. Additionally, this population of primary care and mental health providers in one Air Force treatment facility may not be similar to healthcare professionals or support personnel in other fields or military branches. To generate a larger sample and simultaneously gather more statistically significant data, the needs assessment could be conducted in several Air Force, Army and Navy MTFs. Future studies could also include clinicians outside of primary care and mental health to evaluate the perceived need for postvention in other practice specialties.

The reliance on self-reported data risks several potential biases, such as selective memory, attribution, and exaggeration of past experiences. Additionally, a portion of responses to the needs assessment were hypothetical. Responses from providers who had not experienced

the loss of a patient to suicide required those providers to predict their reactions and expected needs following the loss of a patient to suicide rather than basing responses on actual experience.

Lastly, the basis of this project was research on postvention programs for providers, which is limited and largely theoretical, lacking in randomized control trials or meta-analyses. This project adds to the body of evidence supporting the need for clinician-focused suicide postvention programs.

Proposed Postvention Guidelines

The majority of data collected from this needs assessment suggested a need for more emotional and institutional support following the loss of a patient to suicide. Additionally, the results supported a less punitive approach to the standard of care review. The proposed postvention guidelines will address the needs of clinicians following a patient suicide within four specific domains: emotional, educational, institutional and administrative (Grad, 2012).The emotional and educational components stress the inclusion of support during duty hours, daily check-ins with the impacted provider, and an opportunity for the clinical team to review the case. The administrative component should secure logistics, such as how to engage with the patient's family and review ethical and legal matters. The institutional component should ensure that guidelines are implemented and consistently utilized in organizations through policy and standardization. These guidelines will be the foundation for a postvention algorithm in a future pilot study, which will include step-by-step instructions starting with notification of the suicide and following through to assess how the clinician felt their needs were met 1 year after the event.

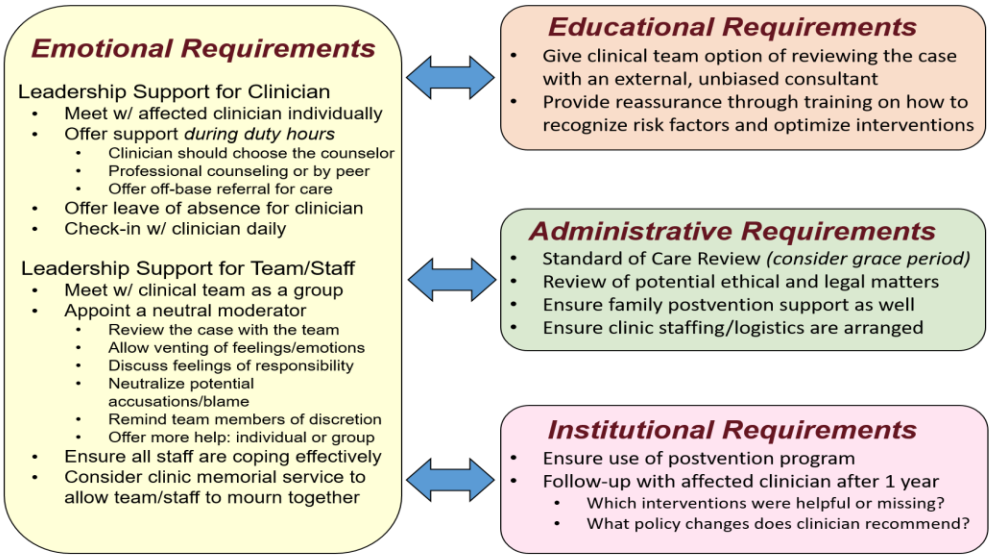

Figure 3. Postvention guidelines.

Future Pilot Study

The results of this project support existing evidence of the need for clinician-focused postvention guidelines. While these results add to the body of evidence supporting the need and benefit of a clinician-focused suicide postvention program, there is less literature demonstrating the specific outcomes of implementing such a program. Ultimately, it is the authors' hope that a postvention program be piloted, reviewed, improved, and implemented at MTFs across the DoD. Further assessment is needed to evaluate the contextual needs of clinicians following a patient suicide. Evaluation of how factors such as time constraints and feasibility may affect program utilization will be important to address before the development and implementation of a standardized protocol across the MHS. Uniformed Services University's psychiatric mental health nurse practitioner class of 2021 is currently working on a complementary clinician-focused postvention project.

Conclusion

In the months since this project began, unfortunate new statistics were released by the Department of Defense. In 2018, the United States military had the highest number of suicides among active duty personnel since 2012. A total of 321 active duty members died by suicide in 2018, including 138 soldiers, 58 airmen, 68 sailors, and 57 marines (Kime, 2019). While the tragedy of these suicides cannot be overstated, we must also remember that in the aftermath of every death, there may be one or more healthcare providers who are also grieving, distressed, struggling, and may need help so they can eventually move on to do what we as military healthcare providers all do best—care for others.

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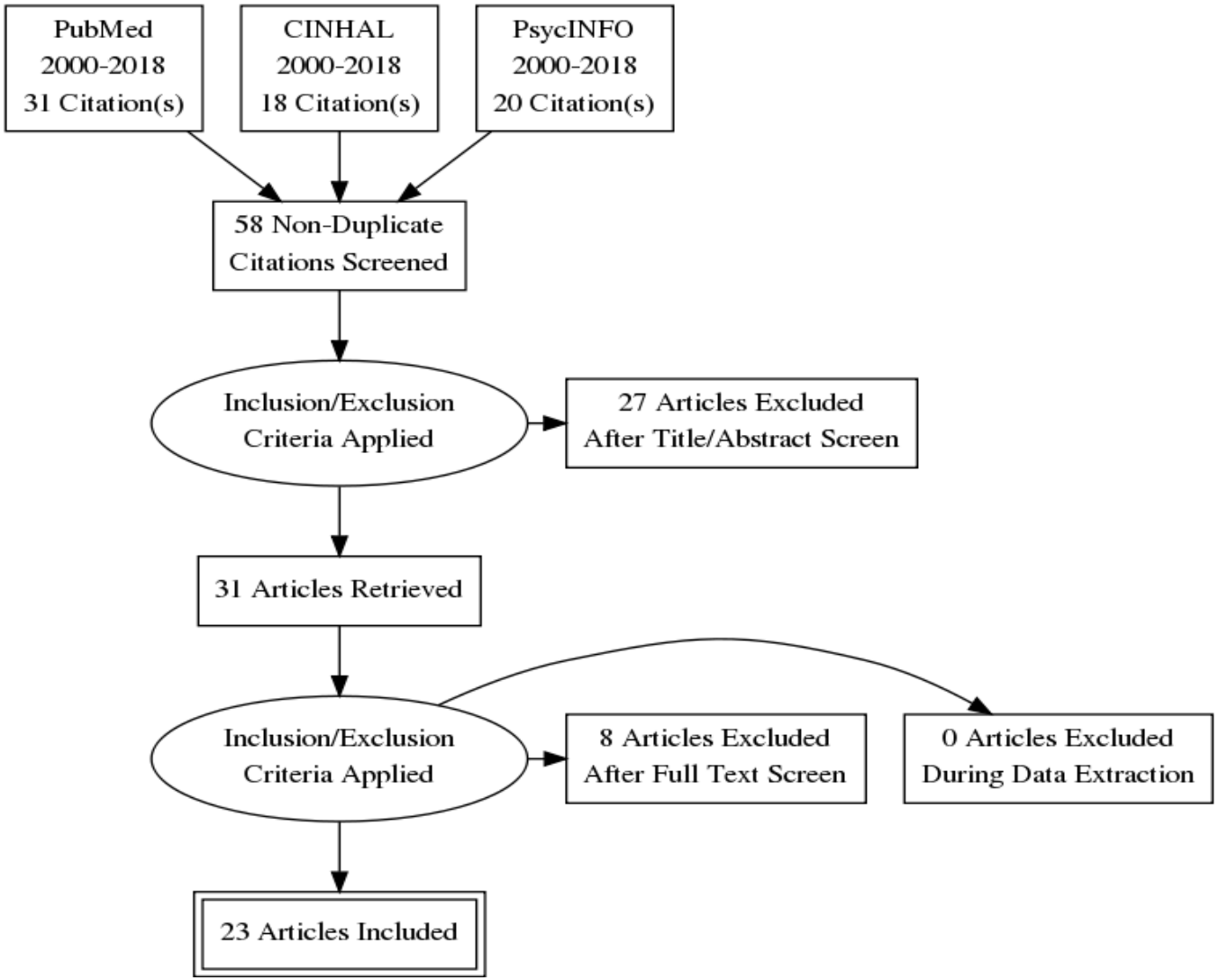
Appendix A.
PRISMA flow diagram of studies included in DNP Project Proposal



Appendix B.
Evidence Table

Title	Abbreviated Bibliographic Citation	Level of Evidence	Relevance to PICOT + to ++++	Sample Size	Outcome Variables	Measures	Analytical Approach	Findings	Limitations
Stress Reactions After a Patient Suicide and Their Relations to the Profile of Mental Health Professionals	(Dransart et al., 2015)	VI	++++	666 Mental Healthcare Professionals	Stress reactions after a patient suicide	Questionnaire and Impact of Event Scale-Revised (IES-R)	SPSS was used, Hierarchical clustering analysis	Most respondents faced more than one patient suicide during their career	Study relied on self-reported data, instrument could be too narrow, possible selection bias, retrospective in nature
The Impact of Patient Suicide and Sudden Death on Health Care Professionals	(Draper et al., 2014)	VI	+++	303 Healthcare Providers (HCPs)	Compare professional and personal impact of patient suicide	Interview-phone and face to face	Odds Ratios with 95% confidence interval were calculated; Fisher's Exact Test, SPSS was used	Suicide deaths have a greater impact than sudden deaths on HCPs	Low response rate of HCPs, open ended queries on the impact of sudden death/suicide
Client Suicide: What Now?	(Ellis & Patel, 2012)	VII	++++	N/A	N/A	N/A	N/A	Presents an overview of literature of the impact of client suicide an ideas for coping with psychological and professional issues that may arise	Expert opinion; low level of evidence
Why We Need to Enhance Suicide Postvention	(Erlich et al., 2017)	VI	++++	90 Participants	Reactions to postvention intervention	Administered survey at the Group for the Advancement of Psychiatry (GAP)	STATA, descriptive statistics and analyses	More than 1/3 of the responses included psychiatrists who had experienced 1 or more patient suicides and psychiatrists with more years in practice were more likely to have more patient suicides. Only 9% of the psychiatrists utilized a postvention strategy	Preliminary study, small sample size

Exploring the Impact of Suicide on Clinicians: A Multidisciplinary Retreat Model	(Figueroa & Dalack, 2015)	IV	+++	103 Clinicians	Responses and experiences of patient suicide	Pre and post Retreat Survey	N/A	A multidisciplinary retreat could facilitate clinical discussions post patient suicide	Survey results were largely qualitative
Impact of Patient Suicide on Front-Line Staff in Ireland	(Gaffney et al., 2008)	VI	+++	447 Front-line Clinicians	Reactions to patient suicide	Written Postal Questionnaire	SPSS was used; Chi-square analyses	Significant association was found between gender and the effects if client suicide on people' ability to carry out professional duties; anger, sadness and guilt also emerged as common reported emotional responses	Retrospective study, low response rate
The Impact of Patient Suicide on the Professional Practice of Swiss Psychiatrists and Psychologists	(Gulfi et al., 2016)	VI	+++	271 Psychiatrists and Psychologists	Reactions professionally after a patient suicide	Written Questionnaire	SPSS was used; uni & bivariate statistics were utilized; t tests, multiple linear regression analyses	Most respondents had a rather long career and had faced more than one patient suicide; increased anxiety and self-doubt reported when dealing with suicidal patients	Participants were volunteers, possible recall bias due to retrospective nature of study
Unexpected Death or Suicide by a Child or Adolescent: Improving Responses and Preparedness of Child and Adolescent Psychiatry Trainees	(Jadhav, Chandra, & Saranga, 2011)	VI	++	1 Patient case report	Reaction to the death of patient; perceived support from staff	N/A	N/A	Experience was used to assist CAP trainees in dealing with the painful process of losing a patient	Small, single case report
Effects of Patient Suicide on the Multidisciplinary Team	(Kelleher & Grad, 2014)	VII	+++	N/A	N/A	N/A	N/A	Estimated that 22-39% of psychologists and 51-82% of psychiatrists experience at least one suicide during their career	Expert opinion; low level of evidence

Impact of Patient Suicide on Consultant Psychiatrists in Ireland	(Landers, O'Brien, & Phelan, 2010)	VI	+++	182 Responses	Reaction to patient suicide	Postal Questionnaire	N/A	33% of consultant psychiatrists reported that the best support would be to discuss the case informally with colleagues	Retrospective tends to recall bias
Coping with a Patient Suicide: A Curriculum for Psychiatry Residency Training Programs	(Lerner et al., 2012)	VI	++++	42 Clinicians	Attitudes and knowledge of topic assessed	Pre and Post program surveys	Paired t-tests, general linear model, Cohen's d was used	Increased knowledge on coping with patient suicide and increased confidence	Small sample size, single institution, lack of comparison and control group
Improving Support of Residents After a Patient Suicide: A Residency Case Study	(Mangurian et al., 2009)	VII	+++	N/A	Reactions to patient suicide	N/A	N/A	Gives an insightful point of view of the reactions of several residents in regards to a patient suicide (personal experience)	Expert opinion, Low level of evidence
"Collateral Damages:" Preparing Residents for Coping with Patient Suicide	(Prabhakar et al., 2013)	VI	+++	35 Participants	Response to DVD and Pilot program	Pre and post program surveys	N/A	Program could be a valuable asset in enhancing the well-being of physicians and residents	Small, single case study
Helping Psychiatry Residents Cope with Patient Suicide	(Prabhakar et al., 2014)	IV	+++	8 Psychiatry Residency Programs; 167 participants	Response to Collateral Damages DVD and 90 minute interactive curriculum	Pre and post program surveys	N/A	Knowledge of issues related to patient suicide were increased after the program	Results are based on a convenience sample and may not be reflective of all residency programs in USA. No control group for comparison
The War Within: Preventing Suicide in the U.S Military	(Ramchman et al., 2015)	V	+++	N/A	N/A	N/A	N/A	After an extensive literature review, the RAND study had 14 recommendations for all service branches in the military in managing suicide	Limited evidence regarding best practice postvention programs

Impact of Patient Suicide on Psychiatrists and Psychiatric Trainees	(Ruskin et al., 2004)	VI	+++	239 Participants	Response to retrospective survey	Written Survey	N/A	One-half of responders experienced at least one patient suicide	Small, retrospective study
Professionals' Reactions Following a Patient's Suicide: Review and Future Investigation	(Seguin et al.,2014)	V	+++	37 Articles were evaluated	N/A	Grief Experience Questionnaire, Emotional Impact Questionnaire	Used SPSS compare findings of various studies in literature review	Patient suicide may have an impact on or change a clinician's professional practice and strategies used in dealing with a patient suicide	Conclusions from different studies are difficult to compare and are still inconsistent
How a Therapist Survives the Suicide of a Patient	(Skodlar & Welz, 2011)	VII	+++	2 case studies	Reactions to the patient suicides	N/A	N/A	Gives an insightful expert opinion point of view of reactions in regards to a patient suicide from personal experience	Low level of evidence
Patient Suicides in Psychiatric Residencies and Postvention Responses: A National Survey of Psychiatry Chief Residents and Program Directors	(Tsai, Moran, Shoemaker, & Bradley, 2012)	VI	+++	148 Responders	Response to survey	Online National Survey and Questionnaire	N/A	About 1 in 20 residents experienced a suicide in a 12 month period; postvention protocols could be developed by residents as a need to address patient suicide	Low response rate as compared to Ellis et al. survey
After a Client Death: Suicide Postvention Recommendations for Training Programs and Clinics	(Veilleux & Bilsky, 2016)	VII	+++	N/A	N/A	N/A	N/A	This article gives concrete guidelines of a postvention program for psychology residents	Low level of evidence
Suicide and the Air Force Mental Health Provider: Frequency and Impact	(Welton & Blackman, 2006)	VI	++++	97 Air Force Mental Health Providers	Response to survey	2 Page Survey	N/A	Nearly ½ of Air Force Mental Health Providers had a patient commit suicide	Small, single case study

The Therapist's Reaction to a Patient's Suicide: Results of a Survey and Implications for Healthcare Professionals' Well-Being	(Wurst et al., 2011)	IV	+++	185 Psychiatric Clinics	Reactions to patient suicides	63 Item Questionnaire	SPSS was used; non-parametric and parametric tests were used, regression analyses, receiver-operated characteristic (ROC) curve analysis	3 out of 10 therapists who experienced a patients suicide suffered from severe distress	Unclear how representative the study is and its retrospective nature
How Therapists react to patient's suicide: findings and consequences for healthcare professionals' well-being	(Wurst et al., 2013)	IV	++++	227 Therapists	Reactions to patient suicides	63 Item Questionnaire	SPSS was used; Kolmogorov-Smirnoff test, Mann-Whitney U test, ANOVA was used to analyze emotional reactions over time	4 out of 10 cases where therapists experienced a patient suicide, they suffered from severe distress	Remains unclear how representative the study is; unknown total of suicides in participating hospitals as compared to the reported suicides by therapists

Appendix C.
Postvention Needs Assessment Survey

Postvention Needs Assessment

Everyone fill out this portion:

1. Specialty/Area of Practice:
   - ☐ Mental Health
   - ☐ Family Medicine

2. Professional Group:
   - ☐ Physician (MD/DO)
   - ☐ Nurse Practitioner
   - ☐ Physician Assistant
   - ☐ Psychiatrist
   - ☐ Psychologist
   - ☐ Social Worker
   - ☐ Medical Student

3. Years in practice:
   - ☐ 0-5 years
   - ☐ 6-10 years
   - ☐ 11-15 years
   - ☐ 16-20 years
   - ☐ Over 20 years

4. Workplace:
   - ☐ Mental Health Clinic
   - ☐ Family Health Clinic
   - ☐ Family Medicine Residency Clinic

5. Have you had previous training on managing the aftermath of a patient suicide (postvention)?
   - ☐ Yes
   - ☐ No

6. If so, where: _____

7. To what extent do you feel capable of caring for suicidal patients?
   - ☐ Not capable
   - ☐ Somewhat capable
   - ☐ Very capable

8. Based on the information presented today, do you think a clinician-focused postvention program would be helpful?
   - ☐ Yes
   - ☐ No

   Why or why not?

   _____

Please fill out this portion if you <u>HAVE NOT</u> provided care for a patient who has died by suicide:

1. If you were to have a patient die by suicide, what emotions do you think you'd experience?
   - ☐ Sadness
   - ☐ Guilt
   - ☐ Shame
   - ☐ Relief
   - ☐ Self-Doubt
   - ☐ Anxiety
   - ☐ Fear
   - ☐ Anger
   - ☐ Irritability
   - ☐ Disbelief
   - ☐ Indifference

2. Choose to what extent the following would be helpful:

	Not helpful at all	Slightly helpful	Helpful	Very helpful	Most helpful
Supervisor/leadership support					
Talking to colleagues					
Talking to family and friends					
Professional counseling					
Reviewing case with clinical team					
Time off from work					
Temporary reassignment					
Contact with the patient's family					
30-day grace period before standard of care review begins					
Annual refresher training on suicide postvention					

Please fill out this portion if you <u>HAVE</u> provided care for a patient who has died by suicide:

1. What emotions did you experience?
   - ☐ Sadness
   - ☐ Guilt
   - ☐ Shame
   - ☐ Relief
   - ☐ Self-Doubt
   - ☐ Anxiety
   - ☐ Fear
   - ☐ Anger
   - ☐ Irritability
   - ☐ Disbelief
   - ☐ Indifference

2. How long did you experience these emotions?
   - ☐ 30 days or less
   - ☐ 1 – 6 months
   - ☐ 6 – 12 months
   - ☐ Over a year

3. Did you experience changes in your own clinical practice?
   - ☐ Increased time spent record keeping/documenting
   - ☐ Increased number of hospitalizations/admissions
   - ☐ Increased referrals to Mental Health/Psychiatry
   - ☐ Increased prescribing of antidepressants
   - ☐ Sought out further education/training on suicide
   - ☐ Avoided suicidal patients
   - ☐ Avoided contact with peers
   - ☐ Loss of motivation/burnout

4. How long did you experience changes in your clinical practice?
   - ☐ 30 days or less
   - ☐ 1 – 6 months
   - ☐ 6 – 12 months
   - ☐ Over a year

5. Did you feel supported by your unit/organization?
   - ☐ Not supported
   - ☐ Somewhat supported
   - ☐ Very supported

   Why or why not?

   _____
   _____
   _____
   _____
   _____

6. If utilized, choose to what extent the following were helpful:

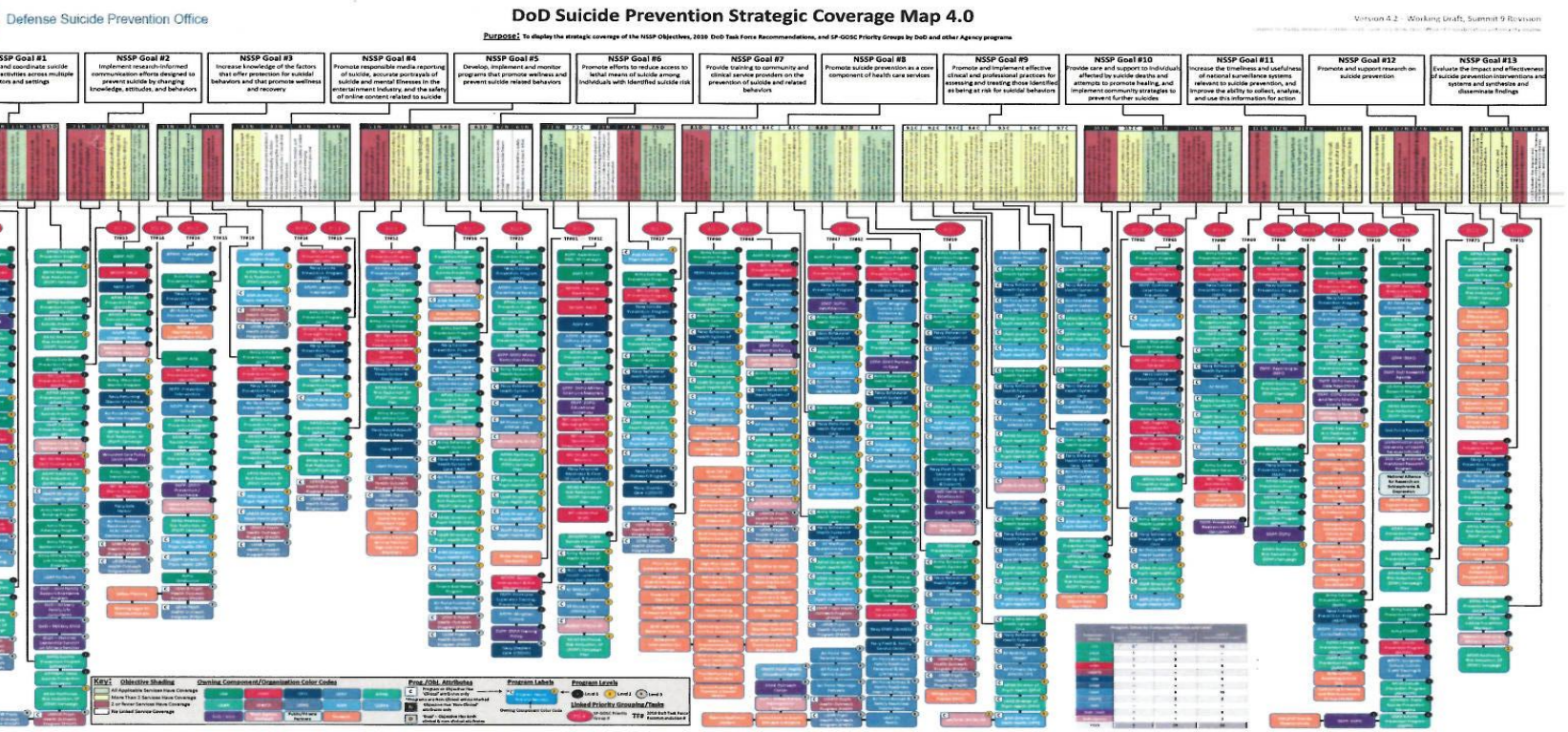
	Did not utilize	Not helpful at all	Slightly helpful	Helpful	Very helpful	Most helpful
Supervisor/leadership support						
Talking to colleagues						
Talking to family and friends						
Professional counseling						
Reviewing case with clinical team						
Time off from work						
Temporary reassignment						
Contact with the patient's family						
30-day grace period before standard of care review begins						
Annual refresher training on suicide postvention						

Additional comments

If you have any additional comments on experiencing a patient's suicide or regarding the presented material, please use the section below to share those with us:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Appendix D.
DoD Suicide Prevention Strategic Coverage Map 4.0


Defense Suicide Prevention Office
DoD Suicide Prevention Strategic Coverage Map 4.0
Purpose: To display the strategic coverage of the NSSP Objectives, 2030 DoD Task Force Recommendations, and SP-GOSC Priority Groups by DoD and other Agency programs
NSSP Goal #1
NSSP Goal #2
Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors
NSSP Goal #3
Increase knowledge of the factors that offer protection for suicidal behaviors and that promote wellness and recovery
NSSP Goal #4
Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide
NSSP Goal #5
Develop, implement and monitor programs that promote wellness and prevent suicide related behaviors
NSSP Goal #6
Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk
NSSP Goal #7
Provide training to community and clinical service providers on the prevention of suicide and related behaviors
NSSP Goal #8
Promote suicide prevention as a core component of health care services
NSSP Goal #9
Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors
NSSP Goal #10
Provide care and support to individuals affected by suicide deaths and attempts to promote healing, and implement community strategies to prevent further suicides
NSSP Goal #11
Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention, and improve the ability to collect, analyze, and use this information for action
NSSP Goal #12
Promote and support research on suicide prevention
NSSP Goal #13
Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings
Key:
Objective Shading
Owning Component/Organization Color Codes
Prog./Obj. Attributes
Program Labels
Program Levels
Linked Priority Grouping/Tasks

Appendix E.
CITI Certificates

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- Name: Andrea Barajas (ID: 5743124)
- Email: andrea.barajas@usu.edu
- Institution Affiliation: Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- Phone: 6789258074

- Curriculum Group: OUSD P&R Human Research
- Course Learner Group: Biomedical Investigators and Research Study Team
- Stage: Stage 1 - Biomedical Investigators

- Report ID: 20624705
- Completion Date: 27-Aug-2016
- Expiration Date: 27-Aug-2019
- Minimum Passing: 80
- Reported Score*: 81

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	27-Aug-2016	3/3 (100%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	27-Aug-2016	3/5 (60%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	27-Aug-2016	5/5 (100%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	27-Aug-2016	No Quiz
History and Ethics of Human Subjects Research (ID: 490)	27-Aug-2016	4/7 (57%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	27-Aug-2016	3/5 (60%)
Informed Consent (ID: 3)	27-Aug-2016	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	27-Aug-2016	2/4 (50%)
Records-Based Research (ID: 5)	27-Aug-2016	2/3 (67%)
Genetic Research in Human Populations (ID: 6)	27-Aug-2016	5/5 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	27-Aug-2016	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	27-Aug-2016	3/3 (100%)
FDA-Regulated Research (ID: 12)	27-Aug-2016	5/5 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	27-Aug-2016	4/5 (80%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	27-Aug-2016	No Quiz
The Federal Regulations - SBE (ID: 502)	27-Aug-2016	4/5 (80%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- Name: Andrea Barajas (ID: 5743124)
- Email: andrea.barajas@csulb.edu
- Institution Affiliation: Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- Phone: 6789258074

- Curriculum Group: OUSD P&R Human Research
- Course Learner Group: Biomedical Investigators and Research Study Team
- Stage: Stage 1 - Biomedical Investigators

- Report ID: 20624705
- Report Date: 27-Aug-2016
- Current Score**: 81

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
History and Ethics of Human Subjects Research (ID: 498)	27-Aug-2016	4/7 (57%)
Informed Consent (ID: 3)	27-Aug-2016	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	27-Aug-2016	2/4 (50%)
Records-Based Research (ID: 5)	27-Aug-2016	2/3 (67%)
The Federal Regulations - SBE (ID: 502)	27-Aug-2016	4/5 (80%)
Genetic Research in Human Populations (ID: 6)	27-Aug-2016	5/5 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	27-Aug-2016	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	27-Aug-2016	3/3 (100%)
FDA-Regulated Research (ID: 12)	27-Aug-2016	5/5 (100%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	27-Aug-2016	No Quiz
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	27-Aug-2016	4/5 (80%)
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	27-Aug-2016	3/3 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	27-Aug-2016	3/5 (60%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	27-Aug-2016	3/5 (60%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	27-Aug-2016	5/5 (100%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	27-Aug-2016	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- Name: Michelle Binder (ID: 5746057)
- Email: michelle.binder@usuhs.edu
- Institution Affiliation: Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- Phone: 4196190381

- Curriculum Group: OUSD P&R Human Research
- Course Learner Group: Biomedical Investigators and Research Study Team
- Stage: Stage 1 - Biomedical Investigators

- Report ID: 20633552
- Completion Date: 28-Aug-2016
- Expiration Date: 28-Aug-2019
- Minimum Passing: 80
- Reported Score*: 90

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	28-Aug-2016	3/3 (100%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	28-Aug-2016	4/5 (80%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	28-Aug-2016	5/5 (100%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	28-Aug-2016	No Quiz
History and Ethics of Human Subjects Research (ID: 490)	28-Aug-2016	5/7 (71%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	28-Aug-2016	5/5 (100%)
Informed Consent (ID: 3)	28-Aug-2016	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	28-Aug-2016	3/4 (75%)
Records-Based Research (ID: 5)	28-Aug-2016	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	28-Aug-2016	5/5 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	28-Aug-2016	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	28-Aug-2016	3/3 (100%)
FDA-Regulated Research (ID: 12)	28-Aug-2016	4/5 (80%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	28-Aug-2016	4/5 (80%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	28-Aug-2016	No Quiz
Cultural Competence in Research (ID: 15166)	28-Aug-2016	5/5 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the required scores at the time all requirements for the course were met.

- Name: Michelle Binder (ID: 5746067)
- Email: michelle.binder@tufts.edu
- Institution Affiliation: Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- Phone: 4156190381

- Curriculum Group: OUSD P&R Human Research
- Course Learner Group: Biomedical Investigators and Research Study Team
- Stage: Stage 1 - Biomedical Investigators

- Report ID: 20533552
- Report Date: 28-Aug-2016
- Current Score**: 90

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
History and Ethics of Human Subjects Research (ID: 490)	28-Aug-2016	5/7 (71%)
Informed Consent (ID: 3)	28-Aug-2016	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	28-Aug-2016	3/4 (75%)
Records-Based Research (ID: 5)	28-Aug-2016	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	28-Aug-2016	5/5 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	28-Aug-2016	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	28-Aug-2016	3/3 (100%)
FDA-Regulated Research (ID: 12)	28-Aug-2016	4/5 (80%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	28-Aug-2016	No Quiz
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	28-Aug-2016	4/5 (80%)
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	28-Aug-2016	3/3 (100%)
Cultural Competence in Research (ID: 15166)	28-Aug-2016	5/5 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	28-Aug-2016	5/5 (100%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	28-Aug-2016	4/5 (80%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	28-Aug-2016	5/5 (100%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	28-Aug-2016	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Catoya Hale (ID: 5731223)
- **Email:** catoya.hale@usuhs.edu
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Phone:** 2404725173

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 20583328
- **Completion Date:** 27-Aug-2016
- **Expiration Date:** 27-Aug-2019
- **Minimum Passing:** 80
- **Reported Score*:** 85

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	27-Aug-2016	3/3 (100%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	27-Aug-2016	3/5 (60%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	27-Aug-2016	4/5 (80%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	27-Aug-2016	No Quiz
History and Ethics of Human Subjects Research (ID: 498)	27-Aug-2016	5/7 (71%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	27-Aug-2016	5/5 (100%)
Informed Consent (ID: 3)	27-Aug-2016	4/5 (80%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	27-Aug-2016	4/4 (100%)
Records-Based Research (ID: 5)	27-Aug-2016	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	27-Aug-2016	4/5 (80%)
Vulnerable Subjects - Research Involving Children (ID: 9)	27-Aug-2016	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	27-Aug-2016	3/3 (100%)
FDA-Regulated Research (ID: 12)	27-Aug-2016	4/5 (80%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	27-Aug-2016	4/5 (80%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	27-Aug-2016	No Quiz
Avoiding Group Harms - International Research Perspectives (ID: 14081)	27-Aug-2016	3/3 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Catoya Hale (ID: 5731223)
- **Email:** catoya.hale@usuhs.edu
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Phone:** 2404725173

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 20583328
- **Report Date:** 27-Aug-2016
- **Current Score**:** 85

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
History and Ethics of Human Subjects Research (ID: 498)	27-Aug-2016	5/7 (71%)
Informed Consent (ID: 3)	27-Aug-2016	4/5 (80%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	27-Aug-2016	4/4 (100%)
Records-Based Research (ID: 5)	27-Aug-2016	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	27-Aug-2016	4/5 (80%)
Vulnerable Subjects - Research Involving Children (ID: 9)	27-Aug-2016	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	27-Aug-2016	3/3 (100%)
FDA-Regulated Research (ID: 12)	27-Aug-2016	4/5 (80%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	27-Aug-2016	No Quiz
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	27-Aug-2016	4/5 (80%)
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	27-Aug-2016	3/3 (100%)
Avoiding Group Harms - International Research Perspectives (ID: 14081)	27-Aug-2016	3/3 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	27-Aug-2016	5/5 (100%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	27-Aug-2016	3/5 (60%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	27-Aug-2016	4/5 (80%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	27-Aug-2016	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: https://www.citiprogram.org/verify/?87b400f8-5194-414f-a212-bcf67d032e82

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

Appendix F.
USU (VPR) Form 3202N

USU
Uniformed Services University

OFFICE OF RESEARCH
4301 JONES BRIDGE ROAD
BETHESDA, MAYLAND 20814
PHONE: (301) 295-3303; FAX: (301) 295-6771

NOTICE OF PROJECT APPROVAL
Change Number: Original

VPR Site Number:	GSN-61-10254
Principal Investigator:	Barajas, Andrea
Department:	Graduate School of Nursing
Project Type:	Student
Project Title:	Postvention Program for Clinicians after Loss of Patient to Suicude
Project Period:	8/15/2018 to 5/18/2019

Assurance and Progress Report Information:

Name	Sup	Approval Type	Status	Approved On	Forms Received
Progress Report	0		Final	To be Submitted	N/A

Remarks:
This Notice of Project Approval has been reviewed and approved. Please remember that you must submit a final Progress Report (Form 3210) upon completion of this project.

Questions regarding this approval should be directed to the following person in the Office of Research:
Gale Morgan, (301) 295-0137.

[redacted] 6 Dec 2018

Yvonne T. Maddox, Ph.D. Date
Vice President for Research
Uniformed Services University of the Health Sciences

cc: Barajas, Andrea
File
Andrea Barajas
Linda Wanzer

Appendix G.
MTF IRB Determination

DEPARTMENT OF THE AIR FORCE
60TH MEDICAL GROUP (AMC)

18 December 2018

MEMORANDUM FOR Maj Mary Kelley

FROM: 60 MDG/CIF

SUBJECT: Exempt Determination Official Determination

Principle Project Name(s): Andrea Barajas, Michelle Binder & Catoya Hale
E-mail address: andrea.barajas@usuhs.edu
Phone: 707-423-5174
Activity Title: Needs Assessment for Clinician-focused Suicide Postvention Guidelines

☒ This activity does not involve human subjects or it is not research.

☐ This activity is research involving human subjects eligible for exemption under Category _____.

Changes to the activity may affect the exempt status and must be reviewed by me.

☐ This human subject research has been referred to _____ for further review or consideration.

Rationale for this determination: The purpose of this project is to provide David Grant Medical Center providers with an educational briefing on suicide postvention to elicit feedback on whether the providers believe a postvention program for providers would be helpful.

Printed EDO Name: Lt Col Dawnkimberly Hopkins Date: 18 Dec 2018

Signature: [redacted]

Appendix H.
PAO Clearance/Level of Dissemination Classification

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS 60TH AIR MOBILITY WING (AMC)

18 April 2019

MEMORANDUM FOR CAPTAIN MICHELLE BINDER, ET Al.

SUBJECT: Approval of Submission/Presentation

1. On 18 April 2019, the Clinical Investigation Facility Publications Monitor received clearance/approval for your abstract, manuscript, PowerPoint, and poster submissions titled: **"Postvention Program for Clinicians after Loss of a Patient to Suicide".**

2. Please contact our office if your submission is published and provide a printed version for our records. Also, please contact our office if you receive any awards for your submission.

3. If you have any questions, I can be reached at 707-423-7316 / DSN 799 or e-mail at eileen.m.foster4.civ@mail.mil .

[redacted]
EILEEN M. FOSTER, CIV, DAF
Gifts and Grants Technician

1st Ind, 60 AMW/PA

MEMORANDUM FOR CAPTAIN MICHELLE BINDER, ET Al.

PA Security and Policy Review was conducted IAW 35-102 and there were not any issues.

Approved/~~Disapproved~~ for publication.

4/18/2019

[redacted]
TONYA A. RACASNER, GS-12, USAF
Deputy Chief, Public Affairs
Signed by: RACASNER.TONYA.A.1231677131

TERMINI NON EXISTENT ... *THERE ARE NO BOUNDS*

Appendix I.
DNP Project Completion Verification Form

DOCTOR OF NURSING PRACTICE PROJECT
Completion Verification Form

The DNP Project titled: Postvention Program for Clinicians after Loss of a Patient to Suicide

was completed at David Grant Medical Center, Travis AFB, CA by the following student(s):

(type student name)	*(signature)*	*(date)*
Capt Andrea Barajas	[redacted]	22 Apr 19
Capt Michelle Binder		22 Apr 19
Capt Catoya Hale		22 Apr 19

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation of DNP project to the leadership/stakeholders at the Phase II Site,
- Abstract/Impact Statement (*Appendix F*), and
- DNP Project written report.

Verified by: *(type name)*	*(signature)*	*(date)*	
LTC JoEllen Schimmels	[redacted]	23 Apr 19	Senior Mentor
Lt Col Mary Kelley		22 Apr 19	Phase II Site Director