Can a lecture influence attitudes to suicide prevention?

H G Morgan MD FRCP FRCPsych Mark Evans MRCGP MRCPsych
Christine Johnson MRCPsych Ruth Stanton BA MSc

J R Soc Med 1996;**89**:87–90

Keywords: *suicide prevention; attitudes; healthcdre*

SUMMARY

Attitudes held by various groups of healthcare professionals with regard to suicide prevention were assessed using an attitude inventory before and after they attended a formal lecture. The lecture presented basic facts and statistics, discussed clinical techniques and challenged negative attitudes. Evidence is presented to suggest that a reduction in the proportion of expressed attitudes which were equivocal or negative towards the feasibility of suicide prevention in clinical practice, can be achieved by a lecture of this kind.

INTRODUCTION

As a result of the renewed interest in suicide prevention which has been generated by the *Health of the Nation* mental illness targets[1], one of us (HGM) received a considerable number of invitations to lecture on the subject during the autumn of 1993 at various centres throughout the south and west of England. This paper describes the way in which an attempt was made to exploit this opportunity to assess attitudes to suicide prevention and their response to the educational initiative which was undertaken.

METHODOLOGY

Each lecture set out the basic statistics and clinical facts about suicide, followed by discussion of good clinical practice in the assessment and management of suicidal persons and the appropriate organization of clinical services. During the lecture a variety of negative attitudes was also challenged. The outline text of the lecture has been published elsewhere[2]. Each presentation lasted about 50 min and was followed by discussion for a further 15 to 20 min.

Attitude assessment

In order to evaluate the impact which the lecture may have had, attitudes were assessed before each lecture and again immediately afterwards. The instrument used (see appendix) was administered in written form and consisted of an inventory of 10 negative attitude statements which are commonly expressed by healthcare professionals concerning the feasibility, practicability and even desirability of regarding suicide prevention as a reasonable task for healthcare professionals to undertake. Responses to each statement were along a five point scale ranging from strong agreement to strong disagreement. Interpretation of scores derived from such an instrument cannot be sophisticated, and it was decided to divide responses into no more than two categories: (*a*) those which were more positive than the equivocal middle; and (*b*) those which were either equivocal or more negative. Category (*b*) is referred to as a negative response. The overall negativity of each audience was assessed by the number of responses in category (*b*), expressed as the total number of responses for all questionnaires.

A test–retest reliability exercise in which 20 psychiatric trainees responded to the inventory on two occasions separated by an interval of 1 month revealed that 16.5% answers were negative initially and 16.0% a month later. Seventeen (85%) showed little or no change (Table 1). Two (10%) changed their responses to two statements (one became more negative, i.e. changing from category (*a*) to (*b*); one less negative, i.e. changing from category (*b*) to (*a*)). One (5%) changed his/her responses to four statements, becoming less negative. This suggests that according to this method of scoring, responses were reasonably stable over a period of time identical with that used in the study.

Change in attitude following the lecture was expressed as a proportion (%) of the pre-lecture negativity score. The sign test was used to evaluate the significance of overall shift of attitudes in each audience by matching individuals' pre and post lecture responses.

RESULTS

The results reported here concern eight lectures when attitudes were assessed immediately before and after the presentations.

The Department of Mental Health, University of Bristol, 41 St Michael's Hill, Bristol BS2 8DZ, England

Correspondence to: Professor H G Morgan, Norah Cooke Hurle Professor of Mental Health

Table 1 **Results of a test–retest exercise**

Response to statements	Number	%
No change	8	40
Changed response* to one statement	9	45
Changed response* to two or more statements	3	15
Total	20	100

*Category (*a*) to (*b*), or (*b*) to (*a*)

Baseline attitudes

All groups initially exhibited a certain proportion of negative attitudes as defined, ranging from 11% to 36% of responses (Table 2). This means that up to one-third of the responses on the 10 question schedule were initially either equivocal or actually negative in attitude to the concept of suicide prevention.

Attitude change

Tables 2 and 3 show the amount of change which occurred when follow-up assessment was carried out immediately after the lecture. Table 2 shows the reduction in the degree of negative attitudes expressed by the whole group and the statistical significance which in all groups was <0.05. Table 3 gives the raw data. It should be noted that the proportion of negative responses expressed before the lecture was low in most of the groups tested.

DISCUSSION

Measuring attitude change is never easy. Designing an appropriate sensitive, reliable instrument for measuring such

Table 2 **Attitude change to suicide prevention before and after a lecture**

		Proportion of negative responses (%)		
Group	Audience	Before lecture	After lecture	Reduction following lecture (level of significance)
1	Approved social workers (*N*=29)	22	12	45 (0.001)
2	Prison medical officers (*N*=25)	25	20	20 (<0.02)
3	Mixed GPs/psychiatrists (*N*=26)	23	16	30 (0.03)
4	GPs (*N*=11)	30	13	57 (0.008)
5	GPs (*N*=23)	36	26	28 (0.001)
6	Mixed mental healthcare professionals (*N*=17)	18	7	61 (0.006)
7	Trainee psychiatrists (*N*=10)	21	7	66 (0.016)
8	Trainee psychiatrists (*N*=12)	11	5	55 (0.016)

GP=General practitioner

Table 3 **Attitude change before and after a lecture**

		Completed forms		Number of forms which showed no change		Number of forms showing negative change in one response[†]		Number of forms showing positive change in one response		Number of forms showing positive change to two or more responses	
Group*	Number in audience	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
1	29	22	(75.9)	4	(18.2)	2	(9.1)	8	(36.4)	8	(36.4)
2	25	17	(68.0)	5	(29.4)	0	(0)	9	(52.9)	3	(17.6)
3	26	26	(100)	10	(38.5)	4	(15.4)	7	(26.9)	5	(19.2)
4	11	11	(100)	4	(36.4)	0	(0)	3	(27.3)	4	(36.4)
5	23	23	(100)	6	(26.1)	3	(13.0)	7	(30.4)	7	(30.4)
6	17	17	(100)	6	(35.3)	1	(5.9)	4	(23.5)	6	(35.3)
7	10	10	(100)	4	(40.0)	0	(0)	2	(20.0)	4	(40.0)
8	12	12	(100)	6	(50.0)	0	(0)	5	(41.7)	1	(8.3)
Totals:	153	138		45	(32.6)	10	(7.2)	45	(32.6)	38	(27.5)

*For compositions of Groups 1–8 see Table 2
[†]No forms showed negative change in more than one response

change and then establishing norms and criterion points is a time-consuming task. In the present study, the instrument used to assess attitude change consisted of a list of negative statements derived from questions and debate which took place during the discussion period after the lecture on suicide prevention had been delivered by one of us (HGM).

As the validity of such an instrument was unproven, a high degree of scepticism was applied to it and a strict degree of proof was demanded of it. Thus, the equivocal middle was scored as negative and the responses were divided into just two categories—negative or positive (as described in the methodology section). Sophisticated analysis of such results was judged inappropriate. The sign test was used because it has high power–efficiency for low numbers of subjects (approximately 95% for $N=6$) and is useful for data on variables with underlying continuity but which can be measured in only a very gross way. Norms and criterion points were not established.

The inventory demonstrated that the proportion of equivocal or more negative attitudes in a range of attitudes to suicide prevention as held by various groups of healthcare professionals varied from 11% to 36%. We would suspect that mental health professionals would hold more positive attitudes than are held in the general population and also that these attitudes, having been more considered and tested in action, would be more stable and less liable to change.

Clear reduction in the amount of negativism (the actual reduction ranged from 20% to 66%) was demonstrated by comparing attitudes immediately before and after the lectures. The lecture did not remove negative attitudes but it did seem to have an influence in increasing positive attitudes with regards to the various practical issues involved in the clinical task of suicide prevention: an overall average of 45% reduction in negativism immediately post-lecture was achieved. We cannot comment at this stage on how enduring such attitude change may be.

A lecture costs little, and our findings indicate that an educational input of this kind should be regarded as an important element in the current suicide prevention initiatives which are encouraged by the *Health of the Nation*[1]. The findings lend weight to other recent initiatives which suggest that seminars and debate concerning attitude to suicide and practical issues relevant to its prevention are capable of influencing clinical practice for the better[3,4]. Experience of lecture delivery in the present study suggests that ideally it should be free-standing in its own right rather than part of, say, a conference or study day which may have a wider remit. Allowance of adequate time for full debate and discussion after the lecture delivery appears to be important in order to exploit its potential to challenge negative attitudes effectively. This approach is now proceeding further with the development of an attitude questionnaire which will permit more detailed analysis, and a videotaped version of the lecture for wider use.

Acknowledgments We gratefully acknowledge financial support from the Department of Health and NHS Health Advisory Service. Thanks are also due to all those who so willingly collaborated in completing the questionnaires.

APPENDIX

The inventory of negative attitudes

1 Suicide is a private and personal matter, and whether or not to commit it should be left for each individual to decide.
2 Not all suicides can be prevented. By focusing on those which occur we merely accentuate the guilt feelings of healthcare professionals who did their best under difficult circumstances.
3 There is no prospect of reducing suicide rates unless adverse economic and social factors are dealt with, and these are not within the power of healthcare professionals to influence.
4 It is not feasible to expect healthcare professionals to contribute to a reduction in suicide rates when suicide is such a rare event.
5 Persons who commit suicide are reluctant to seek help before the event and it is therefore unreasonable to expect doctors to play a part in preventing such deaths.
6 Even when suicides do make contact with services prior to their deaths, their true motive is often not made clear, and doctors cannot be expected to see through their disguise.
7 It is dangerous to open up the topic of suicide when interviewing someone who is at risk.
8 Once a person gets into a suicidal crisis then the suicide is inevitable and the process cannot be influenced by outside intervention.
9 Even when a suicidal person is recognized, present day clinical techniques in prevention are very ineffective and unlikely to influence the course of events.
10 Sometimes a person's life situation becomes truly hopeless and impossible to face. In such circumstances suicide should be regarded as the best solution for that individual.

A separate response according to the following scale is made to each of the above statements: strongly disagree; on balance disagree; my opinion is not inclined in either way; on balance agree; strongly agree.

REFERENCES

1 Department of Health. *Health of the Nation: Key Area Handbook on Mental Illness 1993*. London: Department of Health, 1993

2 Morgan HG. How feasible is suicide prevention? *Curr Opin Psychiatr* 1994;**7**:111–18

3 Michel K, Valach L. Suicide prevention: spreading the gospel to general practitioners. *Br J Psychiatr* 1992;**160**:757–60

4 Rutz W, Knorring GL, Walinder J. Long term effects of an educational programme for general practitioners given by the Swedish Committee for the Prevention and Treatment of Depression. *Acta Psychiatr Scand* 1992;**85**:83–8

(Accepted 7 July 1995)