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Counseling Suicidal Patients about Access to Lethal Means: Attitudes of Emergency Nurse Leaders

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Abstract

Introduction—For emergency department patients with suicide risk, counseling to reduce access to lethal means (including firearms) is recommended yet not routine. To enhance practice uptake, we sought to examine the attitudes and beliefs of emergency nurse leaders concerning the acceptability and effectiveness of lethal means counseling.

Methods—We invited a nurse leader (emergency department nurse manager or Chief Nursing Officer) at each hospital-based emergency department in the 8-state Mountain West region of the U.S. to complete a closed-ended telephone survey. Questions assessed current practices and leaders' views on suicide prevention and lethal means counseling. Responses were weighted to all eligible hospitals to adjust for non-response.

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Results—From 363 eligible hospitals, 190 emergency nurse leaders responded (overall response rate 52%). Emergency nurse leaders thought providers at their emergency departments did an excellent job of safety counseling (74%) for suicidal patients. Most respondents believed that talking about firearms with suicidal patients is acceptable to patients (77%), supported by hospital administration (64%), effective in preventing suicide (69%), and something that providers should do (91%). However, the majority also had doubts about whether suicide is preventable (60%).

Discussion—Despite expressing high levels of support for the acceptability and effectiveness of lethal means counseling, high proportions of emergency nurse leaders expressed skepticism in the preventability of suicide, a finding consistent with prior work. Our results support the need to address and modify misperceptions about suicide prevention in any efforts for widespread implementation and dissemination of lethal means counseling.

Keywords

suicide prevention; lethal means; firearm; counseling; emergency department leader

INTRODUCTION

Suicide is the 10th leading cause of mortality in the United States,¹ with half of all suicides completed using a firearm. Firearm access increases suicide risk because of the impulsivity of many suicide attempts and the inherent lethality of firearms as a suicide method.^{2,3} Reducing access to firearms for suicide is the focus of lethal means counseling, a suicide prevention approach with a strong empirical foundation⁴ and support from national organizations and practice guidelines.^{5–7} Yet in a recent multi-site study, only half of suicidal patients had medical record documentation that a provider had talked about lethal means access,⁸ though many ED patients with suicide risk do have firearm access.⁸

Low rates of lethal means counseling may stem from provider ignorance or discomfort discussing firearms,^{9,10} or from negative provider attitudes towards patients with behavioral health issues.¹¹ It is important to note that, as of 2017, no state or federal law prevented provider questioning about firearms in cases of suicide risk,¹² and many patients appear open to respectful, nonjudgmental education from clinicians.^{10,13} System-level barriers to lethal means counseling also exist; these include time pressures, busy ED environments, and multi-disciplinary teams with unclear assignment of responsibility for lethal means counseling.^{8,14}

A key question has been how to encourage lethal means counseling in emergency departments in order to enhance care – and prevent deaths – for patients at risk of suicide. Our earlier analyses from this same survey of revealed that only 31% of hospital EDs discuss firearm storage with all suicidal patients at discharge, but that such discussions were more common in EDs with written practice guidelines or protocols.¹⁵ In this paper, we moved our focus from reported practices to the beliefs and opinions of nurse leaders, recognizing that these can influence individual and organizational performance and willingness to change.^{16,17} Specifically, leaders' beliefs may affect their enthusiasm and advocacy for specific clinical programs; this might be particularly impactful in an emergency department with multiple competing priorities or initiatives.

METHODS

We surveyed nurse leaders from hospitals with emergency departments located within the eight-state Mountain West region (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah and Wyoming), with detailed methods described elsewhere.¹⁵ At each facility we attempted to reach the emergency nurse manager, or, if unavailable, the Chief Nursing Officer (CNO). We chose these individuals based on results of qualitative interviews concerning influential decision-makers. We conducted most surveys via computer-assisted telephone interviews, with paper and online versions sent to non-responders. All respondents had the option to be entered into a drawing for an iPad, and the Colorado Multiple Institutional Review Board and the VA Research and Development Committee and Subcommittee on Research Safety both approved our protocol.

Drawing from qualitative interviews conducted to inform the survey content and wording, and from pilot testing,¹⁵ our final survey instrument included 80 items designed to learn about hospital protocols and practices for counseling suicidal patients at discharge from the emergency department, as well as influences on protocol development at each facility. In addition, we asked emergency nurse leaders twelve questions about their beliefs about lethal means counseling practices and suicide prevention. All survey items were closed-ended with some allowing the respondent to choose “other” and then specific a response not listed. Many items utilized a Likert scale set of responses. Participants from the qualitative interviews were not eligible to complete the survey and pilot testing occurred among practitioners at facilities in contiguous states not included in the study population.

For analysis, we accounted for non-response bias by using weights reflecting hospital type (i.e., private for-profit; private non-profit; state/local public; or church owned, physician-owned, or other) and total bed count (<70 or ≥70 beds). We treated VA hospitals as a separate stratum. We conducted all analyses using SAS Version 9.4 (Cary, NC) and report weighted proportions with 95% confidence intervals, with differences testing using a Rao-Scott chi-square.

RESULTS

From the 363 eligible hospitals, 190 emergency nurse leaders responded (overall response rate 52%), 90% of them by telephone. Most respondents were white (92%), non-Hispanic (92%) and female (77%); 28% were aged <44 years, 38% were aged 45–54, and 33% were ≥55 years. Experience as an emergency nurse ranged from less than 10 years (39%) to 20 or more years (30%), and experience in current leadership role ranged from less than one year (30%) to five or more years (21%). Most participants were the nursing manager or nursing director of the emergency department (66%), while 22% were the CNO of the hospital; 2% had another clinical role, and 10% did not report their role.

We next asked emergency nurse leaders about their emergency departments’ usual practices for suicidal patients being discharged home (Table 1). Respondents answered a series of questions specifically about ED-based lethal means counseling, including perceptions of typical practices and their own personal beliefs about the appropriateness or acceptability of

counseling (Figure 1). Very few respondents (8%) believed that providers should *not* talk to suicidal patients about firearm safety or firearm storage, and 52% indicated they thought patients and families would follow the advice they received. The majority of respondents said that discussing firearms with suicidal patients and their families was supported by hospital legal or risk management administrators (78%), acceptable to most patients and their families (77%), and considered part of standard practice by ED leadership (78%). When asked whether mental health providers or ED physicians should take on the responsibility of addressing firearm storage with suicidal patients, 31% replied mental health providers alone, 14% said ED physicians alone, while 13% said “both”, and 38% “neither”

Of note, four questions in this series had over 5% of responses as “don’t know” or missing, including perceived support by hospital legal/risk management administrators (25% don’t know), likelihood that patients and their families would follow advice (16% missing, 5% don’t know), acceptability of counseling to patients (11% don’t know), and perception that key decision makers think firearm safety discussion should be part of standard practice (6% don’t know).

When asked about their own beliefs on the inevitability or preventability of suicide, 60% of emergency nurse leaders indicated they believed suicidal individuals would find a way to end their lives, no matter what they were told in the ED (Figure 1). At the same time, 67% of respondents said that talking about firearm storage with suicidal patients and their families is an effective way to prevent suicide. When these two questions were analyzed together, 54 respondents (29%) appeared somewhat optimistic, indicating that a suicidal individual would not find a way to die and that talking about firearms is an effective approach. Conversely, 41 individuals (21%) appeared more pessimistic, with responses that a suicidal individual would complete suicide no matter what counseling they received and that talking about firearms is ineffective. 46% of respondents had discordant answers, agreeing with only one of the two questions but not the other. Responses to these two questions did not significantly vary by respondent age, gender, race, ethnicity, or years of clinical experience or of leadership experience (data not shown).

DISCUSSION

In this multi-state survey, nurse leaders appeared to have generally supportive views towards ED-based lethal means counseling for suicidal patients. However, consistent with other studies,^{9,18–20} many of these nurse leaders expressed skepticism about the preventability of suicide. Over half (60%) thought suicidal patients would find a way to end their lives despite interventions in the emergency department, an estimate similar to prior surveys of front-line emergency nurses.⁹ This discordance may reflect ED providers having cared for patients who re-attempt but without getting feedback about patients who recover and thrive (because they do not return to the emergency department). Regardless of the reason for these views, further discussion in ED settings is warranted to encourage emergency nurse leaders and other providers to be fully supportive of implementing suicide prevention interventions.

Nurse leaders’ uncertainty about the effectiveness of LMC also highlights an area for further research. In addition, it is commonly recommended that LMC be delivered as part of a

“safety planning”,²¹ a more comprehensive suicide prevention intervention that includes discussion of coping strategies and support systems. How LMC is viewed and implemented, and how effective the intervention is as a stand-alone strategy versus as part of safety planning is also an area that needs additional research. Prior studies suggest that counseling parents of adolescents at risk of suicide does lead to safer home firearm storage, as assessed by telephone follow-up.²² Larger trials with both adolescent and adult populations are necessary to further solidify this evidence and determine the best methods for disseminating research findings to clinical providers. Similarly, we did not ask about familiarity with emerging clinical guidelines and resources about how ED providers address firearm access.^{6,12,23} Going forward, examining how providers respond to these resources will be important in the process of improving clinical practice.

Though convinced that hospital administrators supported lethal means counseling in the emergency department, many emergency nurse leaders were uncertain about the hospital legal or risk management administration’s views on “talking about firearm storage with suicidal patients or their families”. This suggests that engaging the range of relevant hospital decision makers in early discussions about lethal means counseling may be important as hospital policies are being established. Similarly, clear communication from administrators to ED leaders is critical to ensure that providers feel confident that they are providing care in line with their institution’s policies.

An additional area of uncertainty was who is responsible for lethal means counseling. There is often overlap – and perhaps unintentional gaps – in the duties of emergency physicians and the mental health clinicians caring for suicidal ED patients.^{6,24} In many facilities, the emergency nurses and physicians rely on a mental health provider who may be internal or external to the hospital, which may also contribute to gaps in lethal means counseling. Clear communication and clarification of job responsibilities will be key to efficient integration of lethal means counseling into routine care.

LIMITATIONS

Our study does have limitations. We cannot be sure that nursing leaders reported accurate perceptions of typical care, or whether their responses overestimated the quality of safety counseling practices at their facility. However, to the extent that, as they reported, they are key decision makers about ED procedures and protocols in their facilities their views are likely very important in driving practice decisions. Our study was conducted in one region of the US with high rates of both suicide and firearm ownership; we cannot generalize to other regions. Nevertheless, these findings provide insights worthy of further examination in other settings. We weighted responses by hospital size (operationalized by bed number) and type as we felt these characteristics might be most influential on decisions, but this weighting would not adjust for other factors. A small number of respondents (5%) reported they do not evaluate suicidal patients at their facility. It is not clear how a patient could be transferred without an evaluation, so we are not entirely sure how to interpret these responses. It is possible those hospitals do conduct a preliminary evaluation before transferring patients but interpreted our question to be about a more extensive evaluation that is conducted at another facility. In any case, we chose to retain all respondents to provide a more complete picture of

the attitudes and behaviors of nurse leaders that could influence policy and protocols, whether those policies have to do with safety planning or with initial evaluation and care coordination decisions. Finally, most responses were by telephone; it is possible that social desirability bias may have impacted responses as compared to other methods, but telephone surveys can lead to higher response rates and less missing data, and the survey questions were not of a personal nature.

IMPLICATIONS FOR EMERGENCY NURSING

Among the many patients evaluated in emergency departments for suicidal thoughts or behaviors, many are discharged home, making lethal means counseling a critical part of their discharge planning.⁶ Our findings demonstrate high levels of support by emergency nurse leaders for firearm safety counseling with suicidal ED patients. Yet the simultaneous finding of high levels of skepticism about the preventability of suicide highlights the need for continued efforts to educate healthcare providers about suicide prevention.²⁵ Given that our survey respondents were in leadership positions—and that their views could create an environment in which the rigorous practice of lethal means counseling is implicitly or explicitly valued (or not), targeted education of nurse leaders, among others, is particularly important.

CONCLUSION

The beliefs of key leaders can influence institutional policies and the beliefs of employees—all of which impact practice. In this multi-state study, our findings from surveys of emergency nurse leaders point to the need to engage these individuals—as well as other key hospital decision makers—in education about the preventability of suicide and the importance of lethal means counseling for suicidal patients being discharged from the emergency department. As leaders, these nurses' beliefs about the development of policies and protocols has the potential to influence significantly the nature of care provided to suicidal patients in the ED.

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CONTRIBUTION TO EMERGENCY NURSING PRACTICE

- Examination of emergency department nurse leaders across the U.S. Mountain West region found general support for lethal means counseling for patients at risk of suicide.
- Skepticism about the preventability of suicide highlights the need for better, focused suicide prevention training of nurses during training and through continuing education.
- Efforts to implement, sustain or improve lethal means counseling practices in emergency departments can be more successful if they engage nurse leaders.

Figure 1. Perceptions of emergency nurse leaders on ED-based lethal means counseling (N=190, weighted estimates presented)

^aQuestion polarity reversed for presentation clarity; original question was “Health care professionals should not talk to patients about what to do with their firearms.” Missing data not shown. ^bQuestion response range was “very unlikely” (lightest grey), “somewhat unlikely”, “somewhat likely”, and “very likely” (black). ^cMissing/don’t know >5% (see text). Also note that greater agreement with the third question (“if someone is suicidal they will find a way...”) indicates greater skepticism about the preventability of suicide.

Table 1

ED characteristics and reported practices in lethal means counseling for suicidal ED patients (n= 190; weighted estimates presented)

	N	% ^a	95% CI
Type of hospital			
Freestanding	92	43	40–49
Part of a larger system	77	45	39–47
Missing/Don't know	21	12	9–16
Total patient visits in the emergency department in 2014			
1–499	7	3	2–4
500 to 4999	56	25	22–28
5000 to 14,999	57	25	22–28
15,000 to 50,000	51	34	29–38
>50,000	16	11	7–15
Provider type emergency department relies on to evaluate suicidal patients			
Treating ED physicians or emergency nurses	47	24	20–28
Mental health providers (ED- or hospital-based)	46	29	24–34
Mental health providers (external agency)	82	41	36–46
Don't evaluate at this facility	13	5	4–7
Visit disposition for suicidal patients			
Transfer or admit all suicidal patients	41	21	16–26
Discharge some suicidal patients	130	70	62–75
Don't know	15	8	5–11
ED has written protocols for safety planning			
Yes	65	36	31–41
No	82	42	37–47
Missing/don't know/don't discharge any suicidal patients	43 ^b	22	18–26
Nursing director would have significant influence for protocol or standard practices changes for suicidal patients	166	88	85–91

^aPercentages may not sum to 100 due to missing data (not shown if <5%).

^bn=41 for “don't discharge any suicidal patients”