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

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Contribution to Emergency Nursing Practice

- Examination of ED nurse leaders across the United States 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.

Abstract

Introduction: For ED patients at risk of suicide, 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 (ED nurse manager or Chief Nursing Officer [CNO]) at each hospital-based emergency department in the 8-state Mountain West region of the United States to complete a closed-ended telephone survey. Questions assessed current practices and leaders' views on suicide prevention and lethal-means counseling. Reponses were weighted to all eligible hospitals to adjust for nonresponse.

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 regarding the preventability of suicide, a finding consistent with previous work. Our results support the need to address and modify misperceptions about prevention of suicide in any efforts for widespread implementation and dissemination of lethal-means counseling.

Keywords: Suicide prevention; Lethal means; Firearm; Counseling; Emergency department leader

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Introduction

Suicide is the 10th leading cause of mortality in the United States,[1] with half of all suicides completed using firearms. Firearm access increases suicide risk because of the impulsivity of many suicide attempts and the inherent lethality of firearms as a method of suicide.[2,3] Reducing access to firearms for suicide is the focus of lethal-means counseling, a suicide-prevention approach with a strong empirical foundation[4] and support from national organizations and practice guidelines.[5–7] Yet, in a recent multisite 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 access to firearms.[8]

Low rates of lethal-means counseling may stem from provider ignorance or discomfort discussing firearms[9,10] or from negative provider attitudes toward 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 multidisciplinary 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 to enhance care—and prevent deaths—for patients at risk for suicide. Our earlier analyses from this same survey revealed that only 31% of hospital emergency departments discuss firearm storage with all suicidal patients at discharge but that such discussions were more common in emergency departments with written practice guidelines or protocols.[15] In this article, 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 have particular impact on an emergency department with multiple competing priorities or initiatives.

Methods

We surveyed nurse leaders from hospitals with emergency departments located within the 8-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 nurses 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 nonresponders. 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 12 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 specify a response not listed. Many items used 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 nonresponse bias by using weights reflecting hospital type (ie, private for-profit; private nonprofit; 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, North Carolina) 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 to 54, and 33% were ≥55 years of age. 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 1 year (30%) to 5 or more years (21%). Most participants

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