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Nurses' attitudes to supporting people who are suicidal in emergency departments

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An exploratory survey of adult field emergency nurses' attitudes and knowledge of supporting suicidal patients attending emergency departments in the UK

Abstract

Suicide is preventable yet accounts for thousands of deaths annually. Suicidal individuals often present to emergency departments (ED); during which time emergency nurses have opportunity to intervene. Some patients describe emergency nurses' attitudes as negative, whilst others report experiencing empathy. This survey questioned 'What are emergency nurses' attitudes towards suicidal patients attending ED'. To illicit nurses' knowledge and perceived ability to support suicidal patients, data was collected using a validated questionnaire. Attitudes were coded and analysed for variance. Attitudinal difference was evident. Risk assessment can predict suicidal risk yet nurses' ability to assess suicidal risk appears disparate. Results draw a correlation between suicide prevention training and nurses' perceived competence to triage suicidal patients ($P=0.001$). Recommendations are made for future research and nurse education and training on suicide prevention, aiming to improve attitudes, increase knowledge and thus emergency nurses preparedness responding to suicidal patients.

Key words

suicide, emergency department, nurse, attitude, risk, training

Introduction

Suicide, the deliberate act of ending one's own life (Wasserman and Wasserman 2010) is a complex phenomenon progressing from suicidal thoughts, to planning, attempting and finally dying by suicide (International Association for Suicide Prevention 2012). Suicide is an international problem with over 800,000 worldwide deaths annually; a 'preventable' death every forty seconds (World Health Organisation (WHO) 2017). In 2015, 6,188 UK deaths were attributed to suicide for

individuals over 10yrs (Office of National Statistics (ONS) 2016). International plans are in place to reduce suicides by 10% by 2020 (WHO 2013), despite national guidelines to standardise service provision for those in psychological distress, variability in provision exists (National Institute of Clinical Excellence (NICE) 2004; NICE 2011). Individuals with mental health problems often present to EDs, up to a third experiencing suicidal thoughts (Hawton and Heeringen 2009; Hawton *et al* 2013), a pre-cursor to suicide might include failed attempts or self-harm necessitating emergency care and it is at this point that emergency nurses are ideally situated to intervene (NICE 2004; WHO 2017).

Main Body

Suicide remains the leading cause of death for both genders aged 20-34 in England and Wales, with greater occurrence between ages 45 to 59. Significant rise is also evident for those late in years (ONS 2016), one in seven maternal deaths are attributed to suicide (Gray *et al* 2015). Whilst regional variations are evident, overall trends show an increase of ten per cent in suicides, with male rates the highest since 2001 (Department of Health (DoH) 2012; ONS 2016). Men remain three times more likely to commit suicide than women, having greatest propensity in middle age (University of Manchester 2015). Counselling agencies suggest men have in recent years seen devastating identity loss, relationship and employment changes personifying suicide risk; the 2008 recession the catalyst (Samaritans 2012; Equality and Human Rights Commission 2015), others suggest men are more likely to drink excessively, use fatal self-harm methods, be stoic and avoid help. Men's uptake of health care is far less than women's especially for mental health and coping issues (NICE 2011; Bergmans *et al* 2014).

Many suicidal individuals attend ED sometimes due to self-harming behaviour necessitating treatment; 6% of those that self-harm go on to complete suicide

(Bergmans *et al* 2014). Busy EDs are risky environments for those with mental health issues often viewed as a lesser priority (Mental Health Network NHS Confederation & National Patient Safety Agency 2012), there is countless evidence suggesting self-harming and suicidal service-users are less than satisfied with ED care, feeling inferior to 'medical patients' due to negative nurse attitudes (Cleverly 2014; Conlon & O'Tuathail, 2012; Farrell *et al* 2012), in practice negative attitudes can perpetuate depressive issues (Cole-King 2013a). However, negativity may wrongly be assumed when in fact nurses lack confidence to support patients vocalising suicidal ideation (Boore *et al* 2007; Clarke *et al* 2007; Dickinson and Hurley 2012; Conlon and O'Tuathail 2012).

Alongside self-harm there are other suicide risk factors, such as previous suicide attempts, alcohol dependence, social isolation, economic problems etc. (Dennis and Mitchell 2006; University of Manchester 2015). Despite countless individuals attending ED with suicidal risks there is variance in emergency nurse preparedness to assess them (Chan *et al* 2009; Dickinson and Hurley 2012) with reliance on mental health services (Farrell *et al* 2012). However the Nursing and Midwifery Council (NMC) stipulate all nurses should be able to assess deteriorating mental health to optimise patient safety (NMC 2015a). Suicide prevention starts with identification of those at risk of suicide (Mental Health Network NHS Confederation and National Patient Safety Agency 2012; WHO 2013; WHO 2014). Little is known of emergency nurses preparedness for encountering suicidal patients and many suggest increasing emergency nurses' knowledge improves nurses attitudes and risk assessment reinforcing interventions to allay suicidal behaviour (Asarnow & Hughes 2013; Atkins *et al* 2011; Caine *et al* 2010; Cole-King *et al* 2013b; Comtois *et al* 2013; DoH 2015; Harrison *et al* 2013; Hirayasu *et al* 2006).

Research Question: 'What are emergency nurses' attitudes towards suicidal patients attending ED?'

Aims: To explore attitudes and knowledge of adult field emergency nurses' supporting suicidal patients presenting to ED.

Ethical issues

Ethical approval was sought from the University and NHS Trusts. Research activity adhered to the principles enunciated in the declaration of Helsinki (World Medical Association 2013). As professional staff members were recruited there were no perceived external confidentiality issues (NMC 2015a). Questionnaires were placed in named envelopes in the EDs for delivery to recipients but all responses were anonymous. Assurance was given that no attempt would be made to identify individuals' answers (reinforced in participation leaflet). Psychiatric liaison nurses (PLNs) acted as research assistants, distributing and collecting questionnaires. Whilst nurses were asked probing and thought provoking questions the research was conducted in the least intrusive manner by using self-report and pre-validated questionnaires (Allsop & Saks 2013). As suicide is an emotive subject participants were offered confidential counselling from mental health nurses bound by ethical NHS principles. Participants were advised to self-refer to their GP and no records kept.

Method

A survey was conducted using a questionnaire in order to facilitate both attitudinal measure and illicit adult field emergency nurses knowledge to support suicidal patients attending ED. To promote uptake a covering letter was issued depicting rationale (Parahoo 2014), identifying current practice and exploring knowledge of adult field emergency nurses supporting suicidal patients attending ED. Consent was assumed with completion of the questionnaire (Beck and Polit 2014). A pilot was

conducted to enhance clarity of questions. In total the questionnaire consisted of 34 questions (Appendix A). The least threatening questions about demographics at the beginning (Bryman 2012), next nurses attitudes towards suicidal patients were measured using a forced likert scale similar to the Suicide Opinion Questionnaire by Domino *et al* (1982), a valid tool to measure health professionals attitudes (Boore *et al* 2007), the later section asked open questions like, can you list suicide risk factors?

Purposive sampling was used to identify participants that met inclusion criteria (Beck & Polit 2014) (table 1). As some of the staff may have known the researcher, bias was minimised with PLNs distributing questionnaires, reducing coercion potential (Burnard & Newell 2011). The research population was derived from adult field emergency nurses supporting suicidal patients employed in one of two EDs. As individual EDs have unique cultures affecting attitudes and behaviours, two sites enhanced data richness, improving external validity and generalisability (Burns *et al* 2013).

Table 1

Participant Criteria	
Inclusion	<ul style="list-style-type: none"> • Consenting adult field nurses working within 2 studied EDs with the potential to support suicidal patients.
Exclusion	<ul style="list-style-type: none"> • Nurses working in the EDs that are from mental health, learning disability or sick children’s fields.

Data analysis.

Data was interpreted with descriptive statistics. As the questionnaire facilitating attitudinal measure was based on one devised by Boore *et al* (2007) interpretation of data was similar in method. Likert categories determined the level of agreement with particular statements pertaining to attitude towards suicide and suicidal behaviours (1= strongly disagree, 2= disagree, 3 =undecided, 4= agree and 5= strongly agree) statements started with positively worded statements (items 1, 3-8 & 10-21) 5 points attributed to strongly agree, 1 for strongly disagree, remaining questions were negatively worded so scored in reverse (2, 9 & 22). The coding framework had a range of 22-110, with higher scores denoting more positive attitudes. Cronbach's alpha was employed to check the internal consistency of the attitudinal measure (0.72).

The ability to identify known risk factors was also measured on a likert scale with 8 subsections, always a risk scoring 1 to never associated scoring 5; a score of 8 shows identification of all risk factors, scoring 40; recognising none. Correlation was explored for knowledge of suicide prevention using additional open questions like, 'can you list any of the risk factors for suicide?' looking for knowledge of risks such as suicidal familial history, self-harm and previous attempts (University of Manchester 2015). Prior training and self-reported confidence and attitude and risk scores were analysed for variance considering association between attitude scores and training and experience using one way ANOVA and t-tests using IBM SPSS version 22 (CI 95%), statistical significance set at $P \leq 0.05$.

Findings

113 adult field nurses were invited to participate from 2 EDs, 38 responded (3 incomplete questionnaires were excluded); equating to 31%, typical for postal surveys (Beck and Polit 2014). As participation may depend on interest in a topic this

may have resulted in exclusion of those least interested in suicide possibly biasing findings (Parahoo 2014). A study by Coggan *et al* (2006) measuring attitudes towards self-harm achieved a 50% response perhaps due to more pre-notification work, which might have enhanced this study (Allsop and Saks 2013).

Participant's gender, 11% of respondents were male, representative of nursing registrants (NMC 2015b). 12 nurses were aged between 21 and 35, 19 were 36-50 and 4 were aged between 51 and 65 years. The median age of the nurses lies between 36 and 50 years, the largest proportion of participants, representative of average nurses' age of 45 years (NMC 2015b).

Table 2

Total attitude scores for all participants			
Score	Frequency	Percent	Cumulative Percent
57	1	2.9	2.9
58	1	2.9	5.7
59	1	2.9	8.6
60	1	2.9	11.4
61	2	5.7	17.1
62	2	5.7	22.9
63	1	2.9	25.7
64	1	2.9	28.6
65	2	5.7	34.3
66	2	5.7	40.0
67	6	17.1	57.1
68	1	2.9	60.0
70	2	5.7	65.7
71	1	2.9	68.6
72	2	5.7	74.3
73	3	8.6	82.9
75	2	5.7	88.6
77	1	2.9	91.4
85	1	2.9	94.3
88	2	5.7	100.0
Total	35	100.0	

Variance is apparent in attitude scores, the average 68, median and mode scores were 67; note non-universal scores from 57 to 88 with a range of 31 (table 2). The rating scale depicts a more positive attitude towards suicidal patients the higher the score. Variance in scores suggests attitudinal difference.

Figure 1 Boxplot of participant attitude scores

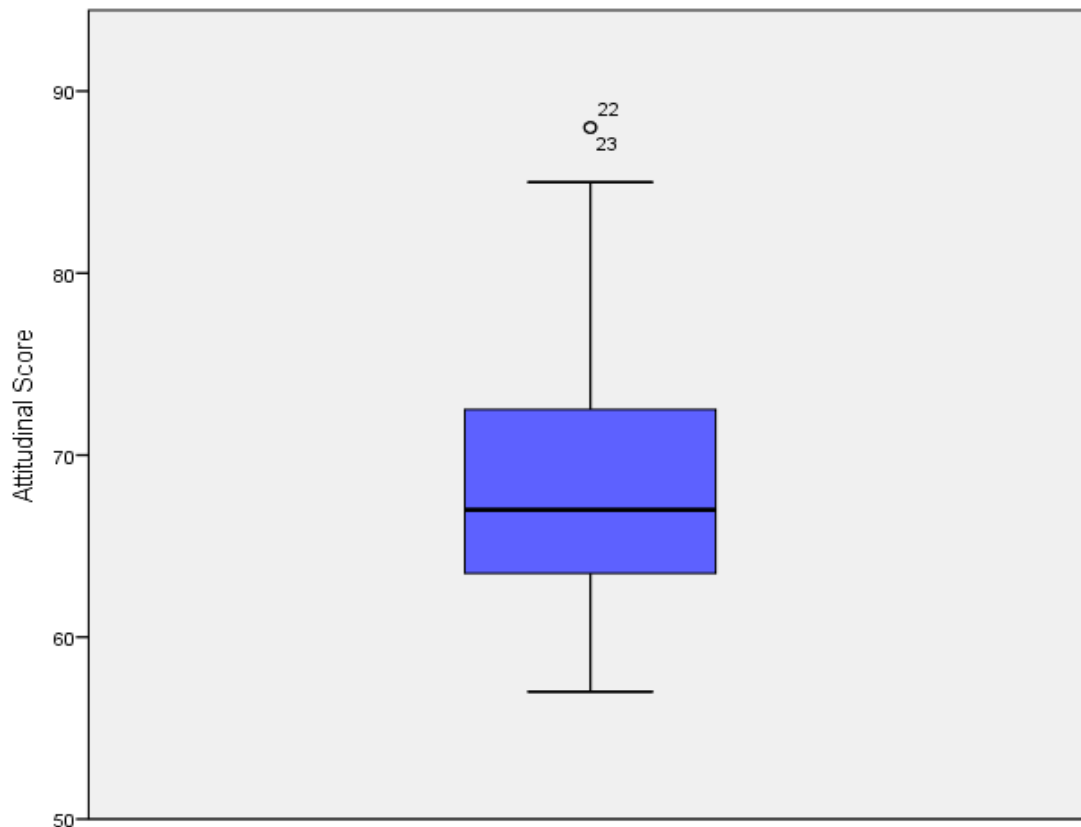


Table 3

Participant risk assessment scores			
Risk Score	Frequency	Percent	Cumulative Percent
8	2	5.7	5.7
9	3	8.6	14.3
10	1	2.9	17.1
11	1	2.9	20.0
12	1	2.9	22.9
13	1	2.9	25.7
14	3	8.6	34.3
15	4	11.4	45.7

16	10	28.6	74.3
17	2	5.7	80.0
18	3	8.6	88.6
19	3	8.6	97.1
21	1	2.9	100.0
Total	35	100.0	

A sum of total scores for risk recognition of 8=all risks identified, to 40=no risk recognition. Respondents identified many suicidal risk factors, two respondents (mode=6%) identified all, of the remainder, variable risk recognition is apparent, 94% recognised self-harm as a risk, 91% previous attempts, 97% noted mental illness was an associated risk, 91% substance misuse, 97% alcohol dependence 88% physical illness and social isolation. Contrasting beliefs are evident with 15 (42%) of participants disregarding suicide risk factors equating to 37% of risks denoted as rarely or never associated with suicide.

Table 4

Family history recognised as suicide risk			
	Frequency	Percent	Cumulative Percent
Often	4	11.4	11.4
Sometimes	17	48.6	60.0
Unsure	8	22.9	82.9
Rarely	5	14.3	97.1
Never	1	2.9	100.0
Total	35	100.0	

17 respondents were unsure of a least one particular risk, the least recognised risk was familial history of suicide unidentified by 17% (n=6), with a further 23% being unsure (n=8) of association (table 4).

Table 5

Number of participants having had some suicide prevention education or training			
	Frequency	Percent	Cumulative Percent
Yes	5	14.3	16.1
No	26	74.3	100.0
Total	31	88.6	
?	4	11.4	
Total	35	100.0	

Only 14% of participants recorded receiving education or training on suicide prevention (table 5).

Table 6

Independent Samples Test Suicide Prevention Training Versus Self-Reported Triage Competence

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Perceived triaging ability	Equal variances assumed	13.681	.001	-1.224	29	.231	-.300	.245	-.801	.201
	Equal variances not assumed			-1.342	6.188	.227	-.300	.224	-.843	.243

On analysis of variance between suicide prevention training and self-reported triaging ability an association can be seen that is statistically significant, suicide prevention education or training positively correlates with triage confidence (P=0.001).

Discussion.

Participation was 31%, 89% female, the majority aged between 36 and 50 years, most of remaining younger. Of the 35 respondents the average attitude score was

68, median and modal scores 67, a range of 31, the lowest 57 and highest 88, hence it is apparent scores are not universal with variance suggestive of attitudinal difference (table 2). Lower scores propose negative attitudes towards suicidal patients. 40 percent scored below average suggestive of negativity. Higher scores should correlate with more positive attitudes (40 percent). However if respondents anticipated desirable answers, or those with negative attitudes did not participate, results may be skewed, as suicidal patients profess negative nurses attitudes in ED, this may well be the case (Conlon and Tuathail 2012; Doyle *et al* 2007; Kondrat & Teater 2010).

Whilst the study has achieved the objective of measuring adult field ED nurses attitudes assuming the premise of those attitudes is challenging. It is apparent that scores are not universal, with disparity in positivity not of benefit to patients (Richards 2011). Coggan *et al* (2006), Cutcliffe *et al* (2006) and Farrell *et al* (2012) postulate that attitudes are affected by individual nurse and patient characteristics, with Barrowclough and Mackay (2005) and Austin-Payne and Whealtley (2009) suggesting characteristics affect the propensity of healthcare workers to support self-harming patients hence further exploration of characteristics may have been enlightening.

Experience relating to supporting suicidal patients was explored as was knowledge of perceived assessment ability, education and training undertaken or desired. Again difference was apparent for knowledge, self-rated assessment skills and educational experiences. The consensus that 'mental health nurses' are deemed more appropriate to care for emotionally distressed individuals (Farrell *et al* 2012) remained unchallenged. Relational conclusions from this and prior studies suggest education and training is associated with more positive attitudes towards suicidal patients attending ED. This study suggests suicide prevention education and

training positively correlates with increased adult field ED nurses confidence in triaging suicidal patients ($P=0.001$) (table 5). Although numbers are few so general inference is not feasible. Still if suicide prevention education and training enables nurses to confidently triage emotionally distressed patients, emanate compassionate care for suicidal patients, this substantiates the drive for education and training for adult field nurses working in ED (Barrowclough and Mackay 2005; Gijbels and McCarthy 2010). 40 percent of participants specifically request education and training. 5 per cent request training delivered by mental health personnel. Education and training is also known to improve referral rates to additional services thus having the potential to improve overall care and positively affect outcomes promoting suicide prevention (Carli *et al* 2011).

The questionnaire also measured participants' knowledge of suicide risk factors including self-harm, previous attempts, familial history, mental health disorders, substance abuse, alcohol dependence, medical illness and social isolation (University of Manchester 2015). All respondents identified numerous risks yet only two identified all, showing disparity in risk assessment, inferring cues may be missed and the likelihood of terminating life underestimated (table 3). Doyle *et al* (2007) postulates recognition of risk ensures staff maximise care by avoiding self-discharge by high risk patients. In practice a pathway aids assessment with 9 respondents referring to this, however Barr *et al* (2005) argue that even checklists necessitate education and training. Self-harm may for some patients be predictive of suicidal behaviour (Armitage *et al* 2006; Austin-Payne & Wheatley 2009) unlike findings from Coggan *et al* (2006) all but two participants in this study recognised self-harm as a potential suicide risk.

Table 6

Recommendations
<ul style="list-style-type: none"> • Evidence based education and training for adult field nurses working in ED on suicide prevention. • Derision of the content of the education and training programme to be constructed using tripartite methodology including contributions from service users ,PLNs and adult field nurses working in ED. • A blended approach to education and training programme delivery using both web-based training and face to face taught content delivered by PLNs. • Education and training could be rolled out to other healthcare personnel that suicidal patients encounter in ED including administrative staff, non-registered nurses, medics and radiographers. • Greater inclusion of suicide prevention education in pre-registration healthcare programmes. • Further research exploring healthcare professional's attitudes in supporting suicidal patients.

Table 7

Limitations
<ul style="list-style-type: none"> • This is a small exploratory study; a larger study would pose greater relevance. • The study sample was small (n=35) reducing generalizability of findings to a wider population.

- Participation of 31% equates to small uptake.
- ED nurses possessing negative attitudes may have chosen not to respond.
- There was little inclusion of individual ED nurses thoughts, feelings, attitudes and experiences which may be illuminated from a further study using focus groups.
- Only registered adult nurses were questioned despite a large number of medics and healthcare support workers caring for suicidal patients attending ED.

Conclusion

In many instances suicide can be prevented and healthcare staff important stakeholders in suicide prevention (WHO, 2013). This exploration of adult field emergency nurses attitudes towards suicidal patients attending ED identifies variance in nurses' attitudes however attitudes are not static and are dynamic so measurement is extremely complex. Nurses' preparedness to deal with suicidal ED patients was considered, again difference was apparent in nurses' knowledge and confidence in triaging ability (Barrowclough and Mackay 2005; Boore *et al* 2007; Chan *et al* 2009). Nurses feeling most able to care for suicidal individuals had received training in suicide prevention. In conclusion as education and training may positively affect attitude, risk identification and nurses' confidence to support suicidal patients attending ED, education and training in suicide prevention is recommended to benefit both patients and nurses. This propulsion towards suicide prevention could commence with greater inclusion of suicide prevention education and training in relevant pre-registration healthcare programmes.

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Appendix A

Questionnaire

Part 1-Demographics

Please tick one of the following options

1. What is your gender?

Male Female

2. Are you aged between?

21-35 36-50 51-65 66 or over

3. Was your pre-registration place of study?

School of Nursing University

4. What was your initial registration qualification?

State Enrolled Nurse Registered Nurse Diploma

Advanced Diploma Degree

Other please state.....

5. Have you undertaken any post-registration training?

Yes No

If Yes please state.....

6. What is the highest qualification you currently hold?

Diploma Advanced Diploma Degree Doctorate

Other please state.....

7. How long have you worked in Emergency Departments

<1 year 1-5 years 5 years or more

Part 2-Attitudes

Please indicate to what extent you agree or disagree to the following statements:

1. Suicide is an acceptable way to end an incurable illness

Strongly Agree Agree Unsure Disagree Strongly Disagree

2. If someone wants to commit suicide , it is their right and we should not interfere

Strongly Agree Agree Unsure Disagree Strongly Disagree

3. Suicidal behaviour in young individuals is never acceptable

Strongly Agree Agree Unsure Disagree Strongly Disagree

4. Potentially, every one of us can be a suicide victim

Strongly Agree Agree Unsure Disagree Strongly Disagree

5. Suicide is selfish behaviour

Strongly Agree Agree Unsure Disagree Strongly Disagree

6. It is the professional duty of the nurse to prevent any suicidal client from dying

Strongly Agree Agree Unsure Disagree Strongly Disagree

7. Those who attempt suicide are usually trying to get sympathy from others

Strongly Agree Agree Unsure Disagree Strongly Disagree

8. Individuals who attempt suicide are usually mentally ill

Strongly Agree Agree Unsure Disagree Strongly Disagree

9. Individuals should not have the right to take their own lives

Strongly Agree Agree Unsure Disagree Strongly Disagree

10. Suicidal behaviour among younger individuals is particularly puzzling as they have everything to live for

Strongly Agree Agree Unsure Disagree Strongly Disagree

11. Individuals who attempt suicide and live should be required to undertake therapy to understand their inner intent

Strongly Agree Agree Unsure Disagree Strongly Disagree

12. Suicidal behaviour can be irritating

Strongly Agree Agree Unsure Disagree Strongly Disagree

13. Suicidal behaviour is particularly difficult to deal with and requires specialist care

Strongly Agree Agree Unsure Disagree Strongly Disagree

14. Further training in the development of interpersonal skills would be of benefit when caring for the suicidal patient

Strongly Agree Agree Unsure Disagree Strongly Disagree

15. More than 50% of suicidal persons sought medical help within the six months preceding suicide

Strongly Agree Agree Unsure Disagree Strongly Disagree

16. Suicidal behaviour is essentially a way of crying out for help

Strongly Agree Agree Unsure Disagree Strongly Disagree

17. Individuals who commit suicide using public places (buildings or bridges) are more interested in getting attention than committing suicide

Strongly Agree Agree Unsure Disagree Strongly Disagree

18. Often individuals who attempt suicide are trying to make someone else feel guilty

Strongly Agree Agree Unsure Disagree Strongly Disagree

19. Individuals who talk about suicide often commit suicide

Strongly Agree Agree Unsure Disagree Strongly Disagree

20. Individuals who attempt suicide are often not religious

Strongly Agree Agree Unsure Disagree Strongly Disagree

21. Individuals who lack family relationships are more likely to attempt suicide

Strongly Agree Agree Unsure Disagree Strongly Disagree

22. Once an individual survives a suicide attempt, the probability of his/her trying again is minimal

Strongly Agree Agree Unsure Disagree Strongly Disagree

Part 3-Experience

Please choose an option

1. Do suicidal Patients present with any of these factors?

Self-harm?

Often Sometimes Unsure Rarely Never

Previous suicide attempts?

Often Sometimes Unsure Rarely Never

Family history of suicide

Often Sometimes Unsure Rarely Never

Mental health disorder

Often Sometimes Unsure Rarely Never

Substance abuse

Often Sometimes Unsure Rarely Never

Alcohol dependence

Often Sometimes Unsure Rarely Never

Medical illness

Often Sometimes Unsure Rarely Never

Social isolation

Often Sometimes Unsure Rarely Never

2. Do you feel confident triaging suicidal patients?

Yes No

Please explain.....

.....

3. How do you identify high risk suicidal patients?

.....

4. Have you had any training on suicide prevention if so what?

.....

5. Can you identify any training needs for those dealing with suicidal patients in Emergency Departments?

.....

Thank You for taking time to complete this questionnaire