Changing National Policy to Address Nurse Suicide

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EMOTIONAL ALERT: Sensitive Content Ahead

The following articles discuss topics related to suicide, mental health struggles, and emotional distress. Please be mindful of your well-being before continuing. If you or someone you know is experiencing thoughts of self-harm or suicide, please immediately seek support. You are not alone—help is available.

Immediate Support:

- **988 Suicide and Crisis Lifeline:** This hotline is available for people experiencing a mental health crisis. The 988 Suicide & Crisis Lifeline is designed to be a memorable and quick number that connects people who are suicidal or in any other mental health crisis to a trained mental health professional. Simply call or text the numbers 9-8-8.
- **Crisis Text Line** – Text HOME to 741741: This chat is staffed by trained volunteer crisis counselors.
- **911:** Importantly, if you or someone you know is experiencing a mental health crisis and immediate support and action is required, please call 911 or present to the nearest emergency department.
- **National Suicide Prevention Lifeline:** 1-800-273-TALK (1-800-273-8255)

Please take care of yourself, and don't hesitate to ask for help.

Dr. Judy E. Davidson serves UC San Diego as a nurse scientist, supporting nurses with project development, presentation, and publication. Her research focuses on issues of workplace wellness. She authored a textbook on workplace wellness and has published widely on the topics of blame, cultivating kindness in the workplace, suicide, and suicide prevention among healthcare professionals.

In the Beginning

I spent more than 30 years of my career in and around intensive care, as a staff nurse, clinical nurse specialist, and manager. I developed the first nurse protocol for train of nerve stimulation[1] and was lead author on the national practice guidelines for family centered care.[2,3] After moving into my role as nurse scientist, I continued to focus on researching topics related to critical care. Then one year, I heard through whispers in the wind, that not one, but three different nurses had died by suicide among our ranks.[4] After confirming, I went to the literature to see if this was higher than the expected incidence of suicide. Very little was known about nurse suicide in the world at that time. So, I cobbled together a research team and despite no funding, set out to find the answers. Were nurses at increased risk of suicide? The purpose of this article is to briefly describe our cumulative findings and advocacy efforts resulting in change to national policy.

"Hear me, see me, speak to me".
Artist: Linda Lobbestael, MSN, RN

The Shocking Truth Behind Job-Related Factors Associated with Nurse Suicide

We first studied nurse suicide in San Diego and found that the raw numbers among nurses were higher than non-nurses, but the findings were not statistically significant, probably due to small sample size.[5] We knew we were on to something, though, so we applied for access to the national suicide dataset maintained by the Centers for Disease Control and Prevention and embarked on studying the incidence of suicide among nurses, pharmacists, and physicians. We found that physicians were not at higher risk of suicide overall than non-physicians, but they had more known job-related problems prior to death than others.[6,7] The same exact finding came up with pharmacists. Incidence was not higher than the general population, but they had more known job-related problems prior to death.[8,9] Nurses, however, were a different story. For each of the years that the data existed (2005-2016) female nurses were at a higher incidence than non-nurse females. Male nurses were significantly higher for most years.[10] It's not that the problem was new or rising, the problem had always been sitting there in the data without anyone knowing it because no one had looked. Since that time, other researchers have confirmed our findings.[11,12] The shocking part of the story became evident quite quickly. When we looked at all the nurses who had job-related problems known prior to death and read the narratives from the death investigations conducted by police and coroners, we found something deeply disturbing. More than 90% of those nurses were either out of work or being processed out of their jobs for mental health concerns, chronic pain, illness or injury, or substance use disorder. Many of them were going through fitness for duty evaluations or criminal proceedings with the boards of nursing. The process of losing their job or license was thought to have tipped them over the edge. Lose hope and die by suicide was the assumption.[13] We've conducted iterative projects exploring the details trying to learn how to improve the situation and disseminated the results through national presentations and publications to raise awareness.[14-17] Our most recent paper, which covers data through the first two years of the COVID-19 pandemic, showed that female nurses were between 21 and 40% more likely to die by suicide than female non-nurses in the U.S.[18]

While discovering that nurses were at a higher risk of suicide than others, we simultaneously expanded the physician suicide prevention program at UC San Diego Health so that nurses and hospital staff could benefit from the program.[19] With the knowledge that nurses were at higher risk of suicide than the physicians, we were compelled to take action and equalize access to the unique suicide prevention services UC San Diego Health has to offer. The Healer, Education, Assessment and Referral (HEAR) Program was designed by physicians in 2009 after a series of physician deaths. The program includes confidential, encrypted, mental health screening as well as group emotional process debriefings after emotional workplace events. A third arm of the program centers around providing education to reduce stigma against seeking mental health treatment. My personal mentor, Dr. Sidney Zisook MD, worked in collaboration with Christine Moutier MD, Medical Director of the American Foundation of Suicide Prevention, (once a UC San Diego Health physician) to develop the screening tool used by HEAR. The screening covers many different mental health conditions known to be associated with suicide and works through anonymous encryption.[20] This means that each individual can complete the online screening and contact a therapist through encryption without ever disclosing their identity. The next step is referral into treatment when indicated without anyone knowing. Each individual seeking help can get the advice needed to take a leave of absence for substance use disorder treatment before being found impaired on the job or diverting medications, which could lead to discipline and termination known to be associated with suicide.[21] Since expanding this program to the entire hospital staff, we have referred over 1600 nurses and staff into mental health treatment in a psychologically safe manner.[20,22]

Contact hear.ucsd.edu to complete the anonymous encrypted screening and share with colleagues.

Advocacy and Outcomes

Internally, in addition to the extension of the HEAR program to all health system staff, the annual training on the topic of diversion of medications

has been reformed to openly discuss how to receive help for substance use disorder, converting the language from 'catching criminals' to 'connecting staff with care for a treatable disease'. Notably, we have worked with the medical staff office to improve credentialing questions, decreasing the stigmatizing questions that nurse practitioners and physicians answer to become credentialed at UC San Diego Health. Kristina James DNP, RN, who was one of the nurse managers conducting research on our team about nurse deaths during the pandemic, developed a program with Rachael Accardi, LMFT, HEAR therapist, to provide sorely needed training on how to talk to a suicidal colleague. We have also advocated with facilities management to begin to address the risk of suicide from tall buildings.

Externally, our research and prevention measures deployed by a large group of volunteers (our research has been nearly all unfunded) has led to national recognition and policy change. The surgeon general recognized and endorsed our method of detecting health care workers at risk using anonymous encrypted screening.[23] The Centers for Disease Control and Prevention commissioned the American Hospital Association to create a toolkit for healthcare executives to address the risk of suicide in health systems. I was called to serve as a content expert for the project including toolkit creation. Our collective research was cited to endorse these suicide prevention strategies.[24] The American Academy of Nurses further endorsed the nurse extension of the HEAR program for suicide prevention as an Edge Runner: a model for replication.[25] The National Academy of Medicine, in the Future of Nursing Report, and the American Academy of Nurses further endorsed separate calls for action to address suicide prevention for nurses.[26,27] The Dr. Lorna Breen Heroes' Foundation and Lorna Breen Act were stimulated by a physician death during the pandemic. The goals of these efforts were to address outdated licensure and credentialing issues, which ask about past personal mental health problems and sometimes medications. The questions violate The Americans with Disabilities Act and promote stigma against help-seeking behavior. The efforts of The Dr. Lorna Breen Heroes' Foundation were at one time focused purely on providers. Our research team collaborated and successfully advocated with the foundation to expand their scope of work to now include nurses.[28] Given what we have found related to the process of investigation for substance use disorder, and death by suicide, we have been advocating for changes in the system with the National Council of State Boards of Nursing, Tri-Council of Nursing, Nursing Organizations Alliance, Federation of State Medical Boards and the National Association of Boards of Pharmacy.[15,29,30] Internationally, our work was used to help stimulate changes in policies in suicide prevention for healthcare workers in England. Scientists used our collective work to establish the need to study nurse suicide in England, where the same problem was found. Following publication of their results the National Health Service created a nurse suicide dataset, a toolkit for suicide prevention, and mandated suicide prevention in all healthcare systems in the country.[31,32]

Conclusion

We noticed a heartbreaking problem, heard from those who died by suicide by analyzing their data and reading their stories in the death narratives recorded at the times of their deaths, published, and presented widely to speak the truth. This truth-telling resulted in change.

It started out of curiosity spurred by emotions. How could three nurses die in one year from one organization? The research mission of UC San Diego Health is truly enculturated. Our institutional spirit of inquiry coupled with the autonomy afforded to our research team to conduct this research, has since resulted in a great awakening within the profession. As I now prepare for retirement in June 2025, I leave behind a long list of leaders prepared to continue this advocacy into the future (See list of authors in references for a complete list). I thank every volunteer on our research team who has engaged in this work over time, and especially thank my mentor Dr. Sidney Zisook for guiding me in the process.

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