American individuals attempt suicide at alarmingly high rates of approximately 1.1 million times per year. Yet the United States has failed to adopt a systematic approach to suicide prevention, particularly via universal screening. Given the increasing number of individuals with suicidal ideation presenting to emergency departments (EDs), all patients who present to the ED for treatment should be screened, as opposed to only individuals with mental health complaints. In the current article, barriers to suicide screening in the ED are discussed, as well as strategies to move ED providers toward the goal of universal screening. The current article entreats nurses to be leaders in achieving universal screening and provides practical actions to begin the process. Specific recommendations for action include improving training, increasing lethal means assessment, and achieving compliance with The Joint Commission suicide screening guidelines. [Journal of Psychosocial Nursing and Mental Health Services, 56(10), 21-26.]
numbers, the United States has failed to adopt a systematic approach to suicide prevention.

Olson, Marcus, and Bridge (2014) declared that reducing the rate of suicide has become an elusive public health goal. Crafting a public health approach to the issue will demand a multifaceted approach, particularly viewing suicidal ideation in relationship to multiple forms of violence (e.g., interpersonal) and seeing risk as not only a mental health issue, but connected to phenomena such as life stressors and financial problems (Crosby, 2015). Increasing preventive detection is one element of the approach (Caine, 2013). Preventive detection must be comprehensive, adopted by schools, community health agencies, and hospital centers, particularly EDs.

To achieve preventive detection, universal suicide screening (i.e., screening for suicide in all patients who present to the ED rather than only individuals with mental health complaints) is necessary. Although improving ED preventive detection seems a reachable goal, significant barriers exist at the organizational and provider levels. For instance, ED provider attitudes, beliefs, knowledge, and confidence impact willingness to screen individuals (Betz, Miller, et al., 2013). In addition, a systems-level barrier, lack of access to mental health experts, compounds screening issues (Betz, Miller, et al., 2013; Betz, Sullivan, et al., 2013).

Understanding the interplay of these barriers is essential to crafting a feasible agenda for preventive detection, which, in the ED, includes universal screening. In the current article, researchers examine the multiple barriers that impact universal suicide screening in EDs and suggest strategies to address them. Barriers were identified through a literature search via the CINAHL, Psychiatry Online, Google Scholar, and PsycINFO databases, using key words emergency department, emergency room, suicide, and suicide screening. To formulate barriers, researchers drew heavily from the most recent, largest, data-based studies. Implications for nursing include a call to action for nurses to collaborate regarding the public health goal of achieving universal screening.

A multiphase research study on suicide screening in the ED provides an excellent start to the discussion of barriers to suicide screening. As the Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE; Boudreaux et al., 2013) project is the largest study to date on suicide screening in the ED and the basis for several related studies, the project is explained in detail.

EMERGENCY DEPARTMENT SAFETY ASSESSMENT AND FOLLOW-UP EVALUATION STUDY

In the ED-SAFE study, Boudreaux et al. (2013) used a three-phase approach in eight hospital EDs. First, researchers implemented universal screening as well as interventions for those who screened positive for suicide risk. Between phases two and three, an intervention was introduced that included a safety assessment and planning as part of a brief ED intervention, as well as a follow-up telephone intervention that included post-ED counseling (Boudreaux et al., 2013). Outcomes evaluated across phases included rate of detection of ideation and behavior, suicidal behavior, receipt of a personalized safety plan, and behavioral health engagement.

Following the study, participating EDs’ charts were examined to determine the degree to which providers were adhering to interventions the research team implemented (Ting et al., 2012). Researchers found that despite participating in the study, ED staff members were not assessing all patients for suicide. Of the sample of patient charts (N = 800) from various study sites, only 39 charts contained documentation that a suicide screening was completed. The biggest patient predictor for being screened was whether the patient reported a psychiatric issue, alcohol or drug abuse, or current or past suicidal ideation (Ting et al., 2012). Yet, even patients with these risk factors were not necessarily screened.

BARRIERS TO SUICIDE ASSESSMENT

Limited Provider Confidence and Self-Efficacy

A significant barrier to screening is provider confidence and self-efficacy regarding suicide assessment and screening (Betz, Sullivan, et al., 2013; Zun, 2012). Suicide screening involves several elements (e.g., assessment, determining risk), and provider confidence varies depending on which of these elements is required. Although ED providers believed they could confidently screen a patient for suicide, they were less confident assessing actual level of risk or providing counseling to the patient (Betz, Sullivan, et al., 2013). Providers’ discipline (e.g., nurse, physician) mattered, and providers in different disciplines had different confidence levels. Although all providers expressed low confidence in safety planning, physicians were less confident than nurses forming a safety plan with patients who were suicidal. Interestingly, nurses were more likely to engage in universal suicide screening than physicians, a phenomenon that was directly related to self-identified confidence in assessing suicidal patients (Betz, Sullivan, et al., 2013).

Another way to view screening confidence is to consider the relationship between knowledge, self-efficacy, and suicide screening. In one study focused on this relationship, four dimensions were considered: knowledge, confidence, effectiveness, and negativity (Egan, Sarma, & O’Neill, 2012). Providers who participated in the study by Egan et al. (2012) expressed limited knowledge and lack of confidence in assessing and treating patients who were suicidal. Confidence impacted self-efficacy in ED providers’ management of patients who were suicidal, which in turn impacted their performance (Egan et al., 2012). Self-efficacy, a component of Bandura’s Social Learning Theory, holds that task completion depends in part on an individual’s belief in his/her ability to succeed in a given situation (Bandura, 1997). In the view of Egan et al. (2012), self-efficacy played a particular role: high self-efficacy positively
impacted individuals’ abilities to appropriately respond to situations and their emotional reaction to that situation. When surveyed, approximately 15% of staff participants reported they were “not at all confident” in their ability to respond to self-harm patients.

In a related study, Gordon (2012) surveyed junior physicians who were just beginning their ED rotations, examining confidence, knowledge, and skills, as well as concerns junior physicians had related to assessment of patients with mental illness, and, specifically, a threat of self-harm. More than 80% believed they had inadequate knowledge about mental health, and 72% reported low or partial confidence in their assessment of mental health patients (Gordon, 2012). A significant predictor of partial confidence in mental health assessment was previous psychiatric training. Participants also reported their assessment of patients with self-harming behaviors. Of those who participated, 13% used assessment strategies that were considered inadequate based on National Institute for Health and Clinical Excellence standards. Approximately 35% gave assessment measures that were better, but still incomplete. These strategies missed important assessment features, such as asking about psychiatric history and the actual intent of the suicidal act (Gordon, 2012). Gordon (2012) concluded that approximately one half of the junior physicians did not have the knowledge or confidence to appropriately assess patients who were suicidal.

Provider Attitudes and Beliefs

Provider attitudes and beliefs also impact universal suicide screening. The relationship between these variables is complex, as are the attitudes that impact screening, such as providers’ attitudes toward patients who self-harm (Zun, 2012). In Egan et al. (2012), researchers found that the majority of ED providers (e.g., nurses, physicians) had at least somewhat negative attitudes toward patients who present with self-harm. As knowledge and sense of self-efficacy increased, providers’ negative feelings toward this patient population decreased (Egan et al., 2012). Attitudes also varied depending on the individual’s presentation. High rates of self-harm and “repeat” patients generated more negative attitudes among ED providers.

Another perception that influences screening is whether suicide is preventable and the likelihood that the attempt will be repeated (Betz, Miller, et al., 2013; Betz, Sullivan, et al., 2013). Negative attitudes can arise from personal bias and internalized societal beliefs and stigma regarding individuals with mental health issues (Zun & Rozel, 2016). Such attributions, along with low optimism for success, are associated with a reduction in helping behavior (Mackay & Barrowclough, 2005).

Evidence supports that restriction of access to lethal means is an effective suicide prevention strategy, yet providers may not share this belief. In the EDSAFE study, many ED providers did not believe that removing access to a firearm would prevent a future successful suicide attempt (Betz, Miller, et al., 2013). In addition, ED providers (nurses and physicians alike) believed that patient/family conversations regarding restricting firearms should be performed by a mental health expert, such as a psychiatrist, psychiatric nurse, or social worker. As a result, 60% of ED providers who were surveyed stated they “hardly ever” counseled patients and families on this topic (Betz, Miller, et al., 2013). Therefore, discussing effective suicide prevention strategies, such as removal of access to lethal means, is a missed opportunity in many EDs.

Another factor that influences universal screenings is providers’ beliefs regarding how suicide screening impacts ED workflow (Betz, Sullivan, et al., 2013; Petrik, Gutierrez, Berlin, & Saunders, 2015). The ED is a busy place, and patients with psychiatric concerns can be seen as a drain on time, as well as taking away focus from medical emergencies (Petrick et al., 2015). Unsurprisingly, the ED-SAFE study found that providers believed universal screening would lead to an increase in number of required psychiatric evaluations. In addition, most physicians said universal screening would cause a delay in clinical care. However, only approximately 30% of nurses agreed, indicating that generally, nurses believed ED workflow could accommodate universal screening (Betz, Sullivan, et al., 2013). Thus, the perception that universal screening would impact workflow is compounded by the belief that suicide screening is time consuming and would add additional pressures to an already burdened system (Petrik et al., 2015).

Provider Screening and Access to Mental Health Experts

Although ED staff are often first line providers for assessing patients who are suicidal, many staff members believe it is not their responsibility to perform suicide assessment, or that it is safer if a mental health expert performs the assessment (Betz, Miller, et al., 2013; Petrik et al., 2015). ED nurses and physicians also identified insufficient knowledge of legal regulations, which they perceived left themselves and patients vulnerable (McAllister, Creedy, Moyle, & Farrugia, 2002). Thus, lack of access to mental health experts is a significant barrier to universal suicide screening (Roy et al., 2017), particularly when accompanied by the belief that support from mental health providers was rarely available when needed (Betz, Sullivan, et al., 2013). Providers also identified lack of training and knowledge on how to care for patients who are suicidal, particularly after patients screened positive for suicide risk. Providers believed they were ill-equipped to determine the acuity of suicidal ideation, for instance assessing the lethality of a plan or passive versus active ideation (Betz, Sullivan, et al., 2013). Unfortunately, with increasing numbers of patients presenting to EDs with psychiatric complaints and limited psychiatric providers (Association of American Medical Colleges, 2016), follow-up assistance on handling individuals with positive suicide screens may not be available.
STRATEGIES TO INCREASING SUICIDE SCREENING RATES

Given the barriers, a comprehensive approach to suicide screening is needed. Targeted interventions for increasing screening among ED staff members have been identified. Strategies include educating providers, increasing availability of screening tools that facilitate screening, and designing workflows for in-hospital mental health consultation and after-care referrals (Suicide Prevention Resource Center, 2015). In addition, emerging standards in practice guidelines on prevention and risk assessment provide guidance for key areas that should be included as institutions form their clinical guidelines (Bernert, Hom, & Roberts, 2014).

Several effective approaches are available to address deficits in provider education. Giordano and Stichler (2009) provide a roadmap for implementing staff education and evaluating its outcomes. But educational approaches need not be complex. Currier et al. (2012) evaluated the efficacy of education via a simple educational poster and clinical guide on suicide. The poster focused on suicide prevention and offered data on suicide. The clinical guide included much of the same information as the poster but also incorporated information on risk assessment and discharge and documentation checklists. Participants included all ED providers. Surveys were administered before and after the educational materials were distributed and 218 providers completed the intervention. Results support that these types of educational tools increase ED provider knowledge on suicide risk and improve management of patients with suicidal ideation (Currier et al., 2012).

Education on interventions, including follow-up procedures, also improves suicide screening (Betz et al., 2015). Interventions incorporate safety planning with the patient and offer suicide prevention resources. Interventions do not require mental health experts, but can be guided by a safety plan template the provider completes with the patient. Additional resources for staff training can be found on the American Foundation for Suicide Prevention website (access http://afsp.org/wp-content/uploads/2016/04/Health-Professional-Training-Issue-Brief.pdf).

As screening is impacted by attitudes and confidence level, education should aim to improve provider attitude and self-efficacy. Changing the content delivered in continuing education and workshops is one way to improve provider attributes (McAllister et al., 2002). Patterson, Whittington, and Bogg (2007) used the Self Harm Antipathy Scale to measure levels of antipathy experienced by a sample of 69 health care professionals. Participants completed a module called “Understanding and Managing Self Harm and Suicide.” After completion of training, participants experienced a significant drop in antipathy toward patients with self-harm and suicidal ideations.

Education on attitudes should include content to increase empathy, decrease work stressors related to management of individuals who are suicidal, and increase self-awareness of providers’ feelings about suicide. To increase confidence in screening, suggested educational content includes use of information and practicing skills. Staff education modules should also include information on follow up and aim to improve knowledge of local and institutional regulations.

For successful adoption of universal screening, impact on workflow must be recognized. Boudreaux et al. (2016) found that providing simple universal screening tools increased ED providers’ likelihood of screening for suicide. More frequent screenings also led to an increased rate of identifying patients with suicidal risk. Although screenings and risk detection increased, there was no significant impact on providers’ workflow routine (Boudreaux et al., 2016). The Suicide Prevention Resource Center (2015) Guide provides suggestions on how to incorporate screening and documentation into workflow.

One strategy to facilitate workflow is making screening tools part of the electronic medical record. Another workflow modification would establish a two-step screening process with a tool such as the Patient Health Questionnaire-9 (PHQ-9). Screening tools such as the PHQ-9 or PHQ-2 can detect patients at risk for suicide who would not have been identified otherwise (The Joint Commission, 2016). A medical assistant could be trained to complete the first two-question screen (PHQ-2).

Staff members often are reluctant to screen without a procedure in place to manage positive screens. Workflows must be established for how ED staff connect with mental health consultation teams, particularly to perform further evaluation of risk level. For EDs without on-call or available psychiatric providers, the time to assessment can be problematic. In a system short on mental health providers, telepsychiatry may be an option, as it has been supported as an evidence-based method to assess ED patients. Seidel and Kilgus (2014) found no differences in the disposition recommendation, strength of recom-
mendation, or diagnosis when telepsychiatry assessment was used compared to face-to-face assessments.

A CALL TO ACTION FOR INCREASING SUICIDE SCREENING

Suicide risk continues to go undetected in health care settings, including the ED. Yet the ED has been recognized as an appropriate setting for managing imminent risks, such as suicidality (Babeva, Hughes, & Asarnow, 2016). Researchers note the use of screening tools fits well within ED structure, and that the setting could be resourced to manage positive screens and facilitate follow-up plans (Bernert et al., 2014). Nurses, particularly ED and psychiatric–mental health nurses, must strategize on how to build a structure for universal screening, determine the resources and training such screening will require, and systematically collect outcomes on their efforts.

Emerging regulations should bolster these efforts. The Joint Commission (2015) recently released a National Patient Safety Goal (NPSG) as well as sentinel event alert related to screening for patients who are suicidal. The NPSG holds that any patient in a psychiatric or general hospital being seen for a mental health reason must be screened for suicide. The Joint Commission (2016) has also issued a sentinel event warning, noting that contributing factors to many suicide-related sentinel events were deficiencies in psychiatric assessments. Indeed, patients may have what is considered “silent suicidal ideation” (Ting et al., 2012, p. 239), and individuals may be suicidal although they do not have identified risk factors (The Joint Commission, 2015).

RECOMMENDATIONS

To achieve universal screening, specific actions by the nursing community should include:

- improving training in suicide assessment for all professionals, including mental health providers (Schmitz et al., 2012), which is in line with recommendations of the American Association of Suicidology Task Force;
- increasing lethal means assessment of individuals who screen positive for suicide risk;
- contributing to development of interdisciplinary guidelines for suicidal assessment and intervention in the ED, such as ones suggested by Betz and Boudreaux (2016);
- developing mechanisms to monitor compliance with The Joint Commission recommendation on screening; and
- examining root causes of delays in reaching psychiatric consultation and trial possible solutions, such as telepsychiatry and response to crisis, using living room models.

CONCLUSION

Suicide is a national health emergency. The ED has become the first point of contact for patients with suicidal ideation. Universal screening is imperative to ensure adequate risk assessment for all patients, not only ones presenting with primary mental health complaints. Nurses are critical to action on this issue due to their role in assessing for suicide risk and planning management strategies for patients who screen positive, and nurse leadership on this issue is essential. Together, armed with knowledge of barriers and evidence-based approaches to screening, psychiatric and ED nurses can accomplish universal screening and help decrease the rate of suicide.

REFERENCES


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