Royal College of Nursing

Understanding the factors underpinning suicidal ideation amongst the UK nursing workforce from 2022 to 2024

RESEARCH REPORT

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Understanding the factors underpinning suicidal ideation amongst the UK nursing workforce from 2022 to 2024

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Foreword

Nursing is vital to the health and care system, providing care and support to patients, service users and their families. However, it is essential to acknowledge that registered nurses themselves can face significant challenges, some of which can adversely affect their mental health, including thoughts of suicide. This report explores the prevalence of this issue and its impact. It highlights the urgent need to address mental health support for registered nurses, including the creation of supportive and empowering workplaces.

The report recognises that suicidal ideation is complex and that talking about causality is something to be avoided. And we know that high-stress levels and suicidal thoughts among registered nurses can be attributed to factors beyond the workplace, such as personal circumstances or external stressors. But if registered nurses are being pushed so hard at work they feel suicidal – sacrificing their welfare to care for patients – then that should be a cause for great shame.

The introduction of national suicide prevention programmes UK-wide and the creation of specific toolkits for employers are positive steps in addressing mental health issues and suicide in the workforce. However, this report serves as a reminder of the existing gaps in mental wellbeing support, the adverse effects of harmful workplace cultures, and the need for additional policy, organisational and individual action.

Addressing mental health issues among nursing staff does not solely depend on policy changes but also on shifts in societal attitudes. Anti-stigma campaigning and the availability of appropriate support structures for all health and care workers, in and outside of work, are paramount. By acknowledging recommendations and addressing the challenges outlined here, we can create an environment where the nursing workforce feels valued, supported and enabled to provide high-quality care.

I extend my gratitude to the researchers, contributors and everyone involved in bringing this report to fruition. I am confident that the insights contained within it will contribute to positive change in the nursing and midwifery workforce. Together, we can work towards a future in which parity of esteem between physical and mental health is given the importance it deserves, and each member of the workforce receives the support needed to thrive personally and professionally.

Professor Nicola Ranger

General Secretary and Chief Executive, Royal College of Nursing

Executive summary

This report sheds light on the factors influencing suicidal ideation in the UK nursing workforce and is based on a deep dive into RCN member-support data from February 2022 to February 2024. The findings have been crucial in understanding the challenges faced by nursing staff and identifying potential areas of system-wide intervention and support.

The sections of the report include a literature review, an in-depth analysis of RCN data, a description of data from the RCN Counselling service, recommendations, plus appendices with additional supporting information.

The report underlines the lack of literature on the prevalence of and factors that contribute to suicidal thoughts among UK nursing staff. Key findings include a notable increase in "high-risk" cases and a rise in members expressing suicidal thoughts, as demonstrated by RCN data, and a rise in demand for RCN Counselling services.

Workplace pressures are a particular focus of the report; they were among the contextual and influencing factors for 69% of members who accessed RCN Counselling services with reported suicidal ideation.

In response to the challenges identified, the RCN plans to continue its collaboration with partners and stakeholders to advocate for evidence-based, integrated suicide prevention programmes for the nursing workforce. The report also outlines our 4 important workstreams to address equity, reduce stigma, promote civility and compassion, and leverage influence and accountability.

The RCN is developing Compassion in Practice – an initiative to establish new workplace standards that address the work-related pressures faced by the nursing workforce across the UK. Focused on promoting compassion in practice, this project aims to set new benchmarks for the nursing and broader health and care workforce, ultimately enhancing the experiences of nursing professionals in health and care services.

The significance of this report cannot be overstated as it confirms the pressing need for action to support the mental wellbeing of the UK nursing workforce, which is at a higher risk of suicide compared to the general population. The report's insights and recommendations serve as a clarion call for all to prioritise the mental health and wellbeing of nursing staff[1] across the UK.

1 The term nursing staff includes registered nurses, registered nurse associates and nursing support workers.

Glossary of terms

Suicide: this is the term for the act of intentionally taking one's own life.

Suicidal ideation: this broad term refers to the thoughts and feelings people experience about suicide.

Diathesis: this refers to a stress theory that proposes that both genetic predisposition and exposure to stress contribute to the development of mental disorders and medical conditions.

Contextual factors: this report considers the organisational culture, environment, structure and processes that underpin the experiences of the nursing workforce.

Influencing factors: this refers to circumstances and events that may, individually or in combination, contribute towards someone's experiences of suicidal ideation.

Workplace pressures: a combination of contextual and influencing factors that emerge through the workplace and are perceived as contributors to suicidal ideation.

Section 1: Background and context

At RCN Congress in 2023, members voted in favour of a resolution calling on RCN Council to lobby for an evidence-based, integrated suicide prevention programme for the nursing workforce across the UK.

As a result, the RCN will collaborate with partners and key stakeholders UK-wide to promote and engage with strategic and operational activities that support the implementation of such a programme. Furthermore, the RCN has identified 4 workstreams to underpin the broader scope of work in this area.

1. To enhance equity and support for marginalised groups.
2. To reduce the stigma surrounding mental health and suicide.
3. To move organisational and team-level culture towards civility and compassion.
4. To use our lobbying powers to influence change, strengthen accountability, while celebrating and recognising best practices.

It is documented that registered nurses are at a higher risk of suicide compared to the general population (National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), 2020). However, there is a lack of information available in the literature regarding the prevalence of and factors that contribute to suicidal thoughts among UK nursing staff.

RCN Counselling services have seen a significant rise in “high-risk” cases between 2022 and 2024, with a surge of over 200% in members requiring immediate safeguarding and intervention due to mental distress. This troubling trend is supported by broader RCN data, which shows an increase in members expressing suicidal thoughts during the same period, with or without accessing our counselling services.

With new data emerging from RCN member cases, there is a moral obligation to investigate and report on this issue. Doing so will strengthen the RCN’s position to act and lobby for the implementation of an evidence-based and integrated suicide prevention programme for the UK nursing workforce.

The latest data on suicide (Office for National Statistics (ONS), 2023a) recorded 5,642 deaths in the England and Wales. Of these, 4,179 (74.1%) were males, and 1,463 females (25.9%). These gender disparities are observable across the recorded suicide data, with male fatalities surpassing those of females. However, suicide data reported by the NCISH identified an opposing trend, with female registered nurses more likely to die by suicide than male registered nurses (the data is limited to individuals identifying as male or female). In addition, female registered nurses are considered to be 23% more likely to die by suicide than females in the general population (NCISH, 2020).

The Health and Safety Executive (HSE) (2022) states that isolation, relationship breakdown, financial problems and pre-existing mental health conditions, along with other workplace factors such as bullying, job insecurity, discrimination and work stressors may contribute to suicide. This is echoed in the NHS Wellbeing Framework Strategic Overview (NHS England, 2021): 28.5% of NHS staff reported experiencing bullying in the previous 12 months, and 12.3% said they had experienced bullying and harassment at work from managers and 19% from other colleagues. The behaviour of managers is understood to increase staff stress, with 69% of employees identifying this as an issue (NHS England, 2021).

International picture

Concern about suicide risk in registered nurses is not a new phenomenon and has been highlighted since the 1990s (Kelly et al., 1995; Kelly and Bunting, 1998; Hawton and Vislisle, 1999), with the vulnerability of female registered nurses identified in the national and international literature (Hawton et al., 2002; Alderson et al., 2015; Windsor-Shellard and Gunnell, 2019). There is plenty of international research dedicated to understanding suicide in the nursing workforce. A full review and discussion of this are outside the scope of this report. However, a recent high-quality systematic review examined prevalence, contributory factors and prevention interventions relating to suicide, self-harm and suicidal ideation in registered nurses and midwives in the international arena (Groves et al., 2023).

From an eligible 100 articles, the review team concluded that a combination of factors contributed to the elevated risk of suicide in the nursing workforce, with mental illness, psychological health, occupational factors, alcohol misuse and physical health being particularly significant. Other factors highlighted in US studies were the impact of formal work processes such as investigations and related threats of financial worries and job loss. There was an overall elevated risk of suicide among female nursing staff related to their perceived burden of caring and longer working hours.

UK picture

There is limited research on suicide in the nursing workforce in the UK. A small, dedicated group of academics have studied and continue to study and collate information in a bid to understand and contribute to the prevention of suicide in this occupational group. Prior to 2023, there were no organised processes or systems to track suicide in nursing staff, despite the focus on the issue in the 1990s, mentioned above.

In their study of nurse suicide in England and Wales, Hawton et al. (2002) concluded that addressing issues of substance misuse and comorbidity, while detecting incidents of self-harm and previous suicide attempts were vital in suicide prevention. Relationship and financial difficulties, access to means of suicide, and knowledge of how death occurs were also found to be significant risk factors associated with suicide in nursing staff. It is more than 20 years since this research was published and reports continue to show nursing staff are a high-risk group, with similar themes presented as risk factors following the coronavirus pandemic and the recent UK financial crisis.

The NCISH brief report on nurse suicide (2020) revealed that an average of 47 registered nurses in England died from suicide each year from 2011 to 2016, a total of 281 deaths. Male and female registered nurses aged between 45 and 54 are considered to be more likely to die by suicide (NCISH, 2020), and female registered nurses have a 23% higher risk of suicide than other women (NHS England, 2023). Despite these concerns, Peate (2022) highlighted that there were no national studies in the UK to determine factors related to suicide in registered nurses. This may change with collaboration between NHS England and NCISH to develop data-collection strategies.

General UK population data

The impact and ripple effect of the loss of an individual to suicide are tangible in communities connected to the person, and it is not unusual for those bereaved to experience suicidal thoughts. The crucial point of intervention is preventing such thoughts from converting to distress and associated action. Suicide prevention is a priority for each country in the UK. The main findings in national general population data drives suicide prevention frameworks. For example, the National Records of Scotland (2023) record an increase in male suicides in the year to date, with suicide 3 times more common in places of socioeconomic deprivation. In addition, family breakdown, insecurity of employment, and alcohol and substance misuse are significant risk factors. In Northern Ireland, people are 3 times more likely to die by suicide if they live in an area of socioeconomic deprivation. There is also a noted trend of suicide in people who are single or divorced, consistent with the other UK countries (NISRA, 2023).

Data from a 10-year census (2011-2021) in England and Wales highlights sociodemographic inequalities. A higher risk of suicide than the general population is also reported for those identifying with a disability (limiting health-impacting day-to-day activity in the last 12 months or more), those who are long-term unemployed or not working, or single or separated (Ward et al., 2024). The University College Administration Service (2021) noted that 13% of UK nursing applicants declared a disability on their application form compared to 14% of all UK university applicants; those applying for mental health nursing courses were twice as likely to report mental health conditions; and children's nurses were twice as likely to declare a long-term illness, highlighting vulnerability to changes in health status prior to the demands of university and working life. In addition, people who have self-harmed or are in contact with mental health services or justice systems, autistic people, and pregnant and new mothers are listed as high-risk groups (Department of Health and Social Care (DHSC), 2023). National data on suicide recorded by the NCISH (2021) showed middle-aged men (aged 40 to 54) as the highest-risk group; 34% of men in this category who took their own life were bereaved (6% by suicide); 4% had previously self-harmed; and 52% had a recorded physical health condition. This data was extracted from several official sources in England, Scotland and Wales. This list is not exhaustive: different reports, data and evidence suggest other pronounced risk factors.

There are similarities in risk factors for suicide across the 4 UK countries, and obviously there is no single reason for a death by suicide. Rather, there is a complex aetiology with interrelated factors, along with a demographic context that influences significant life events and stressors. The deep dive into RCN data outlined in this report is aimed at understanding the contextual and influencing factors that contribute to suicidal ideation or attempts at suicide among RCN members.

Understandably, national challenges for suicide prevention are ongoing. Regardless of regular government funding in this area, the number of suicides recorded is not decreasing significantly. There are many reasons why. However, with the National Audit Office (2023) recording concern over the projected continuing gap between supply and demand for mental health services, the focus is on nurse employers, communities and charities to collaborate and produce a cohesive approach to suicide prevention. If nursing students can be equipped with an understanding of suicide and the skills to respond with compassion to distress, it is hoped these qualities can, on registration, transfer into the workplace and beyond so that nursing staff can recognise and reach out to one another. Given the national picture of suicide and the rising moral and ethical tensions connected with stress in the workplace, it can be argued that professional bodies have a duty of care to respond to concerns about suicide in the nursing workforce.

Section 2: Aims and objectives

Understanding the contextual factors of suicidal ideation in the UK nursing workforce: a deep dive into RCN data from February 2022 to February 2024

Aims and objectives

Aim

This study aims to understand the contexts underpinning the increase in reported suicidal ideation in the nursing workforce in the UK, from February 2022 to February 2024, by exploring RCN data[2].

Objectives (subject to available data)

1. Review the existing empirical literature to gain better insight into the prevalence and contexts of suicidal ideation in the UK nursing workforce from 2014 to 2024, identify gaps and make recommendations for further research, policy, and practice.
2. Through RCN data, explore and understand the factors influencing suicidal thoughts among the UK nursing workforce.
3. Through RCN data, investigate the contextual factors contributing to the increase in suicidal ideation in the nursing workforce.
4. Through RCN data, understand the support or interventions that may have helped members of the nursing workforce to manage and overcome suicidal thoughts.

Intended outcomes

To publish a report that provides background information, reviews the empirical literature, analyses RCN data, and presents recommendations for the RCN and our UK-wide stakeholders, including employers and the extensive health and care system.

For the RCN to have a robust understanding of the factors behind suicidal ideation in members, guiding the Congress-mandated programme, and to enhance meaningful communications and external influence.

Ethical considerations

Although incidences of suicide will not be referred to explicitly, the topic of suicide and self-harm can be distressing and triggering. The Samaritans' Media Guidelines on reporting on suicide and self-harm will be adhered to, ensuring a robust quality assurance process to guide this study's formation, publication and dissemination (Samaritans, 2020). Information governance is central to this study.

2 The RCN has a member support and advice line that provides free, confidential advice, representation and support on various issues that affect members at home and at work.

Confidentiality

The analysis of RCN data was managed with care, and extra measures were taken to ensure the anonymity of members and staff. The RCN Counselling service holds brief notes from the counsellor and Clinical Outcomes in Routine Evaluation (CORE) statistics, following the General Data Protection Regulation and the 2018 Data Protection Act. The RCN Counselling service contract refers to the CORE questionnaire for routine service evaluation. The contract stipulates: “The information provided helps the service to be more responsive to members’ counselling needs, to improve the service and to provide general anonymised statistics about the service for the purpose of promoting the wellbeing of registered nurses and health care professionals” (RCN, 2019).

Section 3: Literature review

This section reports on the grey and empirical literature regarding suicide among registered nurses in the UK. Empirical research in the UK is limited so the grey literature is an essential inclusion to share national data, highlights reports and policies, and provides analysis and commentary, as well as a relevant and broad picture.

Literature search

The narrative review included searches in CINAHL and MEDLINE databases and a scan of reference lists for possible missed studies. See Appendix 1 for a complete record of the inclusion and exclusion criteria, search terms and Boolean indicators. Note that a search of the UK literature regarding nurses and suicide revealed no empirical studies related to protected characteristics as identified in the Equality Act 2010. An additional search included a combination of the search terms Black, Asian and ethnic minority and showed no returns. Adding titles for health care assistants and the workforce returned no additional articles.

Concerning Appendix 1, results were taken from lines 14 and 17 of the search (383 results), and reference management software was applied to remove duplicates and irrelevant results using appropriate subject headings. The search strategy was broad, given the specific focus on the UK. Keyword and subject headings were adopted for the UK to help narrow the results to the last 10 years. The remaining 30 articles were assessed for eligibility and a reference chase identified one more article. The final number of articles included was 8 after news articles, international studies and systematic reviews were removed.

There is a substantial amount of international literature on nurse suicide, but it is remarkable that there is a paucity of research in the UK related to suicide in the nursing workforce, specifically qualitative studies exploring work stress and suicide, female nurse perspectives of lived experience (related to the identified elevated risk in female registered nurses), and studies exploring supportive and helpful interventions. The impact of COVID-19, media impact and self-harm are the main identifiable themes.

The impact of the COVID-19 pandemic

Padmanathan (2023) aimed to gain an understanding of NHS health care workers' suicidal ideation, attempts and self-injury during the COVID-19 pandemic, as well the interrelationship of these and occupational risk factors. This was a longitudinal study involving 18 NHS trusts in England. Data was collected via surveys in 2 phases (total sample size: 2,501). Questions explored suicide attempts and self-harm. Suicidal ideation and attempts were more common in clinical staff and related to safety issues and access to personal protective equipment, including lack of confidence in reporting to managers and moral injury. The authors conclude that distress increases in staff facing reduced standards of care. Identifiable pre-pandemic data is limited, and it is therefore complex to compare this sample group to other studies; also, completed suicide data is collected, where attempted suicide is not.

Maben et al. (2022) investigated UK registered nurses' distress and psychological health needs during the pandemic through analysing longitudinal narrative interviews. The authors identified impoverished care, systemic challenges and self-preservation, emotional exhaustion and (un)helpful support as the main themes of experience. They conclude there is a need for a workforce recovery strategy to protect staff wellbeing. There is no discussion of the time needed for recovery, however, a national strategy has not occurred to date, and the nursing workforce has been left to continue functioning despite being described by Maben et al. (2022) as "forever altered". Long-term scarring is referred to leading the British Academy to call for the restoration of nurse wellbeing (British Academy, 2021).

Greenberg et al. (2021) sent questionnaires to intensive care unit (ICU) staff to explore the mental health of those working in ICU during COVID-19; 709 questionnaires were returned from 9 hospitals in England. The authors conclude that 45% of staff met the threshold rated "significant" for mental health problems, including PTSD, severe depression, severe anxiety, alcohol intake and thoughts of suicide or self-harm. This was for all health care staff but the prevalence of difficulties noted above was dominant in nursing staff. Recommendations include exploring ways to support staff wellbeing to prevent unwell people from delivering substandard care due to the presence of their own unmet needs. The authors also refer to the possibility of staff underreporting symptoms to managers.

Lamb et al. (2020) completed a cohort study to explore the psychological impact of COVID-19 on UK health care workers and ancillary staff. The study involved online surveys during the first wave of the pandemic within 3 London-based trusts. Results from 4,378 respondents were analysed, and the most common mental health issues revealed by the survey were PTSD, anxiety and alcohol misuse, consistent with findings from Greenberg et al's study (2021) of staff working in intensive care. Incidents of moral injury predominantly affected women and younger female registered nurses. The authors suggested targeted support for these groups of health care staff.

There is a commonality in the studies relating to possible long-term effects of working in the pandemic and being "forever changed" by the experience. Emotional burnout and PTSD are connected to workload and the authors (Greenberg et al.,2021) argue there is a need for input to help staff recover from working through the pandemic, suggesting that to date there has been limited intervention. Also, the impact of individual life experiences and the complexities of home life outside of work are unknown factors and influences in the studies. Future research will be important in determining clarity as to what is needed from an employment perspective.

Media impact

A study by Groves et al. (2022) explored news reports of registered nurse and student nurse suicide in the UK over a three-and-a-half-year period up to August 2021. The authors used a content analysis approach to analyse the content of newspapers against Samaritans reporting guidelines (Samaritans, 2020). Samaritans and the World Health Organization developed the guidelines in response to research showing how vulnerable groups may be influenced by the reporting of suicide. Of significance is that most of the articles reviewed over the period included reference to: "professional occupation or nursing course in the headline; images of workplace or an individual in nursing

uniform; and discussion of university or work-related triggers to suicide" (Groves et al., 2022) and lacked signposting help. Details in such reports are concerning because Niederkrotenthaler et al. (2020), relay that vulnerable individuals may be influenced by reports of suicide and that associations for some types of reporting (in this case nurses) cannot be ruled out. This is projected from numbers of suicides in the general population increasing by 8-18% up to 2 months after reports of deaths of suicide by celebrities. Niederkrotenthaler et al., add that sensationalist and adverse reporting can impact the public and professional view of nursing as a harmful occupation. Workplace infrastructure to minimise how nurses internalise reporting is suggested, given the occupational stressors and complexities of the interface with suicide.

Self-harm

A study was undertaken to look at the characteristics of registered nurses and midwives presenting at hospitals following self-harm between 2010 and 2020 in the UK (Groves et al., 2023). As pointed out by the authors, and highlighted in this literature search, no other published studies appear to have looked at self-harm among nursing staff in the UK. A proportion of those in the study by Groves et al. (2023) did have suicidal ideation and intent and were assessed as medium to high risk of suicide. This is echoed in population statistics: people with psychiatric diagnoses have an increased risk of suicide.

Using data collected from the Oxford Monitoring System for Self-harm, Groves et al. (2024) studied 81 registered nurses and midwives identified over an 11-year period. Most presentations were by single white females. Over half were working at the time of presentation, with about a quarter unemployed and a small percentage on sick leave. The most common situational and interpersonal factors identified in those presenting with a first episode of self-harm were: in a relationship with a partner (46.9%); 1 or more physical health conditions (42.3%); psychiatric disorder (29.6%) (though this does not explain the root of the presenting behaviour). A quarter reported that they had problems at work at the time of self-harming.

The significant role of alcohol is supported in this study as it was frequently consumed before an episode of self-harm, consistent with national data (NCISH, 2020). These findings (Groves et al., 2024; NCISH, 2020) echo those of previous international research relating to suicide and registered nurses. Employment issues were more common among nursing staff than among the general population, with Groves et al. (2023) relaying job loss, work-related stress and stigma towards mental health and suicide as employment related factors. Suggestions to support registered nurses to minimise self-harm include timely access to psychological treatment and education to enhance wellbeing (Groves et al., 2023), and interventions to address relationship problems, psychiatric disorders, employment problems and alcohol misuse (Groves et al., 2024).

Grey literature

Reports and commentary

The Laura Hyde Foundation, which offers mental health support to health workers, said that 366 registered nurses using their service in the UK in 2022 had reported having attempted suicide, an increase from 319 the previous year (Ford, 2023). Registered nurses were identified as the group of health workers requiring the most support (Ford, 2023). Furthermore, according to the ONS (2017), nurses are 4 times more likely to die by suicide than any other profession. Female registered nurses have a 23% higher risk than women in the general population and are more likely than male registered nurses to die by suicide.

It is suggested by NHS England (2023) that a combination of pressures such as extra shifts during the post-pandemic financial crisis, decreased staffing levels and reluctance to seek mental health support for fear of the impact on employment are reasons for the increase in suicidality. Other reasons shared in the National Health Survey (NHS England, 2022) are stress, bullying and harassment, the experience of physical violence, moral injury and burnout. All of these are likely to increase suicidal ideation, as is discrimination relating to protected characteristics – for example, workplace stress caused by disciplinary processes (NHS England, 2023). Staff from minority ethnic groups and people of colour are reported to be more likely to experience such discrimination (Ross et al., 2020).

Understandably, registered nurses may choose to leave the workforce. In the latest Nursing and Midwifery Council (NMC) report on those who leave nursing (NMC, 2023), retirement is the main reason, with physical and mental health reasons – which may relate to factors within and outside the workplace – rated second. Burnout or exhaustion was the third most frequently cited reason for leaving. Lack of support from colleagues or senior staff rated eighth, and bullying, harassment and discrimination were tenth. For UK-educated leavers (not in the retirement phase), burnout and stress or exhaustion are the main reasons for leaving the nursing register; 52% of leavers said they left much earlier than planned; and 66% said the pandemic did not influence their decision when to leave.

A recurring theme in the RCN's latest biennial employment survey results reflects nursing staff feeling undervalued and unsupported by governments and employers (RCN, 2024). This is a significant driver for those who are considering leaving their jobs, even among respondents who are at the start of their careers. The same survey found that 63% of respondents worked when they were unwell due to stress (RCN, 2024). Furthermore, a minority of the qualitative responses to the *Last Shift Survey* (RCN, 2023) are particularly concerning, with some nursing staff reporting suicidal ideation or being "in a dark place".

The annual statistical report on work-related ill health from the HSE shows that the health and social care sector has the highest rates of work-related stress, depression and anxiety compared to other sectors. Work-related stress, depression and anxiety make up 51% of all ill-health in the sector (HSE, 2023).

Data sources and detailed research informing evidence-based responses to nurse suicide are limited. There is no reliable data beyond that provided by the ONS, and prior to 2023, there was no NHS guidance on staff suicide prevention or postvention (action taken to provide support to staff after someone dies by suicide) but there is a growing call for action in these areas. Recent updates from NHS England include working with the ONS to create a thematic review of nurse suicide data, which will highlight trends in ages and fields of practice. This is due to be published later this year as an update on suicide among female registered nurses (NCISH, 2020). An NHS staff database for death by suicide will be in place for 2026.

Policy

The RCN's call for suicide prevention education and training in the nursing workforce aligns with UK government policy regarding suicide prevention and high-risk groups. Governments of all 4 nations are engaged in suicide prevention with related strategies and plans for delivery. *Suicide Prevention in England: 5-year cross-sector strategy* (DHSC), 2023) includes the following areas in the ambition to make suicide prevention everyone's business:

- every individual across the country has access to training and support that gives them the confidence and skills to save lives
- employers (especially those in high-risk occupations) have appropriate mental health and wellbeing support for their staff – learning from and building on the work the NHS and others are undertaking. This includes members of staff being trained in suicide prevention awareness, particularly those interacting with people who may be more vulnerable.

Under health and safety legislation, employers must take all reasonable steps to protect workers' health, safety and welfare. There is an emphasis on the importance of employers and professional bodies to "take targeted action" to reduce rates in identified groups. The DHSC cross-governmental strategy recommends that research should be undertaken to understand better links between the cost-of-living crisis and suicide, trends in suicide rates in different occupational groups, incidents following a bereavement, and tailored action at a national level to include pregnant women and new mothers, as well as people in contact with mental health services and those who have self-harmed (DHSC, 2023).

The Scottish Government (2022) outlines a strategy for supporting the mental health of the workforce: "We will review the evidence and commission new research where needed to identify where staff are at higher risk or have high exposure to suicide and will use this to inform future suicide prevention activity and targeted support. We will continue to support the wellbeing and mental health of the health, social work and social care workforce through a range of national resources. We will continue to engage with these sectors to identify new initiatives as appropriate."

The action plan leading from this stipulates: "We will continue supporting the wellbeing and mental health (including suicide prevention) of the Health, Social Work and Social Care Workforce"; "We will ensure the Student Mental Health Action Plan (to be published in 2023) prioritises suicide prevention through actions to address suicide prevention in our colleges and universities"; "We will explore how to effectively support

the mental health and wellbeing of the health and social care workforce, including suicide prevention."

The action plan does not explicitly refer to registered nurses but includes the health and social care workforce. Interestingly, there is a specific focus on suicide and links with perimenopause and menopause.

Northern Ireland's suicide prevention strategy (Protect Life 2) was implemented in 2019 and is extended until 2027 (Department of Health 2019). There is no specific reference to nursing or the health care workforce being a high-risk group for suicide; however, there is a reference to self-care and the compassion required by responders and health care workers, and a clear workforce education and training plan.

A Welsh Government paper regarding a suicide prevention strategy for Wales is, at the time of writing, open for consultation (Welsh Government, 2024). It does not identify registered nurses and health care workers as a vulnerable group, although the list of identified groups is extensive and will reflect the characteristics of the nursing population. An earlier strategy referred to "tailored approaches to meet the needs of certain high-risk groups" and registered nurses were listed as one of those high-risk groups (Welsh Government, 2015).

Education of the workforce – suicide awareness and prevention

It is notable how, over 3 decades, the wording of suicide prevention policy has changed, reflecting new insights. Yet at the same time, the reoccurring themes of staff education and training in this area remain unresolved. The dominant rhetoric explored below in relation to training the health and care workforce in suicide awareness and prevention has a focus on helping the public, in the first instance. This is relevant because the skills taught – how to notice, engage and support individuals who are suicidal – apply to everyone.

The Public Mental Health Leadership and Workforce Development Framework (Public Health England (PHE), 2015) stated that PHE supports "the development of leaders and a workforce that is confident, competent and committed to preventing mental illness, suicide and self-harm". The framework describes suicide prevention as a critical competency and priority for the workforce and argues for building capacity and capability in suicide prevention. In the Five Year Forward View for Mental Health (Mental Health Task Force, 2016), suicide prevention is highlighted as a priority, along with developing additional capacity in the workforce and skills for professionals to effectively support people with mental health problems, including suicide.

Changes have occurred in the last 5 years, with the General Medical Council incorporating suicide awareness and prevention into medical training in response to the NCISH report and ONS data. *The Future Nurse Standards of Proficiency for Registered Nurses* (NMC, 2018) are UK-wide and therefore adopted by NMC-validated institutions. Annexe B of the standards says: "At the point of registration the registered nurse will be able to safely demonstrate and use evidence-based, best practice approaches to take a history, observe, recognise, and accurately assess people of all ages for signs of self-harm and/or suicidal ideation."

The Suicide Prevention Competence Framework (National Collaboration Centre for Mental Health, 2018) dovetails with this standard and the leadership qualities expected of nurses. Nevertheless, the education of nurses in this area post-2018 does not guarantee ongoing suicide prevention and awareness skills if the subject of suicide is not revisited beyond qualification. In addition, all nurses (except for mental health nurses pre-2018 standards) would not necessarily have exposure to suicide education during training, meaning, potentially, that many nurses will have worked for decades without formal suicide prevention and awareness education (Rebair and Hulatt, 2017).

Although training approaches are positively received and reported in the literature, key findings indicate that more research is needed to evaluate the efficacy of suicide prevention programmes (Heyman et al., 2015; Zalsman et al., 2016). There is not one advocated evidence-based suicide prevention programme, and there appears to be little evidence underpinning the actual methods of delivery (Heyman et al., 2015). The lasting impact of receiving training is still being determined, suggesting the need for mandatory refresher training needs to be built into delivery plans. Additionally, longitudinal follow-up is limited.

Careful consideration of training delivery is necessary to avoid a tick-box application and instead evoke meaning in the interpersonal process. There is a need for appreciation of the complexity that sits behind delivering programmes, as educating nurses to talk about suicide means preparing to be open to the unfolding situation with another. This is a challenging space to enter for reasons that include personal experiences of suicide, the prevalence of myths, stigma and fear of "getting it wrong", and the emotional capacity to "go there" (Rebair and Hullatt, 2017; Rebair, 2022).

Supportive workforce interventions

With concern growing about suicide in nursing and the broader health and care workforce, many supportive interventions now exist across the 4 UK countries. However, we could not identify studies that helped understand the impact and operationalisation of these interventions and how often staff access resources. The majority are online self-service resources to work through, with links to emergency services, such as Samaritans.

The development of the NHS Health and Wellbeing Framework (NHS England and NHS Improvement, 2022) includes a toolkit for culture change aimed at the health and wellbeing of NHS staff. It is pitched as "high-level" and aimed at organisational development, managers, leaders, and human resources (HR) managers. It is supported by a strategic overview, organisational diagnostic tool and team wellbeing guide, offering guidance from ward to board. It is an excellent comprehensive strategy to address wellbeing and dovetails with the Self-harm and Suicide Prevention Competence Framework (National Collaborating Centre for Mental Health, 2018) and the National Suicide Prevention Toolkit for England (NHS England, 2023) to prevent suicide in the NHS workforce. These strategies and policies are well intended and may be used effectively within the NHS and private sector services. To date, however, there is little evidence of intervention, outcome and plans for sustainability. There is also a danger that these comprehensive toolkits and guides are surpassed with the addition of another strategy.

The HSE's evidence-based management standards provide a framework for employers to support them in meeting their legal duties to tackle the work-related causes of stress, including organisational change, excessive work demands, and lack of support and control (HSE, 2009; HSE, 2021; RCN, 2023). Applied systematically, they can help address the organisational causes of work-related stress. A tool to assess line management behaviours has also been developed and aims to help managers reflect on their management style (HSE, 2009).

Common interrelated factors

The limited available research on suicidality in the UK nursing workforce presents a complex interrelationship of demographic, biopsychosocial and situational factors. It is not possible to draw causative factors from the findings and themes. International literature was discounted for this review, given the focus on the UK context.

Through their systematic review, Groves et al. (2023) conclude that mental illness, psychological health, occupational factors, alcohol misuse and poor physical health increase the risk of suicide in nurses. However, a combination of these factors and specific life stressors is emerging as significantly interrelated. For example, bereavement did not appear significant in the systematic review, though it is in UK policy and related research (National Institute for Health and Care Excellence, 2019; Windsor-Shellard and Gunnell, 2019) and may be the tipping point for some people.

Ethnicity and gender

The nursing workforce in the UK consists primarily of white females and female nurses are reported to be at higher risk of suicide than females in the general population (NCISH, 2020) thereby highlighting focused work in this area. RCN data and research indicates that white nursing staff are more likely to call with suicidal ideation, this reflects the fact that nursing in the UK is predominantly staffed by white people. Little is understood about mental health needs and suicidal thoughts and experiences of health and care staff from minority ethnic backgrounds. As discussed in this report and highlighted in RCN data, employment contexts have an impact upon the mental health of nurses and subsequent suicidal thoughts and feelings. Nurses from minority ethnic backgrounds report experiencing higher levels of discrimination and abuse at work compared to other staff, as do staff identifying as LGBTQ+ (Workforce Racial Equity Standards Team, 2020; NMC 2023b; Social Care Wales, 2024). This is an indicator that nurses may be struggling to cope but may be reluctant to reach out for support in the workplace. It is imperative that further research is undertaken to understand sociocultural constructs and beliefs about suicide and mitigating factors in seeking support.

Summary

ONS data and government reports collated from official sources are the primary sources of evidence underpinning the response to suicide in the nursing workforce in the UK. There is a surprising paucity of UK empirical research on this subject, with no recorded co-produced qualitative research with nurses who have lived experience of suicide. The limited research acknowledges the unknown impact of COVID-19 and suggests it is hidden in burnout and stress experienced by the workforce. Little is known about the experiences of staff from minority ethnic backgrounds regarding suicidal thoughts and experiences at work and help seeking needs.

There is an urgent need to gain an understanding of people's lived experiences of both the contextual and influencing factors of suicidal ideation and suicide attempts from the nursing workforce. Beyond responsibilities for wellness, workplaces should offer safe spaces for staff to appropriately share and receive a supportive response to their health needs. Many interrelated factors contribute to suicide in the nursing workforce. However, it is clear that distress is connected to many of these factors, and their impact on the body and mind needs to be seriously considered. Further research is necessary to understand the experiences of the nursing workforce in relation to suicide.

Section 4a: A deep dive into RCN data

Exploring the contextual and influencing factors that contribute to suicidal thoughts among the UK nursing workforce

RCN datasets are presented below in 2 parts: 4a presents a deep dive into demographic data; and 4b presents a thematic analysis of call content when members telephone the RCN for advice and support. Further contextual and influencing factors are presented in 4c, drawn from RCN Counselling services

Method

The aim of this deep dive is to gain an understanding of suicidal ideation and associated distress among members contacting the RCN for advice. An assessment is undertaken by the RCN adviser taking the call; the member is triaged depending on the level of risk ascertained; and the call is registered and recorded in a database. It is recognised that there are many ways people express distress that could denote suicidal ideation or intent, and the variation in describing this in words is extensive. It was concluded that the appropriate way to search the data was by using the search terms “suicide”, “self-harm”, and “suicidal”.

The database was not set up specifically to gather data on thoughts of suicide. Also, the analysis in this report is based on the assessments made by RCN staff during initial triage contact rather than transcribed call conversations. Therefore, our findings are limited to the available data and may not provide a complete account of the entire discussion. As a result, any initial conclusions can only be drawn from the information at hand.

The data sets extracted spanned 2 years, from February 2022 to February 2024. This period was chosen due to the observed increase in suicide-related calls to the RCN. A total of 1,100 enquiries were found within this timeframe. These were manually reviewed to include only enquires from members, resulting in 392 qualifying enquires in total where members indicated concerns related to suicide, self-harm or feeling suicidal. Of these 392 calls, approximately one third of members mentioned having anxiety and/or depression.

Confidentiality

All names and data-sensitive personalised information were extracted from the spreadsheet at source; data was anonymised, names were replaced with codes and only the RCN’s data analyst had access to the original information. A spreadsheet containing coded numbers and call information was analysed. None of the call data included names and the term “member” was used consistently. Data was password-protected and stored on a computer requiring 2-stage authentications in a locked room, in line with data-management best practice.

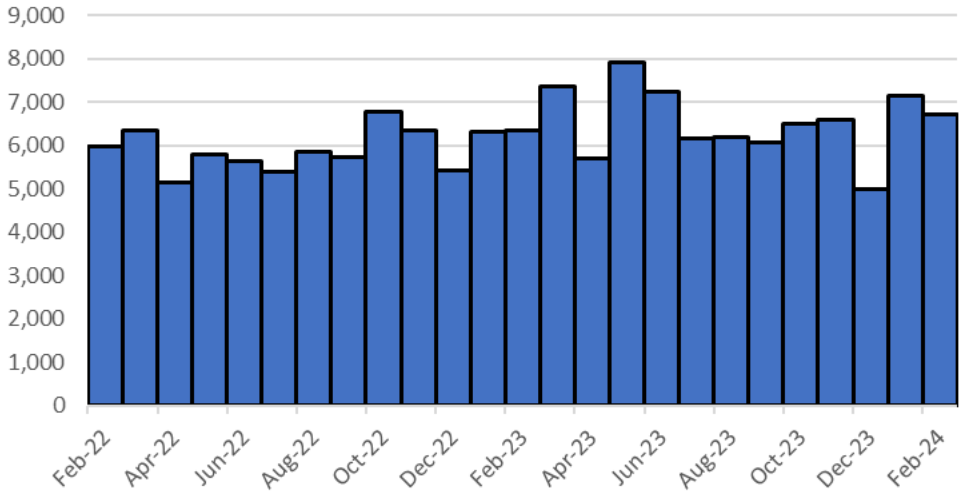
Demographic data

The purpose of this section is to compare the suicidal ideation data against overall RCN membership data. Within selected tables and graphs below, the suicidal ideation data is highlighted under the column “Suicidal ideation data”, while the overall RCN membership data is held under the column “Member data”. Therefore, numbers recorded in “Suicidal ideation data” represent the percentage of the corresponding membership data, so in Table 1, 4.53% of the total members are aged 20 to 24 years and suicide-related calls were recorded for 2.3% of these.

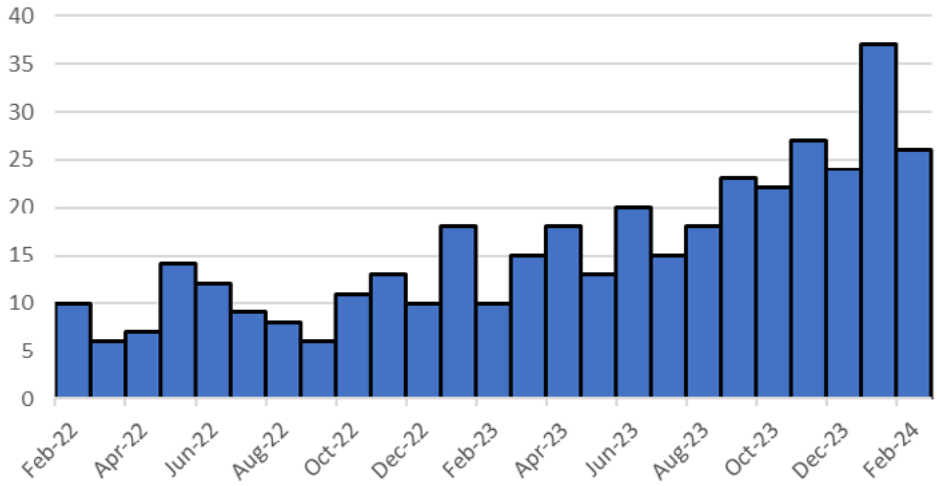
Member suicide enquiries

Graph 1 and Graph 2 below present the total enquiries received at the RCN contact centre per month from members, as well as the total enquiries received at the RCN contact centre where the member has expressed suicidal ideation.

Graph 1: Total contact centre enquiries



Graph 2: Total suicidal ideation enquiries



The data within the total contact centre advice enquiries graph (Graph 1) shows how many enquiries were received per month. Within this date range, the monthly totals have remained similar, although there was 1 period when there was a significant increase in contact – between October 2022 and June 2023. The cause of this increase cannot be fully known. However, it coincides with the industrial action process, where the RCN balloted members, fielded questions about striking, assisted members with the strike process and managed queries about voting on the pay offer received. Enquiries have continued a steady rise.

Within the suicidal ideation graph (Graph 2), there has been a noticeable monthly increase throughout the date range in members presenting with suicidal ideation during contact with the RCN. In 2022, there were, on average, 10 members a month presenting with suicidal ideation, while in the last 6 months of recorded data (September 2023 to February 2024), there was an increase to an average of 27 members a month.

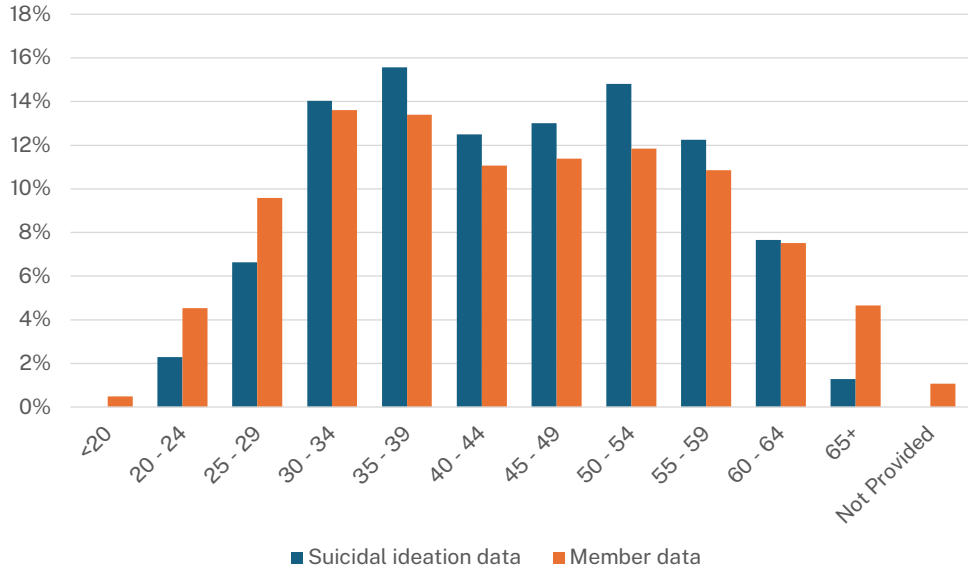
Age

The table and graphs below show demographic data relating to age.

Table 1: Age variation

Age Range	Suicidal ideation data	Member data
<20	0%	0.50%
20–24	2.30%	4.53%
25–29	6.63%	9.59%
30–34	14.03%	13.61%
35–39	15.56%	13.40%
40–44	12.50%	11.06%
45–49	13.01%	11.39%
50–54	14.80%	11.84%
55–59	12.24%	10.86%
60– 64	7.65%	7.51%
65+	1.28%	4.65%
Not provided	0%	1.07%

Graph 3: Suicidal ideation data against overall membership data



When comparing the suicidal ideation data against the overall membership data, the variance is not significant. The 2 age ranges with a higher percentage of suicidal ideation enquiries when compared against overall membership data are 35–39 and 50–54. This data includes members who identify as male and female. In 5-year age groups, those aged 50–54 years had the highest suicide rate in 2022 in England and Wales (ONS, 2023a).

Gender

Table 2: Gender data

Gender	Suicidal ideation data	Member data
Male	15.82%	11.35%
Female	84.18%	88.35%

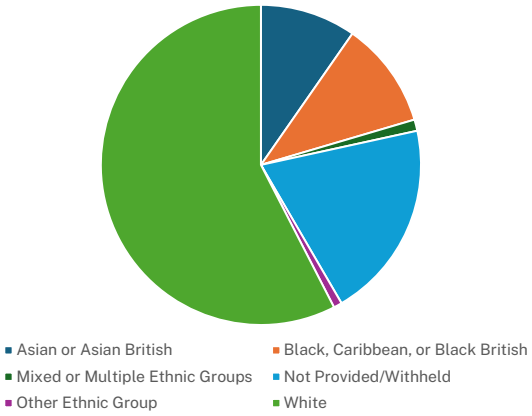
In relation to gender (Table 2), when comparing the two datasets, there is not a significant difference in the data. A slightly higher percentage of males exhibit signs of suicidal thoughts, but the difference is only a few percentage points. No other data regarding gender identity is available.

Ethnicity

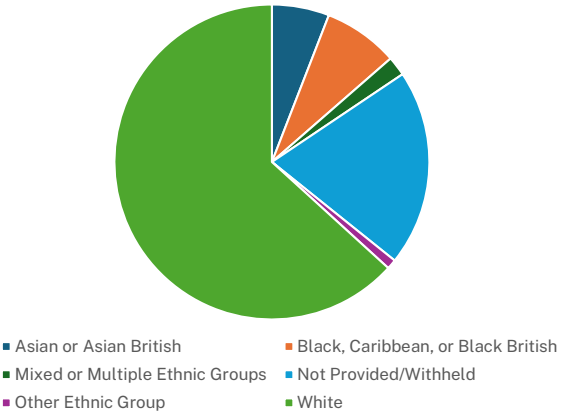
Table 3: Ethnicity data

Ethnic group	Suicidal ideation data	Member data
Asian or Asian British	5.9%	9.69%
Black, Caribbean, or Black British	7.7%	10.75%
Mixed or Multiple Ethnic Groups	2.0%	1.14%
Not Provided/Withheld	20.2%	20.03%
Other Ethnic Group	1.0%	0.85%
White	63.3%	57.56%

Graph 4: Ethnicity member data



Graph 5: Suicidal ideation data and ethnicity



The ethnicity data (Graphs 4 & 5) show the most significant difference in suicidal ideation contact is with the ethnic group “white”, which has a higher percentage compared to the overall membership. This could be due to the UK’s predominantly white female nursing workforce. However, according to ONS data (ONS, 2023b), suicide rates for the general population were highest for white and mixed/multiple ethnic groups in England and Wales, showing consistency.

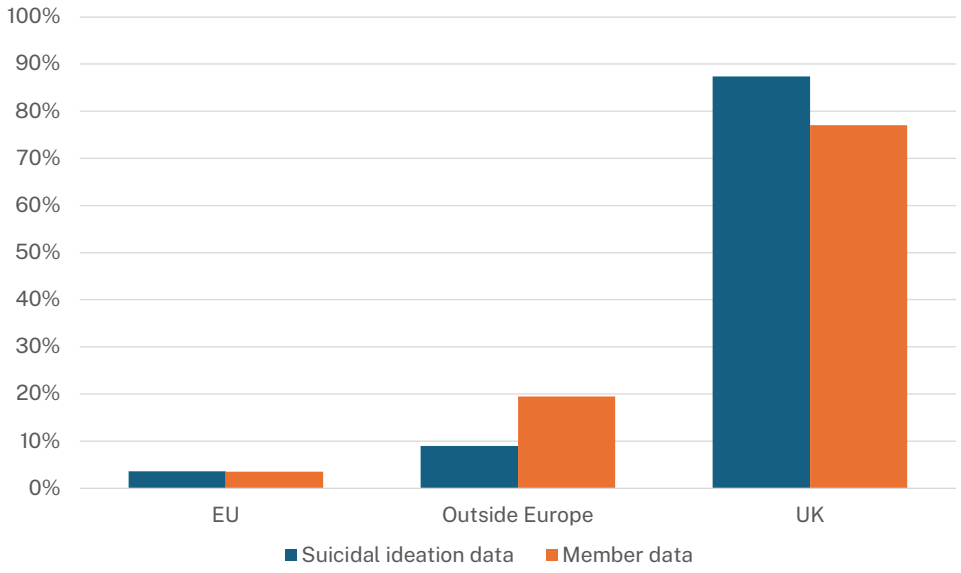
International/UK membership data

Using the last letter of the member's NMC PIN, it is possible to identify where the member gained their nursing qualification. This data is only attainable for registered nurses.

Table 4: UK and international nurse data for suicidal ideation

Nursing qualification attained	Suicidal ideation data	Member data
EU	3.6%	3.5%
Outside Europe	9%	19.5%
UK	87.4%	77%

Graph 6: UK and international nurse data for suicidal ideation



The most significant difference is that a higher percentage of UK-trained registered nurses show suicidal thoughts compared to registered nurses in the rest of the membership data. At the same time, there is a lower incidence among members who trained outside the EU and the UK.

However, we must be cautious when interpreting this finding. There is a dearth of information on suicidal ideation among nurses from an ethnic minority. Furthermore, there may be reasons why internationally educated nurses are not disclosing suicidal ideation during their calls to the RCN.

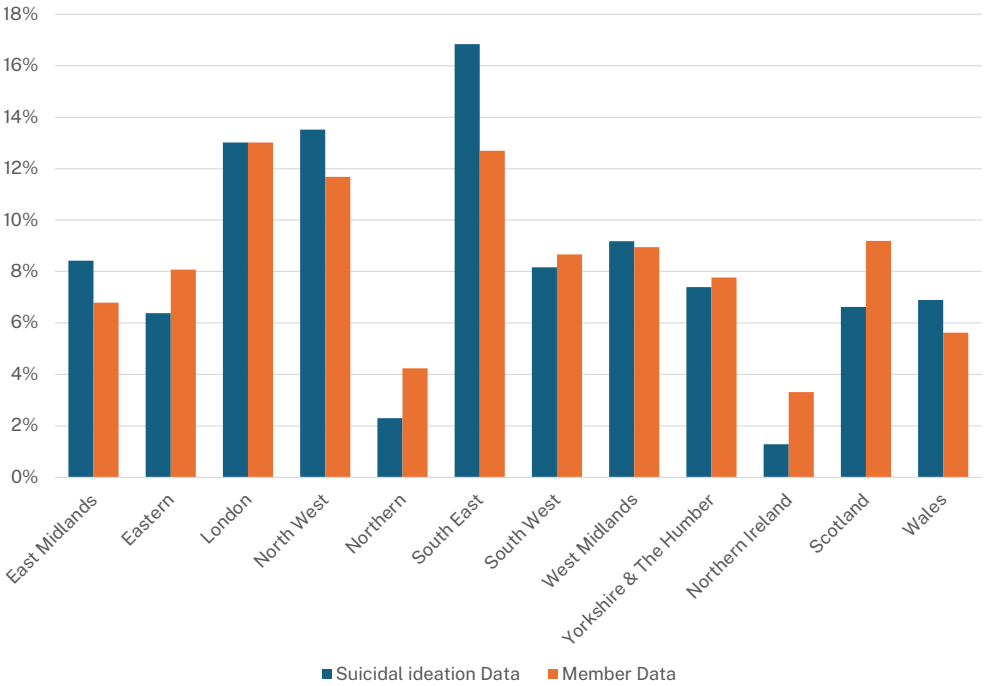
UK country/region of member

Table 5: Member data and suicidal ideation by geographical area of employment

Region/country	Suicidal ideation data	Member data
East Midlands	8.42%	6.79%
Eastern	6.38%	8.08%
London	13.01%	13.01%
North West	13.52%	11.68%
Northern	2.30%	4.24%
South East	16.84%	12.69%
South West	8.16%	8.67%
West Midlands	9.18%	8.95%
Yorkshire & The Humber	7.40%	7.77%
Northern Ireland	1.28%	3.31%
Scotland	6.63%	9.19%
Wales	6.89%	5.62%

The region and country data is based on where the member works rather than where they live.

Graph 7: Member data and suicidal ideation by geographical area of employment



The suicidal ideation data does not show a significant variance from the overall membership data, except for the RCN South East region (excluding London data). The RCN Northern region, Northern Ireland and Scotland have much lower suicidal ideation percentages compared to the membership data. This contrasts with national suicide data, where Northern Ireland, Scotland and North-East England have the highest recorded incidence of suicide (House of Commons Library, 2014). We do not know the reasons for the variation between RCN and House of Commons Library data. It is worth considering factors such as proximity to the RCN head office and the number, relationships and activity of RCN representatives.

Membership categories

Table 6: Member data and suicidal ideation in the area of membership category

Membership category	Suicidal ideation data	Member data
Registered nurse	81.4%	86%
Nursing support worker	16.6%	7.8%
Student	2%	6.2%

The data regarding reported suicidal ideation shows that the membership categories of individuals who contacted the RCN included 319 registered nurses, 65 nursing support workers, and 8 students. When comparing this data to the broader representative member data, it was found that the nurse category did not show a significant difference. At the same time, nursing support workers were over-represented and students were under-represented.

It is important to note that our analysis cannot provide definite reasons for students' under-representation but they may be accessing support from other structures within universities rather than from RCN services.

Of concern is the observation that nursing support workers reporting suicidal ideation through contact with the RCN are over-represented twofold. Despite national attention on higher suicide rates among registered nurses, there remains a lack of exploration of the specific circumstances surrounding nursing support workers.

It is worth highlighting that the HSE Expert Committee (2022) has identified a significantly higher suicide rate among care workers compared to nurses within the female workforce. However, the committee has not detailed the level of training, education or employment location for "care workers". This lack of specificity is a significant gap that requires further investigation.

Counselling referrals

All members who presented as high risk from February 2022 to February 2024 were offered an urgent referral for support from the RCN Counselling team. Within the 2-year period, the team has managed 322 members through this urgent referral process. A total of 114 (29%) of the 392 enquiries stated that the member had already accessed or referred to Samaritans.

Other

Not all calls had an outcome referral, which may not be appropriate for the context. For example, it was logged that some members will receive ongoing support from the workplace, return to occupational health, “watch and wait”, referral to an RCN representative, or follow-up or other agreed outcome specific to the member’s needs.

Learning

Identifying the member’s emotions during a call can be challenging unless it is expressed clearly and recorded within the system. Work is underway with speech analytics software to identify and report on member emotions during calls to improve response, referral, reporting and data extraction. Managing the collation of data is also under review.

Summary

It is impossible to accurately extract and separate contextual factors from influencing factors as the RCN database is not set up to extrapolate complex information from the recorded calls. There are regional variations, with most calls regarding suicidal ideation coming from members in the South East region. White, British-trained nurses appear to account for the majority of calls regarding suicidal ideation. More exploration is needed to ascertain suicidality in the Black, Asian and ethnic minority nursing workforce. Understanding influencing factors around age appears essential, given that over the 2-year period, there was an increase in reported suicidal ideation among members in the age ranges 35-39 and 50-54.

Section 4b: Thematic analysis of recorded call content

Exploring the contextual and influencing factors of suicidal ideation in the nursing workforce.

Method

The data sets taken from RCN data spanned 2 years from February 2022 to February 2024. This timeframe was considered appropriate due to the anecdotal rise in suicide-related calls to the RCN. The search within the stipulated period revealed 1,100 enquiries. These were manually searched to ensure the inclusion of member-only enquires, leaving 392 enquires in total where members referred to suicide, self-harm or feeling suicidal. Any details regarding personal information that could lead to identification were deleted at the source. A spreadsheet contained content from calls and it was this call content that was thematically analysed.

Analysis of data

The call content analysed is the written record created by RCN staff during the initial triage contact call, rather than transcribed conversations.

All the 392 written call records were read. Qualitative analysis based on Burnard's (2006) framework was used to analyse the data. Initially, 2 people generated descriptive open codes following repeated reading of the call content. Connections were then sought to create higher-order headings, which were collapsed through an iterative process to create broader categories. An extensive list of factors was noted in the initial coding process that detailed a member's contextual situation and other influencing factors that were significant to them.

It is impossible to know the actual causative factors for suicidal thoughts for each individual. This is because the information was recorded as part of a conversation, where there may be 1 factor dominating the situation rather than the complexity usually associated with suicidal ideation. It cannot be known if it is this alone or a combination of factors that contributed to the person feeling suicidal unless offered explicitly by the person and then logged by the RCN staff member.

This detailed analysis focuses on the nursing workforce via calls to the RCN, particularly concerning professional and workplace-related issues. The work environment was the main focus for analytical purposes, but factors related to personal events and experiences were also considered.

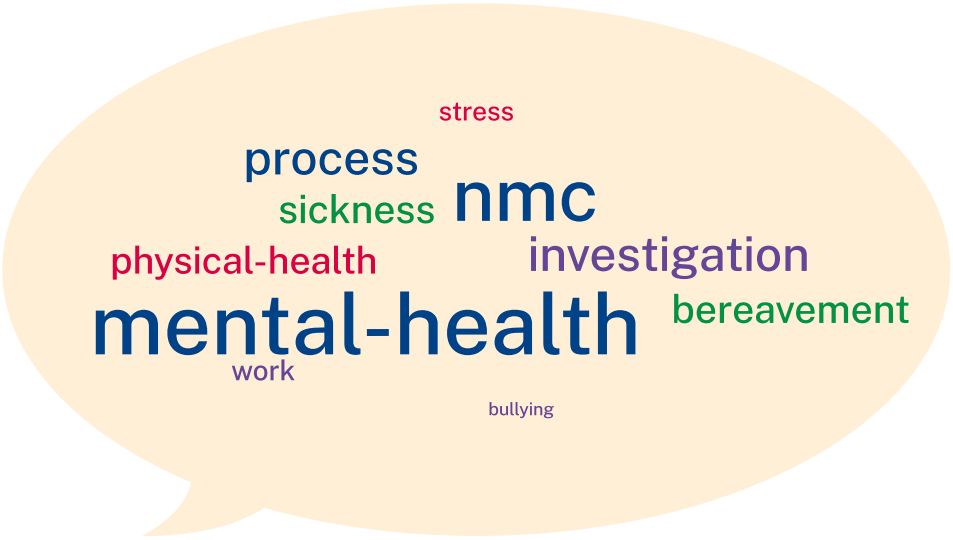
The initial coding phase used NVivo coding to capture the repetition of factors related to suicide. Where there was a repetition of words documented for each caller, the word was only counted once if noted as a contributing factor. Some words or events occurred repeatedly throughout the call log. The word clouds below show the most reoccurring words, those larger and in bold represent the most frequently occurring. These were collapsed into 4 main categories consisting of 10 recurring factors (mental health, NMC, investigations, processes (internal and external), bereavement, physical health, sickness (self and dependants), work, stress, bullying) (see Figure 3).

Further analysis of the data showed that there were shared experiences of vulnerability, confusion and isolation from RCN members, the qualities of these are listed in Figure 4. Vulnerability, confusion and isolation appeared to relate to unmet needs throughout an episode of experience for the member. These are represented as the need for informed understanding, the need for compassion and kindness and the need for clear, timely communication. Figure 3 shows the interrelationship of these elements.

These categories are not interpreted to a higher order as they represent significant events. To check the occurrence of words from the analysis and gain a visual representation, the initial codes were put into a word cloud. Although this can be problematic, it can help check data when supported by contextual analysis (Skepsted et al., 2024). Findings were member-checked with Experts by Experience and the lead for RCN Counselling services.

Figure 1: Word cloud – top 50 occurrences

Figure 2: Word cloud – top 10 occurrences



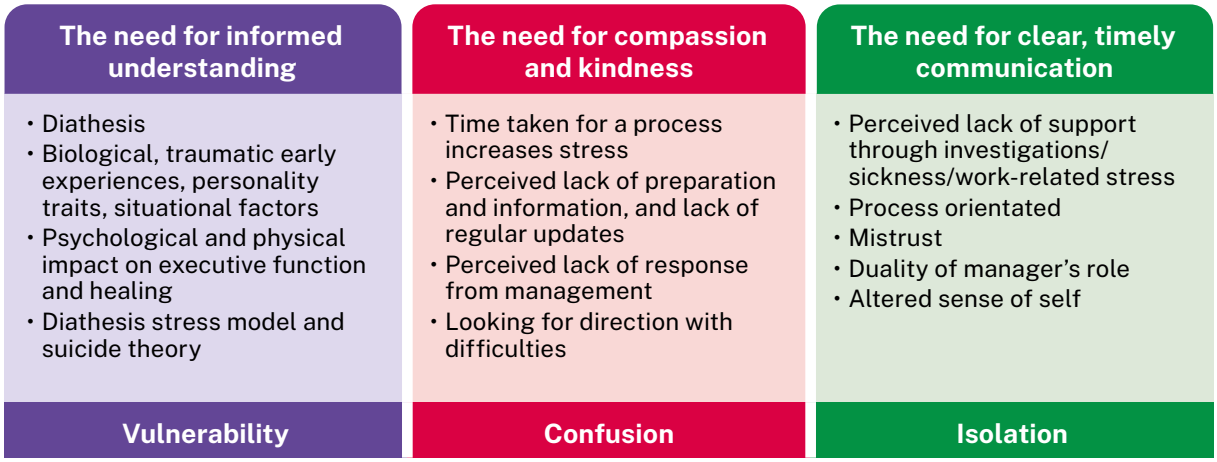
Regular analysis of the data generated 3 higher-order categories. The higher-order categories are contextual needs that wrap around the 10 most recurring factors experienced by the individuals:

1. the need for informed understanding
2. the need for compassion and kindness
3. the need for clear, timely communication.

These qualities are represented further in Figure 4.

Figure 3: Contextual needs and factors contributing to suicide in the nursing workforce.

Figure 4: Qualities of contextual needs



Findings:

4b. First-level analysis

Due to the nature of the subject, the individual call logs demonstrate interrelated contextual and influencing factors. Care was taken to represent the main themes without diminishing the distress and intricacies of people's lives. Feedback was sought by checking thematic categories with Experts by Experience.

Mental health

The theme that contributed most regularly to a situation where a member felt suicidal was mental health. It is impossible to understand the role of the workplace in the decline of a person's mental health, especially where personal influencing factors are present. Personal factors included physical and emotional abuse, divorce/relationship breakdown, financial worries, drug and/or alcohol concerns, the impact of disability, the impact of poor physical health and pain, loss and grief, financial worries, menopause, and trauma. These are expected and consistent with findings from general population data. Moreover, in sociodemographic population data, disability status and ethnicity contribute to suicidality (ONS, 2023b).

Throughout the data, members are documented as "wanting to die", at "breaking point" and feeling "broken", "devastated", "unable to see a way forward" and "lonely". Members relayed "lack of support". Many were receiving support from crisis teams and community mental health nurses; some were on sick leave while receiving care, and others were trying hard to stay at work to avoid triggering sickness processes and the financial impact that would incur. There are references to feeling "ashamed" and "weak".

NMC, investigations, processes

It was not unusual to read that the member was "distressed during the call" and that the related anticipatory outcomes and fear were linked with formal processes relating to their professional work. Members understandably struggle when undergoing formal investigations and processes in the work context while dealing with overwhelming situations at home, further compounded by stress and anxiety.

Within the data, members described feeling "under pressure" to return to work due to "staffing'" or "financial concern", "fear of dismissal" or "fear of triggering the sickness process".

Support from managers was varied. There were minimal references to helpful managers; other responses included members being called to meetings and "not knowing why", complaints of "not hearing back" and "no reply to emails". People described feeling "oblivious'" and "left wondering what is happening".

There is documentation about managers "not keeping to agreed meeting-up arrangements" through formal processes and not considering "reasonable requests for work adjustments".

Members were informed of allegations made but had "not heard anything" after some time, which left them feeling "anxious" and "depressed", with lengthy processes having "devasting impacts upon life". Added to this, members stated that they were reporting incidents to senior staff and HR but "heard nothing", making them unlikely to report ongoing poor practice and "mistrust" of process and colleagues.

Bereavement, physical health, sickness

Members referred to supporting terminally ill family members, followed by bereavement and taking sick leave after the death of a loved one, adding to time off already taken to support the family member in treatment. This created a tension between grieving (and/or other life-impacting events), balancing the sickness processes, fear of dismissal and feeling well enough to work. The literature acknowledges the increased risk of suicide for those bereaved by suicide (McDonnell et al, 2021; ONS, 2023a). The RCN data does not show how people were bereaved, but bereavement in itself is a notable indicator of distress and is acknowledged in this report.

Members of the workforce recounted comments from managers about "unhappiness with their work quality" after returning from compassionate leave. Other stressors were experienced in addition to the context of returning after bereavement, such as "allegations from colleagues" and "increased workload", additional tasks adding to a feeling of being "overwhelmed" and feeling "stressed" due to diminished capacity to cope. Members referred to personal sickness and caring roles, and caring at work.

There was a reference to the impact of "menopause" and "grief" due to the death of children, reccurring "PTSD" due to "work incidents triggering previous trauma". Members with chronic pain needs felt "unsupported", with obstructive responses from managers.

Work stress, bullying

Overwhelming pressures, workloads and expectations of achievements impacted the workforce. This was also apparent when staff returned to work after sickness absence. There were references to experiences of bullying and unkindness in the workplace, with members stating that the workplace had a direct impact on their stress levels and mental health.

Members reported feeling "victimised", "under attack" and "set up to fail" by colleagues and, in other instances, by their manager. There was reference by members to "race and disability" being a concern, "being bullied and treated differently" because of "race". Documented data includes staff being told that others "hate" them. There are references to members reporting that they were told they were "ineffectual" and "unwanted on the team", with reports of judgemental and stigmatising comments from managers about using mental health as an "excuse". Members referred to feeling "intimidated" by managers. Regular references are made to feeling "anxious about returning to work", "lonely", with "little support at work", and "hitting a brick wall" when seeking help.

4b. Second-level analysis

The following 3 categories wrap around the influencing factors identified through the first-level analysis and appear important in data analysis.

The need for informed understanding

Individuals are left vulnerable, given the reports from members of needing to be met with an understanding of their stress by managers, HR or occupational health (OH) services. This includes pre-empting the impact of an event or events in the context of the person's return to work and on their ability to perform their role.

Given the multiple stressors some members experienced, there was little evidence of consideration of long-term stress and the process of healing for individuals returning to work after time away. The recovery process can be arduous if work is not deemed safe or supportive. Stress, anxiety and depression impact sleep patterns, which in turn have a massive impact on functionality. By contrast, a few callers referred to their managers as supportive and helpful. There were unfavourable comments regarding new, younger managers with limited managerial and leadership experience.

The biological impact of stress on physiology, cognition and emotions is extensive and requires informed understanding from managers, HR and OH. Management responses are often driven by process rather than a person-centred approach.

The need for clear, timely communication

Safeguarding processes are essential, in line with the NMC Code (NMC, 2015) and related organisational and legal processes. Yet members had a perceptible struggle to access timely information or receive support. This should not be a cause of stress and nursing staff should not be required to search for help during or after a life-changing event.

The need for kindness and compassion

Being under investigation is burdensome and can impact a person's perceived sense of self. Callers described their long service, with flawless careers, and had prided themselves on good conduct over the decades, so facing a formal process impacted upon their self-perception. Their otherwise enjoyable career had been marred, resulting in a sense of loss.

Where formal processes are anticipated, sensitivity is required. Their potential impact on an individual should be acknowledged and it should be understood that at the same time there may be serious personal issues, not shared with others, that are occurring in people's private lives. These too can affect a person's presentation at work; and while it is not the manager's role to explore such issues, compassionate leadership is expected. Managers should be able to guide staff members to appropriate support.

Discussion

The findings presented here are consistent with the information in the literature and in the NHS survey (2022). The NMC (2023a) lists the most frequently cited reasons for leaving the register as physical and mental health issues, lack of support from colleagues or senior members of staff, and experiences of bullying and harassment. The HSE (2022) states that isolation, relationship breakdown, financial problems, work pressures and pre-existing mental health conditions are significant life events that impact nurses. Furthermore, workplace factors, such as bullying, job insecurity, discrimination and disciplinary processes, may contribute to suicide (NHSE, 2023).

The RCN Congress resolution referred to at the beginning of this report inspired deep concern for the nursing workforce. The resolution called for an evidence-based suicide prevention education programme for the nursing workforce. While suicide prevention education and training is helpful, it does not address the broader systemic and biopsychosocial factors influencing suicidal ideation. Suicide is complex. An informed understanding of the impact of life events and stressors on a person's executive function (higher level cognitive processes involved in goal directed behaviour) is essential. The absence of this is observable in the RCN data.

When staff members are assessed as "well enough" to work, consideration for where the person is in their recovery and how they are functioning is paramount. Cortisol release is linked with stress, and studies show how cortisol plays a role in the exacerbation of chronic pain disorders, impacts the immune system, dysregulates hormones and affects the executive function of the brain (Knezevic et al., 2023). As a result, mental processes and cognitive control, self-regulation, creativity, attention, reasoning, working memory, fluid intelligence, inhibitory control, task switching and mental flexibility can all be disrupted (Diamond, 2013). Therefore, it is arguable that informed understanding for leaders, HR staff and Occupational Health clinicians should include awareness of these effects in the context of the suicide prevention theory model. One suggestion would be the integrated motivational-volitional model of suicidal behaviour (O'Connor & Kirtley, 2018), an evidence-based model appropriate to this task.

The data sets give continuous examples of members looking for help or avoiding the stressor to escape the situation causing pain and distress. Vulnerability, confusion about situations, and loneliness, as identified in the thematic analysis, are essential facets of understanding suicidal ideation and attempts (see Appendix 2).

Given this information, it is little surprise that staff felt the need for compassion and kindness. Jones-Berry (2016) reported concerns that nurses are near breaking point when facing fitness-to-practise investigations and highlighted reputational and financial burdens resulting from nurses often being restricted or prevented from practising during lengthy review processes. The sustained biological exposure to stress is detrimental to psychological functioning, as described above. Data shows that referral to the NMC fitness to practice process is stress-inducing and can be confusing and arduous. The energy staff members have to expend on searching for information or exploring their rights is further detrimental to their wellbeing.

As reported by the NMC (2023a), there has been an exodus of experienced staff in recent years. This may account for a shift in management culture in areas where less experienced staff are promoted to senior leadership and management positions and have yet to gain knowledge and experience or have limited support in new roles. A balance is required for leaders and managers to follow due process with compassion, in a timely fashion. A focus on the human at the centre of any investigatory or review process is required. Approaching from the stance of the Seven Principles of Public Life (UK Government, 1995), NHS values (DHSC, 2023) and the NMC Code (NMC, 2015) sets the foundation for a kinder interaction.

In England, the NHS Wellbeing Framework (NHSE, 2021) is a comprehensive source of support and guidance to help leaders develop basic knowledge of issues related to self-harm and suicide, extend their generic communication skills and respond to the emotional content of conversations with staff. Following its guidance would go some way in supporting staff who are experiencing emotional or physical pain. The challenge is gaining commitment to implementation and sustainability, thereby avoiding a "flash-in-the-pan" response or a perception of top-down implementation without meaning.

The terrain is complex and beyond any single solution. The workforce is struggling on both sides – from those seeking help via enquiries to the RCN, to those who are perceived as unhelpful or unkind. This report's findings are consistent with those of the available literature. The workplace is crucial to establishing a sense of safety and belonging but for the nursing workforce there appears to be no space to recuperate or heal as the profession moves on from the pandemic. Outside work, home life, family responsibilities, care needs, and exposure to death and loss also impact upon personal psychological and physical health, and the enduring impact of stress on mental and physical functioning is a reality for many.

Section 4c: RCN Counselling: support for members experiencing workplace pressures

About the RCN Counselling service

RCN Counselling offers brief therapy over the phone with experienced, highly qualified and accredited counsellors from diverse backgrounds. RCN counsellors are sensitive to the therapeutic needs of cultural minority groups. After an assessment, the service matches members with a counsellor who will schedule all subsequent appointments.

Members using the service are asked to complete a brief, confidential questionnaire. The information provided guides the sessions, helps the counsellor understand the member's current situation, and enables the team to evaluate and improve the service.

When members seeking RCN support express suicidal thoughts or report previous suicide attempts or significant self-harm, they are referred to RCN Counselling as standard practice. Typically, these individuals are contacted within 1 working day, though the official timeframe is 3 working days, and may be directed to emergency services if necessary. A trained and experienced counsellor conducts a thorough risk assessment for these individuals, and most at-risk members receive the RCN brief therapy counselling service.

The clinical team may implement additional safeguarding measures, such as involving the individual's GP or community mental health team. If necessary, individuals are directed to other RCN Member Support Services or to external support. Notably, individuals receiving support from the RCN Counselling service will not be discharged if they are still considered at risk and lacking adequate support.

Method

The data on presenting situations was taken from the RCN Counselling repository. The data span 2 years, from February 2022 to February 2024, in line with the RCN data explored in sections 4a and 4b. The counselling team categorised and anonymised all data before the authors of this report reviewed it. No recorded conversations or details of staff or members were shared.

Discussion of findings

The RCN Counselling service analysed the 352 service users between February 2022 and February 2024 who presented with suicidal ideation in their initial assessment. The data presented is descriptive and limited to the high-level information accessible for this report.

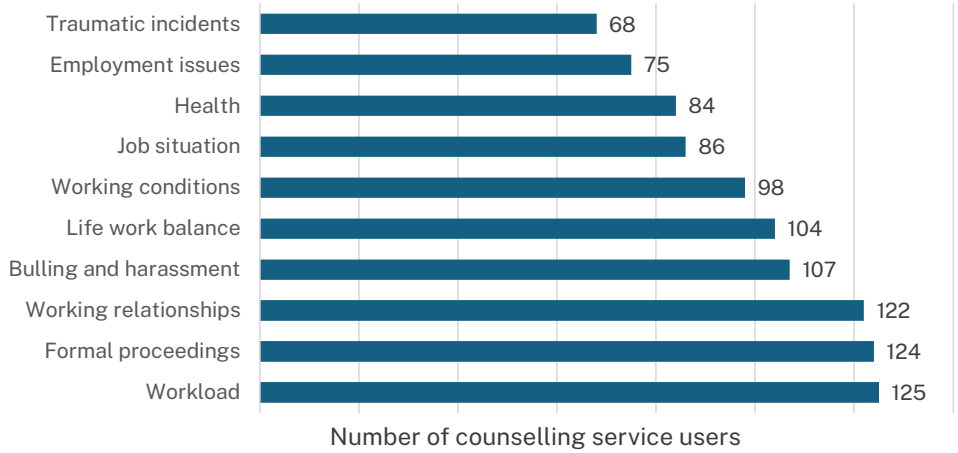
In line with the exploration of contextual factors central to this project's overall enquiry, a particular emphasis was placed on understanding workplace pressures reported by members accessing RCN Counselling. Of those who had an initial assessment, 69% (244) cited "work/academic" as 1 reason they sought help (Table 7).

Table 7: Contextual and influencing factors reported by RCN Counselling services

Presenting problem	Frequency
Anxiety/stress	325
Work/academic	244
Depression	231
Self-esteem	190
Trauma/abuse	140
Interpersonal/relationships	117
Bereavement/loss	110
Physical problems	107
Living/welfare	73
Domestic violence	40

Graph 8 breaks down the subcategories of "work/academic" to contextualise this finding further.

Graph 8: Workplace pressures recorded by RCN Counselling services



Although there is an argument that several of the subcategories are situational, subjective and unique to an individual's experience, these categories are intrinsically interrelated to organisational processes and procedures, as well as workplace culture. The impact of working relationships, formal procedures and workload on suicidal thoughts among the nursing workforce was reported 80% more, on average, than the impact of traumatic incidents.

Moral distress occurs when you know the ethically correct action to take but are constrained from taking it (Jones, 2021). It can significantly impact mental health and threaten the core values of the nursing workforce and is influenced by contextual factors such as end-of-life care, inadequate staffing levels or an inappropriate skill mix in the workplace.

Although workplace pressures cannot be looked at in isolation as causative factors influencing suicidal ideation in the nursing workforce, the workplace is the environment in which our members provide care, treatment, leadership and education.

Moreover, research by the King's Fund (2020) suggests that the nursing workforce has 3 core needs to ensure wellbeing and motivation at work and minimise workplace stress: autonomy, belonging and contribution. Autonomy involves having control over work and acting consistently with personal values. Belonging encompasses connecting with and caring for others at work, feeling valued and respected, and being supported. Contribution relates to experiencing effectiveness in tasks and delivering valued outcomes. Meeting all 3 needs is essential for people to flourish and thrive at work.

Furthermore, the Nursing Workforce Standards (RCN, 2021) and the NMC Code (NMC, 2015) emphasise supporting nurses in self-care and prioritising their health and wellbeing. This is crucial for the quality of care they provide. Employers are responsible for ensuring access to resources such as healthy eating options, wellbeing initiatives, and Occupational Health support to promote the health and wellbeing of nurses.

Echoing the findings outlined in Section 4b, it is essential to recognise that individuals may be dealing with personal challenges that are not openly shared but which can affect their work performance. While it is not the manager's responsibility to delve into personal matters, demonstrating compassionate leadership involves acknowledging the potential for such issues, directing team members to the appropriate support where needed and creating a working environment that is inclusive and psychologically safe for staff and patients.

Section 5: Recommendations and summary

Compassionate workplaces in practice

Consider the following points for creating compassionate workplaces.

1. Use a variety of tools for professional support and integrate them as essential principles of teams. Establish accountability, celebration and recognition.
2. Implement a preventative approach and compassionate responses to pre-empt stressors and the impact of life events by using the HSE's management standards (HSE, 2019) to proactively assess and address the causes of work-related stress at organisational and team levels.
3. Provide support for new leaders and managers undertaking complex processes.
4. Offer anticipatory referral for support at the beginning of a process and ensure the right person is available. Consider trade union support in the early stages of a difficult process.
5. Provide regular updates and clarity regarding processes and investigations.
6. Emphasise recovery and support for returning to and remaining in work.
7. When a formal process is activated, designate a person to automatically reach out to offer general advice and support.
8. Share good practices for supporting workplace culture and creating compassionate communities in UK forums.
9. Establish peer support initiatives and create a safe space for sharing without fear of retribution or stigmatisation, including access to physical spaces for staff to decompress and connect with each other.

Education and learning culture

1. Employers and education providers should implement an evidence-based suicide prevention theory that integrates an understanding of the biopsychosocial impact of stress and its effects on mental and physical health, as well as vulnerabilities to suicide.
2. Education providers and practice placements must ensure that the nursing workforce receives adequate training in suicide awareness and prevention at both pre- and post-registration levels, in line with NMC proficiency standards (NMC, 2018). Training should also extend to the non-nursing workforce and other clinical staff.
3. All people managers, HR staff, personal tutors and OH clinicians should undergo training in suicide awareness and prevention and have ongoing access to refresher courses.
4. Employers should report to the workplace regulator (such as the HSE and the Health and Safety Executive Northern Ireland) in cases where work is a contributing factor to suicide, such as incidents occurring at work or in the context of work, disciplinary actions or investigations.
5. Ensure responsible officers have input into local suicide prevention and postvention strategies and plans.

Research

1. Qualitative research is needed to understand the experiences of nursing staff who have had suicidal thoughts, with a focus on identifying what support and interventions were practical or what could be effective in the workplace.
2. Nursing support workers are the most overrepresented membership group reporting suicidal ideation to the RCN, so significant investigation into the factors influencing their suicidal ideation is required.
3. Further research should be conducted on high-risk staff groups, such as LGBTQ+ individuals and those who are neurodiverse.
4. Additionally, research should aim to understand suicide within ethnic minority nursing communities, including reporting methods, language preferences, cultural factors and supportive communities.
5. It is essential that individuals within the nursing workforce who have experience with suicide are involved in future research on this topic. Their involvement should follow public involvement principles (Health Research Authority, 2024) and align with person-centred values, meaningful engagement and respect for lived experiences.

Limitations

This deep dive is limited to RCN data and therefore not representative of the total nursing workforce. RCN databases are not set up expressly to capture suicidal ideation data, and the qualitative aspect relies upon the recorded data of RCN member-support staff. The causative factors of suicide cannot be differentiated between workplace and personal life due to the way the data is recorded and whether this is disclosed by or known to the caller. Although we can acknowledge trends and prevalence, the contextual issues underpinning mental health and suicidal ideation are complex, overlap and are not definitively identifiable.

Summary

The goal of this study was to understand the factors contributing to the increase in reported suicidal ideation among the nursing workforce in the UK from February 2022 to February 2024, using RCN data. While we acknowledge the limitations mentioned above, our in-depth analysis has identified important factors that need further exploration and research in the discussion on suicide in the nursing workforce.

While we cannot establish causation from our analysis, it is evident that processes are needed to support the nursing workforce referred for fitness to practise or any informal or formal work-related processes. In times of trauma or grief, individuals may be unable to recognise their limitations due to sleep deprivation and disrupted routines stemming from fatigue, long work hours and shift work.

The increasing trend of the nursing workforce to disclose and seek help from the RCN advice line for suicidal thoughts is of enormous concern. The analysis has indicated that implementing an evidence-based suicide prevention education programme for the UK nursing workforce could be beneficial. However, this is one piece of the puzzle. Continuous, comprehensive and supportive system-wide action is necessary to help the nursing workforce thrive.

In direct response to this report, the RCN is developing Compassion in Practice – an initiative to establish new workplace standards addressing the work-related pressures faced by the nursing workforce across the UK. This project aims to set new benchmarks for the nursing and broader health and care workforce, ultimately enhancing the experiences of nursing professionals in health and care services.

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Appendix 1. Literature search and eligibility criteria

Table 1

Inclusion Criteria	Exclusion Criteria
Published in English	Not available in English
Published between 2014-2024	Published prior to 2014
Peer Reviewed	Non-research articles (media reports, PowerPoints, posters, discussion protocol papers, theoretical papers, editorials)

#	Query	Limiters/Expanders	Results
S17	S11 AND S15	Limiters - Publication Date: 20140101-20241231; English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	55
S16	S11 AND S15	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	128
S15	TI intervention* OR strateg* OR support* OR overcom*) OR AB (intervention* OR strateg* OR support* OR overcom*)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	1,263,549
S14	S11 AND S12	Limiters - Publication Date: 20140101-20241231; English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	82
S13	S11 AND S12	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	209
S12	factor* OR caus* OR influence* OR reason* OR determinant* OR predict* OR motivat* OR contribut* OR prevalent* OR context*	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,840,278
S11	S7 AND S10	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	391
S10	S8 OR S9	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	415,847
S9	(MH “United Kingdom+”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	324,843
S8	UK OR “United Kingdom” OR Britain OR England OR Wales OR Scotland OR “Northern Ireland” OR NHS	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	415,847

S7	S3 AND S6	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,670
S6	S4 OR S5	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	608,570
S5	(MH “Nurses+”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	221,533
S4	TI nurs* OR AB nurs*	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	523,496
S3	S1 OR S2	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	47,277
S2	(MH “Suicidal ideation”) OR (MH “Injuries, Self-Inflicted”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	13,667
S1	TI (suicid* OR “self-harm*” OR “self-injur*”) OR AB (suicid* OR “self-harm*” OR “self-injur*”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	44,650

Medline

#	Query	Limiters/Expanders	Results
S17	S11 AND S15	Limiters - Publication Date: 20140101-20241231; English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	118
S16	S11 AND S15	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	228
S15	TI (intervention* OR strateg* OR support* OR overcom*) OR AB (intervention* OR strateg* OR support* OR overcom*)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	4,466,909
S14	S11 AND S12	Limiters - Publication Date: 20140101-20241231; English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	128
S13	S11 AND S12	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	279
S12	factor* OR caus* OR influence* OR reason* OR determinant* OR predict* OR motivat* OR contribut* OR prevalent* OR context*	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	12,431,308
S11	S7 AND S10	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	506
S10	S8 OR S9	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,804,248
S9	(MH “United Kingdom+”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	387,105
S8	UK OR “United Kingdom” OR Britain OR England OR Wales OR Scotland OR “Northern Ireland” OR NHS	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,795,712
S7	S3 AND S6	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,574
S6	S4 OR S5	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	494,307
S5	(MH “Nurses+”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	91,242

S4	TI nurs* OR AB nurs*	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	462,369
S3	S1 OR S2	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	100,007
S2	(MH “Suicidal ideation”) OR (MH “Self-Injurious Behavior”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	21,512
S1	TI (suicid* OR “self-harm*” OR “self-injur*”) OR AB (suicid* OR “self-harm*” OR “self-injur*”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	97,384

Search 2 includes BAME to check returns

CINAHL

#	Query	Limiters/Expanders	Results
S15	S11 AND S14	Limiters - Publication Date: 20140101-20211231; English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	1
S14	S12 OR S13	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	364,141
S13	TI (BAME OR BME OR black OR asian OR “minority ethnic” OR “ethnic minorit*” OR “minority group*” OR “ethnic group*” OR “racial minorit*” OR race OR racial OR ethnic* OR “people of colour” OR POC OR bangladeshi* OR bengali* OR indian* OR chinese OR pakistani* OR african* OR arab* OR “afro caribbean” OR “african caribbean” OR afrocaribbean OR “south asian*”) OR AB (BAME OR BME OR black OR asian OR “minority ethnic” OR “ethnic minorit*” OR “minority group*” OR “ethnic group*” OR “racial minorit*” OR race OR racial OR ethnic* OR “people of colour” OR POC OR bangladeshi* OR bengali* OR indian* OR chinese OR pakistani* OR african* OR arab* OR “afro caribbean” OR “african caribbean” OR afrocaribbean OR “south asian*”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	317,123
S12	(MH “Africans+”) OR (MH “Arabs+”) OR (MH “Asians+”) OR (MH “Black Persons+”) OR (MH “Caribbean Persons+”) OR (MH “Middle Eastern Persons+”) OR (MH “Multiracial Persons”) OR (MH “Roma”) OR (MH “Ethnic Groups”) OR (MH “Minority Groups”)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	136,713
S11	S7 AND S10	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	391
S10	S8 OR S9	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	415,934
S9	(MH “United Kingdom+”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	324,879
S8	UK OR “United Kingdom” OR Britain OR England OR Wales OR Scotland OR “Northern Ireland” OR NHS	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	415,934

S7	S3 AND S6	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,674
S6	S4 OR S5	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	608,763
S5	(MH “Nurses+”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	221,622
S4	TI nurs* OR AB nurs*	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	523,670
S3	S1 OR S2	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	47,304
S2	(MH “Suicidal ideation”) OR (MH “Injuries, Self-Inflicted”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	13,679
S1	TI (suicid* OR “self-harm*” OR “self-injur*”) OR AB (suicid* OR “self-harm*” OR “self-injur*”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	44,674

Medline

#	Query	Limiters/Expanders	Results
S15	S11 AND S14	Limiters - Publication Date: 20140101-20241231; English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	12
S14	S12 OR S13	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	1,195,221
S13	(MH “Ethnic and Racial Minorities”) OR (MH “Minority Groups”) OR (MH “African People+”) OR (MH “Asian People”) OR (MH “Black People+”) OR (MH “Caribbean People”) OR (MH “Middle Eastern and North Africans+”)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	185,387
S12	TI (BAME OR BME OR black OR asian OR “minority ethnic” OR “ethnic minorit*” OR “minority group*” OR “ethnic group*” OR “racial minorit*” OR race OR racial OR ethnic* OR “people of colour” OR POC OR bangladeshi* OR bengali* OR indian* OR chinese OR pakistani* OR african* OR arab* OR “afro caribbean” OR “african caribbean” OR afrocaribbean OR “south asian*”) OR AB (BAME OR BME OR black OR asian OR “minority ethnic” OR “ethnic minorit*” OR “minority group*” OR “ethnic group*” OR “racial minorit*” OR race OR racial OR ethnic* OR “people of colour” OR POC OR bangladeshi* OR bengali* OR indian* OR chinese OR pakistani* OR african* OR arab* OR “afro caribbean” OR “african caribbean” OR afrocaribbean OR “south asian*”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	1,149,547
S11	S7 AND S10	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	506
S10	S8 OR S9	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,805,408
S9	(MH “United Kingdom+”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	387,129
S8	UK OR “United Kingdom” OR Britain OR England OR Wales OR Scotland OR “Northern Ireland” OR NHS	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,796,872
S7	S3 AND S6	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,575

S6	S4 OR S5	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	494,504
S5	(MH “Nurses+”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	91,265
S4	TI nurs* OR AB nurs*	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	462,566
S3	S1 OR S2	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	100,056
S2	(MH “Suicidal ideation”) OR (MH “Self-Injurious Behavior”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	21,520
S1	TI (suicid* OR “self-harm*” OR “self-injur*”) OR AB (suicid* OR “self-harm*” OR “self-injur*”)	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	97,433

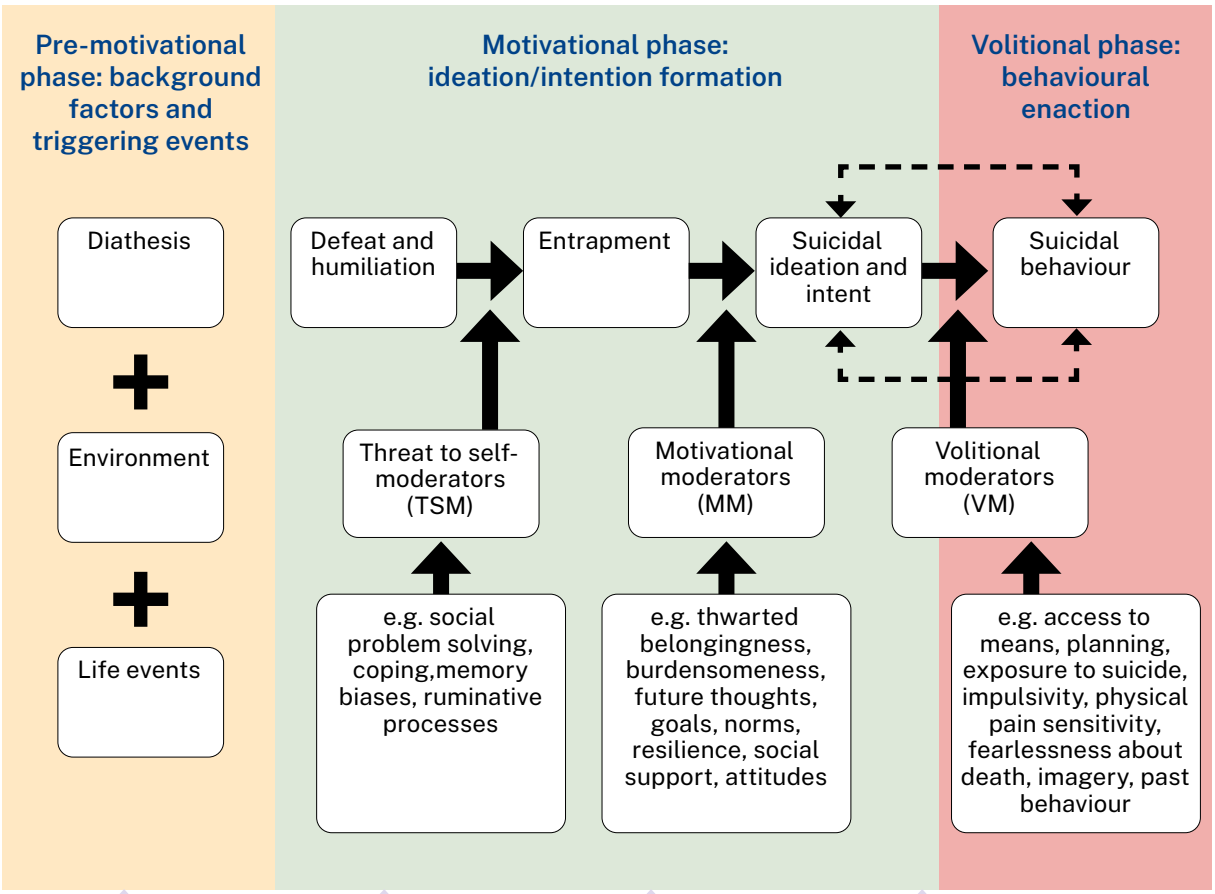
CINAHL

#	Query	Limiters/Expanders	Results
S12	S7 AND S10	Limiters - Publication Date: 20140101-20231231; English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2
S11	S7 AND S10	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	9
S10	S8 OR S9	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	416,097
S9	(MH "United Kingdom+")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	324,946
S8	UK OR "United Kingdom" OR Britain OR England OR Wales OR Scotland OR "Northern Ireland" OR NHS	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	416,097
S7	S3 AND S6	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	29
S6	S4 OR S5	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	11,027
S5	(MH "Certified Nursing Assistants")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	8,644
S4	TI ("healthcare assistant*" OR "health care assistant*" OR HCA OR "nursing support worker*" OR "associate practitioner*" OR "assistant practitioner*" OR "healthcare support worker*" OR "health care support worker*" OR "nursing assistant*") OR AB ("healthcare assistant*" OR "health care assistant*" OR HCA OR "nursing support worker*" OR "associate practitioner*" OR "assistant practitioner*" OR "healthcare support worker*" OR "health care support worker*" OR "nursing assistant*")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	5,056
S3	S1 OR S2	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	47,365
S2	(MH "Suicidal ideation") OR (MH "Injuries, Self-Inflicted")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	13,697
S1	TI (suicid* OR "self-harm*" OR "self-injur*") OR AB (suicid* OR "self-harm*" OR "self-injur*")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	44,731

Medline

#	Query	Limiters/Expanders	Results
S12	S7 AND S10	Limiters - Publication Date: 20140101-20201231; English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	1
S11	S7 AND S10	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2
S10	S8 OR S9	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,809,142
S9	(MH "United Kingdom+")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	387,226
S8	UK OR "United Kingdom" OR Britain OR England OR Wales OR Scotland OR "Northern Ireland" OR NHS	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	2,800,604
S7	S3 AND S6	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	26
S6	S4 OR S5	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	12,799
S5	(MH "Nursing Assistants")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	3,782
S4	TI ("healthcare assistant*" OR "health care assistant*" OR HCA OR "nursing support worker*" OR "associate practitioner*" OR "assistant practitioner*" OR "healthcare support worker*" OR "health care support worker*" OR "nursing assistant*") OR AB ("healthcare assistant*" OR "health care assistant*" OR HCA OR "nursing support worker*" OR "associate practitioner*" OR "assistant practitioner*" OR "healthcare support worker*" OR "health care support worker*" OR "nursing assistant*")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	9,954
S3	S1 OR S2	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	100,233
S2	(MH "Suicidal ideation") OR (MH "Self-Injurious Behavior")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	21,565
S1	TI (suicid* OR "self-harm*" OR "self-injur*") OR AB (suicid* OR "self-harm*" OR "self-injur*")	Limiters - English Language Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	97,609

Appendix 2. The Integrated Motivational Volitional Model of Suicidal Behaviour



(O'Connor & Kirtley, 2018)

Diathesis
Individual vulnerabilities such as personality, perfectionism elevate risk for Suicidal ideation when combined with environmental factors + life event/ acute chronic life stressors

In addition, prolonged stress, bereavement, trauma impacts upon cortisol and executive function, including problem solving and memory.
Impact of formal processes on sense of self, humiliation, and defeat.

No perceived escape or rescue.

Workplace factors and stressors, personal factors, and stressors.

Note that the purple arrows are for explanatory purposes only, showing relevance to the findings from the RCND deep dive.

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