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Shifting the Future: Policy and Research Updates on Suicide in the Nursing Profession

Hosted by the Building Health Care System Excellence; Psychiatric, Mental Health, and Substance Use; and Acute & Critical Care Expert Panels

Shifting the Future: Policy and Research Updates on Suicide in the Nursing Profession

Dialogue Occurred
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INTRODUCTION

In September 2025, the American Academy of Nursing (Academy) hosted a policy dialogue titled "Shifting the Future: Policy and Research Updates on Suicide in the Nursing Profession." The Academy's Building Health Care System Excellence Expert Panel, in collaboration with the Psychiatric, Mental Health, and Substance Use Expert Panel and the Acute & Critical Care Expert Panel, convened this dialogue. Leading experts in nurse suicide prevention discussed emerging data and research, risk identification measures, and strategic initiatives for organizational and policy development.

This document covers key content from the event, including:

- Summaries of the title speakers' content and discussion among speakers and participants;
- Key takeaways; and
- Recommendations for nurses to take actionable steps to promote policy change and mitigate nurse suicide.

Please note: topics discussed include suicide and trauma, which may cause discomfort or distress. Reader discretion is advised. Whether facing mental health struggles, emotional distress, alcohol or drug use concerns, or needing someone to talk to, resources are available. ***Dial 988*** *- Suicide & Crisis Lifeline.*

ABOUT THE AMERICAN ACADEMY OF NURSING

The American Academy of Nursing serves the public by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. Academy Fellows are inducted into the organization for their extraordinary contributions to improve health locally and globally. With more than 3,300 Fellows, the Academy represents nursing's most accomplished leaders in policy, research, administration, practice, and academia.

For over 30 years, the Academy's Expert Panels acted as the organization's thought leadership bodies. Through the Expert Panels, Academy Fellows with subject matter expertise reviewed emerging trends, research, and issues within their field to make evidence-based recommendations. By hosting Policy Dialogues, Expert Panels fostered engaging discussions to further enhance awareness and develop policy proposals that work to achieve the Academy's vision of *healthy lives for all people*. The Academy's Expert Panels transitioned into Thought Leadership Collaboratives prior to the publication of these dialogue proceedings.

Featured Speakers

Amanda Choflet
DNP, RN, NEA-BC
Dean of Nursing,
Northeastern University

Christopher Wojnar
MSN, APNP, PMHNP-BC
Founder and CEO
Christopher M Wojnar, LLC
Vice President
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Allison Norful
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Columbia University School of Nursing
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Main Session Summary

Amanda Choflet
PhD, MPH, RN, FAAN

Dr. Amanda Choflet currently serves as the Dean of Nursing at Northeastern University. Her research involves substance use and the emotional well-being of nurses, nursing students, and other populations where mental health is at risk. Her team has explored maladaptive coping mechanisms and the ways in which modern health care structures influence the help-seeking behaviors of nurses and other health professionals. Dr. Choflet's previous work included system-wide practice integration, standardization of practice and documentation, and the science of symptom management. She received grant funding for her evidence-based practice work in substance use from the American Association of Colleges of Nursing and the Centers for Disease Control and Prevention (CDC).

In her remarks, Dr. Choflet discussed the current findings from studies examining nurse suicide using the National Violent Death Reporting System (NVDRS). The NVDRS is the CDC's comprehensive surveillance system for violent deaths in the United States with data submission participation from all 50 states, the District of Columbia, and Puerto Rico.[i] The data are comprised of quantitative and qualitative fields from deidentified law enforcement reports, coroner/medical examiner (CME) reports, death certificates, and toxicology reports. These data are accessible to researchers with a two-year lag between data entry and access. Given its comprehensive scope, the NVDRS is the most robust data source for understanding violent deaths in the United States.

Dr. Choflet highlighted the work of a research team at the University of California San Diego, led by Judy Davidson, DNP, RN, MCCM, FAAN, to produce a landmark study on nurse suicide using data from the NVDRS.[ii] The data spanned 2005 to 2016 and evaluated nearly 2,000 nurse suicides. It illustrated that both female and male nurses had a higher suicide risk compared to the general population (over 150,000 individuals within the NVDRS). The researchers also discovered key risk patterns, which included work related challenges. Nurse decedents (both male and female) were significantly more likely to have work related challenges reported in the database, history of mental illness, and leave suicide notes prior to death when compared with the general population of suicide decedents. Nurse victims of suicide were older than the general population and disproportionately white, with less racial diversity than the national nursing workforce. The methods were also

different: female nurses most commonly used pharmacological poisoning, followed by firearms. The most used substances were opioids, antidepressants, and benzodiazepines.

In 2020, Dr. Choflet joined Dr. Davidson's team of researchers and published a follow-up study, a comparative analysis examining antecedent variables.[iii] The team expanded the number of nurse suicide cases they reviewed and triangulated the antecedent variables outlined in the NVDRS. The team found that rates of depression and bipolar disorder were higher for nurses than the lifetime prevalence rates in the general population. Physical health appeared to compound the mental health struggles reported at the time of death. A significant number of nurse decedents reported physical health problems, including chronic pain from conditions such as fibromyalgia, osteoarthritis, and work-related injuries. Substance use was also quite prevalent and complex: up to a third of nurse decedents had documented substance use, if alcohol is combined with other substance use categories. These cases often involved prescription medications that were used without a prescription or used more frequently than prescribed. Some decedents were simultaneously in mental health treatment while using substances. For nurse decedents who had post-mortem toxicology screening, substance use at time of death was significantly higher than in the general population decedents. The study also showed that nearly half of nurse decedents reported previous mental health treatment. While further research is needed, an underlying problem highlighted by the findings suggests that mental health treatment was possibly insufficient, inadequate, or not timely.

Given that the timing of this research coincided with the COVID-19 pandemic, the research team then sought to examine the impact of the pandemic on nurse suicide and published a study that explored data from 2017 through 2021.[iv] Similar to national data trends, suicide rates for nurses remained largely level during the COVID-19 pandemic. Previously observed trends continued, reflecting that female nurses experienced higher suicide rates than the general population and male nurse suicide rates remained comparable to the general male population. The previously identified risk factors, which included job and mental health challenges, remained high within this population as well as noted demographic differences.

"We know that our health system depends on nurses for patient care, and we have to therefore prioritize nurse well-being through these evidence-based interventions."
Amanada Choflet

Dr. Choflet underscored that suicide risk factors do not exist in a vacuum and rather are entangled, or impossible to separate. Mental health problems, substance use issues, chronic illness and pain, and work related challenges often interact in ways that traditional linear models failed to capture. Dr. Choflet shared the team's work that resulted in a 2022 study examining the issue of entanglement.[v] Entanglement helps explain why simple interventions are often unsuccessful. A nurse experiencing chronic pain may develop depression, which may lead to substance use and create job concerns, which can in turn worsen mental health and perpetuate a harmful cycle. With complex, interrelated factors, a holistic and humanistic approach is needed. This emphasizes bringing the resources to the individual rather than requiring the individual to overcome challenges to their access. Evidence indicates that some risk factors are modifiable and there are opportunities for health systems, through workplace and systemic interventions, to implement comprehensive prevention approaches.

"We know that our health system depends on nurses for patient care, and we have to therefore prioritize nurse well-being through these evidence-based interventions," Dr. Choflet highlighted.

Christopher Wojnar
MSN, APNP, PMHNP-BC

Christopher Wojnar is the Founder and CEO of Christopher M. Wojnar, LLC, Vice President of United Suicide Survivors International, and a Lived Experience Leader. A psychiatric nurse practitioner and suicide prevention strategist, he integrates lived experience into practice, systems design, and policy development to reduce suicide risk and improve access to compassionate care. His portfolio includes Zero Suicide-informed implementation, structured postvention, psychological safety, and confidential pathways for clinicians. He is also an ambassador for the Dr. Lorna Breen Heroes Foundation and serves on multiple boards advancing nurse well-being and health worker mental health. His work centers on multi-level culture change, data-driven strategy, and pragmatic tools that make help-seeking safe, equitable, and routine across healthcare settings.

In his remarks, Mr. Wojnar framed nurse suicide as a workforce safety issue driven by systemic and policy-level factors rather than individual failure. Drawing on both professional expertise and lived experience, he highlighted how current regulatory, organizational, and cultural structures can contribute to suicide risk. In his remarks, Mr. Wojnar framed nurse suicide as a workforce safety issue driven by systemic and policy-level factors rather than individual failure. Drawing on both professional expertise and lived experience, he highlighted how current regulatory, organizational, and cultural structures can contribute to suicide risk.

> **"Suicide in nursing is not an individual failing. It is a workforce safety issue driven by system-level failures."**
> Christopher Wojnar

Workplace programs intended to support clinicians are often fragmented and insufficiently integrated into broader workforce safety strategies. Many organizations prioritize individual-level interventions without addressing structural barriers such as lack of confidential access to mental health care, punitive responses to substance use or relapse, and regulatory environments that discourage help-seeking. Mr. Wojnar described how certain monitoring and disciplinary programs, particularly those that are perceived as punitive, may exacerbate known suicide risk factors, including shame, financial hardship, and social isolation. When clinicians are required to choose between seeking care and protecting their license or livelihood, these policies can create conditions that increase risk rather than reduce it. These effects are not incidental; they represent policy-driven risk exposures embedded within existing systems.

He emphasized the need for reform of licensure and credentialing practices. Many current applications include questions regarding mental health diagnoses or treatment history that may not align with the Americans with Disabilities Act (ADA).[vi] National best practice, endorsed by organizations such as the Dr. Lorna Breen Heroes' Foundation and the Federation of State Medical Boards, is to adopt a functional impairment standard that limits inquiry to whether a clinician is currently able to practice safely.[vii] Mr. Wojnar also highlighted gaps in confidentiality protections. While health information is protected in clinical contexts, those protections often do not extend to licensing and disciplinary processes, where sensitive mental health or substance use information may become publicly accessible. Strengthening statutory and regulatory protections is necessary to reduce stigma and remove barriers to care.

In addition, he emphasized the importance of integrating suicide prevention, substance use recovery, and mental health access into workforce safety frameworks. Organizational investments in wellness programming are insufficient if they do not address the primary drivers of suicide risk. Comprehensive strategies should include confidential access to care, proactive identification of risk, and system-wide accountability for clinician well-being.

Postvention was identified as a critical but frequently overlooked component. In the absence of structured response protocols, organizational silence or inconsistent communication following a suicide can contribute to stigma, complicated grief, and potential contagion effects. Evidence-informed postvention should include clear and compassionate communication, psychological first aid, peer support, and access to confidential counseling services.

Finally, Mr. Wojnar emphasized the role of lived experience in informing policy and program development. Individuals with lived experience of suicide, either through personal experience or loss, offer critical insights that can improve the relevance, safety, and effectiveness of prevention strategies. Structured frameworks for engagement can support organizations in incorporating lived experience in ethical and meaningful ways.

Allison Norful

PhD, RN, ANP-BC, FAAN

Dr. Allison Norful holds joint appointments as an Assistant Professor at Columbia University School of Nursing and as a Nurse Scientist in the NewYork-Presbyterian Hospital enterprise. Dr. Norful's program of research centers on the impact of work environment factors on physiological and epigenetic stress that precipitates adverse psychological outcomes among nurses, with a particular focus on suicide risk. In addition to this work, she has developed several validated survey instruments, including the Provider Co-Management Index, now in use across six countries in both research and clinical settings. Her expertise spans measurement science, psychometric testing, and care delivery model analysis.

Dr. Norful's leadership extends to national advocacy for nurse practitioner full practice authority as well as international studies of registered nurses in primary care. Her dynamic and innovative methods have been nationally and internationally recognized by leading organizations, including fellowship in both the New York Academy of Medicine and the American Academy of Nursing, as well as the 2024 Academy Edge Runner Award for her work advancing academic–clinical practice partnerships.

In her remarks, Dr. Norful discussed the scope and urgency of nurse suicide research. She emphasized that nurse suicide is a preventable tragedy that demands rigorous science, accurate measurement, and strong advocacy. Nurse suicide has only recently begun to emerge in scientific literature. This has resulted in delays in recognizing warning signs and implementing prevention strategies and interventions.

Nurses face many unique risk factors, including repeated exposure to suffering and trauma, compassion fatigue, high patient acuity, unsafe staffing, and workplace violence. Nurses also report high stress levels, with substantial increases in burnout, depression, and intent to leave the profession following the COVID-19 pandemic. Furthermore, the stigma surrounding mental health care, combined with fear of licensure repercussions, continues to create barriers to help-seeking behaviors. Adding further complexity, the true extent of nurse suicide rates remains obscure. Nurse suicides are often misclassified as accidental overdoses or injuries, occupational coding is inconsistently applied, and coroner and medical examiner practices in classifying cause of death vary widely.

Dr. Norful described the emerging methods she is using with her research team to achieve greater accuracy in nurse suicide research, funded by the National Institute of Mental Health. Moving beyond descriptive studies, which Dr. Norful emphasized are still important, her team utilizes

biologic methods that capture physiological responses to stress exposure. Her team has embedded hair cortisol concentration and DNA methylation as two novel approaches to understanding the implications of stress levels among the nursing workforce. For hair cortisol concentration, hair segments can be analyzed retrospectively to measure cortisol exposure as hair grows approximately 1 centimeter per month. A section of hair approximately the width of a pencil eraser, for example, provides several months of physiologic data. This is a relatively noninvasive and inexpensive method for capturing biologic data and is a better measure than blood or saliva cortisol measurements, which fluctuate daily with the circadian rhythm. For nurses, elevated cortisol is associated with burnout, sleep disturbances, and emotional exhaustion, which are also risk factors for suicidal ideation.

DNA methylation examines epigenetic modification in response to one's environment and can prompt genes to turn on or off. Chronic stress, trauma, and environmental exposures can alter methylation of stress-related genes, particularly those involved in the HPA (hypothalamic-pituitary-adrenal) axis. Studies for populations such as military veterans have identified methylation changes in genes related to serotonin pathways and stress. Applying this measurement to nurses opens a new area of inquiry for nurse suicidology. This new research presents an opportunity to link longitudinal hair cortisol levels to DNA methylation patterns and workplace exposures, such as shift work, violence, and staffing levels. "I'm hoping that this kind of research can really illuminate and lead to possible predictive models that can help us identify nurses at higher risk before crisis occurs," Dr. Norful explained.

"Behind every statistic we know there is a human story. Right now, we have too few platforms for nurses to share those stories. Qualitative research is urgently needed to understand what it means to be a nurse who has survived a suicide attempt or a nurse who is experiencing the devastating loss of a peer."
Allison Norful

Despite the growing number of pilot studies and expanding evidence, the scale and duration of research present a significant gap as most current studies are small and cross-sectional. Large-scale, longitudinal studies that follow nurses over years and measure workplace exposures alongside biomarkers and mental health outcomes are needed to identify causal pathways and evaluate long-term interventions. Furthermore, there is a need to focus on diversity and representation as much current research is derived from urban cohorts in the United States. An expansion of research to include other populations, including rural, international, and minority populations in the workforce, would help illuminate the cultural differences that may influence both biological stress responses and the stigma associated with suicide. Qualitative research is crucial, as numbers alone cannot capture the lived experience. "Behind every statistic we know there is a human story. Right now, we have too few platforms for nurses to share those stories. Qualitative research is urgently needed to understand what it means to be a nurse who has survived a suicide attempt or a nurse who is experiencing the devastating loss of a peer," Dr. Norful underscored.

Dr. Norful concluded by discussing the importance of accurate measurement in research. If mortality data are inaccurate, even the best biologic science will have limited impact. Policymakers may underestimate the scope of the crisis and funding for prevention research could be limited. She emphasized that the critical goal is not just to describe the problem, but to begin using the research to design targeted, evidence-based interventions that save lives. Consistent classification of suicide across mandatory occupational coding and transparent reporting are important to ensure that accurate science can translate into prevention policy. High-quality data can support legislation

mandating workplace suicide prevention programs. Hospitals can use biomarker and epidemiologic data to build their wellness infrastructures. Stress biomarker monitoring at the individual level can help clinicians identify vulnerabilities and connect with support before a crisis occurs.

"Nurses care for society in its most vulnerable moments. Now it's our responsibility as a profession to apply the same rigor, compassion, and urgency to caring for them…Our work as nursing professionals, leaders, and scientists must carry this forward to ensure nurse suicide is no longer hidden, misclassified, or ignored," Dr. Norful concluded.

Discussion Session

How should the nursing profession balance public safety concerns about impaired practitioners with evidence that punitive approaches and regulatory actions may increase suicide risk? What would evidence-based regulation look like?

Dr. Choflet explained that there are significant concerns with continuing current policies. There is a disconnect between the level of concern within the nursing profession and the number of resources available at the state board level. The current regulatory environment, which requires nurses to self-report mental health and substance use problems, puts them at risk of losing their income without providing resources to meet their economic, social, and health needs. Overall, this results in a chilling effect when clinicians continue to feel that there are punitive consequences to reporting. Dr. Choflet highlighted the work of the Dr. Lorna Breen Heroes' Foundation in changing hospital and state board approaches to licensing and credentialing questions.[vii]

Additionally, funded recovery programs for nurses are needed. The financial responsibility for recovery (including drug testing, counseling, and recovery support) is often placed on the individual nurse, who has also had their license and ability to earn an income suspended while in recovery.[viii] Additionally, when nurses have undergone the recovery process and are able to reenter the workforce, it can be difficult to find employment opportunities. State-funded job search and placement opportunities could help ease this transition. Dr. Choflet emphasized that state resources such as these could help meet both aims of public and clinician safety. Ultimately, the current landscape that disincentivizes help-seeking behaviors does not make the public safer; rather, public safety is heightened when resources are available to help those who need them.

What role should state boards of nursing, hospital leaders, and nursing organizations play in removing barriers to seeking treatment and protecting confidentiality?

Mr. Wojnar noted that it is critically important to integrate and engage nurses with lived experience in the creation of policies and programs. Nurses are often left out of decision-making processes that impact them and addressing this is a key step. Regulators, health systems, and professional organizations play interconnected roles in not only dismantling barriers but creating conditions where nurses feel safe to proactively seek help. Hospital and health systems leaders can create confidential and equitable pathways for accessing mental health and substance use support. An emphasis should be placed on fostering a restorative, just culture where mistakes or relapses by a clinician are met with learning and recovery rather than punitive consequences.

Addressing licensing and credentialing application questions is important to remove punitive undertones of certain policies, as punitive undertones can be present even when the stated goals of a policy may be to increase well-being. Regulatory accountability means shifting from punitive compliance to compassionate, safe frameworks. Concerningly, some state boards of nursing publish mental health diagnoses and other health information on nurses as part of compliance with open records laws. Stronger privacy protections are needed to safeguard the information of nurses facing disciplinary proceedings.

How can survivors with lived experience be supported when sharing this sensitive information in research?

Dr. Norful noted that advancing rigorous science must be balanced with ethical responsibility, as conducting research with nurses who have survived a suicide attempt, or experienced the loss of a peer, means working with people experiencing significant pain. Protections are built into each stage of the research process to ensure that nurses feel safe sharing the trauma they have experienced. This includes robust confidentiality policies and processes through clear consent language and strict deidentification of data. Research participants are given unique participant ID numbers to ensure that their information is not tied to their name. Though all research studies must minimize harm, research on suicide involves additional safeguards. For example, in the collection of qualitative data through interviews, trained interviewers can recognize signs of distress and provide immediate referrals for counseling or crisis services.

Dr. Norful also highlighted that biologic studies require explaining results responsibly. With hair cortisol and DNA methylation studies, researchers must be clear that these measures are not deterministic of risk, but rather part of a broader pattern researchers are still learning about. Dr. Norful explains this to research participants as transparently as possible, along with the intended goals for the data, when obtaining their consent. Finally, it is important to view research participants as partners in the research rather than subjects. This means that their feedback is sought and results are shared with nurses in ways that are useful to their needs. “By centering the dignity, safety, and voice of participants, we can not only protect them but ensure the quality and integrity of the science itself,” Dr. Norful underscored. Mr. Wojnar added that when nurses can share their experiences in this way and turn their painful experiences into purpose through research, this is meaningful and can be a protective factor for suicide.

How should health care organizations design employee wellness and suicide prevention programs given that risk factors for suicide are often entangled?

Dr. Choflet highlighted examples including the MINDBODYSTRONG program[ix] and the American Foundation for Suicide Prevention's interactive screening program.[x] Through the interactive screening program, individuals can use validated instruments to assess their own mental health and well-being and obtain confidential organizational access to resources, such as a contracted counselor, with the individual also having the option to remain anonymous. The MINDBODYSTRONG program includes an interactive screening program as well as ongoing support through weekly sessions with participants.[ix]

From a harm-reduction standpoint, Dr. Choflet noted that community and crisis level interventions are important. At the community level, health systems can implement universal education for health care workers. Research has indicated that nurses are at higher risk of harm due to workplace exposure to violence and traumatizing events, which can lead to mental health issues and burnout. Faced with this reality, community level interventions including education are essential to support health care workers. Education could include mitigation strategies including cognitive reappraisal or QPR training (Question, Persuade, and Refer)[xi] as an emergency mental health intervention.

On a crisis level, evidence-based treatment for mental health issues is needed and should be available through easily accessible points close to the work environment. Change could also be achieved through adapting the incentives for health systems, for example with advantages for systems that demonstrate that they are providing evidence-based wellness resources.

Can you explain some of the important physiologic findings from research?

Dr. Norful explained that while findings are not yet available from her research on hair cortisol and DNA methylation, she recently completed a pilot feasibility study using Oura Rings, which are wearable technology that capture physiologic data including heart rate, body temperature, movement, and sleep. With a group of nurses wearing Oura Rings over eight weeks, Dr. Norful found that nurses were experiencing significant sleep deficits. Compared to a typical sleep recommendation of eight hours per night, the nurses in the sample averaged six hours of sleep. A third of the participants slept fewer than three hours in a 24-hour period. Half of the participants spent less than one hour in the REM cycle, which is the important recovery sleep period. When looking at heart rate variability, which is a stress measure, heart rate variability was markedly shorter than normative values for the nurses in the study. This suggests that cumulative stress exposure can result in diminished physiologic resilience. Total sleep duration and time spent in the REM cycle was moderately correlated with nurse-reported quality of care.

Taken together, the results suggest that inadequate sleep and impaired stress recovery provide insight into mechanisms that could impact suicide risk for nurses. The research team then considered interventions that could support better sleep and piloted a sleep health promotion kit containing evidence-based devices, such as aromatherapy, eye masks, and blue light blocking glasses, to promote healthy sleep. They found significant reductions in depressed mood and burnout when sleep was improved among the nurses in their study. Dr. Norful emphasized that precision wellness is important when tailoring interventions. Nurses should be able to select the method that works best for them based on preference, time, and other personal factors.

How do we identify our nursing colleagues who might be at risk for suicide?

Dr. Choflet explained that while research is critical to help pinpoint the interrelated factors that can contribute to increased risk for suicide and build greater interventions, a more universal trauma-informed approach that applies to all nurses is needed. This humanistic approach, as opposed to a punitive approach, seeks to understand why a person may be struggling rather than imposing strict consequences. Dr. Norful added that there is persistent stigma surrounding suicide which should be addressed. Health systems, for example, could implement mandatory training on suicide prevention or identification of risk. The Icahn School of Medicine at Mount Sinai has established the Center for Stress, Resilience and Personal Growth,[xii] which serves as an example of a center where anyone can seek resources. She encouraged all health systems to establish a similar center that is easily accessible.

Mr. Wojnar emphasized the importance of identifying and addressing systemic workplace factors that contribute to elevated suicide risk among nurses. He noted that stigma continues to frame suicide as a personal failing, which can discourage nurses from seeking support or utilizing available resources. While nurses possess extensive knowledge related to health, wellness, and patient care, a persistent gap remains between that knowledge and their ability to apply it to their own well-being. He highlighted the need to examine this gap more closely, including the structural, cultural, and psychological barriers that prevent nurses from translating awareness into action. Efforts to promote help-seeking must go beyond education alone and focus on creating environments in which accessing care is perceived as safe, confidential, and free from judgment. Psychological safety is a critical condition for engagement, particularly in high-stakes professional environments. Mr. Wojnar further noted that systems can be intentionally redesigned to support recovery, healing, and sustained well-being. This includes aligning policies, leadership behaviors, and available resources in ways that reduce fear and reinforce support. As he stated, “Every nurse deserves to have that opportunity, and we have to create those conditions where people can truly thrive.”

How do we interrupt or eliminate barriers between intent and action for nurses taking care of themselves?

Mr. Wojnar described a pivotal moment in which he reframed his belief that prioritizing his own care was selfish, emphasizing that caring for oneself is caring for others. He noted that introspection can help identify barriers and support the development of habits that promote follow-through. Programs such as MINDBODYSTRONG that build cognitive and adaptive skills can be beneficial and should be integrated into nursing education and professional development.[ix] However, individual skills must not be monotherapy and do not replace addressing organizational and/or departmental contributors to mental-ill-health.

What can nurse leaders do to shift the conversation surrounding nurse suicide and create a safer workplace?

Mr. Wojnar noted that leadership plays a critical role in shaping culture and signaling what is safe within an organization. He described leading with lived experience as one approach to fostering psychological safety, while acknowledging that leaders do not need direct personal experience with suicide to model openness and vulnerability. When leaders demonstrate willingness to engage in honest conversations about stress, mental health, and well-being, it can reduce stigma and make it more acceptable for others to speak up and seek support.

He emphasized that culture change must be supported by operational action. Leaders should implement structured postvention protocols that provide clear guidance following a suicide, including communication strategies, psychological first aid, peer support, and access to confidential counseling. In the absence of these protocols, organizations may default to silence or inconsistent responses, which can increase distress and perpetuate stigma.

Dr. Norful added that nurse leaders themselves experience significant stress and trauma that may differ from what is experienced by bedside nurses. Nurse leaders are a largely understudied group among the nursing workforce with regard to stress and mental health. More research is needed to better understand occupational factors that induce or prevent their role-specific stress exposure and subsequent implications. Additionally, Dr. Choflet noted that the prevalence of substance use among nurses remains understudied. One study found that nurse managers and other administrators had nine to twelve times the odds of having a substance use disorder compared to educators and researchers,[xiii] which speaks to the particular stress points and needs of nurse leaders. Finally, she echoed Mr. Wojnar in noting that while not all nurses have an experience with suicide or suicidality, all nurses have experience with grief which can center these conversations.

Key Takeaways

Nurses Have Elevated Rates of Suicide Compared to the General Population

Nurses often face repeated exposure to suffering and trauma, compassion fatigue, high patient acuity, and workplace violence. Nurses also report high stress levels, with substantial increases in burnout, depression, and intent to leave the profession following the COVID-19 pandemic. Stigma surrounding mental health care, combined with fear of licensure repercussions, continues to create barriers to help-seeking behavior for nurses.

Elevated Rates of Nurse Suicide Are a Workforce Safety Crisis and Systemic Failure

Suicide in nursing is not an individual failing but rather a systemic failure and crisis driven by stigma, lack of confidentiality, punitive cultures, and lack of sufficient access to effective mental health care. Meaningful reform is needed, including removing intrusive questions about mental health diagnoses and treatment from licensure processes and strengthening protections to prevent public disclosure of nurses' sensitive and private health information.

Healthy Work Environments and a Humanistic Approach Are Needed

Suicide risk factors are entangled, or impossible to separate. Mental health problems, substance use issues, chronic illness and pain, and job problems often interact and create harmful cycles. With these complex, interrelated factors, a holistic and humanistic approach that seeks to understand and bring resources to the individual is needed. People with suicide lived experiences are important to inform and guide prevention and well-being strategies.

Suicide Prevention and Postvention Must Be Integrated into Every Well-Being Strategy

Comprehensive mental health, substance use, and suicide awareness, intervention, and postvention frameworks must be embedded as a core component of workforce safety. Fragmented programs, outdated policies, and cultural norms can drive nurses who are struggling into silence. Systems that force a choice between seeking care and protecting one's career can increase suicide risk. Expanding access to confidential, supportive resources is essential. In addition, organizations should implement structured postvention protocols that include clear, compassionate communication, psychological first aid, peer support, and access to confidential counseling following a loss.

Measurement of Nurse Suicide Data is Essential to Drive Prevention Policies

Nurse suicide has only recently begun to emerge in scientific literature, which has resulted in delays in recognizing warning signs and implementing prevention interventions. New evidence may help identify risk factors for nurse suicide and inform more effective prevention strategies. Additionally, human stories are important. Qualitative studies with survivors and peers can shape prevention strategies that are practical, compassionate, and effective. High-quality data can support legislation that advances workplace suicide prevention programs.

Recommendations

Based on the discussion, the following policy recommendations were highlighted as key priorities:

1. Support sustained funding and implementation of the Dr. Lorna Breen Health Care Provider Protection Act. First enacted in 2022 and reauthorized through Fiscal Year 2030 as part of the Consolidated Appropriations Act, 2026 (P.L. 119-75), this legislation advances suicide prevention resources, training materials, and evidence-informed initiatives for clinicians and health systems. Continued federal investment and appropriations are necessary to ensure these programs are fully operationalized, scaled, and accessible across health care settings.
2. Address licensing and credentialing barriers at the institutional and state level, including invasive questions about mental health diagnoses and treatment, that deter help-seeking behaviors by clinicians.
3. Promote a functional impairment standard for licensure that focuses on questions about mental health only if a clinician is currently unable to practice safely.
4. Integrate suicide prevention, substance use recovery, and postvention strategies as part of workforce safety.
5. Increase the availability of confidential mental health resources that are easily accessible through the workplace.
6. Implement increased protections for the privacy of nurses' health information, such as mental health diagnoses, including for nurses facing disciplinary proceedings.
7. Engage lived experience suicide experts to guide safe and effective policies.
8. Increase funding for research that examines the scope of nurse suicide and serves to better inform tailored, effective prevention strategies.

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