



# **Therapeutic engagement between people experiencing suicidal crisis and mental health nurses**

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This thesis is dedicated to my friend Martin, to all the other people who have died too soon by suicide, and to those who have suffered or continue to suffer with suicidal thoughts or behaviours. It is dedicated also to those who seek to understand and help people for whom suicide is an issue.

# Declaration of Originality

I, David Lees, am the author of the thesis titled *Therapeutic engagement between people experiencing suicidal crisis and mental health nurses*, submitted for the degree of Doctor of Philosophy. I declare that the material is original, and to the best of my knowledge and belief, contains no material previously published or written by another person, except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright. The thesis contains no material which has been accepted for a degree or diploma by the University or any other institution.

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# Statement of Ethical Conduct

The research associated with this thesis abides by the international and Australian codes on human research and was approved by The Tasmanian Health and Medical Human Research Ethics Committee (reference number: H001075).

# Acknowledgements

I would like to acknowledge and sincerely thank all of the people who participated in this research and who shared their stories of suicidal crisis and nursing care. Without your generous commitment to participation this research would never have been possible. My greatest hope is that I have done justice to your experiences.

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# A note concerning help-seeking

This thesis explores experiences of suicidal crisis and related mental health nursing care. It thereby raises some sensitive and potentially confronting issues. The thesis embraces the notion that the possible risks associated with ‘talking about’ suicide in the public domain (Philips 1974; Pirkis & Blood 2001; Niederkrotenthaler et al. 2012) are outweighed by the value of bringing it ‘out into the open’ where it can be discussed responsibly and constructively (McGorry 2010, cited in Drape 2010; Webb 2005a; LIFE 2007; SPA 2011). It is appreciated, however, that suicide can be a challenging issue to consider, especially if one is currently, or has been, directly affected by it. If you are problematically confronted by suicide or any other issues raised in this thesis, or if such issues are a concern for you or someone you know, please seek help.

## Australian help-seeking resources:

- Lifeline ..... 13 11 14
- Suicide Call Back Service..... 1300 659 467
- Kids Helpline ..... 1800 55 1800
- SANE Helpline ..... 1800 18 SANE (7263)
- Mensline ..... 1300 78 99 78
- Emergency services ..... 000
- SANE Australia ..... [www.sane.org](http://www.sane.org)
- LIFE ..... [www.livingisforeveryone.com.au](http://www.livingisforeveryone.com.au)
- Suicide Prevention Australia..... [www.suicidepreventionaust.org](http://www.suicidepreventionaust.org)
- MHS Helpline(Tas) ..... 03 6233 2388

*Strange is our situation here on Earth. Each of us comes for a short visit, not knowing why, yet sometimes seeming to divine a purpose. From the standpoint of daily life, however, there is one thing we do know: that man is here for the sake of other men [sic] – above all for those upon whose smiles and well-being our own happiness depends (Einstein 1931)*

# Abstract

People are encouraged to seek, and are sometimes legally compelled to receive, mental health service around experiences of suicidal crisis. Nurses typically constitute the largest discipline group with the greatest consumer contact in settings providing such service. Nursing care in this context is positioned as a key element in the process of recovery from suicidal crisis. However, the nature and role of such nursing care is not adequately understood and there is indication that its therapeutic potential may be under-developed and under-realised. There is, therefore, a need to examine experiences of service with a view to extending the limited evidence base and promoting positive reform.

This thesis contributes to the existing evidence base by generating and exploring survey and first-person interview data concerned with mental health care consumer suicidal crisis and related mental health nursing care. An interpretive, multi-method approach embracing critical intent gives voice to nurses and consumers and helps contextualise their accounts. This extends the predominantly qualitative nursing research in this area and helps to redress the broader quantitative bias in suicidology. The methodology also gives insight into how 'reductive' bias in clinical contexts may be better understood and ameliorated.

The findings highlight the relevance of a multidimensional understanding of suicide, within which intrapersonal and interpersonal factors are of central importance. Therapeutic interpersonal engagement is indicated to be particularly important as it may enable consumers' intrapersonal experiences to be understood and positively affected. Benefits are suggested to potentially occur in this respect as engagement itself is experienced therapeutically, and as engagement can enhance the various other interventions available (such as observation, risk assessment, medication and broader management within secure hospital units). Concerningly, however, the findings also indicate that the desired quality and extent of therapeutic engagement experienced between nurses and consumers may be experienced as minimal. This, in

turn, infers that issues of isolation, distress, loss of control, and objectification, may be potentially compounded.

The thesis highlights the pertinent theme of how, within a time of reform, promotion and development of the nurse-consumer relationship may help realise aspirational principles of care such as 'holism' and 'recovery'. In this regard the thesis has implications for how nurses are educated and supported to therapeutically engage with people at risk of suicide. The thesis establishes that, both in clinical and research contexts, movement beyond over-reliance on medicalisation and objectification of consumers is required in order to better understand and respond to people at risk of suicide. It is argued that this necessarily entails clarifying and evolving the greater paradigm changes inherent in human/social research and suicidology, mental health nursing, and the broader mental health care 'recovery' movement. In particular, it is highlighted that suicidal consumers must be engaged in ways other than, or additional to, the 'reductive' and dichotomous practices which in the past have created an unnecessary 'distance' between nurses and consumers. It is argued that therapeutic relationships enabling this give people voice, harness the expertise of lived experience, appreciate people's individuality and complexity, work to preserve people's essential rights, and promote the potential to learn from and help one another.



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# Preface

## Introduction

As I neared completion of this thesis I returned to clinical work as a mental health nurse. On my first shift back at a psychiatric / mental health hospital inpatient unit after a two year absence I provided one-on-one nursing care to a young adult at risk of suicide. This account of my experience with 'Jake' highlights something of the nature and potential importance of interactions between people at risk of suicide (herein referred to interchangeably as 'patients', 'consumers', 'clients' or 'service-users') and mental health nurses. Some of the complexities and challenges this may entail are highlighted, and the principle issues and questions that I believe it raises, and which underpin this thesis, are identified.

Jake arrived on the unit a short time after I began my shift. I welcomed him, gave him a quick orientation to the unit, and showed him to his room. He appeared tired and anxious. We sat down in his room and in order to promote communication I purposely adopted a relaxed and open body position, leaned forward slightly to speak with him, met his gaze gently and spoke calmly and softly. We spoke for about 20 minutes about Jake's history, his present situation, what he hoped to gain from hospital admission, and what I thought the service could offer. I found Jake to be a friendly, intelligent, physically healthy young man with a professional and well-paid job that he enjoyed, and family and friends who seemed to care a great deal for him. Many of the outward and initial indications were thus of success, potential, and significant resources and supports. However, our conversation also revealed that Jake was suffering in his present experience of living and that he had reached a crisis point. Furthermore, it was apparent that, while Jake was somewhat relieved to be receiving service, he was sceptical about what his hospital admission could achieve. He felt that the admission was something of a 'last-ditch effort', and he had agreed

to come to hospital essentially at the behest of his mother and his General Practitioner.

After a break following that initial interaction (allowing Jake to eat dinner, receive a phone call from his mother, and generally 'settle in'), Jake and I spoke at greater length. That extended interaction revealed more fully the depth of Jake's suffering. Jake explained to me that he had become increasingly fixated on the option of death as an escape from the 'pain' of living. If things did not change for the better soon, death was the only option, as far as he could see. He described to me his detailed suicide plan, how he had gathered the means to complete that plan, and how lately, as he drank himself into unconsciousness alone every evening, he had started 'rehearsing' his violent end by inflicting increasing physical pain and injury on himself. He showed me his recent self-inflicted wounds.

Jake and I then developed a 'care plan' which highlighted the issues at hand, the goals that Jake wanted to work towards, and the various steps we thought were achievable towards those goals. The plan was supported by Jake's psychiatrist who joined us in conversation for about 20 minutes that evening. The psychiatrist also formally diagnosed Jake with 'depression', 'anxiety' and 'situational crisis', and prescribed anti-depressants as well as some other 'as required' medications intended to help manage anxiety and insomnia. We all agreed that the most immediate goal was to reduce and manage Jake's risk of self-harm and suicide. We also agreed it was important to progress towards a holistic response that addressed the multiple factors and related needs present (i.e. aimed at addressing the interrelated biological/physical, psychiatric, social, psychological, and philosophical, dimensions of Jake's life). Specifically, the plan involved keeping Jake physically safe, monitoring and managing the effects of his medications, providing counselling, education, mindfulness and relaxation therapy, and cognitive behavioural therapy, amongst other interventions.

Jake actively participated in that initial planning of his care, agreeing to 'shelve' his suicide plan and give treatment a trial. I was satisfied with our interaction. I felt that

there was a degree of understanding and trust established between us, that we had genuinely collaborated to develop a 'good' plan, and that Jake had benefitted by sharing his story and had become a little more hopeful as the evening passed. In respect to that initial goal of managing risk of harm, I felt that the quality of our interaction enabled me to be reasonably confident that Jake would not harm himself in the short-term and that he would let me know if he was no longer feeling safe. Nevertheless, it was not possible to be 100% sure about Jake's immediate safety and I stayed in close proximity to him throughout that shift. I felt our interactions had established an understanding between us, and enabled appropriate responses to be constructed, and initiated.

Before I returned to my next shift several days later, however, Jake discharged himself from the unit against the recommendation of staff. Apparently Jake did not leave the unit in a positive frame of mind and was disappointed and frustrated by his experience of 'care'. His risk of suicide at the time of discharge was assessed as 'moderate' (as opposed to 'high', on admission) and the grounds for involuntary detention were not established. While his suicidality may have abated somewhat during his brief hospital admission, the issue was not fully resolved. I questioned whether, from Jake's perspective in particular, care had been the best it could have been, and whether the expectations that I had helped establish on that first day had been justified. In that context, I also questioned what was guiding and coordinating nursing practice in this case – particularly in respect to the design and implementation of Jake's care plan. I remain concerned that Jake's 'last-ditch effort' to seek help may not have been as successful as possible.

I could share many other, and far more extreme, accounts from my mental health nursing care of people at risk of suicide. Some of those accounts concern people who died by suicide while attempting to access service, while hospital inpatients, or following discharge from hospital or community case management. I could share other accounts concerning people who made remarkable recoveries, found renewed and sometimes greatly enhanced purpose and happiness in life. However, I feel that

Jake's case is more typical of my experiences and most relevant to consider, particularly as it points to more ambiguous experiences and outcomes.

As with all cases I can recall providing nursing care to people for whom suicide was an immediate and serious concern, Jake's case highlights the potential importance of mental health (nursing) care in relation to suicidal crisis. In particular, it suggests that interactions between nurses and patients may help generate understanding and underpin appropriate and effective care. However, it also reflects my experience that outcomes will often be less than clear and less than perfect, that initial plans and hopes around admission to service may prove challenging to build upon and that positive engagement and consumer participation is not assured. As part of such challenges and limitations, Jake's story suggests to me that there is often very little to promote or guide a coordinated and effective evidence-based approach to mental health nursing care of people experiencing suicidal crisis. Thus, while acknowledging the reality that ideal pathways and positive outcomes may remain elusive in such challenging circumstances, I assert that there is a pressing need to more fully understand both nursing care and consumer needs in this context, and how evidence-based care responses may be more fully developed and realised.

For me, then, Jake's story reflects a pressing dilemma. People are increasingly encouraged to seek, and are sometimes legally compelled to receive, mental health care service around experiences of suicidal crisis. Within mental health services nurses are typically the largest discipline with the greatest client contact. Thus there is a clear imperative for services and nurses therein to be able to provide the most effective and appropriate care possible. However, it is still unclear how nurses and patients actually experience 'care' in this context, and there is arguably an inadequate evidence base and the necessary conditions to support 'best practice'. In response I am prompted to ask the following research questions:

1. *What are the experiences and needs mental health service-users have around suicidal crisis and to what degree are these needs met?*

2. *What role(s) do mental health nurses play in this context, particularly in regard to their interpersonal interactions with service-users?*
3. *What are the contextual factors which likely impact the quality of care experienced?*
4. *What implications does this knowledge have for the practice, preparation, support and development of nurses?*

These questions form the basis of this thesis. Particularly as these questions have arisen from my practice as a mental health nurse and I have employed an interpretive methodology, the question of objectivity arises. However, I do not claim to be an objective agent in this research. Rather, the chosen methodology invites subjectivity, and indeed harnesses it in order to explore the lived experiences and interpretations of events that belong to the participants.

## **Thesis overview**

Chapter 1 reviews the broader literature relevant to mental health care and service-user suicidal crisis. In considering something of the occurrence of suicide, and the burdens that it may reflect and impose, the importance of optimally understanding and responding to suicide and suicidal people is reinforced. The discourse surrounding suicide is then explored, and the central role that mental health services have been positioned to play is illustrated. Analysis of the discourse and quality of care it infers highlights the potential for serious limitations to arise when mental health services are difficult to access and overly reliant on 'reductive', medicalised, objectifying and coercive approaches. The potential to promote more therapeutic mental health service responses to people at risk of suicide is then discussed in respect to the principles and practices of multidimensionality (holism), 'recovery', and therapeutic alliance. It is proposed that these principles and related practices may be considered essential to the concept of 'therapeutic engagement' as it is explored in this thesis. The chapter concludes, however, that there is insufficient data to fully describe mental health services, the nature of therapeutic engagement, and how such engagement may be promoted in practice.

Chapter 2 explores the specific mental health nursing literature to highlight the need for greater evidence regarding the role of therapeutic engagement in the integration of traditional approaches within a holistic and recovery-oriented approach. The chapter also highlights that towards generating such evidence, first-person accounts of experiences of suicidal crisis and related nursing care are of particular value. The chapter reinforces the importance of generating more local, recent, and adequately critical knowledge which is able to constructively examine the contextual factors potentially mediating the quality of care. Chapters 1 and 2 thus establish the rationale for the thesis and reaffirm the relevance of the research questions.

Chapter 3 explores the methodological (philosophical, theoretical, and paradigmatic) foundations of the current clinical and research approaches to suicide and suicidal people. This highlights the limitations of 'reductive' (positivistic) bias, and promotes

the value of alternate or complementary interpretive, multi-method, narrative and critical approaches. The methodological underpinnings which support the generation of research knowledge have strong parallels with therapeutic engagement. Both place the participant(s) at the centre of an approach based on collaborative construction of understanding, within a holistic framework aimed at facilitating effective action based upon positive intrapersonal and interpersonal experiences.

Chapter 4 discusses the framework of inquiry that was developed to engage with stakeholders and participants and generate and analyse the research data. This discussion (and framework) moves beyond the limitations of reductive approaches by embracing multiple perspectives and methods, and doing so on the basis of ethical interpersonal engagement. In explicating how research may successfully be conducted with potentially vulnerable people around a sensitive issue the research framework provides transparency in respect to the present study and also generates understanding of how inquiry may be pursued in comparable contexts. Thus Chapters 1-4 establish that, while social/human research and nursing have theoretical foundations supporting interpretive inquiry, there is the need and potential to extend relevant understandings, more fully integrate potentially complementary approaches, as well as more effectively translate theoretical understandings into clinical practice within this time of reform and possibility.

Chapters 5 – 8 present the research findings to highlight and explore the experiences of nurses and consumers in respect to consumer suicidal crisis and related mental health nursing care. Chapter 5 presents findings that demonstrate how suicidal crisis is a multidimensional experience within which intrapersonal and interpersonal elements are of particular relevance. The holistic nature of suicidal crisis is shown to correspond to the needs of consumers and the aims of nurses at the time of crisis and intersection with services. The findings reveal that both consumer and nurse participants appreciated the care imperatives of access to service, physical care and safety, treatment of psychiatric symptoms, and therapeutic interpersonal engagement. It is reinforced that therapeutic engagement was of particular importance to consumer needs and nurse aims. This is significant, given that the care

context was often experienced as one that potentially compounded issues of isolation, distress, loss of control and objectification. Indeed it is evidenced that at a time when therapeutic interpersonal engagement was important for both consumers and nurses, the predominant experience was actually one of minimal engagement and interpersonal isolation.

Chapter 6 explores the interrelated elements that constituted inpatient unit service around consumer suicidal crisis. It is demonstrated that care revolved around detention, observation, medication, and management within a particular physical and social inpatient unit environment. These elements of service are explored to highlight the potential for therapeutic engagement to be therapeutic in itself, enhance the other principle interventions, and thereby help address issues of isolation, loss of control, distress and objectification.

Chapter 7 moves to consider in more depth the elements that constituted effective and appropriate therapeutic interpersonal engagement, and how such engagement could contribute to positive intrapersonal change and recovery around suicidal crisis. This discussion illustrates the aspirational model of care as it was understood by the nurses and consumers and thus represents the potential of nursing care of suicidal people. It is evident that notions of holism, recovery and therapeutic alliance are central to such therapeutic engagement.

Chapter 8 concludes the findings section with a discussion of the factors that mediate the potential to realise therapeutic engagement, and best practice care. The findings identify how a complex interplay of consumer, nurse and contextual factors are relevant to care experiences and outcomes. It is argued that the intentions, preparation, and support of nurses, are particularly important to therapeutic engagement and to service quality more broadly. Thus the findings build understanding around the nature, limitations and strengths of the status quo, explicate actual and aspirational approaches to care, and highlight the factors which may reasonably be considered to affect the quality of care.



Chapter 9 concludes the thesis by summarising the findings in respect to the research questions. The chapter outlines recommendations which are aimed at enhancing practice, notes the limitations of the study, and makes proposals around further research. The chapter concludes with a reflection on the research process. The thesis utilises the experiences and expertise of consumers and nurses with first-hand knowledge of suicidal crisis and related mental health nursing care in an exploratory and constructive project. In doing so it demonstrates how ethical interpersonal engagement, use of multiple methods of inquiry, incorporation of multiple perspectives, and consideration of broader contextual factors, can contribute valuable understandings to the mental health nursing of those in suicidal crisis.

## **Literature search process**

Because the suicide-related literature is so vast my review of literature was initially broad, in order to encompass the various discourses, policies and practices which relate to how people at risk of suicide are understood and responded to. My review then became increasingly focused on the research questions concerning mental health nursing and related consumer suicidal crisis. This means that I have focused on literature regarding suicide rather than self-harm, on adults and on the discipline of nursing in respect to mental health service provision. There is also a focus on more recent and 'Western' literature.

Literature was gathered from electronic database cross-searches under the categories of medical sciences, nursing, psychology, philosophy, sociology and theses. Databases accessed included BMJ Clinical Evidence, CINAHL, Medline, Proquest Health & Medical, PsycINFO, PubMed, Scopus and Web of Science. Key search terms utilised were suicide, suicidal crisis, suicidality, nursing, mental health nursing, psychiatric-mental health nursing, engagement, alliance, therapeutic engagement / alliance / interaction, observation / special observation, mental health, psychiatry, history of suicide, consumer, consumer movement / voice / participation, patient, client, service-user, holism, multidimensionality, and recovery. These search terms were utilised individually and in combination. Several of these key searches were established as alerts for regular updates on emerging literature. The search process also utilised hard copy journals, library catalogues, internet search engines and media reports. With some relevant exceptions the searches prioritised post-1999 literature. An additional strategy involved ongoing input from academic and practice colleagues to help focus my attention on relevant literature. Attendance at mental health and suicide prevention conferences was also invaluable in this respect.

# **Chapter 1 – The ‘problem’ of suicide and the need to understand and evolve mental health service responses**

This chapter identifies the clear and pressing need to better understand and respond to suicide and suicidal people. Fullest realisation of this imperative is argued to be of value in limiting the occurrence and burden of suicide, and in providing broader understandings of how humans can live more successfully. It is noted that publicly provided mental health services are of particular importance in defining how suicide and suicidal people are understood and responded to. The need to explore such services is reinforced by the suggestion that they may be underpinned by a dominant discourse and related practices which do not support an optimal quality of care. In particular it is suggested that mental health services may be difficult and daunting to access and overly reliant on medicalised, coercive, objectifying and interpersonally isolative approaches.

This chapter argues that optimum care is that which is based on principles of multidimensionality (holism), the recovery model of care, and therapeutic alliance. It is proposed that these principles and practices are essential to the concept of ‘therapeutic engagement’ as it is defined and explored in this thesis. It is further proposed that such engagement may underpin the integration of potentially dichotomous elements of service. The chapter concludes that further research is required to more fully ascertain the nature of current services, and to promote progress towards therapeutic engagement in specific contexts (such as mental health nursing care which is explored in-depth in Chapter 2).

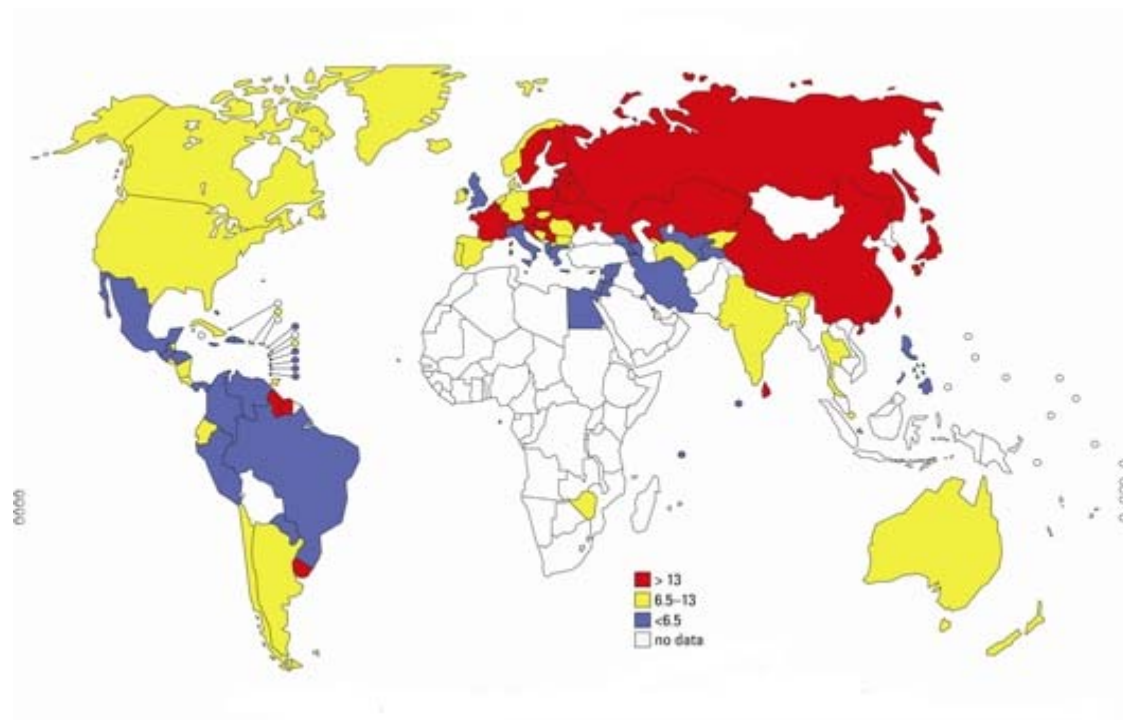
## 1.1. The imperative of limiting the occurrence and burden of suicide

This section identifies that there is a clear and pressing need to limit the occurrence and burden of suicide, and that there are important direct and indirect benefits to be realised in such endeavour. Noting the significant demographic variability in rates of suicide, the imperative of better understanding and responding to those at risk of suicide is reinforced and it is highlighted that mental health care provision within regional locations such as Tasmania is a particularly important context within which to pursue this.

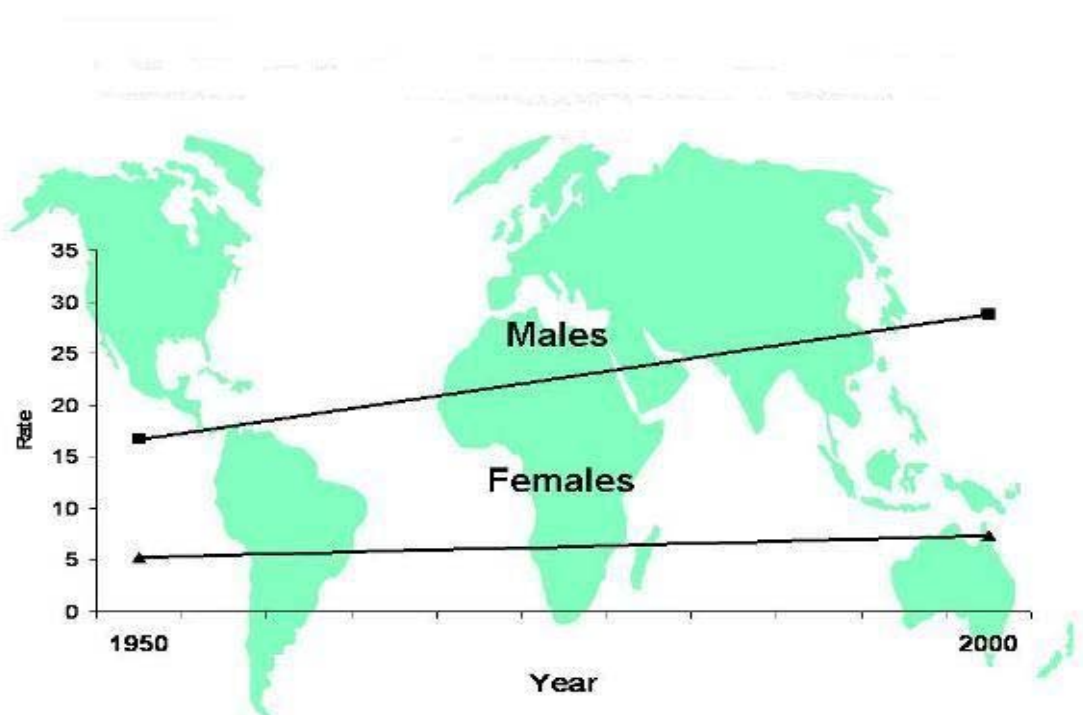
### 1.1.1. The occurrence of suicide

The overall global suicide rate has been steadily rising at least since the 1950s (WHO 2012; Figures 1.1 and 1.2 below). Globally, more than 1 million people die by suicide each year, with that figure expected to exceed 1.5 million by 2020 (WHO 2009). This reflects a rate of approximately 15 people per 100,000 worldwide dying by suicide per year (WHO 2012).

**Figure 1.1. Global suicide rates per 100,000 people, 2009 (Image adapted from WHO 2009)**



**Figure 1.2. Global suicide rate increase per 100,000, 1950-2000 (image adapted from WHO 2012)**



There were 2361 registered deaths by suicide in Australia for the year 2010, with that representing a death rate of 10.5 people per 100,000 (ABS 2012). These figures reflect a continuing upward trend since 2006 and support the 2010 prediction of a 10-25% increase in suicide in Australia in the near future (Mendoza & Rosenberg 2010, p. 24). Additionally, it is acknowledged that the official rate of suicide is very much a conservative estimate and that a sizeable proportion of the more than 6,000 'other' deaths in Australia each year classified as 'accidental' or of 'undetermined intent' may actually be death by suicide (ABS 2010a).

For every person who dies by suicide there are also around 20 (WHO 2002) or 20-30 (Tondo et al. 2003) people who attempt suicide, and who may suffer serious non-fatal injuries in the process. Additionally, for every person who dies by suicide there are approximately 200 people who experience serious suicidal ideation (AIHW 2009). Thus, in Australia alone, it is evident that around 600,000 people are directly affected by *their own* serious suicidal thoughts or actions each year. Extrapolating

those figures globally suggests that over 200 million people are directly affected by their own suicidal thoughts or actions each year.

Suicide rates feature important demographic variations. For example, in Australia, around 80% of people who die by suicide are male (ABS 2010a), and indigenous Australians die by suicide at nearly three times the rate of non-indigenous Australians (approximately 4% of all deaths compared to 1.5%) (ABS 2011). Furthermore, while the highest overall age-related death rate is in the 85+ age-group, it is noteworthy that for Australian women aged 15-34 and men aged 15-44 suicide is the number one cause of death (ABS 2010c), and is the 15<sup>th</sup> leading cause of death overall in Australia (ABS 2012). Additionally, suicide rates are highest in regional, rural and remote areas and in states in which the population is most decentralised. This geographical variation is borne out by a comparison of rates of completed suicide across Australian States and Territories. According to the ABS the rates of registered suicide averaged across the period 2005-2009 in descending order were 20.1 per 100 000 in the Northern Territory, 15.1 in Tasmania, 12.1 in South Australia, 11.8 in Western Australia, 11.2 in Queensland, 9.7 in the Australian Capital Territory; 9.3 in Victoria; and 7.9 in New South Wales (ABS 2011).

In Tasmania (where this study was conducted) suicide is acknowledged to be an issue of particular concern (Tasmanian Government 2007; DHHS 2008; DHHS 2009a; Sayer 2006). Tasmania's suicide rate is increasingly far above the national average (ABS 2010). In 2009 it was approximately 50% above the national average (15.1 on average compared to national average of 9.9) (ABS 2010a, b) and it has experienced regional peaks of more than double the national average (Sayer 2006). Of all Australian states and territories, Tasmania recorded the largest rise in suicide rates in 2009 (with only South Australian and Tasmanian rates rising). Furthermore, Tasmania was the only state or territory not to record a decline in the suicide rate from 1997 to 2006 (ABS 2008; Brown 2009), and from 2000 to 2009 only Tasmania and Western Australia recorded a rise in suicide – with Tasmania's rate rising 66% and Western Australia's rising 5.7% (ABS 2008). Possible reasons why suicide is so relatively prevalent in Tasmania include the decentralised nature of the population,

and social determinants including high unemployment and high rates of various physical and mental ill-health (DHHS 2007a, p. 12). Therefore, the need to better understand and respond to suicide in regional locations such as Tasmania is indicated to be especially urgent.

Another particularly important variation in rates of suicide is that related to mental ill-health. An association between mental ill-health and suicide has been established (Hawton et al. 2005). This means, for example, that people with mental health problems are understood to die by suicide at approximately ten times the rate of the wider population (Cutcliffe & Stevenson 2008a). That is to say, that 15% of people affected by mental illness take their own lives (Khan et al. 2002), compared to approximately 1.5% for the whole population (ABS 2010a). It follows that there is also a strong association between suicide and mental health service-use. In this regard it is noted that suicide is 'the main cause of premature death' in users of mental health services (McMyler & Prymachuk 2008, p. 512), and that both admission to, and discharge from, psychiatric inpatient settings are associated with increased suicidal behaviour (De Leo & Svetcic 2010, p. 8). Indeed, it has been demonstrated that around 40% of people who died by suicide received psychiatric inpatient care in the year prior to their death and that up to 9% of those 40% killed themselves within one day of discharge (Goldsmith et al. 2002). Similarly, it has been found that 33% of people who died by suicide had contact with mental health services (and approximately 45% with primary care providers) within 1 month of their suicide (Luoma et al. 2002, p. 909). This association between suicide, mental ill-health, and related service provision, is discussed throughout this thesis. The association implies that mental health service provision is a key area to consider in regard to better understanding and responding to those at risk. Given the huge variations in the geographical distribution of suicide, there is particular need to investigate suicide in mental health care contexts in regional areas such as Tasmania.

### **1.1.2. The burden of suicide**

Beneath the statistics of suicide lie profound human experiences, typically indicative of intense suffering (Shneidman 1993, 1996a), and great psychological (Feldman

2006), social (Maris 1997), spiritual (Lester 1998) and economic (Lifeline 2010; Mendoza & Rosenberg 2010) burdens. Drawing upon existing knowledge – much of which incorporates compelling first-person accounts – recent reports (Mendoza & Rosenberg 2010), inquiries (Australian Senate 2010; DHHS 2009a), media coverage (SBS 2010, 2011), and lived-experience research (Webb 2005a; Walen 2002), highlight something of the great personal and social costs of suicide. Such sources reveal that suicidal behaviour may indicate, and also generate in others, intense distress, trauma, grief, guilt, blame and remorse (Mendoza & Rosenberg 2010, p. 32; Australian Senate 2010; DHHS 2009b). It is noted, for example, that at least 6 other people (Corso et al. 2007), but in many instances whole communities, may be ‘profoundly and negatively affected’ by an individual completed suicide (Australian Senate 2010, p. 7). Indeed, those bereaved by suicide may experience social isolation, deterioration in physical and mental health, financial problems, employment difficulties, a sense of hopelessness (Mendoza & Rosenberg 2010, p. 32; Australian Senate 2010), and increased risk of suicide themselves (Mitchell et al. 2005). It is also noted that many people may also be negatively affected by the non-fatal suicidal thoughts and behaviours of others (Mendoza & Rosenberg 2010). Thus it is clear that suicide reflects and imposes great human burdens, both in respect to people who themselves experience suicidal thoughts and behaviours, and in respect to others associated with suicidal people.

It is also clear that suicide involves huge economic burdens, both for individuals and society as a whole. While the Tasmanian Government costed suicide at \$29.2 million per year (Tasmanian Government 2010b, p. 8), more comprehensive modelling suggests that suicide in Australia costs around \$12 billion (Australian Senate 2010) to \$17.5 billion per year (Lifeline 2010; Mendoza & Rosenberg 2010). Indeed, Mendoza and Rosenberg (2010) argue that \$17.5 billion per year is actually a conservative estimate. If Mendoza and Rosenberg’s (2010) modelling is applied to suicide in Tasmania (a state with a population of approximately 500,000 people) suicide is shown to cost over \$500 million per year. If we apply it to the global rate then the economic burden is suggested to exceed \$6 trillion per year. Thus it is clear that



suicide reflects and imposes huge burdens, both for individuals and society as a whole.

Beyond the obvious value of limiting the occurrence of suicide in order to reduce and respond to the burdens it reflects and imposes, there may be other highly significant benefits to be realised in addressing suicide. As well as realising moral and altruistic imperatives, it may be that coming to better understand and respond to suicide and suicidal people reveals something of how, in a more general sense, humans may live more 'successfully' (Maris et al. 2000a, p. 3-4). It is argued, for example, that generating understanding and related action in this context can help challenge the tendency to make our lives 'shorter' and 'narrower' (Shneidman 1996a, p. 63). Thus, efforts to understand and respond to suicide and suicidal people may give rise to 'secondary' personal and collective benefits – not just averting suffering and death but actually promoting more positive living in general. On many important levels then, there are clear imperatives to limit the occurrence and burden of suicide.

### **1.1.3. Summary**

Suicide has been described as Australia's 'greatest preventable public health and social challenge' (McGorry 2010a). Limiting its occurrence and burden is argued to be of urgent concern in Australia (DOHA 2009; Mendoza & Rosenberg 2010), as it is globally (McMyler & Pryjmachuk 2008, p. 512; WHO 2009; Talseth & Gilje 2011; Lakeman & Fitzgerald 2009; Cutcliffe & Stevenson 2008). However, suicide remains something of a 'hidden epidemic' (Mendoza & Rosenberg 2010, p. 12) and efforts towards limiting its occurrence and burden have had ambiguous results (De Leo & Sveticic 2010; De Leo & Evans 2003; De Leo et al. 2006; Goldney 2006). In Australia, it is argued that suicide has not received the degree or quality of attention that it warrants (Webb 2005a; McGorry 2010, cited in Drape 2010; Mendoza 2009 in Pollard 2009). This is amplified as a concern in that suicide rates – which are already alarmingly high, particularly in certain subsections of society – appear to be on the rise both in Australia (Mendoza & Rosenberg 2010, p. 24) and globally (WHO 2009). There is, then, a pressing need to understand more about suicide and to productively explore how it may be better responded to. Clearly there are hugely significant

benefits to be realised in such endeavour – both in terms of reducing the occurrence of suicide and the burdens that it reflects and imposes, and also towards providing useful understandings which may be of value more broadly. Because of variability in rates – particularly in respect to location and the association between suicide and mental ill-health – mental health care in regional locations such as Tasmania is indicated to be a particularly important context within which to conduct relevant research.

## **1.2. The evolving discourse of suicide and related service responses**

This section explores the evolving discourse of suicide to help clarify how suicide and suicidal people have come to be understood and responded to. It is argued that a more ‘reductive’ discourse has come to dominate and to underpin mental health service responses to people experiencing suicidal crisis. The result is argued to be services which are potentially difficult and daunting to access and overly reliant on medicalised, coercive, objectifying and interpersonally isolative approaches. This suggests the importance of understanding more about the nature of current services, and exploring how potential limitations and biases may be redressed.

### **1.2.1. Historical evolution of ‘Western’ suicide**

Ways in which suicide and suicidal people are understood and responded to have evolved over time. In the Western context, suicide in ancient Greek and Roman times was commonly seen as heroic or romantic and as a valid response to shame or loss (Maris et al. 2000a; De Leo et al. 2006). Suicide was then outlawed by the Roman Catholic Church in the 4<sup>th</sup> century (Goldsmith et al. 2002, p. 23) and by secular authorities in the 14<sup>th</sup> century (De Leo et al. 2006, p. 7). Thus suicide became both a criminal offense and a mortal sin (Alvarez 1972; Maris et al. 2000a; De Leo et al. 2006, p. 7; Marsh 2010, p. 10).

Later centuries saw alternative discourses of suicide emerge which challenged the crude ‘prevention strategy’ (Marsh 2010) of moral and legal sanctions (Cholbi 2009;

More 1977; Ferngren 1989, p. 160–161). Such discourses acknowledged a libertarian perspective and posed more ‘rational’ explanations for suicide (Maris et al. 2000a, p. 116). In particular, from the 18<sup>th</sup> century onwards, suicide increasingly became seen through the lenses of science, medicine, sociology, and psychology (Cholbi 2009; De Leo et al. 2006; Minois 1999). There was also differentiation between suicide of one who was ‘sane’ and suicide of one who was ‘insane’, ‘melancholy’ or ‘mad’ (Maris et al. 2000a, p. 112).

The idea that suicide, amongst other things, could be an act of freedom (supported, for example, by Schopenhauer and Nietzsche cited in Minois 1999) was pushed aside in the 19<sup>th</sup> century by the view of suicide as a ‘mental, moral, physical and social ill’ (Minois 1999, p. 321). Of particular note in the 19<sup>th</sup> century was the development of the sociological discourse of suicide – greatly influenced by Durkheim (1951 [1897], p. 209) – and the emergence of the psychiatric discourse of suicide. Where the sociological perspective widened the focus of suicide to encompass forces external to the individual, it is noted that psychiatry firmly moved the focus back to what was becoming constituted as a ‘sick’ individual (Marsh 2010). It is argued that psychiatry came to dominate the Western discourse as it established itself as a discipline in its own right, and as one which could treat the mental disorders (Cholbi 2009) and personal deficiencies (Marsh 2008) proposed at the time to be present in the suicidal person. Illustrating the rapidity of this so-called ‘medicalisation’ of suicide, De Leo (2011) argues that in 1650 less than 10% of suicides were attributed to ‘insanity’, with that figure rising to 30% by 1690, 40% by 1710, and to virtually all cases by 1800. Notwithstanding the co-emergence of a sociological perspective of suicide, the 19<sup>th</sup> century thus saw the priest replaced by the medical doctor at the side of the suicidal person (Maris et al. 2000a, p. 120) as psychiatric treatment came to dominate attempts to treat and prevent suicide (Marsh 2010).

With psychiatry’s rise to dominance during the 19<sup>th</sup> century came an increase in the number of asylums (Foucault 2001 [1961]) and the treatment of suicidal people within them. Related treatment may be broadly considered in respect to the two branches of psychiatry which evolved: medical-psychiatry which prioritised diagnosis

and a focus on the brain and reinforced objectifying and potentially alienating care; and social-psychiatry which prioritised a focus on the mind and social context of the person and implied the importance of interpersonal interaction aimed at understanding people's intrapersonal experiences (Maltzberger 2011, p. 35). Thus the historical precedent of responses which remains today can be identified: from a more objectifying and medicalised approach largely reliant on 'physical' interventions such as observation, containment and medication; to an approach more interested in the subjective and contextualised experience of the individual and more reliant on psychological therapies and interpersonal interaction between clinician and patient.

Within the new asylums, attendants were being replaced by nurses (Boling 2003, p. 29) whose approaches, in parallel to psychiatry, also became defined by diverse approaches. For example, 'psychiatric nursing' at the time potentially involved a largely 'physical' role of observing and protecting 'the body', and the administration of various physical and medical treatments (Boling 2003, p. 26). However, it was also likely influenced by the emergence of 'moral' psychiatric treatment (Maltzberger 2011, p. 35), and by general nursing training which was aiming to establish nursing as an interpersonal activity (Glod 1998) which had the potential to both reduce and create patient suffering (Nightingale 1859, p. 5-6). Thus, in parallel to the alternatives of medical and social psychiatry, on one hand emerged objectifying and alienating psychiatric nursing care which prioritised a medical, observational and custodial approach; and on the other hand emerged nursing care concerned with understanding and engaging with the individual. It is this diversity – or dichotomisation – of approaches which is of central importance to this thesis, particularly in respect to how the different elements and the potentials they offer may be integrated in an optimal quality of care.

### **1.2.2. Summary**

Suicide has been understood and responded to variously as heroic, romantic, illegal, immoral, and/or 'mad'. The evolving discourse of suicide has more recently seen major disciplines including medicine, psychiatry, psychology, sociology, – and, as

shall be explored, nursing and (research) philosophy also – contribute to how suicide and suicidal people are understood and responded to. However, this evolution has arguably given rise to some negative interpretations of suicide which may still linger to render it a shameful and hidden experience. Furthermore, it appears to have resulted in the dominance of a ‘reductive’, medical-psychiatric discourse and associated responses which can dominate more ‘holistic’, social-psychiatric discourse and responses. Thus, in one sense clinicians have ‘moved a great distance toward understanding the experiences of mental patients, crossing a great gulf, coming closer and closer to them’ (Maltzberger 2011, p. 30). However, an increasing bio-medical focus on mental ill-health, and the fact that suicide became so strongly aligned with such ill-health, has seen suicide and suicidal people responded to *predominantly* via more medicalised and objectifying approaches (Marsh 2008, 2010).

### **1.3. Limitations of current service responses to people at risk of suicide**

This section explores the current association between mental ill-health and suicide and the mental health service responses this infers. The available evidence suggests that serious limitations may currently exist in that mental health services can be difficult and daunting to access and overly reliant on ‘reductive’, medicalised, coercive, objectifying and interpersonally isolative approaches. It is thereby further highlighted that more knowledge is required to clarify the present nature of service with a view to redressing limitations.

#### **1.3.1. The association between suicide and mental illness**

As noted, suicidal acts and suicidal people have become associated with mental illness (De Leo 2005; Pirkis et al. 2001, p. 31; De Leo & Svetcic 2010). Indeed, mental illness is argued to be the leading risk factor for suicide (Qin et al. 2003), and it is claimed that as many as 90% (Penrose-Wall et al. 1999; Kelleher 1996) to 98% (Bertolote & Fleischman 2002) of people have a diagnosable mental illness at the

time of their suicide. This claim is not without contention however, and methodological limitations around the estimation of presence of mental illness have been noted (Bertolote et al. 2003). Furthermore, the assumption of a link between psychopathology and suicide is argued to be potentially problematic (Michel et al. 2002; Marsh 2010). Nevertheless, it is evident that the dominant view does closely associate suicide with mental ill-health. This is reinforced by, for example, the Australian National Survey of Mental Health and Wellbeing via which 72% of people who reported experiencing suicidal ideation also reported having a mental health disorder (ABS 2008).

Suicide has been particularly strongly associated with affective (mood) disorders (ABS 2008), especially depression. Indeed, it has been found that 60-70% of people with acute depression experienced suicidal thoughts, that 10-15% of people with acute depression completed suicide (Moller 2003, p. 73), and that depressive disorders featured in around 60% of completed suicides (Cavanagh et al. 2003). It has also been found that around 1 in 3 people who died by suicide fitted the criteria for a diagnosis of personality disorder – usually borderline personality disorder (BPD), or to a lesser extent antisocial personality disorder (Henriksson et al. 1993). It has been found that up to 70% of people diagnosed with BPD attempted suicide (Gunderson 2001) and 5-10% completed it (Black et al. 2004). In addition, it is evident that people diagnosed with schizophrenia die by suicide at higher rates than the general population: 1.8% to 5.6% according to Palmer et al. (2005) or 9 to 14% according to Meltzer (1999). There is also a strong association between substance abuse disorders and suicide, with measurable levels of alcohol and other drugs found in 30-50% of people who died by suicide in Australia (Hamilton 2009). Thus an association between mental ill-health and suicide has been established.

The American Psychiatric Association proposes to effectively further strengthen the association between mental illness and suicide by including 'suicide ideation and behaviour' (as well as the proposed related diagnoses of 'non-suicidal self-injury' and 'bereavement-related disorder') as a new psychiatric diagnosis within the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), planned for release in 2013.

It is argued that this move represents ‘the final step’ in the ‘complete medicalization of suicide and suicidal behaviours’ (De Leo 2011, p. 234). The medicalisation of suicide has profound implications for how people at risk of suicide are understood and responded to.

### **1.3.2. The implications of associating suicide with mental ill-health**

Associating suicide with mental ill-health positions mental health care providers as key respondents to people at risk of suicide. This infers both advantages and disadvantages. The treatment of mental ill-health is believed to be one of the most effective suicide prevention measures (WHO 2009). It has been argued, for example, that elimination of mood disorders may result in up to 80% reduction in risk of suicidal behaviour (Beautrais et al. 1996). While such claims may be difficult to substantiate, it is demonstrated that the education of physicians in the recognition and treatment of depression does reduce suicide rates (Mann et al. 2005, p. 2064). Mental health care may indeed be the best investment in suicide prevention (Goldney 2005; Mendoza 2009 in Pollard 2009; Mendoza & Rosenberg 2010; WHO 2009; IASP 2008). The available evidence suggests, however, that current models of care are limited in that services can be difficult and daunting to access and overly reliant on medicalised, coercive, objectifying and interpersonally isolative approaches.

Regarding access, for example, it is recognised that stigma creates barriers to help-seeking for people at risk of suicide (Mendoza & Rosenberg 2010). Indeed, it is argued that ‘stigma is the strongest obstacle to help seeking’ (De Leo 2011, p. 238). Mental health care consumers in Australia have indicated that services can be stigmatised and difficult or daunting to access and navigate (MHCA 2005). The notion that services may be difficult to access is reflected by the finding that only 35% of people with a mental disorder received any care for their disorder in a 12-month period (Meadows & Burgess 2009) – while over 80% of people with common physical disorders received care in a 12-month period (Andrews & Carter 2001).

Furthermore, it has been reported that people who do attempt to access services may be refused service if they are suicidal but do not have a history of mental illness – thereby potentially ‘slipping through the cracks’, and either not receiving care or becoming a police matter (ABC 2010). It has also been found that people may be excluded from service if they are not deemed to be in an ‘acute’ state of need (MHCA 2009), with this potentially creating a ‘perverse incentive’ for a person to progress from thoughts of suicide to acts of self-harm or suicide in order to cope with their distress and to attract help (MHCA 2005, p. 39-40). Additionally, certain features of service such as the potential to apply involuntary detention and treatment orders on people deemed ‘at risk’ for indefinite periods in secure units, may create a strong aversion to service (Szasz 1999; Webb 2005b).

In addition to factors which may render access to service difficult or daunting, it is suggested that people who do manage to access service may not experience adequate or effective care. For example, consumers have reported experiencing interactions with health professionals who exhibited ‘stigma or dismissiveness’ towards them in relation to non-fatal suicidal behaviour (Mendoza & Rosenberg 2010, p. 45), and who minimised, denied and ‘disrespected’ their views – even within strict procedural guidelines (Lakeman 2007, p. 152). It has also been found that professionals positioned to care for suicidal people may avoid the topic of suicide altogether (Goldsmith et al. 2002, p. 5), with mental health nurses and other professionals potentially doing so because they do not know what to say, are concerned that talking about suicide may be dangerous, or feel personally confronted by the issue and the person’s suffering (Talseth et al. 1999; Meerwijk et al. 2010). Such limitations to access and quality of service may be especially problematic in regard to people at risk of suicide because suicidal people are commonly ambivalent about accessing help and are understandably reluctant to be negatively evaluated (Maris et al. 2000a; Berman 2006). Given the nature of potential adverse outcomes, possible disincentives and deficiencies of service (which are problematic enough in any context) are particularly concerning in respect to people at risk of suicide.



For people at risk of suicide who can, and do, access services, further and essential limitations to mental health care responses may be associated with the dominance of a medical-psychiatric discourse and model of care which over-emphasises a focus on psychopathology. The role of psycho-pathology in relation to suicide is not clear (Bertolote et al. 2003, 2004) and claims of a causal relationship between mental illness and suicide are challenged (De Leo 2005; Szasz 1999; Pridmore & Jamil 2009; Cutcliffe & Stevenson 2008b, p. 943). In relation to depression, for example, it is noted that symptoms of depression may be treated and even resolved without a corresponding reduction in suicidality (Goldsmith et al. 2002, p. 2). As Shneidman (1993, p. 146) notes in this regard:

*Depression merits treatment for itself, but then to assert that suicide is essentially depression is either a logical mistake, a conceptual confusion, or a professional gambit (Shneidman 1993, p. 146).*

Further limitations are suggested by the tendency towards treating psychopathology predominantly with medication. While the manipulation of bio-chemistry using anti-depressant (Isacsson & Rich 2005, p. 153; Mann et al. 2005), mood stabiliser and antipsychotic medications (Mann et al. 2005; Goldney 2005, p. 134; Meltzer 1996; Potkin et al. 2003) may have preventative effects, it is argued that definitive causal links regarding psychopharmacology and suicide prevention remain unconfirmed. Positive benefits may, for example, be due to other concurrent factors including the actual act of interpersonal engagement by the health professional (Goldney 2005, p. 134). The dominance of a medical-psychiatric model of suicide which assumes and focuses on underlying pathology (Michel et al. 2002; Marsh 2010) also risks reinforcing the 'conceptual confusion' that suicidality essentially *is* a mental illness. This may minimise appreciation that suicide is actually a complex experience and behaviour - *not* a disease (Silverman & Maris 1995), and *not* a mental illness (De Leo 2005; Maris et al. 2000a; Michel 2011).

Psychiatric diagnosis and pharmacological treatment may, then, have a useful role in care of suicidal people. However, there is a risk that current services do not fully

integrate into service many of the interventions shown to be potentially useful in regards to suicidality. These interventions include: psychotherapy (Goldsmith et al. 2002; Mann et al. 2005); cognitive behavioural therapy (CBT) (Brown et al. 2005; Goldsmith et al. 2002, p. 4; Linehan et al. 1991); dialectical behaviour therapy (DBT) (Boyce et al. 2003; Goldney 2005; Linehan et al. 1993; Lynch et al. 2006); and interpersonal therapy (Freedman & Combs 1996; Magnavita 2000). It is thus argued that mental health services may tend to 'treat the illness rather than the person' (Mendoza & Rosenberg 2010, p. 95). Furthermore, it is questionable whether current mental health service responses are justifiable and useful (De Leo 2011, p. 235).

### **1.3.3. Summary**

Concerns as to the nature of current mental health service responses to people at risk of suicide are reinforced by service-users who have been suicidal (Webb 2005a), by people bereaved by suicide (Mendoza & Rosenberg 2010, p. 45), and also by official findings which note, for example, that constraint on the capacity of mental health services can contribute to death by suicide (NSW Mental Health Sentinel Events Review Committee 2007, p. vi). It is argued that mental health care is rightly a principal component of responses to suicide (McGorry 2010a; Mendoza 2009 in Pollard 2009). Additionally, it is reasonably asserted that the medical-psychiatric framework does have important contributions to make (Rutter 2007). However, it is apparent that serious limitations exist. Indeed it is asserted that:

*17 years of mental health reform have failed to deliver the level and quality of accountability required to inspire confidence in stakeholders that systems have the ability to handle suicide well (Mendoza & Rosenberg 2010, p. 168).*

Current mental health care service models may, then, not suit suicidality (Lieberman 2003; Goldsmith et al. 2002; Cutcliffe & Stevenson 2008a; Marsh 2010), particularly if they leave the holistic needs of suicidal patients unmet (Leenaars 2006; Lakeman & Fitzgerald 2008, p. 115). Mental health reform is thus needed to build capacity to respond to people at risk of suicide (Mendoza & Rosenberg 2010, p. 93). It is

suggested that such reform will work to improve access to service for suicidal people and provide care that is not overly reliant on medicalised, coercive, objectifying and interpersonally isolative approaches. More understanding of the nature of service, the needs of consumers and care providers, and understanding of how improvements may be translated into practice, is required to drive such reform.

#### **1.4. Concepts relevant to optimal service responses to people at risk of suicide**

This section explores concepts relevant to exploring service in the context at hand, and to redressing potential service limitations. These concepts are multidimensionality (holism), the recovery model of care, and therapeutic alliance. It is acknowledged that these principles are not all that may be relevant. For example, they are not necessarily directly concerned with the resource constraints or other systemic issues highlighted to be important (McGorry 2010, cited in Drape 2010; Mendoza 2009 in Pollard 2009; Mendoza & Rosenberg 2010). Nevertheless it is proposed that appreciation of such principles and practices may be considered essential to the concept of therapeutic engagement as it is explored in this thesis. It is argued that such a quality of engagement may be central to the integration and promotion of useful elements of service, and the term ‘therapeutic engagement’ will be utilised throughout this thesis in respect to ‘best practice’ approaches. The need for further research to understand the current nature of services, and to develop and promote therapeutic engagement in the context at hand, is reinforced.

##### **1.4.1. Multidimensionality (holism) and suicide**

Many disciplines make important contributions to understandings and practices around suicide, providing as they do, for example, psychiatric, sociological, psychological, psychoanalytic, epidemiological, biological, and economic perspectives (Maris et al. 2000b, p. 27). However, while single disciplines may be multifaceted to some extent in their approaches to suicide (psychiatry, for example,

may draw from both 'social' and 'medical' 'branches'), there is a tendency for them to adopt an overly narrow focus.

The dominance of any single disciplinary perspective of suicide may infer limitations, particularly as it minimises appreciation of the inherent multidimensionality of suicide (Shneidman 1993, p. 147; Shneidman & Leenaars 1999, p. 154; Kleinman in Goldsmith et al. 2002, p. ix). This may involve, as noted in the case of systems biased towards medical-psychiatric practices, a predominant focus on psychiatric diagnosis and pharmacological treatment; or in the case of sociology a predominant focus on social forces and related social responses. Thus the importance of integrating multiple perspectives is indicated (Van Orden 2010, p. 280). To this end, multidimensional (holistic) perspectives of suicide seek to integrate, for example, 'biological, cultural, social, psychological, and contextual' elements (Beautrais & Mishara 2008, p. 60). Such a holistic approach recognises the complexity of suicide and the co-occurring factors people face when they are suicidal (Hjelmeland et al. 2002). It also reflects that multidimensionality is emerging as an overarching perspective of human behaviour (Hutchinson 2003).

The value of a holistic understanding is appreciated by suicidologists (Silverman et al. 2003; Shneidman 1993; De Leo et al. 2006; Maris et al. 2000b, p. 50; Leenaars 1999; Lieberman 2003), suicide prevention organisations (IASP 2008), and governments (DOHA 2007), and is highlighted within suicide prevention strategies (LIFE 2007; Tasmanian Government 2010a). Examples of holistic approaches to suicide include: Blumenthal and Kupfer's (1986) model of suicide which combines biological, psychosocial, personality, psychiatric disorder, family, and genetic factors; Maris' (1997) bio-psycho-social model; Rogers' (2001) existentialist and constructivist response model; Leenaars' (2004) model combining intrapsychic and interpersonal perspectives; Henry and Short's (cited in Maris et al. 2000b, p. 44) combination of the sociological and psychodynamic theories of Durkheim and Freud; Pridmore's (2010) 'predicament' model; Shneidman's (1993) 'psychache' model; and the 'threshold and trigger' model incorporated into Australia's suicide prevention strategy (LIFE 2007).

While holistic models may be considered superior to single-theory models, it is suggested that they too may be limited if they do not adequately incorporate intrapersonal understandings. For example, understanding the meaning that the suicidal individual constructs in response to the various elements at play may be of crucial value. This reflects the notion that the presence of multiple risk factors for suicide does not adequately assist to predict suicide in individuals, identify what the best interventions are, nor indeed how interventions may best be enabled (Van Orden et al. 2010). In this regard it is suggested that incorporating intrapersonal (psychological or subjective) knowledge of the suicidal individual into a holistic model is important.

Some holistic models embrace the special significance of the intrapersonal dimension. Shneidman (1993), for example, argues strongly that the intrapersonal experience is of primary concern within a broader holistic model. While criticised for 'disregarding' dimensions of suicide other than the intrapersonal (Leenaars 2010, p. 7), Shneidman (1996a, p. 5) does clearly acknowledge that biological, biochemical, cultural, sociological, interpersonal, intra-psychic, logical, philosophical, conscious and unconscious elements 'are always present' in the suicidal action or person. He clearly appreciates the holistic nature of suicide. However, Shneidman (1996a, p. 4-5) highlights the particular importance of the intrapersonal dimension arguing that, while many other factors may play contributory roles, suicide is 'chiefly a drama in the mind' (Shneidman 1996a, p. 4-5). From this standpoint, the intrapersonal component (within a holistic construct) is of particular importance in optimally understanding and responding to suicide (Shneidman & Leenaars 1999, p. 154; Leenaars 2010, p. 7-8).

Joiner (2005) and Van Orden et al. (2010) also infer that a superior holistic model is one that is concerned with the intrapersonal meaning of the various relevant factors, rather than the factors themselves. In this regard it is argued, for example, that risk factors 'elevate' risk because they are indicators of experiences such as 'thwarted belongingness, perceived burdensomeness, or acquired capability [to attempt

suicide]’ (Van Orden 2010, p. 591). Such holistic models of suicide – at the centre of which is the intrapersonal experience of the individual – reinforce that holism may be understood as ‘a response’ to ‘biological reductionism’, and that ‘the whole’ is greater than just the sum of its parts (Freeman 2005, p. 154-165. Patterson 1998, p. 287). Such an approach also highlights the interconnectedness of the person (Patterson 1998, p. 289), implying the importance of more collaborative approaches which are able to access (and potentially positively affect) the intrapersonal experience in the holistic context.

#### **1.4.2. ‘Recovery’ and suicide**

Complementing holism (within which intrapersonal and interpersonal dimensions are central), the concept of recovery in mental health care may also be seen as vital to evolving services beyond the current limitations suggested. In particular, a fuller realisation of recovery approaches, within a holistic model, may support notions of individualised, empowering and collaborative care, recognised as essential to quality mental health service (Laugharne & Priebe 2006; Lammers & Happell 2003). Indeed, the aspirations of mental health service providers and clinicians may be seen to coincide with the needs of mental health care service-users at risk of suicide around the concept of recovery.

The recovery model of mental health care emerged from the psychiatric rehabilitation model (Anthony et al. 1990). It was developed in the 1980s during the period of psychiatric deinstitutionalisation, and has been linked to the US civil rights movements of the 1960s and 1970s (Barker and Buchanan-Barker 2011b, p. 351), and also to drug and alcohol support programs such as alcoholics anonymous (Frank 1996). Additionally, recovery originated around the time the World Health Organisation began promoting the notion of health as being more than just the absence of illness symptoms. Drawing on such influences, while the recovery approach may entail diagnosis, symptom reduction and medical treatment, it is also deeply personal and concerns ‘the development of new meaning and purpose’ (Anthony 1993, p. 17). The concept highlights that people need to recover from the effects of ill-health which can include disempowerment, unemployment,

discrimination and marginalisation. Indeed recovery models appreciate that the consequences of 'illness' may be just as important to focus on as the 'illness' itself (Anthony 1993, p. 22). Thus recovery aims to attend to issues including 'crushed dreams', the harms caused by lack of opportunity 'for self-determination', and to the 'iatrogenic effects of treatment settings' (Anthony 1993, p. 17).

Anthony provides a foundational description of recovery as:

*A deeply personal, unique process of changing one's attitudes values, feelings, goals, skills and roles...a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness (Anthony 1993, p. 17).*

Furthermore, a recovery-oriented nursing process has been described as:

*A holistic approach that goes beyond merely treating symptoms; promoting individual decision-making and empowering people towards self-management; meeting basic needs and attempting to alleviate individual problems of living; orientating care towards hope and attempts to build upon strengths; assisting consumers to help and support each other; and focusing care on positive functioning and rebuilding positive relationships (Tooth in Onken et al. 2002, p. 21).*

As noted regarding certain conceptualisations of holism, intrapersonal and interpersonal dimensions are also central to the notion of recovery. Recovery embraces individual choice and autonomy, but it also values 'partnership and communication' (Burgess et al. 2010, p. 3), supportive, healing relationships, and enhanced social functioning (Mancini 2008, p. 359). While personal and unique, recovery also identifies the importance of conditions external to the person, including relationships with services and the professionals within them (Mancini 2008d). Therefore, a recovery approach may be seen to prioritise appreciation of individual (intrapersonal) experience within the holistic and interpersonal context. It may do this by, for example, helping people access their intrapersonal narrative

accounts in order to reclaim and progress their 'story' (Barker & Buchanan-Barker 2011b, p. 353). Recovery thus represents an important step towards ethical person-centred care (Coleman 1999).

The recovery model is increasingly recognised as important in progressing and improving mental health care (Burgess et al. 2010, p. 6). However, while recovery is 'exerting increasing influence on mental health services and policy-making across the globe', definitions of it are often confused (Barker & Buchanan-Barker 2011) and contested (Pilgrim 2008, p. 302). Additionally, recovery is unsupported by a robust literature base (Mancini 2008, p. 358) and, reflecting and shaping the critique of services above, recovery is arguably struggling to be realised. Indeed, Australia's Fourth National Mental Health Plan's vision of 'a mental health system that enables recovery' (Commonwealth of Australia 2009) arguably remains largely unrealised (Mendoza 2009 in Pollard 2009).

To help translate the rhetoric of recovery into practice, to resist the potential for reductive or radical interpretations of recovery (Pilgrim 2008, p. 299), and to apply its particular nuances to specific contexts such as mental health nursing care of suicidal people, there is a need to explore 'mental health practices that are conducive to and consistent with recovery' (Mancini 2008, p. 358). The health service at the centre of the current study purports to support a recovery model of care (DHHS 2006). Thus the need to explore just how nurses and consumers have experienced and envisaged services that are supposed to be recovery-oriented, is reinforced. Furthermore, it is indicated that the intrapersonal and interpersonal dimensions of suicidality and related 'care' are central to exploration of what recovery is, and what it should or could be in the context at hand.

#### **1.4.3. Therapeutic alliance and suicide**

The concepts of holism and recovery accentuate the importance of intrapersonal dimensions of suicide and related mental health service responses. This infers that interpersonal interaction between consumers at risk of suicide and clinicians (such as mental health nurses) may be of central importance. In the clinical context,



therapeutic interpersonal interaction is encapsulated in the notion of 'therapeutic alliance'. Therapeutic alliance in broad terms is 'the active and purposeful collaboration between patient and therapist' (Gaston et al. 1998, p. 190). It relates closely to Rogers' (1961) interpersonal theory which highlights the potential of therapeutic relationships which are characterised by genuineness, respect, empathy and unconditional positive regard.

Therapeutic alliance highlights that 'therapy happens not in the patient nor in the [clinician] but between the two of them' (Balint 1973, p. 2). In the broad context of mental health therapy, alliance is considered 'a moderating variable without which no therapy would succeed' (Roth & Fonagy 2005, p. 477). Indeed, regarding treatment of depression it is demonstrated that treatment outcomes were more attributable to the quality of the alliance than to the specific treatment methods (Krupnick et al. 1996, p. 536).

Regarding mental health / psychiatric hospital inpatient experiences specifically, it is noted that relationships between staff and service users may be 'one of the most significant factors' in determining the 'success or otherwise' of service (Nolan et al. 2011, p. 359). Consumer survey results concerning psychiatric hospital admission, for example, reflect that:

*The most influential factor of negative or positive experience was the quality of relationship with the staff and other patients (Biancosino et al. 2009, p. 122).*

Furthermore, regarding suicide specifically, it is appreciated that:

*the relational factor represents a key point both as a trigger for the suicide attempt and for promoting the communication of the intent or for preventing a repeat suicide attempt (Ghio et al. 2011, p. 510).*

Thus it is suggested that the quality of the therapeutic alliance may be more important than ‘the specific actions’ undertaken (Mishara 2008, p. 2). This is affirmed by Ghio et al. (2011, p. 510) who note that:

*interpersonal relationships and an empathic environment were, in essence, what was perceived as therapeutic and protective and enabled the expression of thoughts and self-understanding (Ghio et al. 2011, p. 510).*

Maris et al. (2000), Leenaars (2006), Michel et al. (2004), and Reeves & Seber (2004) are amongst those who agree that the therapeutic relationship, more than any specific intervention, is the most important factor in the treatment of suicidal people. This is congruent with the notion that human connectedness is believed to be a factor that protects against suicide (De Leo 2002, p. 372; De Leo 2004, p. 155. De Leo & Krynska 2007; Beautrais et al. 2005; WHO 2004).

Thus it is appreciated that therapeutic alliance is a significant therapeutic element that can help a suicidal person ‘in the short term as well as in the long term’ (Michel 2011, p. 24). Furthermore it is evident that ‘the heart of the treatment of suicidal individuals is the relationship of the therapists to the patient’ (Maris et al. 2000a, p. 13). This infers the importance of exploring the quality of therapeutic relationships in the context at hand (Berman 2006, p. 182-183). However, it is noted further in this regard that:

*Therapeutic alliance is considered a prerequisite for successful therapy outcome by virtually all therapy protocols for suicidality, but, surprisingly, it has hardly been conceptualized (Michel 2011, p. 4).*

Work towards conceptualisation of therapeutic alliance in the broad context of mental health care of suicidal people has been generated by the Aeschi group (Michel & Jobes 2011). Alliance in this context is centred on appreciating the person’s inner experience, and in line with Rogers’ (1961) principles it is seen to require empathy, unconditional positive regard, and a non-judgemental approach on

behalf of the clinician (Michel 2011, p. 21-22). Furthermore, it is noted that the alliance should constitute a collaborative effort based on shared understanding of the person's 'predicaments and needs', and also function as a model for interpersonal relationships external to the therapeutic context (Michel 2011, p. 23). Importantly, it is noted that such an approach avoids the externalisation of locus of control as may be the case in the traditional medical model (Michel 2011, p. 23). Thus therapeutic alliance is further indicated to be congruent with notions of holism and recovery.

While the central importance of therapeutic alliance is strongly indicated, the nature of such interpersonal engagement, how it affects suicidal people, and indeed how it may be more fully promoted, is complex and inadequately understood (Michel 2011). However, it is suggested that, central to therapeutic alliance, is a relationship in which the suicidal person is listened to and understood and appreciated as a person who is both expert and teacher in relation to their care. However, more understanding about the occurrence, nature and role of therapeutic alliance in this context, and how it may be more fully realised within a holistic and recovery-oriented service, is clearly needed. The nature, potential and current limitations of therapeutic relationships are exemplified and explored further in Chapter 2 which concerns the nursing-specific literature base.

#### **1.4.4. Summary**

Available evidence suggests that the quality of care provided by mental health services may be limited in the ways that it understands and responds to people at risk of suicide. In particular, the limited available evidence suggests that services can be difficult and daunting to access, and overly reliant on medicalised, coercive, objectifying and interpersonally isolative approaches. Principles and practices related to holism, recovery and therapeutic alliance may be crucial to explore and develop in order to better understand, and help to develop services able to better meet the needs of people at risk of suicide. It is proposed that such principles and practices may be considered essential to the concept of 'therapeutic engagement' as it is explored in this thesis. It is argued that such engagement may be central to the

‘integration’ of diverse and potentially dichotomous elements of service. However, it is not clear what the quality of care actually is at present nor exactly how therapeutic engagement may be more fully promoted. This lack of clarity, amidst the suggestion that there can be serious service limitations, points to a clear need to explore more closely experiences of service in the context at hand, and to take a particular focus on intrapersonal and interpersonal dimensions in doing so.

## **1.5. Australian and Tasmanian suicide prevention strategies and the central importance of therapeutic engagement**

This section discusses the Australian and Tasmanian suicide prevention strategies to further critique the role that mental health services play in responding to people at risk of suicide. The discussion highlights the ways in which these services may be limited in their potential to provide optimal care which encompasses therapeutic engagement constituted of holism, recovery, and therapeutic alliance. It is emphasised further that, especially in a period of reform and strategy implementation, there is an urgent need to more fully explore peoples’ experiences of suicidal crisis and care within mental health services, and to consider how the quality of service may be promoted.

### **1.5.1. Australia’s national suicide prevention strategy**

Federal government suicide prevention programs in Australia essentially resided within mental health policy until, in the wake of ineffective efforts from the various National Mental Health plans to address suicide (Mendoza & Rosenberg 2010, p. 122), and subsequent to the 1995 launch of the *National Youth Suicide Prevention Strategy*, the first comprehensive *National Suicide Prevention Strategy (NSPS)* was released in 1999. This strategy is guided by the *Living Is For Everyone (LIFE) Framework*, which was subsequently revised and re-released in 2007 (LIFE 2007). Relevant to the current study, the *LIFE Framework* (2007, p. 26-33) highlights the importance of improving the evidence base around suicide and implementing benchmarking to ensure quality standards in suicide prevention. Within the national

strategy, mental health care and consumer engagement and participation are seen as areas of particular importance and it is acknowledged that further understanding and development of them is necessary (LIFE 2007, p. 26-33).

The current National Suicide Prevention Strategy (NSPS) is complemented by the 2010 Senate Community Affairs References Committee report: *The Hidden Toll: Suicide in Australia* (Aust Senate 2010). Recommendations from that report relevant to the present study include improving training for frontline carers and relevant health professionals, reviewing the support for professionals exposed to suicide, enhancing follow-up support to people who have been in psychiatric care following an attempted suicide or who are assessed as being at risk of suicide, better linking of relevant services in support of people at risk of suicide, and engaging stakeholders to help develop awareness campaigns (Australian Senate 2010, p. xvii-xxii). The Commonwealth response to the recommendations (Australian Senate 2010) includes additional funding and support for clinical services, as does the 'Mental Health: Taking Action to Tackle Suicide' 2010 Federal election package.

The national suicide prevention strategy may be seen as a framework to encourage the evolution of service-responses to people at risk of suicide. This is particularly so as it highlights the central role of mental health services and infers the importance of a particular quality of therapeutic engagement (encompassing holism, recovery and therapeutic alliance). However, the knowledge and action required to achieve such reform is arguably lacking and is effectively deferred to mental health services which may similarly lack the knowledge, leadership and resources to realise significant changes. This is exemplified further in the case of Tasmania.

### **1.5.2. Tasmania's suicide prevention strategy**

The 2007 *Tasmanian Parliamentary Joint Standing Committee on Community Development Strategies for the Prevention of Suicide* recommended that Tasmania institute its own (first ever) state-wide suicide prevention strategy to complement the national strategy. The committee noted the importance of the mental health care sector in any strategy and the need to conduct more research into suicide in

Tasmania. The Committee specifically highlighted that data and understandings were limited and inadequate and tended to be based on statistics and demographics which provided little or no insight into experiences and perceived needs (Tasmanian Government 2007).

One of the outcomes of the Joint Standing Committee's report was a recommendation to strengthen the community links to the Tasmanian Suicide Prevention Steering Committee (TSPSC) - operated under the auspices of Mental Health Services Tasmania (MHS) – and suicide prevention efforts more generally. Subsequently the TSPSC conducted a state-wide community consultation and released the results of this consultation in April 2009. Amongst the findings it was highlighted that suicide prevention was indeed an important issue, that improved training for relevant professionals was required, and that hospital admission and discharge policies were inadequate (DHHS 2009a). Recommendations of the community consultation included the need to develop a regionally focused state-wide strategy for suicide prevention, and the need to review admission and discharge policies and procedures for hospital emergency and psychiatric in-patient units. A further recommendation was that the TSPSC should work with undergraduate and postgraduate training organisations to encourage and support training and awareness of suicide prevention (DHHS 2009a).

Subsequently the Tasmanian State-wide Suicide Prevention strategy was developed and released in 2010 and this exists in addition to the national policies mentioned above (section 1.5.1.). As nationally, suicide prevention in Tasmania is also delivered in less direct ways by other social and health programs and is more generally affected by social and environmental conditions. However, it is clear that mental health care is a central feature, particularly in relation to intervention around suicidal crisis.

Similarly to the National Strategy, key aspects of the Tasmanian Strategy relevant to the present study include the need to staff emergency settings with appropriately trained staff, enhance support of inpatient staff, and improve discharge and follow-

up community care for people recently discharged from an inpatient setting. Importantly, the Tasmanian strategy notes that:

*Individuals working in the acute care sector have traditionally been trained to look after those diagnosed with schizophrenia – they are not necessarily well placed to assess and manage those presenting with complex psychosocial issues, abuse and suicidal ideation (Tasmanian Government 2010a, p. 6).*

This statement may be seen as acknowledgement of the need to move beyond over-reliance on a medical model of care. Reinforcing that notion, the Tasmanian strategy specifically notes the importance of supporting the acute inpatient services workforce to reduce ‘compassion fatigue and ensure clients are treated with empathy and dignity’ (Tasmanian Government 2010a, p. 51). It is noted further that:

*The tertiary prevention workforce needs to be significantly increased and clinicians in specialist facilities need to be trained to a high level to both assess and support distressed patients (Tasmanian Government 2010a, p. 36).*

Actions proposed to achieve this include investigating new options for training and workforce support, organising the work in inpatient services to provide less stressful and alienating conditions for staff, and better supporting people recently discharged from acute psychiatric inpatient settings (Tasmanian Government 2010a, p. 51). The outcome for these actions is noted as an increase in the workforce’s capacity to deliver ‘best practice services’ (Tasmanian Government 2010a, p. 51). Additionally, the strategy proposes to support research efforts ‘to better understand key factors in suicide prevention and the approaches that can produce positive outcomes’ (Tasmanian Government 2010a, p. 13).

In addition to Tasmania’s suicide prevention strategy, the overarching Tasmanian Government Department of Health and Human Services (DHHS) strategic plan emphasises collaborative care and person-centeredness (DHHS 2009c). The strategy notes, for example, that:

*Every Tasmanian has the right to safe, high quality, affordable health and human services when they need them. They also have the right to expect their experience of these services will be positive and coordinated, and will take into account their individual views and needs (Roberts in DHHS 2009c, p. 2).*

Other strategic documents similarly highlight the importance of evolving current models of care. Mental Health Services' Strategic Plan 2006-2011, for example, leads with the statement '*partners...towards recovery*' (DHHS 2006). Furthermore, SMHS Tasmania is a service that claims to embrace the concepts of recovery, consumer participation and holistic care (DHHS 2007b). Thus, Tasmania's Suicide Prevention Strategy, and supporting policy in Tasmania, reinforces the importance of therapeutic engagement (encompassing holism, recovery, and therapeutic alliance). These policies note the importance of improving the evidence base, educating, training and supporting relevant clinicians, and they infer building and utilising links between education providers and the health service.

### **1.5.3. Summary**

The need to support and enhance responses from the public mental health care sector is an important feature of the Australian and Tasmanian suicide prevention strategies. Particularly important areas of service are noted to be admission and discharge practices and continuity of care, as well as the quality of inpatient hospital care. In respect to such elements of service, the Tasmanian strategy is notable for its explicit recognition of the limits of a model of care predominantly focused on treating mental illness. Its intention to enhance service provision by, for example, 'investigating' and 'exploring' how staff may experience 'less stressful and alienating conditions' so that they may better support clients in respect to 'complex psychosocial issues' and 'suicidal ideation' (Tasmanian Government 2010a, p. 36) through the delivery of 'best practice services' (Tasmanian Government 2010a, p. 51) is laudable. However, the responsibility for this is apparently deferred to the service provider, an adequate evidence base regarding 'best practice' arguably does not exist, and steps to achieving change are unclear – particularly within a climate of



limited resources within Tasmania's Mental Health Services. At the time of writing of this thesis – more than a year after the release of the Tasmanian Suicide Prevention Strategy – there is a lack of evidence indicating that moves to enhance the hospital inpatient care of suicidal service-users have been made. In short, it is not evident that rhetoric is being translated into practical steps, nor that there is an adequate evidence base to do so. Thus, further investigation is needed to ascertain the nature of services and to provide added impetus and practical knowledge to promote the required reforms.

## **1.6. Conclusion**

Limiting the occurrence and burden of suicide is an important concern which demands that people at risk be understood and responded to in the best possible ways. It is argued that suicide is largely avoidable in Australia (Lifeline 2010; McGorry 2010, cited in Drape 2010) and that certain activities and interventions do help (Goldsmith et al. 2002; McGorry 2010a; Lifeline 2010; WHO 2009; Leenaars 1999). For example, there is some cause for optimism that suicide prevention strategies can coordinate and promote reform (Goldney 2005, p. 135) and that mental health services may provide effective and appropriate responses (Goldney 2005; McGorry 2010, cited in Drape 2010; Mendoza 2009 in Pollard 2009; Mendoza & Rosenberg 2010; WHO 2009; IASP 2008). However, it is also argued that the effectiveness of strategies and of current services may be lacking (Robinson et al. 2008; Goldney 2006). Indeed, it is noted that:

*What elements in the chain of well-intentioned approaches to treating psychiatric illness and suicidality fail to protect this vulnerable population is still unclear (De Leo & Svetcic 2010, p. 8).*

While relevant evidence is limited, it seems likely that current mental health care service models may not optimally suit suicidality (Cutcliffe & Stevenson 2008a; Lieberman 2003; Leenaars 2006; Lakeman & Fitzgerald 2008, p. 115; Goldsmith et al.

2002; Marsh 2010). Specifically, there is cause for concern that current mental health service for people at risk of suicide may be difficult and daunting to access and overly reliant on medicalised, coercive, objectifying and interpersonally isolative approaches (Marsh 2010; Cutcliffe & Stevenson 2008a; Shneidman 1993; Lieberman 2003; Leenaars 1999; Marsh 2010; Pridmore 2010). It may thus be argued that suicide-related service provision has not received the attention required (McGorry 2010, cited in Drape 2010; Mendoza 2009 in Pollard 2009; Brogden 2010 in Agius 2010).

More research and evaluation is needed to determine where and how best to strategically direct efforts (Mann et al. 2005), and to generate and translate understandings, policies and goals into effective action (Beautrais & Mishara 2008, p. 62). In particular, it is evident that greater evidence is required of the present nature of service in order to help promote the fuller realisation of therapeutic engagement (which has been defined in this thesis as embracing principles of holism, recovery and therapeutic alliance). It is suggested that exploring intrapersonal and interpersonal experiences of suicide and related mental health care may be of crucial concern in this regard.

## **Chapter 2 – The potential of mental health nursing care of suicidal people**

This chapter explores literature more specific to mental health nursing to reinforce the need for further research and reform in relation to mental health service responses to suicidal people. The importance of nursing practice in this context is highlighted as registered nurses in Australia represent around 64% of the specialist public mental health workforce (DOHA 2010b) and are believed to regularly encounter service-users at heightened risk of suicide (Lakeman & Fitzgerald 2009, p. 16; Sun et al. 2004; Cutcliffe & Stevenson 2008a; Lakeman 2010a; Valente & Saunders 2002). While nurses encounter people at risk of suicide in various settings, unique from any other discipline they collectively provide continuous (24/7) service in mental health inpatient settings (Cutcliffe & Stevenson 2008b, p. 943). It is asserted that the quality of such nursing care of people at risk of suicide impacts on experiences and outcomes, potentially being the difference between life and death (Carrigan 1994; Lewis et al. 1986). However, it is also apparent that, reflecting and shaping the broader context discussed in Chapter 1, nurses may be struggling to realise their fullest potential in this important service context. Thus it is evident that further understanding is needed regarding the nature of such nursing care and how it may be developed (Valente & Saunders 2002; Gilje et al. 2005; Cutcliffe & Stevenson 2008b).

As in the broader context, therapeutic engagement (encompassing holism, recovery, and alliance), is suggested to be vitally important to the development of more 'integrated' and 'evidence-based' nursing practice. It is concluded that understanding and contributing to the development of nursing in this area exemplifies the need to explore care particularly in respect to intrapersonal and interpersonal dimensions. It is also emphasised that more local and recent data

which incorporates a diversity of first-person accounts, and more fully (critically) examines the service context to highlight factors which may mediate the quality of nursing care, is essential. The value of multiple first-person narrative accounts and a critical focus is explored in more depth in Chapter 3 but is mentioned here as part of the review of nursing practice. The research questions guiding this thesis are reaffirmed as appropriate to meeting these research imperatives.

## **2.1. The under-realised potential of mental health nursing**

This section indicates that mental health nursing may contribute to an over-reliance on medicalised, coercive, and interpersonally isolative approaches. As in the broader context, it is noted that therapeutic engagement (encompassing holism, recovery and alliance) can contribute to the integration of diverse approaches to nursing suicidal people. This integration is particularly important as nursing care may be focused on either ‘observation’ or ‘engagement’, while intra- and inter-personal dimensions of care can mediate these extremes.

### **2.1.1. Nurses’ struggle to realise professional aspirations**

General nursing has long sought a model of care embracing principles akin to holism, recovery and therapeutic alliance (Peplau 1991; Benner 1984; Eriksson 1997; ANMC 2010, p. 7). Mental health nursing is supposed to be particularly focused on such a model. For example, it is noted that mental health nursing aims to incorporate multiple variables (Procter 2005, p. 200) in providing ‘holistic’ care that goes beyond expressing ‘medical treatment’ (Barker & Buchanan-Barker 2011, p. 1). Indeed, it is proposed that mental health nurses should:

*concern themselves with providing care to the mind, body, spirit, social and environmental issues influencing the person’s wellbeing [and] care for the ‘integrated whole’ of the person (Cutcliffe 2003, p. 97).*

Mental health nursing also seeks to be recovery-oriented, as epitomised in Barker's (2001) Tidal Model. This model exemplifies the need to have personal experiences validated and understood (Barker 2001, p. 236), and seeks to connect with and help develop 'the lived experience of the person-in-care' (Barker 2003, p. 99). Notably, at the heart of Barker's construction of recovery is a particular relationship in which the nurse enters into the person's narrative of suffering (Barker & Buchanan-Barker 2011b, p. 352). It is thus reinforced that, as with the broader context, at the heart of an optimal quality of care, is a close and particular therapeutic relationship between nurses and consumers.

The standards of practice laid out by the Australian College of Mental Health Nurses reinforce that the aspirations of mental health nurses relate to notions of holism, recovery and therapeutic alliance (ACMHN 2010a). Standard 2, for example, notes the importance of collaborative partnerships between nurses and people with mental health issues (ACMHN 2010a, p. 6); and Standard 3 specifically highlights the importance of the nurse building a therapeutic relationship that is respectful, empowering, and which involves building on strengths and fostering hope to enhance resilience and promote recovery (ACMHN 2010a, p. 6). The central role of therapeutic engagement is also highlighted consistently in various mental health / psychiatric nursing texts (Happell et al. 2008; Glod 1998).

Nurses are then, *potentially and theoretically* well situated to help suicidal people, essentially because they have 'access' to at-risk healthcare consumers, and because principles of holism, recovery and therapeutic alliance are both vital to the care of the suicidal person and recognised to be the proper basis of nursing in general (Benner 1984; Peplau 1991, 1992; Eriksson 1997; Moyle 2003), and mental health nursing in particular (Barker et al. 1997; Cleary et al. 1999a; Walsh 1999; Hummelvoll & Severinsson 2001; Cutcliffe & Stevenson 2008a; ACMHN 2010a; Barker & Buchanan-Barker 2011). However, it is suggested that nursing may remain marginalised in comparison to medical perspectives, both broadly (Street 1992, p. 8), and in contexts such as care of suicidal people (Cutcliffe & Stevenson 2008a, p. 942).

In sum, it is apparent that nursing continues to struggle to realise its aspirations of therapeutic engagement (Barker & Buchanan-Barker 2005, p. 542).

Closer examination of the understandings around mental health nursing reveals the potential for dichotomous categorisations of different approaches to care. Barker and Buchanan-Barker (2011, p. 1), for example, describe the 'potential' and 'reality' of care using the dichotomous concepts of 'mental health nursing' and 'psychiatric nursing', with the former based upon holistic, recovery-oriented, alliance-based care, and the latter primarily concerned with the expressing of treatment within a medical-psychiatric framework. Within this construct:

*Mental health nursing implies something more meaningful, more egalitarian, more 'health promoting', and therefore, more liberating than traditional psychiatric nursing (Barker & Buchanan-Barker 2011, p. 2).*

In contrast, it is argued that psychiatric nursing is 'paternalistic, negative, illness-oriented, and frequently, coercive' (Barker & Buchanan-Barker 2011b, p. 356). Using this construction, Barker and Buchanan-Barker (2011) argue that 'mental health nursing' is something of a myth; that it reflects how nurses would *like* to be, and constitutes 'a professional aspiration, rather than a practical reality' (Barker & Buchanan-Barker 2011, p. 2). The implication they draw from this proposition is that if mental health nurses are to realise their aspirations they must understand and address the inter-professional and interpersonal relationships underpinning service at present. Adopting something of a radical stance, Barker and Buchanan-Barker (2011) assert further that nurses may have to 'divorce' themselves from (medical) psychiatry in order to achieve their therapeutic potential. While a more moderate position that would seek to reconcile and integrate 'mental health nursing' and 'psychiatric nursing' (or medical-psychiatry and social-psychiatry) is arguably preferable, Barker and Buchanan-Barker (2011) reinforce that there can a significant 'gap' between the aspirations of many mental health nurses and what is actually realised in practice.

Numerous other authors have also conceptualised mental health nursing as being essentially defined by diverse or dichotomous approaches. Walsh (1996, p. 6), for example, explores how mental health nurses (taking 'mental health nurse' now again as a generic term for nurses working in psychiatric or mental health care contexts) may operate in what he calls 'they' and 'self' modes of nursing. In the 'they' mode the nurse does not recognise a 'shared humanity' and as a result does not effectively 'strive for positive possibility' in the relationship (Walsh 1999, p. 6). Alternatively, in the 'self' mode the nurse is 'open' to shared humanity, to the patient's self and feelings, and therefore to 'positive possibility', first and foremost for the patient, but subsequently also for the nurse (Walsh 1999, p. 6). Again, this conceptualisation reinforces the central importance of a particular quality of nurse-patient relationship in reflecting and shaping the quality of care.

Similarly, Hummelvoll and Severinsson (2001) describe mental health nursing as being either 'concealing' or 'integrating'. 'Concealing' obstructs the gaining of insight and thus restricts the patient's ability to recover (Hummelvoll & Severinsson 2001, p. 163). Alternatively the 'integrating' style of nursing helps the patient to raise their level of insight and to reconceptualise their experience and suffering (Hummelvoll & Severinsson 2001, p. 163). Crowe (2006), too, notes a diversity of care approaches, which range from a holistic style which sees the nurse attend to the consumer's personal meanings and inner world (of disorder and distress, for example), to very limited approaches wherein the nurse focuses solely on 'illness' and 'diagnosis'. Additionally, Latvala (1999) constructs a typology reflecting the possible diversity of approaches, describing nursing as 'confirmatory', 'educational' or 'catalytic' (1999, p. 64). In this model, 'confirmatory' nursing accentuates a hierarchical, authoritarian and medicalised approach, 'educational' nursing is professionally driven and based on behavioural models that leave the person 'quiet or not present' in their care (1999, p. 69), and 'catalytic' nursing is collaborative, alliance-based and aimed at empowering the patient (1999, p. 64). Reflecting the under-realised potential of mental health nursing in such categorised practice, according to Latvala (1999, p. 64-71) nursing was catalytic in only 13% of cases, yet educational in 40%, and confirmatory in 47%.

Descriptions of mental health nursing care are, then, often characterised by a 'gap' or disconnect between what is possible and desired and what, in practice, predominates. In theory there exists a form of interpersonal care related to notions of holism, recovery, and alliance. On the other hand, more medicalised, coercive, objectifying and interpersonally 'distant' approaches, may predominate in line with the broader limitations outlined. This status quo has prompted criticism of the 'persistence of pyjama therapy in the age of recovery and evidence-based practice' (Lakeman 2011, p. 479). It also highlights an absence or diminished quality of therapeutic relationship between nurses and consumers of mental health services (Shattell et al. 2008). While, then, some point out that mental health nursing has evolved 'from a primitive form of providing institutional, custodial care to a large array of increasingly sophisticated roles' (Boling 2003, p. 38-39), others argue that:

*the profession of 'mental health nursing' is having such a difficult birth, if it is not altogether an aborted project (Barker 2002, p. 22).*

Overall, it may be that nursing's quest for therapeutic engagement (encompassing holism, recovery and alliance) continues to be largely rhetorical. This quest can be traced from Nightingale (1859), to Peplau (1991), to Eriksson (1997), and now more recently to those such as Barker and Buchanan-Barker (2011). As such, it may be argued that the 'new clinical paradigm' (Eriksson 1997, p. 8) has been a long time coming, yet it never seems to fully arrive in clinical practice. At the heart of this under-realisation of optimal care is a diminished nurse-consumer relationship.

### **2.1.2. Integrating elements of 'observation' and 'engagement'**

Reflecting and shaping the broader tendency for mental health care and mental health nursing to be defined by a diversity of 'possibilities', much of the existing literature specific to mental health nursing of suicidal mental health care consumers discusses the issue using the concepts of 'engagement' and 'observation.' 'Engagement' in this context can be seen as corresponding closely with notions of holism, recovery and alliance. 'Observation' on the other hand may be understood



as less interactive, and more focused on 'physical' interventions including risk assessment, 'close', 'formal' or 'continuous' observation, containment and medication (Cutcliffe & Stevenson 2008a). Exploring this dichotomisation highlights further the central importance of a particular quality of interpersonal engagement between nurses and consumers in 'integrating' diverse elements of service within an optimal model of care. It also reinforces, however, that such a model of care arguably remains under-developed and under-realised.

The formal practice of 'observation' (also known as 'close observation', 'special observation' or 'specialling') is supported by some authors (Libberton 1996; Stuart 2001). It is argued that constantly observing consumers at risk of suicide may have 'a modest protective effect' (Stewart et al. 2012, p. 1346), and it has been reported that consumers do sometimes feel secure and like being under observation (Jones et al. 2000). Regarding intermittent observation, it is noted that such practice may be well tolerated by patients and it has been associated with lowered rates of self-harm (Bowers et al. 2008).

However, while evidence supports the use of intermittent observation (James et al. 2011, p. 37-38), it is argued that observation as a *primary approach* is not well supported by evidence (Cutcliffe & Stevenson 2008a, p. 944-945; Andersen et al. 2009, p. 25; Kettles & Addo 2009). Indeed, both consumers and staff have expressed concerns about reliance on observation (James et al. 2011, p. 38), with some nurses finding the practice to be stressful (Westhead et al. 2003), contradictory to humanistic nursing values and therapeutic engagement, and undermining of their sense of 'job control' (Dodds & Bowles 2001). Furthermore, some consumers find observation 'impersonal, intrusive and non-therapeutic' (Stewart et al. 2012, p. 1340), and compounding of their feelings of isolation and pathology (Temkin & Crotty 2004, p. 78). Additionally, Barker and Walker (1999), Jones et al (2000), and Dodds and Bowles (2001) all argue that, contrary to claims made by advocates of observation, consumers under 'observation' commonly feel 'neither safe nor supported' (Cutcliffe 2002, p. 34). Reinforcing such criticism it has been found that between 19% (Appleby et al. 2006) and 20-33% of inpatient suicides were completed

while the person was actually under 'observation' (Cutcliffe & Stevenson 2008a, p. 26; Department of Health 1999, 2001). It has also been reported that, in an acute unit in the UK, change from a formal observation approach to one of structured activity resulted in declines in absconding and self-harm, as well as declines in staff sickness and staffing costs (Dodds & Bowles 2001).

It is noted, furthermore, that a focus on observation may reinforce a traditional medical hierarchy of power relations, minimise the focus on patient rights and therapeutic processes, and raise serious ethical dilemmas (Horsfall & Cleary 2000). Thus it is suggested that:

*The idea of 'observing' rather than 'exploring' such 'things' – or rather the human context, within which they might be operating – betrays the most conservative form of psychiatric medicine (Barker & Buchanan-Barker 2005, p. 544).*

Cutcliffe and Stevenson (2008a, p. 35) argue that mental health care consumers are commonly seen as people who need to be managed and controlled, and that this is reflected in the 'over-zealous' use of observation (as well as 'no harm' contracts and medication). Additionally, Cutcliffe and Stevenson (2008a) describe the potential for observation to be a modern day version of Bentham's Panopticon (Bentham 1995). Indeed, some critics of observation as a primary approach argue that the control and containment (observation) role is 'antithetical' to 'empowering and developmental' (engagement) roles (Barker & Buchanan-Barker 2011, p. 356), and that a focus on observation may actually be preclusive of therapeutic engagement (Cutcliffe & Stevenson 2008a; Barker & Buchanan-Barker 2011),

Towards the potential for 'integration' of diverse elements of care, it is important to note the possibility that observation and engagement may co-exist (Billings 2004, p. 191). Cardell and Pitula (1999), for example, note the potential for 'therapeutic observers' to observe while still being caring, helpful, hopeful, and acknowledging of the person's uniqueness (Cardell & Pitula 1999, p. 1068). Similarly, people have

reported observation to be a positive experience when their nurse engaged with them *within* the observations (Jones et al. 2000), when nurses were both ‘caringly vigilant and inquisitive’ (Bowers et al. 2011, p. 1464), and when consumers were observed by nurses who were familiar to them (Dodds & Bowles 2001) and who talked to them (Jones et al. 2000a). Thus, it is reinforced that a particular quality of engagement may be essential to consumers (Ghio et al. 2011, p. 517. Reynolds et al. 2005) and nurses (Vrale & Steen 2005) experiencing the potentially objectifying and alienating intervention of formal observation therapeutically.

Conceding the potential for integration of observation and engagement, Barker and Buchanan-Barker (2005, p. 545) note that, while observation may exist without engagement, observation is inherent in engagement. In this sense engagement and observation may clearly co-exist. However, it is suggested that the emphasis in current service provision needs to shift further ‘towards’ engagement. This reinforces the potential importance of relationships between suicidal mental health care consumers and nurses (Hewitt & Edwards 2006, p. 666; Cutcliffe & Stevenson 2008a, p. 942). However, it is suggested that, in practice, ‘engagement’ is often undermined by an ‘observational approach’ (Koehn & Cutcliffe 2007, p. 138). Furthermore, it is noted that evidence is lacking for what could effectively replace a focus on observation (Cox et al. 2010).

### **2.1.3. Summary**

By considering the nature of care in general mental health nursing contexts, and specifically in relation to care of suicidal mental health care consumers, it is apparent that there are diverse and potentially dichotomous ‘possibilities’ and elements of service. Reflecting and shaping the broader context discussed in the previous chapter, this diversity is exemplified in notions of ‘engagement’ and ‘observation’. Indications of bias towards more ‘reductive’ forms of care are evidenced by claims that observation is inappropriately prioritised over engagement. While there is debate as to whether engagement and observation approaches are incongruent, the potential for integration is suggested. Furthermore, it is noted that at the heart of such reform may be a fuller understanding and realisation of therapeutic

engagement (encompassing holism, recovery and alliance) between nurses and suicidal people. Clearly, in mental health nursing as more broadly, there is more knowledge and action required to support such reform.

## **2.2. Experiences of care incorporating perspectives of nurses and consumers**

This section extends exploration of mental health nursing's apparent struggle to realise their therapeutic potential in the care of suicidal people. The section reinforces the potential for a dichotomisation of approaches and the dominance of more medicalised, coercive, objectifying and alienating service. It also reinforces the importance of exploring and promoting therapeutic engagement, including in respect to intrapersonal and interpersonal dimensions of care.

This section also introduces the notion that consumer and nurse first-person narrative accounts may be of particular value in providing insight into interpersonal and intrapersonal dimensions. In doing so it is noted that important differences may exist between the consumer and nurse experiences, and this is indicative of the value of combining both nurse and consumer perspectives in single studies. The existing evidence base is also critiqued to conclude that more local and recent knowledge is needed. Additionally, the section argues that more adequately critical evidence is required in order that the significant factors mediating the nature of care (and the potential for therapeutic engagement) may be understood. To help highlight the value, and the current limitations, of research based on first-person accounts, the following sub-sections look in turn at research incorporating consumer perspectives, nursing perspectives, and combined consumer-nurse perspectives.

### **2.2.1. Consumer perspectives of care**

Research identified which incorporates consumer-participant first-person accounts of mental health nursing care around consumer suicidality includes Talseth et al (1999), Cardell and Pitula (1999), Samuelsson et al. (2000), Gournay and Bowers

(2000), Cutcliffe et al. (2006), and Cutcliffe and Stevenson (2007). This literature reinforces the importance of a particular quality of interpersonal nursing within a holistic and recovery-oriented approach. It also highlights, however, that such therapeutic engagement was experienced by the consumers to be minimal. While this literature highlights the important role of consumer narratives, there remains a need for more local, recent research that takes a more adequately critical perspective.

Talseth et al. (1999) analyse consumers' accounts of care (n=21) to describe the care experiences of people who were suicidal in a Swedish psychiatric-inpatient setting. The authors conclude that care constituted either a 'confirming' or 'lack of confirming' approach. A confirming approach was described as one in which the nurse was open and attentive to the person and spent time to listen without prejudice, and which communicated hope. Conversely, an approach they term 'lack of confirming' saw the patient's basic needs overlooked, with the nurse not spending time with the person to let them express their thoughts and feelings, and with the effect of communicating hopelessness (Talseth et al. 1999, p. 1034). Talseth et al. (1999) conclude that most of the suicidal consumers in their sample group reported their nursing care to be a negative experience, with only a minority reporting that the experience was positive. The consumers' main concern was that they wanted to talk with nurses, and to be listened to, but there was apparently very little time available for this. The consumers felt that they were isolated and left alone on the ward, and they felt that sometimes their hopelessness was compounded as the nurses focused mainly on symptomology of depression and on medication (Talseth et al. 1999).

Cardell and Pitula (1999) interviewed inpatients at risk of suicide (n=20) and note that participants expressed positive feelings towards 'observers' perceived to be friendly, engaging and willing to help. Thus positive attitudes and behaviours provided more than just protection and, as discussed previously, the possibility of 'therapeutic observation'. Gournay and Bowers (2000) analysed case studies of consumers (n=31) who either suicided (12) or had serious self-harm (19) outcomes.

The findings highlight environmental factors that could be addressed, considerable variation in the content and quality of observation policy and practice, and the need for further research.

Swedish research on psychiatric inpatients by Samuelsson et al. (2000) further supports the view of nursing care being multifaceted and diverse in nature. Inpatients (n=18) who had recently been suicidal were interviewed about their experiences of the care of the multi-disciplinary team (primarily nurses). The authors note that some consumers found staff to be caring and concerned, while others found the staff to be indifferent and uncaring. The participants highlighted that the opportunity to talk and be understood was of central importance. The authors suggest that continual clinical supervision, adequate knowledge specifically concerning suicide, collaborative care planning with the nurse and consumer working together, as well as generating appropriate attitudes amongst staff, were all important elements in mediating the nature of care (Samuelsson et al. 2000).

In arguably the most major work to date concerning nursing care of suicidal mental health care consumers, Cutcliffe et al. (2006) interviewed consumer participants (n=20) from community, day, and inpatient settings, to develop the grounded theory: 're-connecting the person with humanity' (see also Cutcliffe & Stevenson 2007). This research is the only source located which provides a significant substantive theory of how mental health nurses help facilitate the movement of a person from a death-oriented position to a life-oriented position. The theory frames suicide as a psychosocial problem and explains how nurses may help people recover through an interpersonal process constituting a three stage healing process: 'reflecting an image of humanity', 'guiding the individual back to humanity', and 'learning to live'. In the first stage the suicidal person is engaged by a nurse who models a successful 'image of humanity' and who demonstrates warmth and care such that the suicidal person's suicidal constructs are implicitly challenged. The second stage sees the continuation of a helpful interpersonal relationship that nurtures insight and strengthens pre-suicidal beliefs. The third stage enables the person to accommodate a suicidal crisis (past, present, and future), and allows them

to move forward. This model reinforces the notion that consumers do not want to be treated 'mechanically' - as epitomised by being 'under' observations - rather they prefer a close, human relationship with the nurse (Cutcliffe et al. 2006, p. 792).

In terms of limitations, the 're-connecting the person with humanity' model (Cutcliffe et al. 2006; Cutcliffe & Stevenson 2007) is notable for its lack of nurse participant perspectives. Furthermore, while the model presents a valid and useful approach, a focus on 'what works' is not fully integrated with data concerning what is actually occurring in terms of care, why care might be constituted as it is, and how therapeutic engagement may be more fully realised. In other words, it presents a model which incorporates many of the nuances of holistic, recovery-oriented, alliance-based care, but stops short of creating a clear pathway towards realising this approach in the context at hand.

Research utilising consumer first-person accounts of nursing care is important in identifying and reinforcing the value of therapeutic engagement (encompassing holism, recovery and alliance). Consumers' experiences reflect that nurses can help them, particularly through care constituted of time together, listening, understanding and genuinely caring. Such elements are suggested to promote therapeutic connectedness, restoration of hope, and re-orientation of life trajectory, amongst other potential benefits. Thus it is affirmed that, from the consumers' perspectives, therapeutic engagement, in particular, may be of value in and of itself, and may also be a crucial foundation for the range of other potential interventions (such as observation).

However, literature drawing directly on consumer accounts also reinforces that nurses may be struggling to achieve their therapeutic potential. Rather than simply being a benign influence, it is suggested that a lack of therapeutic engagement, in particular, may actually compound feelings of isolation and hopelessness. The attitudes of staff, the need for more support and training for nurses, and the influence that the clinical environment may have on care, are also highlighted as potentially important in mediating the quality of care. The research based on

consumer accounts is thus shown to be of significant value in exposing the need for greater understanding and development of service in this regard. It is notable that none of the research originates from Australia, that much of it is dated, and that it essentially lacks a critical depth able to adequately explain what may mediate the quality of care.

### **2.2.2. Nursing perspectives of care**

Research which incorporates nurse-participant first-person accounts of mental health nursing care of suicidal mental health care consumers includes Reid and Long (1993), Duffy (1994), Long and Reid (1997), Talseth et al. (1997), Cleary et al. (1999b), Fletcher (1999), Vrale and Steen (2005), Gilje et al. (2005), Carlen and Bengtsson (2007), Rooney (2009), Meerwijk et al. (2010), the Australian College of Mental Health Nurses (ACMHN 2010b), and Talseth and Gilje (2011). This literature reinforces the notion of an under-realisation of potential as reflected and shaped by the quality of nurse-consumer relationship. It also highlights some of the possible challenges to the quality of care, including the confronting nature of suicide, the individual reactions of nurses, and the general lack of preparation and support, and broader conditions prohibitive to 'best practice'.

Reid and Long's (1993) early survey work (n=50) suggests that nurses were not proficient in demonstrating essential interpersonal caring skills. A subsequent survey of nurses (n=45) by Long and Reid (1996) shows that, while nurses held essentially positive views about nursing suicidal people, they often experienced distress around it. A need for further education and training in interpersonal skills and therapeutic modalities in order to enhance care was highlighted.

Duffy (1994) conducted a grounded theory study with nurses (n=10) to consider the role of 'special observations'. Duffy (1994, p. 944) argues that observation 'inevitably violates patient rights' and may be contradictory to 'the humanistic basis of nursing philosophies'. For example, the philosophy of treating the person as an adult, and infusing observation with therapeutic engagement, remained unacknowledged, and nurses were allocated to the task merely due to availability rather than skills,



knowledge or attributes (Duffy 1994, p. 948). It is concluded that tension between paternalism and humanism existed, and that training was needed around the range of skills and attitudes required to implement observation effectively and ethically.

Talseth et al. (1997) interviewed mental health nurses (n=19) to identify the categories of 'close' or 'distant' modes of care. Closeness entailed openness, trust, active listening and attentive focus on the consumer. Distance entailed a lack of trust, an implicit rejection of the patient, and the nurses' focus being directed to the nurse themselves, rather than the consumer. It was found that closeness with suicidal consumers could evoke powerful emotions, but that a more distanced stance could also be a burden (Talseth et al. 1997, p. 362). Distanced nurses did not 'dare' to meaningfully engage with the patients and remained distanced from the patient's thoughts and feelings about wanting to die. This meant that the nurse might seem to be close, but even in interacting they could be inferring that the suicidal person's thoughts had to be removed as they were unacceptable. It is highlighted that this could exacerbate feelings of worthlessness or 'defect' which may be contributory to suicidality. Secondary analysis of this data (Gilje et al. 2005, p. 520) reinforced that nurses may struggle with their own responses when confronted with the suffering of suicidal consumers.

Cleary et al. (1999b) interviewed nurses (n=10) regarding 'special observation'. Noting various concerns and how they may be alleviated, it is highlighted that an enormous burden can be felt by nurses regarding how, within a ward environment and in the context of observation, a therapeutic relationship may be established and maintained. Interestingly, Cleary et al. (1999b) note that sometimes there was a 'waiting period' in which observation would predominate until the person was safe enough to be engaged. Essentially, however, it is argued that a focus on observation, which was aimed at ensuring safety, actually impeded engagement and thus the quality of care. The burden of actual or possible death, and the fact that feedback was not given to staff when a patient suicided after discharge (thereby denying nurses the chance to effectively reflect), was also noted (Cleary et al. 1999).

Vrale and Steen (2005) also (focus group) interviewed nurses (n=5) regarding 'observations', and highlighted the potential for tension to exist between 'control' and the development of a therapeutic relationship. Interestingly, the importance of nurse-consumer relationships to assess the need for observation was noted. Again, a tension between paternalism and autonomy is identified and it is reinforced that 'observation' may be integrated within 'therapeutic relationship'.

Carlen and Bengtsson (2007) interviewed mental health nurses (n=11) regarding the nurses' experiences of providing nursing care to suicidal service users. They concluded, too, that the nurses needed additional support, particularly around reflective practice concerning their experience of 'patient suffering'. Rooney (2009) further explored mental health nurses' (n=6) experiences of 'close observation' of inpatients at risk of suicide. Rooney (2009) reaffirms that nurses can find the experience challenging and are aware of professional and ethical tensions in keeping the person physically safe while wanting to therapeutically engage. Findings highlight the aim of engaging with the person while observing them, and the need for increased training, education, support and teamwork towards that end.

Involving mental health nurses (n=21) as participants, Meerwijk et al. (2010) found that training in basic and advanced assessment was necessary. However, they also highlighted that a focus on assessment did not necessarily lead to better interventions and outcomes. Furthermore, the research suggests that nurses did not necessarily think talking about suicide with consumers was an appropriate or safe thing to do.

Talseth and Gilje's (2011) interpretive synthesis of studies regarding nurses' responses to suicide and to suicidal patients confirms that nurses may be deeply confronted by suicidal consumers, and may find it difficult to enter into the patient's world of 'lonely isolation' (Talseth & Gilje 2011, p. 8). Indeed, it is noted that nurses experienced feelings in response to suicide and suicidal consumers including distress, anger, powerlessness, beneficence, fear, anxiety, panic, avoidance, loneliness, sadness, grief, frustration, helplessness when trying to confront colleagues, and

voicelessness in not talking about the stress of caring for a suicidal person. Alternatively, a lack of distress or anger was described by other nurses, with some reporting no difficulty in their care giving role (Talseth & Gilje 2011, p. 13-14). Talseth and Gilje (2011) also confirm that nurses may waver between being close to the consumer, engaging with them (building an alliance, listening to them, respecting them, and being accessible to them), and being distant from the consumer (not listening, ignoring them or not being attentive).

Talseth and Gilje (2011) also conclude that knowledge was identified as a key factor in enhancing practice, and a lack of knowledge was associated with underestimations of the level of suicide risk. Perceived impediments to 'best practice' were values, feelings, inadequate knowledge, personal experiences and weight of professional responsibility, and deficits in skills and knowledge. Furthermore, the need for support was reinforced, particularly in relation to having adequate time and staff to provide care, support from colleagues and the opportunity to reflect and to express their feelings. The importance of education and professional development, interpersonal skills to interact with consumers and their families, and self-care following a suicide attempt, was also noted.

A submission by The Australian College of Mental Health Nurses to the *Senate Community Affairs References Committee: inquiry into suicide in Australia* (ACMHN 2010b), and the survey that underpinned that submission (ACMHN 2010c), are two of the only recent sources located specifically concerning mental health nursing care of suicidal mental health care consumers in Australia. In their submission, The College highlights the important role that nurses can play through listening, engaging, forming rapport, and providing support to suicidal service users. The College argues that these factors underpin mental health nurses' abilities to assess and manage the risk of suicide, to formulate collaborative care plans, to educate clients and carers, and to deliver therapeutic interventions (ACMHN 2010b, p. 3).

The ACMHN survey of mental health nurses (n=72) in Australia suggests that a significant proportion of mental health nurses' work relates to suicide – for example

31.6% (n=18) reported that 50 - 75% of their work related to suicide (2010b, p. 5). This reinforces that mental health nurses perceive that they are regularly interacting with consumers for whom suicide is an issue. Over 90% of the nurses reported being aware of the National Suicide Prevention Strategy, and 60% reported being aware of the accompanying Living is for Everyone Framework (ACMHN 2010b, p. 8). Furthermore, nurses reported that collaboration with other health professionals helped provide holistic and multidisciplinary approaches to suicidal people (ACMHN 2010b, p. 9).

In the ACMHN survey, assessment and developing care plans were indicated to be the most common activities associated with nursing care of suicidal people (93%, n=53, of nursing respondents for both). While 'delivering psycho-social interventions' was also a popular response (84.2%, n=48, of nurse respondents). The survey findings also suggest that mental health nurses believed that a lack of access to services adequately staffed by appropriately qualified and skilled mental health professionals may be a significant obstacle to providing care to people at risk of suicide (ACMHN 2010b, p. 3). Furthermore, over 80% of the survey respondents felt that ongoing training in the area of suicidality would be beneficial. Additionally, some respondents felt that the care available might be inappropriate for suicidal people, or that services were difficult to access or were fragmented (ACMHN 2010b). The College thus specifically noted the need to use the latest evidence available for ongoing training and education for mental health professionals in suicide-related issues.

Literature drawing directly on nurses' accounts thus highlights that interpersonal therapeutic engagement is appreciated by nurses to be central to optimal care responses. However, it also reinforces that establishing and maintaining such relationships may be very challenging. This is indicated to be the case because to do so may not be prioritised by the nurse or by their service more broadly, and because the nurse may be unprepared and unsupported to therapeutically engage. As part of this under-realisation of 'best practice', nurses reported experiencing powerful and sometimes distressing emotions around caring for suicidal people, and if they did

interpersonally interact with the consumer they did not necessarily do so in a way that was therapeutic.

Research incorporating nurses' first-person experiences highlight the tensions between more medicalised, coercive, and interpersonally isolative approaches and approaches founded on holism, recovery and alliance. In this regard the potential for nurses to assist consumers during a suicidal crisis, particularly via a particular quality of engagement, is reinforced. However, considerable obstacles to achieving such 'best practice' are suggested to exist. While the literature drawing upon nurses' accounts is both more substantial and more critical than the literature drawing on consumer accounts alone, the need for more local, recent and broader research aimed at supporting nurses to provide better care, is reinforced.

### **2.2.3. Nurse and consumer perspectives of care in single studies**

The only studies identified which incorporate first-person accounts of both nurses and consumers in single studies are McLaughlin (1999), Fletcher (1999), and Sun et al. (2004). Bringing together nurse and consumer perspectives in single studies arguably does greater justice to the complexity of identifying the nature of service, and also how a model of care which more fully realises therapeutic engagement may be understood and promoted. However, the need for more local, recent and adequately critical research that draws upon both of these vital first-person perspectives is further reinforced.

Fletcher (1999) highlights the categories of 'controlling' and 'therapeutic' in relation to observation and care of suicidal consumers, noting that when observation was therapeutic it was accompanied by engagement (Fletcher 1999). In a more comprehensive study McLaughlin (1999) used observation and interviews with inpatient consumers who had been admitted with a serious risk of suicide (n=17) and mental health nurses (n=20). Findings highlight that potential for nursing care of the suicidal person lay in engagement and communication directly related to the person's psycho-social difficulties, as well as time spent together and problem solving (McLaughlin 1999, p. 1034). McLaughlin (1999) concludes that to realise the

potential to help through engagement, the nurses would have to prioritise time to spend with the person. Importantly, it is highlighted that the nurse would also have to be able to engage appropriately with the person within that time. Communication is identified as the most important factor by both groups but is noted to be compromised by the nurses' lack of knowledge and skill around building interpersonal relationships, as well as their avoidance of patients due to moral and emotional prejudices.

In McLaughlin (1999) consumers identified a lack of engagement – with less than half reporting having any contact with their nurse on a daily basis. Furthermore, just 35% of patients reported that conversations with nurses were actually about the patient's problems. Although there were reports that the nurses listened and showed compassion, and were more engaging than doctors, the level of engagement was suggested to be inadequate to fully meet consumers' needs. The study provides interesting integration of data from both nurse and consumer perspectives. However, there may have been a restrictive adherence to the interview schedule and much of the data has undergone 'quantification'.

More recently, Sun et al. (2004) conducted a study in Taiwan involving both mental health nurses (n=15) and service users (n=15). The research generated a theory regarding nursing care of suicidal inpatients, highlighting both the importance of the therapeutic relationship and also the notion of 'safe' care (Sun et al. 2004, p. 680). This model is thus noteworthy for its integration of engagement with other key actions such as assessment and protection (i.e. 'observation'). The research describes the experiences of service users and nurses and identifies strategies to enable holistic, engagement-based care including optimising the ward environment, enhancing self-awareness in clinicians, and providing opportunity for nurses to 'be with' patients.

Cutcliffe and Stevenson (2008a), in particular, critique Sun et al. (2004) as emphasising a more custodial-oriented model of care than may be appropriate. Cutcliffe and Stevenson (2008a) argue that there is a contradiction in the claim of

engagement *and* 'safe' ('observation'-based) care and describe the study as 'simplistic' (Cutcliffe et al. 2006, p. 801). Cowman (2007) also argues that there are limitations to the research of Sun et al. (2004). In addition to criticising the study in relation to the single sex sample of nurses, Cowman (2007) argues that the study reflects an 'over simplistic, minimalist and unsubstantiated approach taken, in portraying the role of the psychiatric nurse in very traditional terms' that may not be relevant internationally (2007, p. 806). Additionally, as with Cutcliffe et al.'s (2006) theory, Sun et al. (2004) focus on what is seen to 'work' rather than what is actually happening and in what context. In these regards the Sun et al. (2004) study is arguably limited by method, cultural differences and the lack of a critical focus. Thus, at the time of writing this thesis, there was a distinct lack of rigorous, recent and local research which combines consumer and nurse perspectives in a single study.

Research combining nurse and consumer accounts are valuable in that they arguably do greater justice to the complex nature of experiences of suicidality and related care. Although somewhat dated, McLaughlin (1999) is particularly relevant in highlighting an alarming lack of engagement, as well as the essential importance of both time for nurses and consumers to be together, and the ability to utilise that time in effective and appropriate engagement. While Sun et al. (2004) provides a limited perspective, the notion that engagement and observation-based (safe and compassionate) care may be combined, and not necessarily incongruent, is a valid and important point in the interests of a more 'integrated' model of care. The research combining nurse and consumer accounts is, then, particularly valuable in providing both perspectives of service experiences. However, it is reinforced that there is a lack of local, recent and adequately critical knowledge.

#### **2.2.4. Summary**

The available literature which utilises first-person accounts of consumers and nurses highlights that nurses have the potential to provide care for consumers at risk of suicide. In particular, it is reinforced that therapeutic engagement (encompassing holism, recovery and alliance) can be valuable in enabling suicidal consumers to be understood and helped during critical periods. Indeed, this evidence base which

draws upon the narrative accounts of the key stakeholders, indicates that interpersonal engagement between consumers and nurses has the potential to be therapeutic in and of itself and vital to the enabling of other interventions (such as observation). In this respect therapeutic engagement between consumers at risk of suicide and nurses is further highlighted to be a vital issue to consider towards a more 'integrated' evidence-based model of care.

The literature also reinforces that nurses may be struggling to achieve their potential and to meet consumers' needs. Indeed, the existing evidence consistently points to limitations and significant 'gaps' between the potential and reality of care, with this reflecting that the aspirations and potential of nurses may be seriously under-developed and under-realised. This is highlighted to be particularly evident from the consumer perspective. The under-realisation of potential is suggested to be attributable to a complex interplay of factors related to the nature of suicide itself, the attitudes, approaches, preparation and support of nurses, and to broader contextual factors, particularly within care settings, which may mediate the potential for nurses to therapeutically engage.

### **2.3. Conclusion and research questions**

It is evident that nurses can provide effective care for suicidal people (Lakeman & Fitzgerald 2008, p. 114. Samuelsson et al. 2000), particularly given the extent to which they enable service which is centred on therapeutic engagement (encompassing principles and practices of holism, recovery, and therapeutic alliance). However, the available literature also suggests that, within services dominated by medical and corporate imperatives, the development and realisation of such 'best practice' is not well supported (Cutcliffe & Stevenson 2008a).

The quality of therapeutic relationships between consumers at risk of suicide and nurses is seen to be particularly important in reflecting and shaping the potential for quality care. The existing evidence base concerning mental health nursing care of



suicidal mental health care consumers does provide valuable foundational understandings. It is notable that much of the specific available evidence draws upon first-person 'subjective experiences' (Lakeman & Fitzgerald 2008, p. 114). However, the evidence base needs to be re-visited, extended, and contextualised to present circumstances. While in the literature specific to mental health nursing care of suicidal people the first-person accounts of suicidal people and / or nurses are present, these accounts are not adequately integrated in a way which provides the required understanding of intrapersonal, interpersonal, and contextual and structural factors. In short the breadth, depth, translational potential, and local and recent occurrence of evidence incorporating first-person accounts, is limited to such an extent that practice (and reform) is arguably insufficiently underpinned by evidence.

It is thus reinforced that an adequate evidence base for suicide has not been established, generally (Mishara 2008, p. 1), and in the contexts of mental health care (Cutcliffe 2003) and mental health nursing care specifically (Cutcliffe & Stevenson 2008a, p. 341). The existing evidence base clearly needs to be extended with more recent, local, and adequately critical knowledge which combines the perspectives of nurses and consumers, and which is thus able to support reform and change. It is apparent that consideration of the intrapersonal and interpersonal dimensions of care in this context is of particular relevance. In response to these needs, I reaffirm the research questions which have formed the basis of this thesis:

1. *What are the experiences and needs mental health service-users have around suicidal crisis and to what degree are these needs met?*
2. *What role(s) do mental health nurses play in this context, particularly in regard to their interpersonal interactions with service-users?*
3. *What are the contextual factors which likely impact the quality of care experienced?*
4. *What implications does this knowledge have for the practice, preparation, support and development of nurses?*

Highlighting that current models of care may be limited, and that suicide and suicidal people may be inadequately engaged with, this chapter has culminated in a specific set of questions intended to explore the status quo in a time of reform and possibilities. The questions are aimed at identifying and better understanding consumers' and nurses' experiences of mental health care, consumer suicidal crisis and, in this context, highlighting the needs of consumers and nurses, the extent to which needs were met, the nature and role of therapeutic engagement, and the mediating and contextual factors at play. The questions are thus directed towards exposing the issue of nursing care of suicidal mental health care consumers, giving 'voice' to the people most intimately involved in that context and, ultimately, informing and positively impacting mental health care and suicide prevention reforms. It is highlighted that a particular focus on intrapersonal, interpersonal and contextual dimensions of care is central to this endeavour.

# **Chapter 3 – A methodology of interpretive inquiry in suicidology and mental health care**

This chapter discusses the methodological foundations supporting the exploration of mental health nursing care of patients at risk of suicide. It is highlighted that, in both clinical and research contexts, redressing over-reliance on positivistic ('reductive') approaches is important towards more fully understanding and responding to suicide and suicidal people. To this end, I outline an interpretive methodology which embraces narrative and critical elements of inquiry. This reinforces and further explains the particular relevance of approaches which integrate multiple first-person accounts and meaningful contextual data. It is noted that, at the heart of such a methodology, are particular clinical and research relationships which allow intrapersonal and interpersonal experiences to be revealed and potentially positively affected, within a broader (holistic/integrated) context. The methodology thus exemplifies and explicates how nursing, mental health care, and suicidology, may move beyond the limitations imposed by narrow 'regimes of truth' (Denzin & Lincoln 2005, p. xi), 'divisive dualistic perspectives' and 'unstructured pluralistic world views' (Stajduhar et al. 2001, p.79), which can result from over-reliance on positivistic inquiry.

## **3.1. Positivistic inquiry and suicide**

This section discusses how the dominance of positivist and post-positivist approaches to inquiry concerning suicide reflect the current service limitations. It is noted that, just as elements of more medicalised, objectifying and coercive

approaches to care of people at risk of suicide (such as observation, psychiatric diagnosis and pharmacological intervention) may have potential value within a broader holistic model of care, positivistic research approaches may be an important element in the study of suicide. It is highlighted, however, that an over-reliance on positivistic approaches may fail to adequately understand individuals and may promote a problematic reductionism, objectification and alienation. Thus it is reinforced that overreliance on positivistic approaches, in both clinical and research contexts, has limitations which must be overcome if the potential to understand and help people at risk of suicide is to be more fully realised.

### **3.1.1. Positivistic bias and the 'dead-end' of knowing**

Suicidology is both a theoretical and practical endeavour (Fitzpatrick 2011, p.34) as it typically seeks to understand and explain suicide, as well as limit its occurrence and burden (Webb 2003). This conceptualisation reflects the notion that adequate understanding may be a prerequisite to effective action (Shneidman 1996a, p.7). Since the 1960s, when Shneidman first coined the term 'suicidology' and the contemporary project to 'nibble at the puzzle of human self-destruction' began as a discipline in its own right (Shneidman 1993, p.147), there has been a proliferation of suicidological research. This has coincided with a 60% rise in the global suicide rate (WHO 2009). Despite the increase in the volume of research, it is still not clearly understood why people kill themselves (Lester 2010, p. 76) and responses to suicidal behaviours and current standards of care arguably remain ineffective (Linehan 2011, p. xii). While, no doubt, there are significant inherent challenges in these contexts, it is argued that current understandings and modes of inquiry in suicidology are inadequate (Samuelsson et al. 2000; Rogers 2001; Webb 2005; Cutcliffe & Stevenson 2007; Hjelmeland & Knizek 2010; Marsh 2010).

A key limitation in inquiry around suicide may be an overreliance on positivistic research approaches. Hjelmeland and Knizek (2010) note that 97% of studies published in the three main international suicidological journals from 2005-2007 use solely quantitative methods. This suggests that in suicidology, epidemiological, (neuro)biological, and randomised-control trial (RCT) research dominates. This, in

turn, infers that research outputs are predominantly underpinned by the positivist or post-positivist paradigm. Such a methodological focus can be seen to reflect and shape how suicide and suicidal people can be understood and responded to in limited ways.

Silverman (1997) and Lakeman (2010) are amongst those who point out that quantitative studies are largely concerned with establishing causal and linear relationships between suicide and psycho-pathology, and identifying predisposing biological and psychological factors, and patterns at the population level (see as examples: Hakansson et al. 2010; Verwey et al. 2010). Such data can be very useful in suicide prevention (Goldney 2005), particularly in regards to the identification of risk and protective factors and interventions that may have relevance across populations. However, limitations arise from the inability of positivistic research to access and incorporate intrapersonal, interpersonal, and contextual meanings of suicide (Hjelmeland & Knizek 2010; Lester 2010; Rogers & Lester 2010; Rogers & Apel 2010) – knowledge which is crucial to understanding and promoting optimal therapeutic responses.

It could be argued that positivistic suicidology has thus far achieved a limited understanding of individuals who would be understood and helped. Epidemiological studies, for example, may indicate risk factors but they fail to reveal how those risk factors are mediated by individual, cultural and other contextual concerns (Hjelmeland & Knizek 2010). Similarly, neuro-biological studies may establish a genetic predisposition for suicide or a link between psychiatric disorders and suicide, but they fail to reveal how such links function in individual and contextually specific instances (Hjelmeland & Knizek 2010). Additionally, as noted, studies that establish an association between suicide prevention and various pharmacotherapies (Isacsson & Rich 2005; Mann et al. 2005; Meltzer 1996; Potkin et al. 2003) cannot rule out the possibility that there are other variables such as the experience of interpersonal engagement with the care provider (Goldney 2005, p. 134) which should be considered. This leads several commentators to argue that from a strict application of randomised control trial (RCT) standards, it is difficult, if not impossible, to

establish that any interventions are actually effective in preventing suicide (Lakeman 2010a; De Leo 2005; De Leo & Svetlicic 2010). Thus it is proposed that a positivistic suicidology, pursuing as it does linear and causal explanations of suicide, hits a 'dead-end' of knowing (Hjelmeland & Knizek 2010, p. 74).

The evidence base that suicidology can establish may be further restricted by practical and ethical limitations common to positivistic inquiry around suicide. For example, achieving adequate sample sizes in relation to the relatively rare event of completed suicide (Goldney 2005, p. 129), and the significant ethical challenges of recruitment and experimental control (Lakeman & Fitzgerald 2009; SPA in Australian Senate 2010, p. 122), can narrow the research agenda to such an extent that researchers may avoid certain issues and actually exclude from research the people most representative of those at greatest risk (Lakeman 2007).

Positivistic approaches may also present serious limitations in that they can construct and affect people in potentially problematic ways. In particular, positivistic inquiry – in both psychiatry and in the human social sciences – may infer a 'gaze that objectifies and examines' (Habermas 1987, p. 245a). Such a 'gaze' may take what is observed to be what is experienced (Rossouw 2009, p. 26), veiling human phenomena in how it appears (Heidegger 1962) and rejecting a dialogical relationship between the knower and the would-be-known. Positivistically-oriented approaches are thus criticised for transforming subjects into objects – and 'only objects' (Habermas 1987a, p. 246) – and potentially reinforcing a thesis of aloneness (Descartes 1644), and diminishing the value of a holistic perspective at the centre of which are important intrapersonal and interpersonal experiences. In this way positivistic inquiry may both fail to understand as well as potentially distance already vulnerable people (Frank 1992), thereby reinforcing the limitations of understanding, denying the contextual specificity of experience, and (further) alienating people at heightened risk of suicide (Marsh 2010).

In the clinical context, Habermas (1987a, p. 246) argues that the clinician who takes a narrow medical-psychiatric approach does indeed become a 'practicing positivist'.

Such an approach has the potential to render the person of interest an object of 'supervision, manipulation, isolation...regulation, and... medical research' (Habermas 1987a, p. 246). Such objectification is exemplified in the practice of formal observation, or in the standard mental state exam, which is largely 'an inspection of the patient from an outside perspective' (Maltzberger 2011, p. 31). Lakeman (2010b) labels such objectification 'epistemic injustice', noting that it problematically minimises or ignores the intrapersonal dimension. Thus, in parallel to suicidology, positivistically oriented practice in this context may generate incomplete knowledge and produce experiences of nursing care which are limited, disempowering and alienating (Cutcliffe & Stevenson 2008a; Dodds & Bowles 2001; Barker 2001). These limited methodological approaches may lead to diminished construction of, and relationship with, the person who would be understood and helped in the clinical context, potentially precluding 'therapeutic engagement'.

Suicidology and clinical practice may be overly reliant on positivistic approaches as part of a misguided search for legitimacy. It is argued that suicidology, specifically, lags behind other areas of the human and social sciences as it has acquiesced to the fear of becoming 'unscientific' if it does not reinforce, as its foundation, a positivistic methodology (Fitzpatrick 2011). Edwards (2003:60) discusses this in relation to the issue of suffering. It is appreciated that intrapersonal experiences of suffering are often central to suicidality (Shneidman 1996a). However, because understanding 'suffering' does not lend itself to positivistic inquiry, attempting to understand suicide via the concept of suffering may be seen to jeopardise the 'scientific' status of suicidology. For Fitzpatrick (2011, p. 33) a required focus on the 'subjective and personal dimensions' of suicide (including suffering) have thereby become casualties of a suicidology that insists on attempting to measure and observe in line with positivistic traditions.

The search for legitimacy via the positivistic paradigm which leads to avoidance of dimensions of suicide including intrapersonal experiences such as suffering, can also be seen as an attempt to protect one's emotional and philosophical 'security'. This may entail holding the person and issues such as suffering (Habermas speaks

specifically of 'madness') at arm's length in an effort to safely 'gain mastery of it as an object cleansed of rational subjectivity' (Habermas 1987a, p. 239). Such an objectifying approach is perhaps understandable in response to clinical care contexts which can be deeply confronting (Talseth & Gilje 2011), 'frightening, bewildering' and 'anxiety provoking' experiences (Warne & McAndrew 2008 in Warne & McAndrew 2009, p. 856), particularly as they involve the clinician 'stepping' closer to patient suffering. This reflects that positivistic thinking may represent a yearning for ontological security towards maintenance of emotional homeostasis and sense of self (Laing 1960).

### **3.1.2. Summary**

It is appreciated that positivistic approaches may underpin useful clinical and research practices. However, the 'positivist science of man [sic]' (Habermas, 1987a, p. 246) is insupportable (Denzin & Lincoln 2008, p. 7) in that human knowledge is actually socially constructed, value-laden and contextually specific (Kincheloe 2001, p. 681). Thus it is appreciated that methodology appropriate to understanding natural objects and processes is not appropriate to the study of human experience (Palmer 1969). In theory, the positivistic notion of an objective 'God's-eye view of the world' (Denzin 2007, p. 455) – and of suicide and suicidal people – has been superseded by broader (interpretive and/or mixed methods) approaches which aim to embrace multiple personal and interpersonal meaning and contextuality. Post-positivist approaches may acknowledge some of these factors, but they still work to minimise the very relational, contextual and subjective factors and processes that provide a deeper and more useful understanding (Clandinin & Rosiek 2007).

Positivistic inquiry has a place in suicidology and mental health care. However, it is untenable that it should dominate these fields to the degree that it does. However, it would seem that suicidology has 'bunkered down' in a positivistic stance in an attempt to establish or preserve its legitimacy. Related to this may be an attempt to maintain emotional and philosophical 'security', particularly in the face of potentially confronting and confounding issues such as suffering. This can be seen to have clear



parallels to clinical practice where, as noted, clinicians may avoid or be unable to realise meaningful engagement with suicidal people.

Giving up the 'security' that positivistic approaches 'promise' may seem antithetical, especially amidst the pervasive rhetoric of the need for 'scientific' claims to inform practice (Warne & McAndrew 2009, p. 856). It must be seen as highly problematic, however, that for positivistic inquiry to achieve this 'stability' (Clandinin & Rosiek 2007, p. 44) and 'security', 'large regions of human experience' – including intrapersonal and interpersonal meaning and other contextual dimensions – may be minimised or excluded from inquiry (Clandinin & Rosiek 2007, p. 44). The unacceptable irony in this is that, in a quest for legitimacy and 'security', over-reliance on positivistic suicidology undermines the potential to optimally understand, and respond to, suicide and suicidal people. In this sense, a positivistic methodology is a dangerous illusion: it employs an untenable philosophical reasoning, it reduces people to objects rendering them alone and 'unknowable', and it ignores or minimises the valuable intrapersonal, interpersonal and contextual knowledge which may be gained by embracing a less 'secure' interpretive and relational methodology.

### **3.2. Considering 'mixed methods' towards integration of positivistic and interpretive approaches**

This section discusses the potential for the 'mixed methods' research tradition to enable a more appropriate, 'less secure', and 'integrated' methodological position in research and clinical contexts. In the present multi-methods study I have combined both survey ('general' and largely quantitative) and interview ('particular' and qualitative) data in order to establish fuller understanding. Methodologically, a mixed methods approach could have been utilised to integrate these diverse approaches. Indeed that was where my 'methodological thinking' originally lay. However, after initially considering mixed methods I came to embrace an interpretive multi methodological position in order to generate and integrate the

data sets. Nevertheless, important understandings can be gained by considering mixed methods.

### **3.2.1. The potential of mixed methods inquiry**

Rogers and Apel (2010, p. 94) argue that embracing methodological diversity is an important step in revitalising suicidology, and is preferable to merely shifting the current quantitative / (post)positivist bias towards qualitative / interpretive approaches. Robinson et al. (2008), Niner et al. (2009) and Goldney (2002, p. 70) also agree that considering the nexus between qualitative and quantitative methods may be vital in relation to suicide and its prevention in Australia. Furthermore, suicidology does have a contemporary (e.g. Wong et al. 2011; Walls 2007) and historical (e.g. Durkheim 1951 [1897]) tradition of combining qualitative and quantitative data. Thus, for some (Rogers and Apel 2010, p. 94; Kral et al. 2012), mixed methods research may provide the methodological basis necessary to progress suicidology by exploiting the qualitative and quantitative 'nexus'.

There is a parallel assertion that the mixing of different methods of inquiry and data-types in clinical practice may help evolve care beyond some of the limitations noted. It has been argued, for example, that because nursing may be considered both 'art' and 'science' it may be 'an ideal context for the use of mixed methods approaches' (Carr 2008, p. 25). This position is based on the belief that mixed methods may enable a combination of both general and particular data, and may do justice to explaining the complexity of human behaviour and relationships. In this sense mixed methods inquiry may represent a framework for moving beyond reductive, objectifying modes of inquiry.

### **3.2.2. The limitations of mixed methods inquiry**

Employing mixed methods approaches in domains such as suicidology and nursing may be of value. Upon closer examination, however, there are potential limitations. Limitations arise not in respect to the broad notion of 'mixing' different methods and data, but rather in the ways the mixed method tradition may be understood and applied to these ends. Particularly problematic in mixed methods are issues of

paradigmatic incompatibility (Denzin 1997), the possible promotion of a (post)positivist agenda (Giddings 2007), and the potential to constrain research within the 'walls' of a new tradition in what might otherwise be a more liberated post-paradigmatic era (Bergman 2008, p. 13; Kincheloe 2001).

The notion of paradigmatic incompatibility relates to the association of qualitative research methods (e.g. interview) with constructivism / interpretivism and quantitative research methods (e.g. survey) with positivism / post-positivism (Bergman 2008, p. 11). In the positivist / post-positivist tradition reality is 'out there', objective, and knowable in so much as possibly flawed human apprehension of it allows. Alternatively, in the constructivist / interpretive paradigm knowledge is very much seen as a product of human consciousness. Usually (but not always) mixed methods embraces the notion that different paradigms can be combined to explore that which is 'both socially constructed and yet real' (Hacking 1999, p. 119) – both 'subjective' and 'objective', or 'particular' and 'general'. Thus it may be argued that mixed methods presents a satisfactory solution to incompatibility (Birembaum-Carmeli et al. 2008, p. 435).

However, others argue strongly that it is not possible to reconcile multiple paradigms because 'qualitative' and 'quantitative' represent distinct, mutually exclusive worldviews (Denzin 1997) in which 'one precludes the other just as surely as belief in a round world precludes belief in a flat one' (Guba 1987, p. 31). Additionally, it is argued that one paradigm may guide mixed methods (e.g. critical realism or pragmatism), or that, regardless of potential paradigmatic incompatibility, methods may be combined at the 'technique level' (Sandelowski 2000, p. 248). Clearly, a diversity of positions regarding paradigmatic compatibility exist (for further explication see Teddlie & Tashakkori 2010, p. 13-15; Creswell & Plano-Clark 2007, p. 26-27; Greene & Caracelli 2003, p. 96-103) and the legitimacy of combining qualitative and quantitative approaches aligned with different paradigms is the subject of ongoing debate (Tashakkori & Creswell 2007; Teddlie & Tashakkori 2010).

While the mixed methods tradition does not *always* assert the need to mix paradigms (Symonds & Gorard 2008, p. 6; Haase & Myers 1988; Sale et al. 2002, p. 46; Bergman 2008, p. 13) its tendency to do so may be problematic as it, paradoxically, reinforces a false dichotomisation. Such paradigmatic dichotomisation is argued to be 'misleading' and seriously limiting in relation to suicidology (Fitzpatrick 2011, p. 29), and this may also be the case in broader clinical contexts which seek to move beyond unhelpful dichotomies (which, as noted, may assert that medical and social psychiatry, mental health and psychiatric nursing, or observation and engagement, are incompatible with each other). More broadly, it is noted that in a post-paradigmatic research landscape, the 'either-or' distinction may hamper research which seeks to combine different data types (Bergman 2008, p. 13). Rather than freeing research from the restrictions of paradigms, dichotomisation may actually obscure a more fundamental reintegration and may strip from researchers power to design their own studies to best meet research needs (Symonds & Gorard 2008, p. 15). Therefore, in the present study the interpretive tradition was favoured over mixed methods in order to limit the view that interview and survey methods *inherently* rest upon different (and potentially incompatible) paradigmatic (methodological) foundations. Furthermore, this may be seen to have important parallels in the clinical context, particularly in respect to the fuller integration of diverse approaches to care.

Another related factor rendering mixed methods less attractive is that when multiple paradigms are assumed to be present there may be a tendency to presume 'a methodological hierarchy' which prioritises the (post)positivist paradigm over the interpretive (Denzin & Lincoln 2005, p. 9). In suicidology, for example, it is argued that often 'mixed methods' is merely a quantitative study of qualitative data that reinforces positivistic concepts of validity and generalisability (Fitzpatrick 2011). This claim reflects the broader concern that the mixed methods movement may conceal the 'continued hegemony of positivism' (Birenbaum-Carmeli et al. 2008, p. 436; Giddings 2007). In this regard it is argued that by being guided by the mixed methods tradition one may be responding to the 'disciplinary implosion' with a reductionist notion of 'the proper interdisciplinary research method' (Kincheloe 2001, p. 685).

Again, this may be seen to have parallels in clinical contexts, which arguably involve the dominance of medicalised approaches over other alternate or complementary approaches. Thus it is appreciated that, for some, mixed methods presents a satisfactory solution to paradigmatic incompatibility (Morgan 2007 in Birembaum-Carmeli et al. 2008, p. 435). For others, including myself however, mixed methods represents a limiting 'truce' (Bergman 2008) and something of a 'Trojan horse' for positivism (Giddings 2007).

### **3.2.3. Summary**

The mixed methods research tradition is useful in that it promotes the importance of combining different methods, 'perspectives' and data types in single projects. However, issues of methodological incompatibility and competition render it currently a somewhat problematic tradition. While combining methods can clearly be valuable and necessary for understanding complex human phenomena (Sale et al. 2002, p. 46), preoccupation with paradigmatic incompatibility may not be resolvable at present. Indeed the question of incompatibility may be based on false premises and stand in the way of getting research 'done' (Sale et al. 2002, p. 46). Furthermore, given the positivistic bias in relation to suicidology (and arguably nursing and mental health care more broadly), there is good cause to consider how multiple methods can be combined within an interpretive framework, rather than using mixed methods which may reinforce a positivistic bias.

### **3.3. An interpretive suicidology**

Positivistic bias infers limitations in both clinical and research contexts, and there may also be limitations in mixed methods approaches. As such, it may be argued that there is a particular need to promote more interpretive (qualitative) approaches which incorporate intrapersonal, interpersonal and contextualised understandings of suicide (Hjelmeland & Knizek 2010). Interpretive methodology can provide a legitimate basis for multi method research (Denzin & Lincoln 2005, p. 5), and in the

present study, both the survey and interview data are considered to provide interpretive 'perspectives' in both narrative and numerical form.

In contrast to a positivistic paradigm, the interpretive paradigm does not attempt to capture an objective reality. It understands that human action is *motivated* rather than *caused* (Biesta 2010, p. 103), and it embraces relational, contextual and subjective factors and processes to construct deeper and more useful understandings than the positivist paradigm can provide (Clandinin & Rosiek 2007). Therefore, interpretive methodology may be seen as particularly suited to underpinning exploration of the topic at hand. This is reinforced as there is seen to exist a synchronicity between nursing and interpretive research methodology, particularly in relation to mental health nursing (Cutcliffe 2000). It would appear that a single and definite interpretive tradition has not been established in this respect, although Donaldson (1995, p. 6-13) points to the potential relevance of traditions including Heideggerian phenomenology, scientific realism, pragmatism, hermeneutics, and critical theory.

Within the multi-method interpretive methodology underpinning this study, the traditions of narrative and critical research are relevant. It is also noted that actively pursuing underlying issues such as ethics, representation and language are important to such a methodology (Fitzpatrick 2011). Explication of these points further reinforces that, central to inquiry, should be a particular quality of relationship between the inquirer and the person who would be understood (and helped).

### **3.3.1. Narrative inquiry and suicide**

Amongst the range of interpretive methodologies that may be suitable to both nursing and the study of suicide, narrative research can be seen as particularly relevant (Michel 2011, p. 21-22; Barker 2001; Michel & Jobes 2011). The value of narrative inquiry is essentially that, as the 'medium of the self' (McIntyre 1981), narratives are able to convey the meaning and significance of experience, going beyond mere observation (Clandinin & Rosiek 2007, p. 45) to reveal the

intrapersonal, interpersonal and contextual dimensions of suicidality and related care. Furthermore, there may be positive experiences generated in the sharing and construction of narrative knowledge. This has led Barker (2001, p. 236), for example, to argue that caring 'begins and ends' in narrative construction, and for other authors to call for greater incorporation of patient narratives in mental health care and related research contexts (Gale et al. 2003; Kirkpatrick 2008).

It is thus proposed that narrative research can help develop clinical and research efforts, both as it may enable fuller understanding to be constructed, and as it may also constitute and drive positive action. In this regard, narratives are not just retrospective representations; they are also present and ongoing representations (Clandinin & Rosiek 2007, p. 44). Narrative is, then:

*simultaneously a description of, and intervention into, human experience; it acknowledges that descriptions add meaning to experience, thus changing the content and quality of the experience (Clandinin & Rosiek 2007, p. 44).*

Furthermore, narrative inquiry confirms that what is being studied is not a thing separate from and disconnected from the inquirer, but rather that both are connected and affected in coming together around inquiry. Thus, narrative approaches may enable understanding of an individual's experience of suicide (Lester 2010, p. 77) and possibly affect and define new experiences and narratives.

Overall, narrative inquiry around suicide has been minimal (Maltsberger 2011, p. 38). There is, however, a small and growing literature base concerned with narratives of suicide. Notably, much of the existing mental health nursing literature concerned specifically with care of suicidal people (discussed in the previous chapter) is part of that base. Narrative inquiry around suicide is essentially concerned with intra- and interpersonal *understandings* rather than linear or causal *explanations* of suicide. Such understandings are argued to be crucial to moving suicidology forward (Hjelmeland & Knizek 2010:74). In addition to the research based on nurse and consumer accounts discussed above, the emerging interpretive, narrative evidence

base includes accounts from those who experience(d) suicidality themselves (Webb 2005), those who care(d) for such people (Carlen & Bengtsson 2007), and those bereaved or otherwise affected by suicide (Samuelsson et al. 2000; Cutcliffe & Stevenson 2007; Begley & Quayle 2007). Support for research incorporating such narratives is widespread, coming from suicidologists/researchers (Maris et al. 2000b; Leenaars 1999; Shneidman 2001; Maris 1997; Cutcliffe et al 2006; Cutcliffe 2003; 2005a; Goldney 2002; Lakeman & Fitzgerald 2008; Berman 2011; Warne & McAndrew 2007; Gilje et al. 2005; 2011), suicide prevention peak bodies (Suicide Prevention Australia 2010), media (Killick 2009), mental health care representative bodies (Anglicare 2009), service providers (DHHS 2009), as well as from people with lived experience of suicide (Webb 2005; Walen 2002). Thus it is appreciated that first person narrative accounts are crucial to research, policy, and service responses around suicide (SPA 2008b).

The idea that narrative data may be of importance to understanding and responding to suicide is not new. In *Suicide* Durkheim (1951 [1897]), for example, infers that subjective narrative understandings may have value:

*Each victim of suicide gives his act a personal stamp which expresses his temperament, the special conditions in which he is involved, and which, consequently, cannot be explained by the social and general causes of the phenomenon (Durkheim 1951 [1897], p. 277-278).*

In *The Social Meanings of Suicide* Douglas (1967) also embraces (rather more comprehensively) the effective utilisation of narrative understandings in the study of suicide. Douglas (1967) specifically recognises the importance of exploring personal meanings of suicide using the statements and behaviours of individuals experiencing suicidality. Shneidman (1997, p. 24) also strongly embraces the importance of first-person narratives, noting that:

*Our best route to understanding suicide is not through the study of the structure of the brain, or the study of the social statistics, or the study of*



*mental diseases, but directly through the study of human emotions described in plain English, in the words of the suicidal person (Shneidman 1997, p. 24).*

Similarly, Maltzberger (2011) notes that narrative accounts may have the potential to not only represent, but also positively affect, experiences of suicidality, in that:

*The kind of grasp of a patient's inner experience that fictional or biographical writing permits is highly desirable... In telling about their experience the patient not only helps us better understand them, they may come to learn about themselves also (Maltzberger 2011, p. 32-34).*

Compellingly, calls for research incorporating first-person narratives of suicidality are also made by people who have experienced being suicidal. In his phenomenological PhD thesis of his own suicidality Webb (2005), for example, argues that first-hand narratives are important because:

*The evidence base that suicidology draws on is incomplete and inadequate, and its understanding of suicidality is correspondingly flawed, largely through its determined failure to appreciate and comprehend adequately what suicidality means to those who live it (Webb 2005:5).*

In arguing that adherence to the narrow medical (positivistic) criteria for what constitutes 'valid evidence' limits efforts to understand and help, Webb supports expanding the methodological horizon for what is 'valid' (credible / trustworthy) evidence. For him, first-person narratives are legitimate evidence and the key to effective understanding and response (Webb 2009).

Using diary accounts of her suicidality, Walen (2002) reflects on care around suicidal crisis, and highlights the parallels between research and practice methodologies. In doing so, Walen (2002) urges clinicians to enable people in their care to express themselves and to talk about their feelings and experiences in an effort to ease isolation and enable recovery. Thus, it is evident that narrative inquiry is vital to

gaining access to the first-person accounts essential to extending the evidence base in the contexts at hand.

### **3.3.2. Combining consumer and nurse narratives**

Inquiry may further benefit by combining multiple narrative perspectives. This reflects that there is no single truth in the interpretive paradigm (Rorty 1991), and that the construction of knowledge may best be considered a negotiated, communicative process (Denzin & Lincoln 2005, p. 204). It also acknowledges that multiple truths typically exist in relation to suicidality – truths which are genuine for the individual and cannot be refuted by others (Hjelmeland & Knizek 2010). Combining multiple accounts also acknowledges that, regarding therapeutic alliance for example, there can be misjudgement by therapists regarding the quality of the alliance (Horvath & Lubrinsky 1993). Importantly, it has been found that the patient's own assessment of the alliance tends to be more predictive of outcomes than the therapists' ratings (Horvath & Symonds 1991). Thus, considering multiple narrative perspectives provides the opportunity to consider the 'constructedness' of suicide (Fitzpatrick 2011, p. 34) and related clinical care, and to combine perspectives rather than prioritise one over another. Such an approach may result in useful complementary or contradictory perspectives which provide richer and more relevant data, and it also reinforces the importance of collaboration in the contexts at hand.

Of particular value in combining multiple narrative accounts may be the redressing of power imbalances which, the relationship between nurses and mental health care consumers is subject to. Marsh (2010), for example, argues that expertise in clinical contexts regarding suicide is effectively owned by professionals – particularly psychiatrists, but also nurses, psychologists, social workers, and occupational therapists. For Marsh (2010, p. 65), the owning of expertise within a 'medically delineated, and to a large extent, controlled space' (which as I have argued may have a positivistic methodological bias) maintains suicide as something pathological in nature and reinforces objectification of suicide and suicidal people. Hence Marsh (2010) is a strong advocate for the inclusion of consumer narratives in research and

practice, and is cautious of professional (in particular medicalised) accounts. Incorporating nursing narratives with those of consumers must, therefore, be undertaken with caution in order that the consumer perspective is not marginalised by the professional perspective.

Historically, nurses have been conspicuously silent in articulating their experiences of practice (Morley 2004; Gournay 1995). Thus mental health nurses continue to face being 'defined and directed by others who might have very different agendas' (Barker & Buchanan-Barker 2011:3). As discussed, mental health nurses aspire to move beyond the dominance of a reductive medical-psychiatric perspective (Barker & Buchanan-Barker 2011). It is evident that nurses can be open to embracing interpretive approaches towards achieving this (Omery et al 1995, p. 9). Arguably then, expertise may tend to be 'understood from traditional and dominant discourses', including that of medicine (Hardy et al. 2002). If, however, mental health nurses can move beyond what Barker and Buchanan-Barker (2011) see as a victim mentality and complicity regarding current dominant models of care, and assert their humanistic 'voice', they may contribute positively to challenging the reductive status quo (Marsh 2010, p. 65). In this way, as Talseth and Gilje (2011, p. 1) argue, exploring the experiences, knowledge, attitudes, roles, and needs of mental health nurses may contribute to improving care of suicidal consumers.

It is thus asserted that, in both research and clinical contexts, narrative-based inquiry is of central importance. Narrative accounts may be considered essential to more fully revealing, and to also potentially positively affecting, intrapersonal, interpersonal and other contextual dimensions of suicidality and related care. Furthermore, there may be particular value in the integration of professional knowledge 'with the intimate knowing of the suicidal individual whose words we hear and whose face, body, and posture we see' (Linehan 2011, p. xi). Frank (1992) argues that the discourse of medicine may contrast with approaches that embrace first-person illness narratives. In this sense narrative inquiry is a form of interpretive inquiry that may help redress reductive bias, and potentially help integrate multiple forms of data. In a suicidology free from the illusion of objectivist science, narrative

research may, then, be a means for ‘rendering human subjects in all of their richness and complexity’ (Fitzpatrick 2011, p. 34-35).

### **3.3.3. The role of critical intent in contextualising narrative accounts**

Narratives are both enabled and constrained by a range of contextual factors (Chase 2005, p. 65), they may be constructed collaboratively, and they are ‘always a view from somewhere’ (Fitzpatrick 2011, p. 35). Therefore, there is a need to give consideration to the wider forces which act on narratives, and there is a need to consider issues of interpretation and representation, as well as the ethics, language and relationships, that guide the construction and interpretation of narrative data. Principles drawn from the critical research tradition – enabling what I refer to in this study as ‘critical intent’ – may help support these imperatives.

Where narrative theory prioritises intrapersonal and interpersonal experiences as the most important source of knowledge, critical research theory explicitly draws attention to the role that broader contextual factors (including language, history, gender, class, and institutions) have in informing and shaping ‘reality’ (Holstein & Gubrium 2005, p. 484). In this way, critical approaches seek to expose, explore, and challenge, constituting elements and power relationships (Kincheloe & McLaren 2005, p. 303).

For critical researchers, a focus solely on narrative experiences may appear limited. Because, as noted, narrative accounts are clearly valuable in the present context, the need to integrate narrative and critical approaches is suggested. The present study embraces the notion that critical and narrative researchers share an interest in analysing and affecting the experiences of people, particularly within institutions (Clandinin & Rosiek 2007, p. 47). For example, similarly to the notion that narrative inquiry may both reveal and affect experiences, critical research aims to critique and change, rather than just describe or explain (Thomas 2009, p. 55). As well as reinforcing such important aims, my interpretation of critical intent infers the necessity of exposing and exploring the contextual factors which may affect experiences of suicidality and related mental health nursing care.

### **3.3.4. Research relationships**

In addition to embracing principles of narrative and critical inquiry, addressing issues of ethics, language and representation are considered important towards an interpretive methodology of suicide (Fitzpatrick 2011). Research relationships may be particularly central to addressing these issues in that the essence of narrative research is the endeavour to construct meaning within 'a deeply human, genuine, empathetic, and respectful relationship' with participants (Josselson 2007, p. 539). This highlights further that:

*knowing other people and their interactions is always a relational process that ultimately involves caring for, curiosity, interest, passion, and change (Pinnegar & Daynes 2007, p. 29).*

The correspondence between interpretive research and clinical practice (Miller & Crabtree 2005, p. 619), particularly in respect to interview (Bulpitt & Martin 2010), is central to this study. For example, drawing upon my experience as a mental health nurse, I employed the principles of therapeutic interpersonal engagement – i.e. genuineness, respect, empathy and unconditional positive regard (Rogers 1961) – when conducting the research interviews (these processes are described in detail in Chapter 4). Reflecting elements of 'nursedness' noted by Leslie and McAllister (2002), I also gave the participants 'permission' and opportunity to talk about the taboo, I promoted clarification and reflection on the past, I worked to create a positive and potentially empowering experience, and I generally capitalised on the ethics and honesty that are valued as part of the nursing identity in order to enable people to share their stories. It is believed that such an approach to research relationships fosters trust and rapport and enhances the degree of openness and self-disclosure with which the participant is comfortable, thus rendering the material more trustworthy (Josselson 2007, p. 539).

While such an approach to research relationships holds the potential for generating quality data, having a concurrent identity as nurse and researcher raises some

important ethical considerations. For example, it is important that the relationships which enable data collection or 'story telling' to occur are not confused with clinical relationships, but still provide an overall positive experience for the participant. It is argued that there is no need for the research interview to slip into 'therapy' because the aims of research and therapy are distinctly different (Leslie & McAllister 2002): therapy aims to affect change in the participant, while research aims to affect change in the interviewer by raising understanding of the context of interest (Josselson 2007, p. 546). However, there is clearly the potential for both parties to be affected in this process.

In the present study, it was made explicit that the interview was not intended as therapy. Nevertheless, the anticipation of some emotional impost necessitated the incorporation of basic therapeutic principles and safeguards into the interview, including the provision of counselling and referral should that be required. Thus, research and clinical interactions are different insofar as they are guided by different expectations and the ends 'remain distinct' (Leslie & McAllister 2002, p. 12). Furthermore, it is argued that people often find that the experience of narrating 'a significant life event' can facilitate 'positive change' (Chase 2005, p. 79). Nevertheless, within this context the goals of therapy are important considerations in research interactions, especially when those interactions involve sensitive and potentially confronting issues such as mental health care and suicide. As with clinical care of suicidal people, narrative inquiry must, then, be guided by a particular empathic and 'therapeutic' relationship, as the relational process may affect change in the people involved.

### **3.3.5. Representation and 'voice'**

Issues of representation are also important to consider in an appropriate interpretive methodology of suicide (Fitzpatrick 2011). Representation is far from straightforward because, as noted, there is no objective 'God's-eye view of the world' (Denzin 2007, p. 455) and there cannot be a 'final, accurate representation of what was meant or said – only different textual representations of different experiences' (Denzin 1997, p. 5). Thus, one cannot directly capture lived experience

and there is no 'pure' representation of it, only 'negotiated texts' (Denzin & Lincoln 2005, p. 642). In this regard, representation of the participants' worlds is co-constructed as the researcher interprets participants' interpretations (and then a reader applies another level of interpretation). This reinforces that, indeed, there may potentially be many 'truths' in respect to human experiences.

Central to representation is the notion of 'voice'. Voice concerns both the voice of the researcher and the voice of the respondents. The issue of voice is thus:

*a struggle to figure out how to present the author's self while simultaneously writing the respondents' accounts, and representing themselves' (Hertz 1996, p. 6).*

To help guide the construction and interpretation of narrative I have employed a combination of Chase's (2005) typology of narrative voice. An *authoritative voice* is employed to prioritise my interpretations of the participants' narratives. Such an approach may be criticised for privileging the author's voice 'at the narrator's expense' (Denzin 1997, p. 249). However, I feel that a PhD study necessitates something of an authoritative voice. Towards ameliorating the loss of participant voice in this respect the present study works to consciously represent the diversity of the participant stories, and to remain open to possible alternative meanings and interpretations (Chase 2005, p. 664). This is promoted by the inclusion of extensive quotations to create 'room' for alternative audience interpretations (Chase 2005, p. 665).

Including extensive participant quotations reinforces a *supportive voice* that 'pushes the narrator's voice into the limelight', highlighting the notion of the interview relationship as one of narrator-listener (Chase 2005, p. 665). The supportive voice embraces the importance of 'taking the other's perspective' in order to promote change (Frank 2000, p. 94). The supportive voice also highlights the notion that whatever the participant's performance or response – even if it superficially seemed to be off 'the point' – was 'the point' (Chase 2005, p. 661). It was thus especially

important in the present study to create 'space' to embrace whatever the interviewee's perspective was. This was especially so because 'insiders' (such as nurse-researcher) may have a strong sense of what they deem 'story worthy' (Chase 2005, p. 661). Thus a conscious attempt was made to remain open to the different perspectives. This was enabled, for example, via the use of ample open-ended questions within the interviews. This enabled me to navigate the paradox that:

*On the one hand, a researcher needs to be well prepared to ask good questions that will invite the other's particular story; on the other hand, the very idea of a particular story is that it cannot be known, predicted, or prepared for in advance (Chase, 2005, p. 662).*

Further supporting appropriate representation of the participant narratives, an *interactive voice* was employed to display something of the complex interaction between researcher and narrator (Chase 2005, p. 666). Such an approach makes the author 'vulnerable in the text' and involves some discussion of their 'emotions, thoughts, research relationships' and 'interpretive decisions' (Chase 2005, p. 666). The justification of such an approach lies in the belief that researchers need to be transparent, self-aware and reflective if their interpretations are going to be understood and justified. Such an approach undermines the 'myth of the invisible omniscient author' (Chase 2005, p. 666) and further illustrates the strong parallels between interpretive research and clinical engagement which embraces the intra- and intersubjectivity of human knowledge. Thus, interpretations have been drawn from the data using an authoritative, supportive, and interactive voice. The specific steps involved in this, including the processes of interpretation and representation of data, are considered further in Chapter 4.

### **3.3.6. Language**

Language is another important element to consider in respect to an interpretive suicidology (Fitzpatrick 2011). This is because language not only reflects, but may also create, regulate (Kincheloe & McLaren 2005; Chase 2005), and possibly limit, 'reality'. The language of suicide, in particular, can both *reflect* and *affect* suicide and



suicidal people. This is true in terms of how suicide is experienced (Webb 2002; 2005b), researched (De Leo et al. 2006; Cutcliffe & Ball 2009, p. 211), conceptualised (Marsh 2010), and responded to (SPA 2010). In research, for example, a lack of clear and consistent language can complicate the comparison of studies (Lineham 1997) and confuse, inconvenience, or obstruct, the estimation of rates and the generation and application of cultural and socio-demographic data (Goldsmith et al. 2002, p. 27; De Leo et al. 2006, p. 5). Additionally, in the clinical context language can impact on assessing and communicating a person's state of mind, their experiences and difficulties, the meaning of their care plan (Keval 2003), or their level of risk (De Leo et al. 2006, p. 7).

Employing language judiciously in this study meant, for example, avoiding pairing 'suicide' with terms such as 'commit' and 'fail' which might reinforce value judgements of sin, crime, wrongdoing or failure (De Leo et al. 2006, p. 9); or with the term 'successful' which might inappropriately imply a positive outcome. Language was also considered in relation to the terms employed to identify participants (in particular those people who had been suicidal and had intersected with health services). It is notable that in Great Britain it has been found, in the case of consultations with mental health nurses, people preferred the term 'patient' over 'client' – with 'service-user' or 'survivor' being least preferred terms (Simmons et al. 2010). While 'patient' may be criticised for its overtones of paternalism, passivity and enduring suffering (Langer & Abelson 1974; Atkinson 1993; Kalle 2012) it may, on the other hand, be preferred because it is the same term used commonly for other people in general health care scenarios. For others, 'client' may be preferred as it describes 'a professional relationship with a practitioner' (Happell et al. 2008, p. 6). However, being a client infers the right to refuse service – which in the present context is not always the case. 'Client' also infers that the person is paying the clinician for service, whereas in public mental healthcare it is the institution (government) that pays the clinician – the person is only ostensibly a client (Szasz 1970). Thus, while 'consumer' is preferred by some it does not always capture the nature of the relationship with service.

The reality is that some service-users care about terminology, and others do not (Happell et. al. 2008, p. 6). Different people will have different preferences in different situations. Generally speaking, it would seem best to use the term preferred by the person of concern. Of course, such a stance is dependent on understanding what a person's preference is. Taking these complications into account, the terms 'consumer', and also 'client' or 'patient', are all used in this study to reflect that they were commonly used by different people involved in the study in different contexts. Wherever possible, however, 'person' or a pseudonym is used so as to humanise the person. However, something of that personalisation has been 'traded' regarding the nurses, to differentiate the consumers from the nurses, and to achieve appreciation by the audience of whether the nurse was an acute care or community-based nurse. This means, for example, that a nurse may be referred to as 'AcuteRN1' to denote that they were the first nurse I interviewed and that they were working in an acute care setting. This also has the effect of redressing the arguably greater social dehumanisation of mental health care consumers (compared to nurses).

Another important consideration with respect to language in this study was to define 'suicide' and 'suicidal crisis'. Having considered definitions of suicide (Durkheim 1951 [1897]; Shneidman 1985; WHO 1986; WHO 1998; Leenaars 1999; Goldsmith et al. 2002), the following definition from De Leo et al. (2006, p. 12) is preferred in this study:

*An act with fatal outcome, which the deceased knowing, or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes (De Leo et al. 2006, p. 12).*

Defining 'suicidal crisis' – and sharing that definition with research participants – was particularly important in this study. Shared understanding of what constituted suicidal crisis was vital in order to establish that participants were referring to comparable experiences, and towards establishing the results as relevant to comparable contexts. Central to creating a definition and shared understanding of

suicidal crisis was the issue of intent. Understanding intent can be difficult as arguably it cannot be directly observed by another, it can be interpreted in different ways, and it can be falsified (De Leo et al. 2006:8; Lebacqz & Englehardt 1980; Cholbi, 2009). Furthermore, the suicidal person's or the observer's beliefs and judgements, the suicidal person's ambivalence about living or receiving help (Maris et al. 2000b:43), as well as recall bias or moral or social resistance against an assessment of suicidal intent (Shneidman 1973), are all factors which may challenge understanding of intent (and broader meaning and knowledge) around suicide.

Measurement scales such as Beck's Suicide Intent Scale (Beck et al. 1974), the Lethality of Suicide Attempt Rating Scale (Smith et al. 1984), and The Columbia–Suicide Severity Rating Scale (Posner et al. 2011) can be utilised to assess intent. However, in the interests of privileging the participants' stories over a rendering of those stories into numbers, it was preferred that intent was established via description and consensus. In this way people's perspectives were valued and the presence of suicidal crisis was verified either from multiple sources (e.g. consumer and clinician), or by my consideration of the claims of suicidal crisis as they related to the content of the narrative accounts given.

Regarding the relevance of findings to people at risk of suicide when focusing on data concerning non-fatal suicidality, it is acknowledged that people who partake in fatal suicidal behaviour and people who partake in non-fatal suicidal behaviour can be seen as two different groups (Stengel 1964). Indeed, there may commonly be some differences between them (Goldney 2005), particularly concerning intent and motive (Pompili 2011, p. 8). Nevertheless, this study embraces the notion that they are two overlapping populations (Beautrais 2001; Lester et al. 1979) who may experience 'a common suicidal process' (Ottoson 1979; Van Orden et al. 2010:576). Part of that common process is, typically, a crisis point within the experience of suicidality. This may be referred to as 'suicidal crisis', and defined as a relatively short period of high and dangerous lethality, usually counted in hours or days (Shneidman 1973). Suicidal crisis in this sense may be related to fatal outcomes, but it is also related to near-lethal attempts in which death does not result but 'which

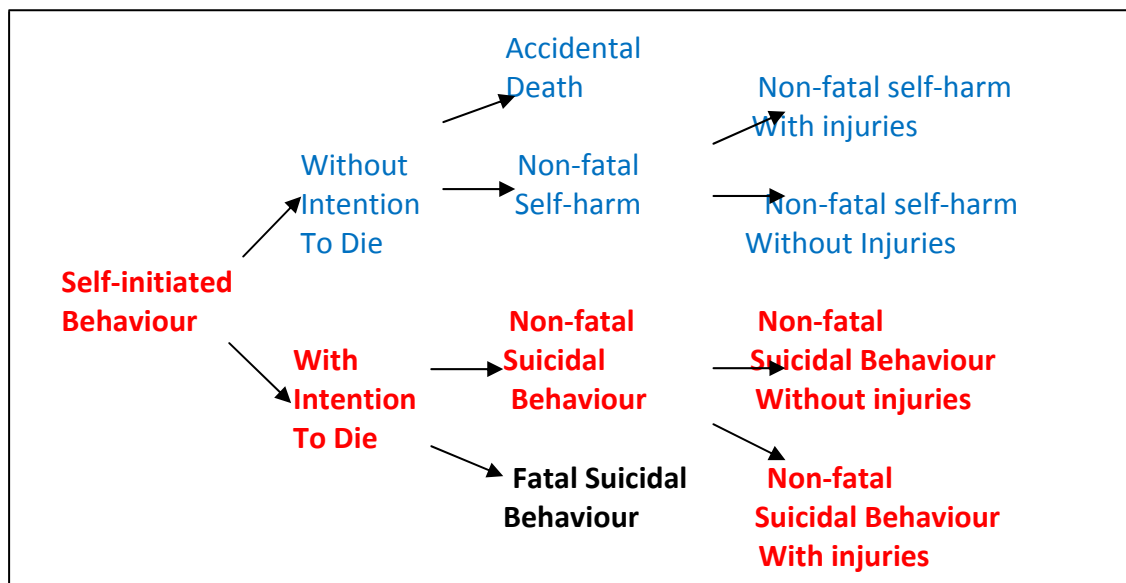
the person presumably survived by chance' (Van Orden et al. 2010, p.576). To operationalise this concept, this study expanded upon Shneidman's definition of suicidal crisis as follows:

*A situation in which a person had tried, or was trying, to kill him or herself or was seriously contemplating or planning to do so. In the situation completion of suicide was imminent or likely to occur if immediate intervention or other change in circumstance had not occurred.*

*(Adapted from <http://encyclopedia.thefreedictionary.com/Suicidal+crisis>)*

The flow chart below (Figure 3.1.) was also developed to help clarify which 'populations' nurse and consumer participants were speaking from or referring to. Most of the knowledge generated with client participants relates to their own suicidality and thus they are (with a small number of exceptions when they talk of other people) referring to suicidal crisis with intent to die and with non-fatal outcomes with or without injuries. The information generated with nurses primarily concerned suicidal crisis that was not restricted in relation to outcomes (thus encompassing intent to die with both fatal and non-fatal outcomes).

**Figure 3.1. A spectrum of self-injury** (Adapted from De Leo et al. 2006, p. 3)



-- Experiences referred to by consumer participants

-- & -- Experiences referred to by nurse participants

-- Excluded

It is hoped that by considering these issues of language, the credibility, transparency and ethical imperatives of the present research methodology and related practices have been enhanced.

### 3.3.7. Summary

An interpretive methodology which embraces principles of narrative and critical research, and which addresses issues of ethics, representation and language, is of particular relevance to suicidology and related mental health care. Such a methodology is further complemented by the integration of consumer and nurse narrative accounts and survey data. These methodological aims and imperatives are argued to support the integration of intrapersonal, interpersonal and contextual data in ways that provide fuller understandings, and enhance the potential for more positive experiences, responses and reforms to be realised. How this was achieved is detailed further in Chapter 4.

### **3.4. Conclusion**

Moving beyond current limitations of how suicide and suicidal people are understood and responded to in mental health care contexts demands adequately complex and broad investigative and interpretive processes. In parallel to clinical practice, reductionism or bias towards a particular factor, discipline or research method must be recognised as providing, at best, a partial 'view'. Clearly, humans do not behave in 'a linear fashion or disconnected from their context' (Hjelmeland & Knizek 2010:78), and positivistic approaches cannot be applied to people and society as they might be to 'objectified natural processes' (Habermas 1987b, p. 3). Indeed, positivistic methodologies, in practice and research contexts, may misunderstand or even potentially exacerbate suicidality by objectifying, pathologising, and (further) marginalising suicidal people.

The mixed methods research tradition highlights the importance and the possibility of combining multiple perspectives and data types in single studies, and thereby doing greater justice to the complexity of the issues at hand. However, issues of paradigmatic incompatibility, the possible promotion of a (post)positivist agenda, and the potential to constrain research and reinforce dichotomies, render mixed methods problematic in the present contexts.

Towards exploring the intrapersonal, interpersonal and contextual dimensions of suicide and related mental health nursing, it is argued that a multi-method, interpretive methodology is most suitable. This methodology embraces the central tenets of narrative and critical research, and addresses issues of ethics, representation and language. It also allows for the incorporation of numerical and narrative survey data into a single interpretive project. The methodology thus supports research which is at once exploratory – seeking to discover a 'world' of which little is known – and also aimed directly at addressing specific questions in order to explain, inform and potentially influence, relevant reforms. Within such a methodology, the imperatives of bringing suicide 'out into the open' (McGorry 2010, cited in Drape 2010), and enabling people to contribute their lived experience as part

of 'normal society' (Holland 2009), can be promoted. It is reinforced that, as in respect to quality clinical practice, particular ethical relationships are at the heart of this research endeavour.

## **Chapter 4 – A method of engagement-based inquiry**

This chapter outlines the method developed and employed to explore mental health nursing care of patients at risk of suicide. The method is underpinned by the methodological principles outlined in the previous chapter and is aimed at addressing the research questions. Fundamental to the research method was the development and management of a range of stakeholder relationships. These relationships underpinned a comprehensive research framework supporting the engagement with consumer and nurse participants. This framework was important because of the ethical and practical issues that researching people at risk of suicide involves (Lakeman & Fitzgerald 2009). It was also important because mental health settings can be difficult and complex contexts to negotiate as a researcher, particularly when attempting to conduct research with consumers (Gillard et al. 2010). The research framework enabled a survey of mental health nurses which provided preliminary understandings and contextual data, and it also enabled in-depth interviews with nurses and consumers.

In discussing the method, this chapter also provides some 'secondary' data gained from reflection on the research processes. This data highlights that suicide can be a challenging topic to investigate, that there are significant potential risks and aversions around 'talking about' suicide, and that structures and pathways to access and support participants must be carefully planned and operationalised. It also highlights that the inquiry process may be valuable not only towards generating fuller understanding of suicidal crisis, but also in generating positive experiences, particularly as people are enabled to share their stories. It is also anticipated that the research framework may be useful for others when undertaking inquiry in similar contexts.



## **4.1. Stakeholder engagement and approval processes**

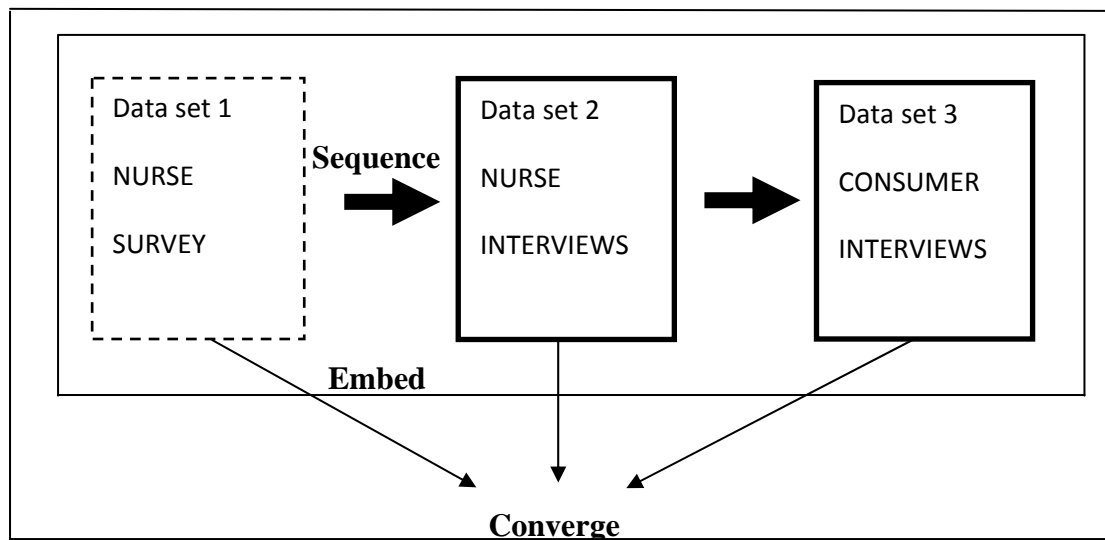
This section explains how the research framework was developed as part of planning, stakeholder engagement, and institutional and ethics committee approval, processes. It is highlighted that these initial steps revealed some of the particular challenges related to ensuring the reliability of data and the health and wellbeing of participants. It is also noted that essential concerns were addressed and refined through extensive stakeholder engagement, careful development and implementation of a comprehensive framework of participant support, and an appropriate approach to the collection, analysis and interpretation of data.

### **4.1.1. Initial research design model**

Considering the research questions (section 2.3.), and the methodological imperatives of constructing multiple narrative perspectives and contextualising those narratives, led to the design of an initial research model. It was decided that a broad survey followed by in-depth interviews with people with first-hand experience of nursing care of suicidal consumers would best meet the research imperatives. Because of the commitment and importance to individually support consumer participants, a broad survey of the consumer population was not possible (although this may have been ideal in terms of data mix) and so only nurses were surveyed. To build some general and contextual knowledge around the questions, the data collection involved a sequence from the survey of nurses, to interviews with nurses and finally interviews with consumers, with some overlap of these phases occurring.

Particularly in the initial planning stages, it helped to conceptualise the data construction sequence as embedding and converging the three data sets with the aim of exposing multiple, complementary and / or contradictory perspectives of the issues at hand (see Figure 4.1. below). While such a conceptual model does, in retrospect, oversimplify the dynamic and complex research process which unfolded, the basic design below was a helpful guide in the initial planning and approval stage.

**Figure 4.1. Research Methods Design Model** (adapted from Creswell & Plano-Clark 2007)



#### 4.1.2. Engaging partners

Denzin and Lincoln (1994, p. 20) note that approaching and entering the research field can involve extensive practical, ethical and political challenges. Meeting these challenges was framed at the outset by the approval processes established by UTAS (University of Tasmania), SMHS (Southern and Mental Health Services Tasmania, which manages MHS, the public mental health care provider in Tasmania), and The Tasmanian Health and Medical Human Research Ethics Committee. The approval processes reinforced the two overarching imperatives of minimising and managing the possible risks involved, and generating rigorous and valuable data and findings. These imperatives reflected the recognised necessity of ensuring a favourable risk - benefit ratio in suicide-related research (Lakeman & Fitzgerald 2009).

While engagement with the consumer and nurse participants was at the heart of the research, a range of stakeholder partnerships were essential to firstly developing the project and gaining institutional approval for it to proceed. Key partners in the development and approval stage included the CEO of SMHS, the Director of Nursing for SMHS, the Chair of Suicide Prevention Australia, numerous mental health nursing academics and clinicians from Tasmania and Western Australia, as well as my

research supervisors. These 'partners' played non-intrusive, yet supportive, constructive, and valuable roles, in reviewing and endorsing the initial research plans. Their involvement provided collaborative expertise to the project and inferred a degree of shared responsibility. In addition to immersion in the relevant literature from this early stage, the partnerships helped generate appreciation of, and planning around, some of the challenges and imperatives of producing rich and meaningful data. They also helped identify the potential risks in the study and how the participants (particularly the consumers) could be best supported.

In developing and coordinating these partnerships it was apparent to me that should any of these key aspects fail (the quality of the data, the safety of participants, or indeed relationships with any of the key partners) then justification and support for the project could be threatened or the model of participant engagement could effectively collapse. Thus, while time consuming and not without challenges and potential complications, the value of constructing a research project which was sustained at crucial points by stakeholder involvement, was appreciated.

This initial planning and collaboration highlighted the reality of the significant practical and ethical challenges common to suicide-related research (Gilje et al. 2005, p. 520; Lakeman & Fitzgerald 2009). Indeed I came to more fully appreciate that challenges can be so great (or perceived to be so great) as to discourage research involving people with first-hand knowledge of suicide (Rudd et al. 2001). As Macgill (2008) found when attempting to conduct her own suicide-related PhD research in Australia, the potential exists for researchers to encounter insurmountable hurdles when seeking approval to conduct suicide-related research. This included the possibility that ethics committees may conclude that not talking about sensitive topics or painful experiences is preferable to talking about them (Josselson 2007, p. 543). Such concerns are arguably not without basis, as it is recognised that sometimes 'talking about' suicide can increase risk for vulnerable people (Philips 1974; Pirkis & Blood 2001; Niederkrotenthaler et al. 2012). However, such a premise denies one of the central arguments of this thesis: that to talk about suicide in appropriate, supportive contexts is necessary if suicide and suicidal people

are to be better understood and responded to. Thus, by conducting this research I have worked to counter the ‘paradox of exclusion’ which can reinforce inadequate evidence by excluding from research the very people who hold some of the most pertinent knowledge (Lakeman 2007).

#### **4.1.3. Identifying the ethical challenges**

Central to developing the research framework, the process of identifying the key ethical challenges required considerable efforts, in part because of a lack of guidelines specific to *non-intervention* suicide-related research. The lack of pre-existing specific guidelines may be reflective of the notion that some research approaches (including narrative inquiry) cannot be predicted or defined in the ways that ‘stable forms of inquiry’, such as medical-model research, can (Craig & Huber 2007, p. 270). It is argued that an ‘ethics as process’ (Ramcharan & Cutcliffe 2001) approach can be helpful in this respect. ‘Ethics as process’ acknowledges that potential risks and benefits can arise in a dynamic and somewhat unforeseeable way as the research evolves (Ramcharan & Cutcliffe 2001). The concept embraces the importance of building research relationships based on trust, regularly revisiting consent and the participant’s wellbeing and need for support, and ensuring that research relationships are concluded appropriately and not abruptly. Key to ‘ethics as process’ is, then, the quality of the research relationships and the ability to mobilise a ‘safety net’ of support should it be necessary (Lakeman & Fitzgerald 2009, p. 15).

The specific guidelines available in relation to *intervention* research with people at risk of suicide were drawn upon to help construct a model of engagement, within the ‘ethics as process’ approach. Such guidelines place an emphasis on the need for clear risk assessment, treatment and referral protocols, researcher competency and training, and obtaining informed consent (Pearson et al. 2001). These elements are in keeping with the research findings of Lakeman and Fitzgerald (2009) regarding what researchers themselves, in the absence of specific guidelines for non-intervention studies, believed were the ethical imperatives in suicide-related research. They also correspond closely to general guidelines offered by ethics

committees in Australia (Australian Government 2007), and with broader guidelines for ethical research (Josselson 2007, p. 537), which emphasise the importance of free and informed consent, confidentiality, and protection from harm.

In further highlighting the parallels between clinical and research relationships, it is noted that ethical research with people who may be at risk of suicide is similar to good clinical practice (Lakeman & Fitzgerald 2009, p. 16). Both are guided by the broad principles of beneficence, doing no harm, and of interpersonal 'alliance', and both ideally draw upon a network of people for input and support. Thus, the guidelines for non-interventionist research around suicide are not specific. However, informed by broad research and clinical principles, drawing upon stakeholder input, and adopting an 'ethics as process' approach, ethical research imperatives may be identified. As in the present study, a framework can then be developed around meeting those imperatives. In this study a framework was developed around the following principal ethical issues:

- Access to, and recruitment of participants;
- Providing support and protection to participants;
- Researcher competency; and
- Confidentiality and disclosure.

Consideration of these ethical issues provided impetus for construction of a comprehensive research framework. It is important to reinforce that the construction and operationalisation of this framework required extensive planning and efforts which involved gaining the support of key mental health and suicide prevention leaders. My supervisors and I invested significant time in 'networking' to achieve this. One of the key elements of the framework was detailed planning around the involvement of a 'participant support person' who would join me in interview with consumer participants and help ensure that ethical issues – in particular participant health and wellbeing and consent – were thoroughly attended to. The support person was a senior mental health nursing academic and clinician

who I had previously worked with in another qualitative mental health nursing research project. The development of her role was considered essential by all of the research partners and is explained in more detail below in relation to the consumer-interview phase of the research. It was also very valuable during this development and approval phase for me to present the research framework to peers, including to an international suicide prevention conference (Lees 2009).

#### **4.1.4. Summary**

Ethical imperatives were identified and an appropriate research framework developed via processes of reflection, immersion in relevant literature, and engagement with a range of research partners. This occurred amidst considerable practical and ethical challenges and a lack of pre-existing specific guidelines. Central to the development and approval of the research framework was demonstrating the potential for a favourable risk - benefit ratio. Of crucial importance in this regard was ensuring participant health and wellbeing, particularly in respect to consumer participants who had pre-existing suicide risk-factors including previous suicidality, diagnosis of a mental illness/disorder, history of admission to and discharge from psychiatric inpatient settings (Mishara 2007; De Leo & Svetcic 2010), and who, at time of participation, were receiving case-management services from MHS. A particular focus on consumer health and wellbeing acknowledged that risk could be increased should participation in the research process 'aggravate' the consumer-participant's vulnerability (Mishara & Weisstub 2005; Lakeman & Fitzgerald 2009). Thus meeting specific ethical imperatives within a comprehensive framework that supported engagement with consumer participants in particular, was essential. The relevant issues identified in this regard included recruitment, potential harm to participants or the researcher, support to participants, researcher competency, and confidentiality and disclosure. Potential risks to nurses were also considered and attended to within the framework, as is described below.

Ethics committee approval may, then, be a major barrier to doing suicide related research (Mendoza & Rosenberg 2010, p. 66). However, in this study the process of gaining institutional approval assisted in guiding the design and development of a

framework for research engagement. In a sense the approval processes promoted development, ‘testing’ and refinement of the research framework. This occurred through engagement with the institutional bodies and key partners, and also via reflection and immersion in the literature and interaction with peers. Those processes, together, contributed to the development of a comprehensive research model and to the research ethics submission being approved with no requests from the approval bodies for modifications [Human Research Ethics Committee Tasmania Network reference number: H001075].

## **4.2. Survey of Registered Nurses within Mental Health Services**

Following ethics approval, my first engagement with participants was the survey of nurses (Appendix 1). Developing and conducting the survey required significant practical and ‘political’ efforts. As well as generating useful preliminary and contextual data, conducting the survey introduced me and the research to potential nurse interviewees and to the ‘gatekeepers’ of potential consumer-interviewees. Reflective data was also generated via journaling at the time the survey was conducted. This journal record indicated that there was substantial interest in the topic, and that the topic sometimes evoked strong and polarised reactions including possible reluctance to talk about suicide and related nursing practice.

### **4.2.1. Survey design and recruitment**

I sought the advice of a health-science statistician in order to utilise the ‘Survey Monkey’ software in the design and delivery of the survey. Mental health nursing academics in two universities were invited to participate in the first pilot of the survey and modifications around content and question types and scales were made in response. The second pilot involved nurses at two MHS sites and led to further refinement including the addition of questions that were deemed important, and clarification of some of the language. A third pilot involved different nurses at the same two MHS sites, as well as the previous academics, and resulted in the final version.

The survey consists of scaled questions, scaled questions with an open-ended option, and open-ended questions. The survey questions chiefly concern demographic details, how often and in what manner the nurses interacted with consumers in suicidal crisis, what effects the nurses understood their interactions to have, and what they thought mediated the potential for therapeutic interaction (see Appendix 1 for the specific questions). Mindful of the demands on nurses' time, and the broader issue of 'survey fatigue' (Porter et al. 2004), the survey was designed to take 10-15 minutes to complete.

Registered nurses (RNs) employed with MHS during the data collection phase of March to June 2010 (n=235) were invited to voluntarily and anonymously participate in the survey. The invitation was issued via email contact and also through the support and encouragement of MHS team leaders. I visited most of the MHS sites during this phase to answer questions and raise awareness of the study. Participants were offered the choice of completing the survey online or using a hardcopy version. Invitation to participate was made to all MHS registered nurses excluding those working in drug and alcohol and forensic services. Those two services were omitted in the interests of minimising variables to enhance the usefulness of findings using the limited resources and relatively small samples available. Surveys were supplied with an accompanying information sheet (contained within Appendix 1) that included a further invitation to participate in the interview phase of the research should the nurse wish to do so. Consent for the survey was given via submission of the survey.

In promoting the survey and the broader research project, I found that people were, overall, very receptive to the idea of suicide-related research. Nurses expressed to me that they liked the idea of contributing their viewpoints and it was evident that they considered suicide to be a significant issue. It was also evident that nurses perceived that they regularly 'cared' for suicidal consumers and that this care entailed many challenges. However, the nurses' interest in the topic, and enthusiasm for the research, did not necessarily translate into actual participation. Thus, to elicit



responses from 37% of the target population for the survey (n=87) required extensive email contact with individuals and team leaders and saw me personally visit 17 MHS sites (some more than once). Personal contact is demonstrated to increase response rates to online surveys (Cook et al. 2000) and this was my experience. I also posted flyers on noticeboards and in staff 'pigeon-holes', enlisted the support of SMHS directors who made additional contact via email and in person with team members, and I fostered clinical level 'champions' of the research (people who were strongly supportive of the research and happy to promote invitation to participate within their teams). Thus, all possible efforts within the resource and time limitations were undertaken to facilitate the nurses' participation in the survey. Anecdotally, people within MHS who regularly surveyed staff stated that any response rate above 20% was to be considered a relative 'success'.

Survey results reflected the following details of the survey-participant population:

**Table 4.2. Survey-participant demographics**

<b>Gender</b>	43.4% male	56.6% female	(total n=87)		
<b>Location</b>	61.2% South Tas.	23.5% North Tas.	15.3% North West Tas.		
<b>Setting</b>	60% inpatient	28.3% community			
<b>Years of Experience</b>	28.6% 15+	20.2% 10-14	19% 5-9	23.8% 1-4	8.3% <1

In comparing these specific demographic details with nursing workforce statistics supplied to me by SMHS, it is suggested that the sample group was reasonably representative in respect to those demographics.

#### **4.2.2. Summary**

Administering the survey as part of this study was challenging. Despite enthusiasm expressed to me directly, I perceived that 'survey fatigue', a culture of 'busyness' (Street 1992, p. 49; Robinson 1995), the lack of a strong research culture (Retsas 2000), and an apparent reluctance to talk about suicide and/or examine one's own

practice, appeared to account for the moderate participation rate. Another potential obstacle to fuller participation was possibly related to the view expressed by some nurses that a *'survey cannot do justice to the complexity of this issue'* (Survey nurse).

The survey of nurses did, however, help generate valuable contextual data, clarify and identify pertinent issues for the nurses, and give them an initial opportunity to voice their opinions about the topic and the research process. The survey was thus a valuable research strategy, and an effective precursor used to complement the interview data. Conducting the survey also provided a mechanism to introduce me and the research to MHS. This later assisted me to invite participation in the subsequent interview phase.

### 4.3. Registered Nurse Interviews

Following the survey, in-depth semi-structured interviews were conducted from May to November 2010 with 11 registered nurses employed with MHS. The demographic details of the nurse interviewees were as follows:

**Table 4.3. Nurse-interviewee demographics**

<b>Gender</b>	7 female	4 male	
<b>Location</b>	4 North Tas.	4 South Tas.	3 North West Tas.
<b>Setting</b>	6 inpatient	5 community	
<b>Age</b>	Average 48		

In comparing these demographic details with the nursing workforce statistics supplied to me by SMHS, the nurse-interviewee group appears reasonably representative of the wider MHS nurse population in relation to those details. In terms of their experiences and views however, they may represent a particular sub-group of the wider MHS nurse population. Towards identifying why these 11 (from the 235 invited) volunteered their participation I asked each of them why they had decided to participate in the interview. Their responses included wanting to support a research student and suicide prevention research, wanting to talk about and reflect on their practice, a desire to generate evidence of involvement in research for

their professional portfolio, and also having 'nothing better to do at the time'. In particular, the nurse interview participants seemed to have a desire to describe their own practice, put their views forward, and to critique the status quo. That there were only 11 volunteers out of a much larger potential sample is also again, I believe, suggestive of the lack of a research culture, reluctance to talk about suicide, and a pervasive sense of busyness.

The interviews averaged 60 minutes in length and, as recommended, they were held in a quiet, private setting (Burns & Grove 2005) of the participant's choice (Clarke 2006). For seven this was in a room within their workplace and for the other four it was in their own home. Informed consent was obtained and re-visited following the interview. I transcribed the interviews and participants were thoroughly de-identified in the process. The accuracy of transcription and thoroughness of de-identification were checked by my supervisors.

As the nurse interviewee information sheet (Appendix 2) and consent form (Appendix 3) indicate, a key aspect of participation and consent was an agreement that the nurses' health and wellbeing needs would be responded to and that support external to MHS would be made available upon the nurse's request. It was also explained that, in exceptional circumstances, confidentiality could be overridden by a mental health tribunal or coronial inquiry. Although this last point, in particular, may have had an impact on data quality (potentially limiting disclosure) I feel that the risk of this was minimal, firstly because it was difficult to foresee a circumstance occurring where the coroner would request the interview data, and secondly because of the approach by me to the interviews which discouraged identification of individuals.

Semi-structured interviews are often used by health professionals (Whiting 2008), and are particularly valuable in providing flexibility for the interviewer to modify the approach in order to elicit the fullest response from participants, while at the same time remaining focused on the research themes across multiple interviews (Qu & Dunay 2011). Reflecting these points, the semi-structured interviews with nurses in

this study were guided by a schedule (Appendix 4) and were approached in a conversational manner, with my researcher and clinician identity and motivations made explicit.

The opening question of the semi-structured interview is particularly important and should be explicitly focused on the research while also remaining 'open' (DiCicco-Bloom & Crabtree 2006). As such, I commenced each interview by reiterating the purpose of the interview and highlighting that I was interested in the participant's views, experiences, expertise and opinions – whatever they may be. I then invited recollection of the first interaction with a suicidal consumer that came to mind or one that the nurse particularly wanted to talk about. I directed the participants to describe experiences in as much detail as possible in an essentially chronological sequence and I tried to identify the points that they were indicating to be most important. I pursued their main points and then followed up with some more direct probes concerning my overarching research questions. In this way the research questions were attended to while participants were still able to introduce new ideas or questions, as has been noted to be appropriate to the goals of semi-structured interviews (DiCicco-Bloom & Crabtree 2006). Thus a narrative account of their experiences, beliefs and approaches in regard to practice, was generated.

The interviews provided rich descriptions of practice and valuable insights concerning the potential for nurses to care for suicidal consumers. They also revealed that nurses were often frustrated in this endeavour. The nurses were keen to critique colleagues' practice and the quality of service overall and this invariably took up the second half of the interviews. I always concluded the interviews by opening up the conversation to what the nurses felt was most important and to what else they might like to add. Thus, the interviews concluded with a reflection and summation of what the nurse felt most strongly about and also occasionally some new topics emerged at that time. I also embraced the recommended interview technique of returning to less emotionally intense ground towards the end of the interview (Josselson 2007, p. 544). The interviews thus concluded with a focus on

what the participants saw as quality care enabling optimal outcomes and often with specific suggestions they might have regarding service and workforce development.

Concluding the interviews in an appropriately friendly manner allowed me time to consider how the nurse had been affected by the interview and whether they required or wanted to pursue any further de-briefing with me or anyone else. Although the nurses were often emotional during the interviews none requested any further support. Indeed, it was my perception, and was also confirmed directly by several of the nurses, that they were positively affected by the opportunity to talk confidentially and to contribute to research about an important practice issue.

#### **4.4. Consumer participation**

Towards the end of the nurse-interview phase, the interviews with consumers commenced. These provided rich data concerning experiences of being suicidal and of receiving mental health nursing care around that experience. As noted, central to consumer participation in particular (and relevant to the nurse participants also), were some essential practical and ethical issues. Identified in the initial planning and development stages of the research, and then attended to in an 'ethics as process' approach, these were:

- Access to and recruitment of participants;
- Providing support and protection to participants;
- Researcher competency; and
- Confidentiality and disclosure.

Consideration of these issues in relation to consumer participation identifies the central importance of developing and operationalising a comprehensive framework of support, which draws upon the expertise of a range of people.

#### **4.4.1. Consumer participant recruitment**

In-depth semi-structured interviews were conducted with nine MHS consumer participants between July and December 2010. The consumer participants were all people who had previously experienced suicidal crisis, who had engaged with a MHS nurse or nurses in hospital settings (inpatient and emergency units) around the time of that crisis, and who were at the time of interview receiving community case-management services through MHS. The demographic details of the consumer interviewees were as follows:

**Table 4.4. Consumer-interviewee demographics**

<b>Gender</b>	6 female	3 male
<b>Location</b>	6 North Tas.	3 South Tas.
<b>Age range</b>	Early 20s - late 50s	

In comparing these demographic details with the consumer population statistics supplied to me by SMHS, the consumer-interviewee group appears marginally less representative in terms of location and gender (and in size) than it may have been but for unavoidable recruitment issues. As with the nurse-interviewees, it must also be acknowledged that, in respect to their views and experiences, the group may have represented a particular sub-group of the wider consumer population (even amongst the population for whom suicide was an issue). The selection criteria (outlined below), however, ensured some homogeneity of the group and relevance to a wider consumer population.

To facilitate the recruitment of the consumer participants I initially sought collaboration with psychiatrists and case-managers in a Northern and Southern Tasmanian Community Mental Health Team within MHS. As recruitment challenges emerged, this was later expanded to include other MHS Community Teams. The involvement of MHS community case-managers, in particular, was central to the engagement of consumer participants. The case managers were asked to provide initial and ongoing assessment, recruitment, and support to consumer participants. This was in keeping with approaches by other researchers in similar situations who,

to gain access to participants, used 'gatekeepers' who had a duty of care to the person (Lakeman & Fitzgerald 2009, p. 13). While arguably there may be seen to be a potential conflict of interest in employing existing clinical relationships to recruit and support participants, it was felt that any risks in that regard (to voluntary consent for example) were outweighed by the participant's right to be involved in the research and the need to have an effective and appropriate level of support on hand.

The process of engagement with consumers' case-managers was formally initiated in presentations given by myself at 'Community Team' group meetings. The presentations were aimed at establishing clarity regarding the research, particularly around the overall aims of the study, the role that I was inviting the clinicians to take in recruitment and support, and towards exposing and addressing (as a group) potential and perceived risks. At the meetings, and then later in one-on-one follow-up meetings, I carefully explained, and provided information (Appendix 5, Appendix 6, Appendix 7) concerning the proposed role of the case managers in recruitment and support of consumer participants. This involved highlighting, in particular, the specific selection criteria (see 4.4.2 below) and the consent and support processes (see 4.4.3 below).

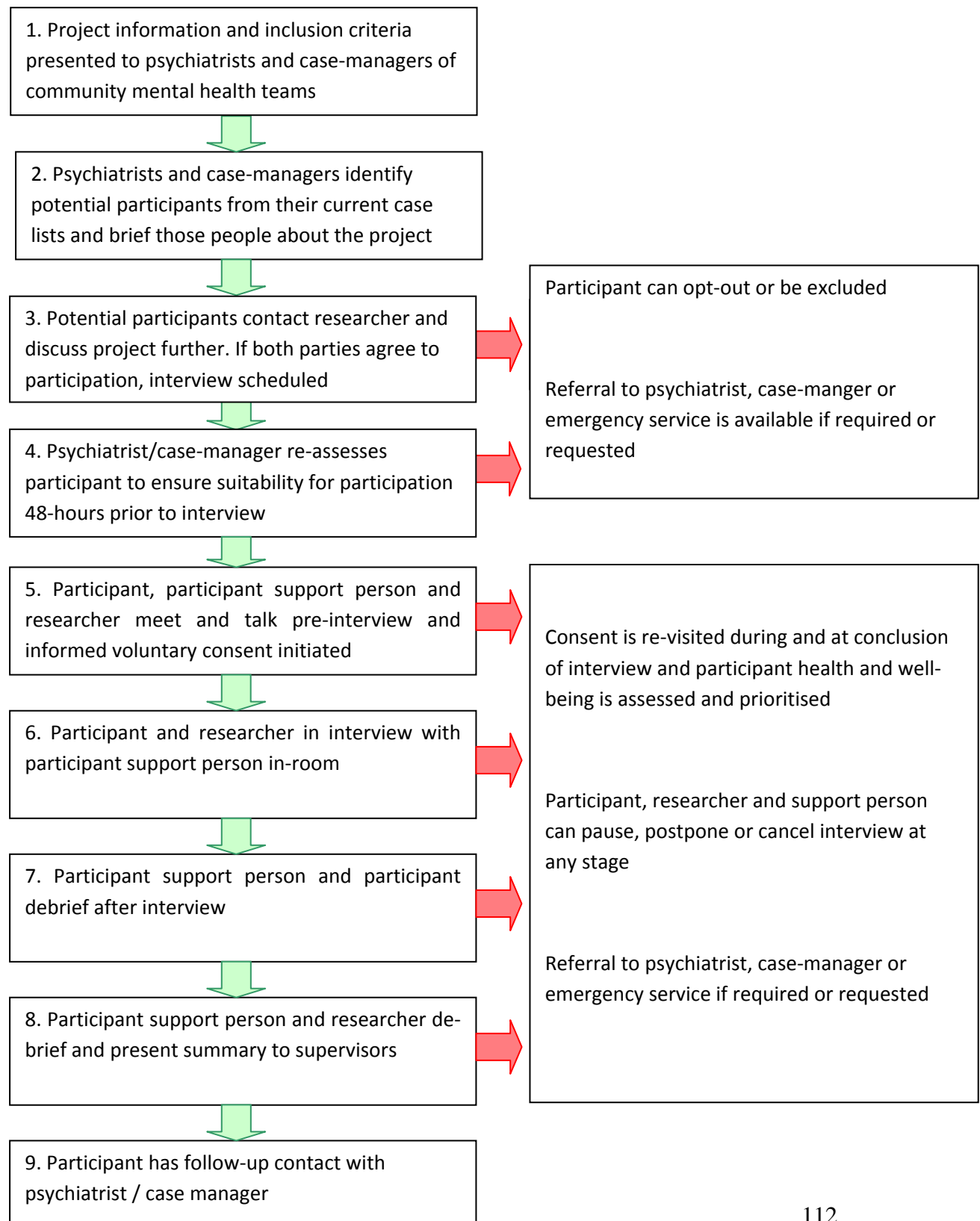
#### **4.4.2. Consumer participant selection criteria**

Consumer participant selection criteria were as follows:

- The person had received MHS nursing care around an experience of suicidal crisis;
- The episode of care occurred after the year 2000 and the person was at least 18 years of age at the time;
- The person has clearly resolved being at risk of suicide and is presently not at any foreseeable risk of experiencing a suicidal, mental health, situational or any other type of crisis;
- The person is not likely to be distressed or adversely affected by participating in an interview that will explore their experience of suicidal crisis and related nursing care;

- The person wishes to be interviewed in relation to their past experience of suicidal crisis and related nursing care;
- The person is able to provide informed and voluntary consent.

#### 4.4.3. Summary of consumer participation pathway





Following consideration of the selection criteria and the consumer participation pathway the case managers were asked to discuss the research and potential participation face-to-face with people on their case-management list who they believed suitable for invitation to participate. This involved discussion of the research in general, and the selection criteria and features of consent in particular. It also involved provision of written information about the research including my contact details.

If the potential participant then chose to do so they contacted me by phone. In that initial contact I introduced myself and reiterated the research aims and described what participation would entail. I was careful to ensure that the person was clear regarding the potential benefits and risks of participation, plans to support them, and the possibility that confidentiality might have to be breached if present risk was identified or at the request of a Mental Health Tribunal or judicial inquest. It was also highlighted to the potential participant that they may wish to discuss participation further with supportive people in their life, with that inviting another level of 'assessment' and support should the person want it.

Following informed consent being established, an interview was scheduled at a time and place preferable to the interviewee. In order to check that suitability for participation still existed closer to when the interview took place, an additional assessment was provided by the person's psychiatrist or case-manager within 48 hours prior to the scheduled interview. Another assessment of suitability and informed voluntary consent was then undertaken in a pre-briefing provided at the interview site by myself in collaboration with the participant support person (whose role is outlined further below in section 4.4.8.).

#### **4.4.4. Consumer participant consent**

Ensuring informed and voluntary consent was an important element of consumer participation. As previously noted, interpretive research may be seen as inherently unpredictable (Craig & Huber 2007, p. 270), particularly around aspects such as interview and the relationships they entail (Josselson 2007, p. 545). Therefore, the

notion of 'informing' the person about what the interview experience would actually be was complicated. Furthermore, some research suggests that the decision-making capacity of depressed people, for example, is not greatly impaired (Appelbaum et al. 1999 in Goldsmith et al. 2002; Rudnick 2002 in Lakeman & Fitzgerald 2009, p. 15). However, others argue that there is insufficient research on the matter and that, as such, extra caution and support around the process is essential (Goldsmith et al. 2002). This acknowledges that decision-making by a person at heightened risk of suicide may, for example, be affected by a diminished desire to care about 'risks or consequences of involvement' (Rudnick 2002 in Lakeman & Fitzgerald 2009, p. 15). Clearly a perception exists that 'the very people who are most in need of treatment or research to guide their treatment may be the most vulnerable in terms of decision making' (Williams 2002, p. 211). However, it was important to balance such potential complications with promotion of the person's right to participate, as well as their autonomy and confidentiality.

The strength of an 'ethics as process' approach is that the capacity to consent can be re-visited throughout the research process. This approach was further enhanced by utilising the research and clinical expertise of a range of people. Again, this is noted by Lakeman and Fitzgerald (2009, p. 13) to be an approach commonly employed by researchers in comparable circumstances. It was vital to this end that the people involved in generating and maintaining informed consent (myself, the case-managers and psychiatrists involved, and the participant support person) were aware of some potentially important factors. In particular, it was essential to ensure that the process was free from coercion, which is argued to be the 'major risk' related to autonomous decision making (Williams 2002, p. 212; Mishara & Weisstub 2005). Thus it was appreciated that people who are socially or politically marginalised, or who have low education levels or impaired literacy/numeracy skills, and people with altered cognitive ability, *may* view members of healthcare teams as very powerful and *may* be vulnerable to coercion.

The power imbalance between the participants and myself and, in particular, between the 'gatekeepers' (case managers and psychiatrists) and participants, was

arguably significant. Therefore, it was important to reflect on the motives of the person's participation (Josselson 2007, p. 541), particularly given the possibility that consumers may pursue actions that they think clinicians may see as favourable (remembering that clinicians have the power to invoke involuntary treatment or detention orders). Despite the potential power imbalance, however, there was an apparently effective effort to separate research involvement from consumers' clinical care. This was promoted by rigorously assessing the person's response to participation and highlighting their right to stop or withdraw participation (or their data) at any time up until publication.

Another key aspect of negotiating informed consent was ensuring that the participant was able to understand the information provided concerning participation – including the likely benefits and risks (Williams 2002, p. 217-218). This meant providing verbal as well as written information concerning the study, confirming comprehension through reflective dialogue, and giving the information more than once. Additionally, as recommended by Williams (2002, p. 211) and Polit et al. (2001, p. 78), it was important to be aware of the participant's perception of the validity of the information, their ability to remember the information, and their ability to weigh, and respond appropriately to the risks and benefits. Assessing and managing informed consent was thus appreciated to be an important and challenging endeavour, and one that further highlighted the central importance of a close and ethical relationship between clinicians, researchers and those whom they would seek to understand.

#### **4.4.5. Challenges of recruitment**

My experiences of entering and negotiating the research field reinforced that there can be major barriers at social, institutional and gatekeeper levels to accessing potentially vulnerable research participants – even *with* ethics committee and institutional approval (Horwood & Moon 2003). As noted, stakeholders and clinicians expressed a high level of interest and support for the research, suggesting a clear recognition of the potential value of consumer participation, in particular. However, the generally positive responses of 'gate-keepers' did not initially translate into

sufficient consumer recruitment. My response was to convene a strategy meeting with the SMHS Senior Consumer and Carer Liaison Consultant, a community mental health team team-leader, an SMHS regional clinical director, the participant support person, my supervisors, and myself. This meeting was aimed at identifying, together, some further actions towards encouraging clinicians to assist in recruiting and supporting consumer participants. The concurrent actions decided upon included:

- Follow-up with individual case-managers by me;
- Follow-up with clinicians by team leaders and ‘champions’;
- Letters from my secondary supervisor, and from SMHS CEO and Director of Nursing, sent to all relevant clinicians;
- Plans to formally recognise employee participation in research organised and ‘advertised’;
- Additional ‘community team’ sites sought and approved by SMHS, with this requiring an ethics committee amendment; and,
- MHS Northern Tasmanian Clinical director was enlisted to invite further psychiatrist involvement in recruitment of case managed clients.

All of these steps were aimed at encouraging and supporting the crucial case-manager involvement. This was recognised as necessary essentially because the ‘research bargain’ (Horwood & Moon 2003, p. 107) I had struck to gain institutional and ethics committee support meant that a great deal of responsibility was deferred to clinicians with a direct relationship and duty of care to potential consumer participants. This was a great strength of the research. However, it also meant that those ‘gatekeepers’ were being asked to take on extra work and responsibility, and that they had power of veto as to who was invited to participate. This was problematic given the perception that, as one senior clinician noted:

*I think there is an issue of finding clients within our service with suicide issues that have now resolved to the extent that the case managers feel confident that these times can be evoked again without a risk of deterioration. I think this*

*is in large part due to the chronicity of the clients in the public system and the multiple maintaining factors that complicate their lives. I don't know if you would meet with more success in the private system? (by email, 1 September 2010).*

Another clinician gave me feedback that 'their' consumer was interested but after she (the consumer) discussed it with her husband she declined to participate as her husband was afraid that if she talked about it she would 'crash again'.

It was likely that the level of 'acuity' of some case-managed consumers was legitimately preclusive of participation in research concerning this sensitive topic. However, the extent to which that rationale was offered by case-managers to support their claim that 'none of my clients are suitable for this research' appears to have been excessive. This is reinforced by the fact that case managers who did more actively support the research were able to recruit and support 2-4 people each from their case-lists. Clearly, many of the case-managers, and some of the clients (and/or the clients' significant others) also, perceived that it was 'too risky' to talk about suicide. This exemplified one of the chief practical contributors to the 'silence' of suicide (Webb 2005) and the 'paradox of exclusion' (Lakeman 2007): fear that it may be counterproductive or dangerous to talk about suicide.

The 'protectiveness' and concern of case-managers, which prevented more active recruitment, demonstrates a level of autonomy and responsibility which is at face-value, I believe, commendable. However, this level of 'protectiveness' is not only potentially problematic in terms of enabling consumer participation in research, but may also be problematic to the extent that it represents a more pervasive reluctance to engage with consumers directly with suicide even at the clinical level. The inability to gain access to participants (and also to requested statistical data) led to a degree of frustration as reflected in the following entry in my research journal:

*SMHS has started to feel to me like a 'fortress'. I feel lost in a maze of meetings, emails, offers of assistance, praise for doing the research, and efforts to help,*

*that still do not provide access to the information and clients to the degree I know is possible. I can't help but think: if I can't get 'in' to the system, how is the story – especially the consumer 'voice' – to get 'out'? SMHS say they support consumer participation – and I believe that they do – yet when a research project comes along concerned with this, and that has the official support of SMHS and others, the system is not effective in giving me access to information and clients (Research journal entry 11 September 2010).*

At the same time as being frustrated, however, I recognised that this experience was actually a potentially valuable finding regarding the 'silence' of suicide (Webb 2005).

The eventual catalyst to gaining access to more consumer participants (and to the SMHS statistical data I had been seeking) was the further fostering of relationships with 'champions' of the research. In relation to consumer access this occurred within the community teams by building relationships further with individual case managers who were willing and able to facilitate access to consumers. It also occurred through the seeking by me of 'second opinions' from the consumers' psychiatrists. These steps did not have the effect of overriding the case-managers' initial responses, rather they seemed to provide extra support which prompted some of the case managers to more actively engage with the clients around research participation. As part of negotiating these manoeuvres I believe that my 'insider' status (particularly as a recent employee of one of the community mental health teams) was a vital asset in part, I believe, because I was seen as someone with clinical experience adequate to engage the consumers in a 'therapeutic' interview.

Notwithstanding the possibility of high levels of acuity and genuine risk being preclusive of meeting the selection criteria, then, I believe that the lack of potential gatekeeper involvement exemplified a failure to embrace the aims and practicalities of consumer collaboration and research-based practice. This illustrates, again, how exclusion can occur and how the consumer voice may be silenced at the point of engagement (in research and practice). Stigma and misunderstanding, issues of confidentiality, the perception of the potential risk of provoking distress and

heightening risk in an arguably vulnerable population, as well as ‘gatekeeper’ apathy and busyness, all served to restrict my access to consumers. In contrast, the more proactive clinicians understood the value of the consumer voice, and they did not perceive they were taking a great risk in inviting and supporting consumer participation. Indeed, they had confidence that there was minimal risk, and conveyed that the interview would likely be a positive experience for the consumer. The case managers also acknowledged that they felt they had the full support of all levels of SMHS. Thus, the participating clinicians promoted the key principles of consumer engagement and the value of a ‘research culture’. The irony here is that, beyond cases that genuinely did not meet the selection criteria, the clinicians who declined to participate in supporting consumers to take part in the research largely justified their actions (implicitly or explicitly) in terms of ‘protecting’ the consumer. In ‘protecting’ the consumer, however, I believe that they were contributing to the ‘paradox of exclusion’, as that relates to both overall research knowledge, and also as it may function in clinical care.

#### **4.4.6. Researcher competency**

The competency of the researcher and the professional stakeholders was vital in supporting engagement with participants. Because in narrative-based research the researcher is the ‘primary tool of inquiry’ (Josselson 2007, p. 545) the ‘skill, availability....sensitivity’ and ‘integrity’ of the researcher are particularly important factors (Lakeman & Fitzgerald 2009, p. 16). My own competency is reflected in the fact that I am a credentialed mental health nurse with a wide range of experience in mental health care, and also that I have experience in interview-based research prior to this project. As professional partnerships supported the research the competency of other stakeholders was also important. The supervisors in this study, during the data collection phases, held senior positions within the health and university sectors and have a history of research and clinical engagement with potentially vulnerable people. One supervisor is a mental health nurse and academic who, amongst numerous other relevant activities and roles, was involved in the development of Australia’s national suicide prevention strategy framework *Living Is For Everyone* (LIFE 2007).

Further competence was evident in regard to reviewers of the research proposal, including the Chair of Suicide Prevention Australia (the peak body for suicide prevention in Australia) and the directors of SMHS. Competence was also provided via the UTAS-SMHS partnership, which drew upon the clinical expertise of psychiatrists and case-managers who had current clinical relationships with the service-user participants. Additionally, as discussed below, the participant support person is an experienced mental health care clinician, researcher and UTAS SNM senior lecturer in mental health nursing. Thus a wealth of experience and demonstrable competence underpinned the study.

Beyond research, interview, and mental health care expertise, it is also relevant that competency encompass the research team's moral stance regarding suicide. Mishara & Weisstub (2005) outline three broad ethical positions that may guide one in explicitly considering and expressing their moral stance regarding suicide, with those being libertarian, relativist and moralist. Reflecting libertarian and relativist positions, certainly there is ongoing debate about whether a rational adult should have the right to suicide (Talseth et al. 1997, p. 362). However, the research team in the present study consciously adopted the moralist stance that supports an absolute obligation 'to render assistance or to obtain help for people at risk' (Mishara & Weisstub 2005, p. 25).

Combined with this moral stance and commitment to protect health and wellbeing was also an openness and acceptance of people's suicidality. I conceptualise this as respecting people's experience of suicidality – and indeed their 'right' to suicide – while at the same time holding the view that to prevent the occurrence and burden of suicide is, in clinical and research contexts at least, an explicit and absolute priority. It was important to clarify this as a research team in the knowledge that participants may well pick up on attitudes, and also to prepare me to stay open to their stories. This is in respect of the possibility that if the participant does not fully or optimally reveal their story, that may be attributable to a researcher's (or clinician's) subtle cues and inability to listen. As Josselson (2007, p. 547) notes,



sometimes 'we listen people into speech'. Thus, to be open to the stories and to be responsive to risk and needs, both the competence and moral position of myself, and that of the broader research 'team', was of central importance.

#### **4.4.7. Confidentiality and disclosure**

Another ethical issue central to the study was that of confidentiality. In particular, it was an important part of consent to make explicit what would necessitate the participant being referred to a third person, or to confidentiality being breached. This is argued to be an issue warranting special consideration in comparable contexts (Lakeman & Fitzgerald 2009, p. 15). The present study considered a present risk of harm to any person to be indicative of the need to breach confidentiality. It was a major strength of the research that multiple perspectives were available to assess risk. Furthermore, if there had been the need to breach confidentiality in order to provide additional support, that would have most likely involved the participant's psychiatrist or case-manager (or in exceptional circumstances emergency services), who all have strict confidentiality guidelines and would in any event not have access to the research data. As noted, it was also necessary to communicate to participants that exceptional circumstances (such as a suicide during the study) might necessitate the provision of interview data to a coronial inquest.

As noted in relation to nurse interview participation, there is the potential that the possibility of confidentiality being breached may have affected the data. It is conceivable that if the participant did not trust that what they said would remain confidential they may have felt less inclined to fully disclose their experience. Thus the data may have been somewhat different if confidentiality had been more fully guaranteed. However, this was not considered to be a major limitation. This is essentially because, as with the nurse interviewees, the conditions under which that may have occurred were unlikely and difficult to foresee, and the interview was conducted in a conversational and friendly way that discouraged the identification of individuals and empowered the participants to speak of only that which they wished. Thus I believe that any concerns regarding confidentiality were overridden by the participant's genuine desire to tell their story and contribute to the research.

#### **4.4.8. Participant support and protection**

In research into suicide – particularly research involving people who have known risk factors for suicide – the risk of psychological or physical harm is an especially important consideration (Lakeman & Fitzgerald 2009). In this study, as in Cutcliffe et al. (2006), in-depth interviewing caused no perceived distress to participants and no participants needed to access any extra support. Indeed, the interviews seemed to have something of a positive effect. That such interviews are generally experienced as positive is supported by the findings of Lakeman and Fitzgerald (2009, p. 5). As noted, Chase (2005, p. 667) also finds that, more broadly, ‘for some people, the act of narrating a significant life event itself facilitates positive change’. Nevertheless it was essential that a ‘safety-net’ of support be in place (Lakeman & Fitzgerald 2009, p. 15) that could assess and respond to risk in a way that maximised service-user dignity and wellbeing, and that maintained, as far as possible, consumer autonomy and confidentiality. The study provided a safety-net of support in the form of psychiatrist and case manager involvement and stand-by clinical support, and researcher, consumer support person, and research supervisor expertise in relevant fields. This can be further appreciated via consideration of the consumer participant interview process.

The semi-structured in-depth consumer interviews, guided by an interview schedule (Appendix 8), ranged in duration from 40-75 minutes. Seven consumer participants were interviewed in their own home and two in a private room at UTAS. At the commencement of the interview I introduced myself and the participant support person. The support person was an experienced qualitative researcher and senior mental health nursing academic and clinician whom I had worked with on a previous mental health nursing interview-based research project. She explained her role to the participants, accentuating that she was there for any extra support should the participant request or require it. As noted, the support person’s role was seen as essential, and was developed and endorsed, by the research ‘partners’ previously discussed. The role was designed to provide maximum participant support but was

also carefully considered in relation to the potential impact on data that the support person's presence in the interview room may have.

From the pre-interview information provision the consumer participants were aware of the support person's role and that she would be present in the interview. Together she and I explored issues of consent prior to, during and post-interview, and were very clear in highlighting that the participant should feel free to stop, postpone or cancel the interview at any time, to have a break should they feel distressed, anxious or tired, to ask any questions, to direct us to erase the interview or part of the interview, or to reconsider answers should they wish to do so. The support person was unobtrusive in the interview and usually sat at an angle to the participant, whereas I sat directly facing them. In doing so I employed established nursing communication techniques which encompasses sitting facing the person, adopting an open posture with arms and legs uncrossed, leaning in slightly to listen to the person, maintaining appropriate eye contact, and presenting a relaxed posture (Burnard 1985; Gibbs 1990). This meant that the participant's attention was directed towards me and our conversation, although occasionally the participant looked to the support person for extra assurance or to ask an opinion – drawing her briefly into conversation from which she would then withdraw quickly and appropriately.

Because of the sensitive nature of the topic and the risk of distress, consumers were supported and encouraged to only talk about aspects of their suicidal crisis and related nursing care that they were comfortable to talk about. As in the nurse interviews, a respectful and genuinely inquisitive conversational style was adopted that invited their story to be told. I began each interview by asking the person if they could describe their experience of suicidal crisis and any interactions with nurses within MHS at that time. I highlighted that the participant could start their story at any point they wished, although I emphasised that I was primarily interested in their suicidal crisis in the context of intersection with MHS nurses.

Most of the consumer participants chose to begin their story by briefly describing how they had tried to kill themselves. Two of the participants who had not experienced a suicidal act began the interview recounting how they had planned to kill themselves and had initiated and then aborted the plan. These 'starting points' led the participants to recount their entry into acute psychiatric inpatient care via hospital emergency departments. From this introductory description the interview broadened to encompass and explore the issues highlighted by the participants in their early statements, and the issues that I felt were relevant in the context of their story and in regard to the research questions. Thus the interviews were focused while also being open to new, unique, and unexpected insights that the interviewee provided, as has been noted to be appropriate (DiCicco-Bloom & Crabtree 2006). This allowed the research questions to be expanded upon while the participants were enabled to talk 'openly and authentically' and to focus on that which they saw as important (Birembaum-Carmeli et al. 2008, p. 431). In exploring and constructing their story, participants were encouraged to express emotions, thoughts, and interpretations, to explain, complain, and to confirm or challenge the status quo, as recommended by Chase (2005). Because of practical and resource factors I did not employ a process of 'member checking' (Onwuegbuzie & Leech 2007b, p. 241) subsequent to the interviews. I did, however, practice reflective listening throughout the interviews, utilising also, as I explain further below, the support person to help me clarify meaning. Additionally, I used a research journal, which as Clarke (2006) notes, can be a valuable tool promoting reflection.

The ability to empathise was key to gaining insight into the participants' intrapersonal worlds, with this illustrating a major parallel between good clinical and research interviews (Miller & Crabtree 2005; Bulpitt & Martin 2010). In this regard I aimed to expose and appreciate what was significant from the interviewees' perspectives, to validate their stories, explicitly note their expertise, bravery and honesty, and genuinely express that they were making an interesting, generous and potentially valuable contribution to understanding. I found that an eagerness to understand the participants' perspectives did seem to encourage deep and honest reflection on the part of the participants and also, I believe, contribute to a sense of

achievement in them. Thus I felt that I was able to understand 'the world as they understand it and to clarify and check my understanding with them' (Bulpitt & Martin 2010, p. 9), and also to help promote a positive experience of participation.

The last half of the interview usually focused on the person's recovery from suicidal crisis and on their suggestions to improve practice. Thus the interviews concluded, on less emotionally intense ground (Josselson 2007, p. 544). Any concerns that the support person's presence might restrict the consumers' or my openness, or the quality of engagement (as, for example, she may be a distraction or seen as an authority figure) were, I believe, not realised. Specific therapeutic intervention by the support person was not required. However, I believe that her presence helped create a supportive atmosphere conducive to meaningful interview engagement. Far from 'corrupting' the data, her presence constituted a positive influence as she assisted me to co-construct the understanding that took place. This meant, for example, that with the permission of myself and the consumer, occasionally she would take some time at the end of the interview to open up a new line of questioning or to re-visit a previous point. This provided some valuable data and I feel it was a great help in giving the consumer participants the fullest opportunity to express themselves. The support person's involvement was also valuable in contributing to my post-interview reflection on both the content and process of the interview.

The conclusion to the interview (after the voice recorder had been stopped) was a casual conversation about how the interviewee was feeling, what their plans were, and what they would do if they later came to feel upset or concerned (including who they would contact). This entailed an informal examination of mental state and risk. Highlighting, again, the parallels between research and practice, Josselson (2007, p. 544) compares the end of the interview to the termination of a psychotherapy session, wherein it is important for all concerned to voice how they feel about the experience. We concluded the engagement by withdrawing unhurriedly, and by thanking the participant and explicitly acknowledging their honesty, bravery and generosity, in telling their story. Judging by all available accounts, the participants,

the participant support person, and myself, were all in some way powerfully and, I believe positively, affected by the interviews, and we shared that, to some extent, in our concluding conversation.

Post-interview, the participant was recontacted by their case-manager, and I provided a summary of the interview content and process to my supervisors, followed by a transcript of the interview when that became available. Data was transcribed using a confidential interstate transcription service and the accuracy of transcription and de-identification was ensured by me and my primary supervisor.

#### **4.4.9. Summary**

The consumer interviews, in particular, provided extremely rich data essential to gaining a depth of understanding that could not otherwise have been generated. Intensely interesting, and often both sad and amusing, the interviews were a privilege to participate in and a source of insight, inspiration, and provocation. The participants seemed to gain something positive as well. Thus, I believe that ethical and productive engagement was exemplified within the interviews. Crucially, it was not just the engagement between myself and the consumer that was central to this process, rather it was a complex network of stakeholder engagement which effectively enabled participants to safely and meaningfully participate in constructing and sharing their valuable stories.

#### **4.5. Data analysis and rigor**

This section returns to discussion of methodology to consider in more depth how the data was constructed, analysed and interpreted. This embraces the belief that not only the processes of data collection, but also those of interpretation, are essential to the construction of credible interpretive knowledge (Denzin & Lincoln, 2005, p. 205).

#### **4.5.1. Data analysis**

As discussed in Chapter 3, I have treated both the survey and narrative data as interpretive representations of inherently socially constructed, value-laden and contextually specific human experiences (Kincheloe 2001, p. 681). This is in keeping with the view that methods such as survey, which are usually associated with positivist or post-positivist methodology, can contribute to a broader interpretive project (Westerman & Yanchar 2011, p. 141; Denzin & Lincoln 2005, p. 5). Using interpretive approaches to achieve meaningful proximity to experience (Denzin & Lincoln, 2005; Leech & Onwuegbuzie 2007), however, means abandoning (the illusion of) certainty (Clandinin & Rosiek 2007, p. 46). Certainty is, in a sense, precluded at multiple levels and points of interpretation. It is thus important to ensure that interpretive gaps are bridged not through prescriptive steps or positivistic analysis of discrete sections, but through iterative immersion in the texts, and by establishing trustworthiness regarding both the design of the study and the interpretation of data.

As noted at the beginning of this chapter (see Figure 4.1.), the construction of data in this research arose from a sequence – from the survey of nurses to interviews with nurses and then interviews with consumers. The sequence allowed the interview phases to draw upon nurses' prior clinical experience, as is noted to be valuable (Miller and Crabtree 2005). The sequence also enabled me to refine my interview skills before engaging with the consumer participants. Sequentially, data was analysed and integrated from commencement of the data collection phase. Within the sequence, interview data was also effectively embedded in the survey data (and the other existing knowledge sources) providing a context for the interview data and the broader project. Further, a convergence of data enabled the comparing and contrasting of all three data sets as part of the analysis (mindful of the potential for survey and interview data concerned with a specific aspect of the topic to actually be looking at somewhat different phenomena). Convergence resulted in a rich mix of consensual, complementary and sometimes conflicting data.

To guide data analysis within the broader sequence, I drew upon what may be described as blended and adapted forms of critical discourse (Blommaert & Bulcaen 2000), constant comparative (Glaser 1965) and classical content analysis (Leech & Onwuegbuzie 2007). Thus, I firstly read the interview texts and considered how they represented the contexts at hand. This involved 'listening' to the narrator's voice concerning *how* they narrated and also *what* they narrated, remaining open to what participants were trying to convey and, while doing so, relating the data to the research questions and also reflecting on my own interpretations.

As in Leech & Onwuegbuzie's (2007) description of a modified constant comparison method, in reading the interview transcripts I proposed some 'codes' that would later be maintained, modified, added to, or removed according to what emerged during the subsequent readings. Using NVivo software, codes were initially identified deductively (identified first and then looked for in the data), inductively (emerging as the data was considered), and also abductively (iteratively) as they emerged from the data. In addition, independent coding of some of the data by my PhD supervisors promoted discussion and a process of consensus-reaching that saw my initial codes changed very minimally. In coding the data I was very careful to compare each piece of data attributed to a specific code with the existing pieces to ensure that they 'fitted' together (represented the same or similar aspect). When data could not be fitted into an existing code a new code was generated. When initial codes or single codes were not added to they were subsumed into other codes if possible or ignored if they were an anomaly that was not of possible interest – while still appreciating that 'outliers' (Onwuegbuzie & Leech 2007b) can have valuable information to contribute. After all of the data was coded the codes were grouped by similarity into themes.

Classical content analysis is similar to constant comparison analysis except that instead of creating themes by grouping the codes together one counts the number of times each code features (Leech & Onwuegbuzie 2007). Thus what emerges is a frequency of codes. This process was employed by me and my supervisors independently to code some of the qualitative (open-ended) survey data in a process



that saw similar terms, phrases or descriptions grouped under the same code. While this treatment of survey data may have overtones of positivistic quantification of interpretive data (Espeland et al. 2008), it was valuable in capturing a collective voice. I thus consider it essentially an interpretive analysis strategy to manage a large set of data.

Because this study prioritises narrative accounts, and because the survey represents nursing views only and features a non-random and moderately sized sample, a greater 'weighting' has been given to the interview data than to the survey data. Some of the numerical survey data could have been treated as 'objective' findings within a post-positivist paradigm. However, the design, responses, and interpretation of the survey involved interpretive steps. The scaled and open-ended questions, in particular, are clearly based on subjective interpretations. Thus, as noted, in an attempt to utilise the data within a larger interpretive project that adheres to my methodological principles, I consciously avoided inferential statistical analysis of the survey data. I take these to reinforce a positivistic knowing that, as discussed, is of limited value in the present context. Instead I have contained the analysis of survey data to basic 'descriptive statistics' (Fisher & Marshall 2009). In this way the problematic reductionism and misleading truth-making discussed in the previous chapter in relation to positivistic approaches was minimised, while something of the broad details and views of nurses was still represented.

#### **4.5.2. Trustworthiness**

Trustworthiness is considered the most widely used global standard for evaluating interpretive studies (Padgett 2009). A trustworthy study is one that is carried out ethically, and one in which the findings represent as closely as possible the experiences of the participants. Transparency which provides a faithful account of 'what happened' (Padgett 2009, p. 101-102) is central to the establishment of trustworthiness. Towards achieving these imperatives I have outlined my interpretive steps to 'faithfully give an account of what happened' (Padgett 2009, p. 101-102) and to make 'the subjectivity of the process transparent' (Sandelowski et al. 2007, p. 244). This has included some discussion of my background, linking of

research questions to a review of literature, and the outlining of methodological foundations and specific methods involved in entering the research field and constructing and analysing data.

#### **4.5.3. Summary**

It seems reasonable to assert that, in the present context especially, a negotiated communicative process of knowledge construction (Denzin & Lincoln 2005, p. 204) is most appropriate. If such inquiry is pursued within a supportive, ethical context, and with critical intent, then the result can be intrapersonal and interpersonal experiences that can generate understanding and, potentially foster positive change. In exemplifying such an approach to inquiry I have argued that all data in this research is interpretive in nature, and that context, history, values and other impacting factors can be embraced in a credible and useful exploration of nursing care of suicidal mental health care consumers. Furthermore, it has been asserted that different 'voices' providing multiple perspectives and data types (words and numbers) are valuable in enabling an exploration of such complex interactive interpretations. Indeed, I believe that the combination of methods (on an interpretive paradigmatic foundation) can be seen as 'a strategy that adds rigor, breadth, complexity, richness, and depth to an inquiry' (Flick 2002, p. 229, in Denzin & Lincoln 2005, p.5). Thus I have taken a particular focus on legitimization according to criteria identified with the interpretive tradition. The final claim to legitimization must, however, be established by an audience engaging with (constructing) the 'final' text, particularly in regards to the presentation and discussion of findings, to which the following chapters turn.

#### **4.6. Conclusion**

Current limitations to how people at risk of suicide are understood and responded to within mental health services may be reinforced by a paucity of relevant research underpinned by appropriate inquiry approaches. Thus, I have argued that there is a pressing need to incorporate multiple first-person narrative perspectives and

broader contextual data into an exploration of experiences of suicidal crisis and related mental health nursing care. This infers the need to engage stakeholders in research so that their 'voices' can be heard and their expertise integrated into an evolution of knowledge and practice. In the present project this endeavour was underpinned by constructing accounts with consumers and nurses which focused on the experiences and needs of consumers and nurses in the context at hand, the extent to which needs were met, the potential role that interpersonal interaction had in that context, and what contextual factors mediated the quality of care.

Establishing the rationale to interview consumers who had experienced suicidal crisis and related nursing care, and to survey and interview nurses regarding that context, was the first step in what evolved to be a challenging and complex inquiry process. Creating a pathway 'in' to MHS in order to access, construct and find a way 'out' for the participant's accounts, required extensive practical and 'political' efforts. Fundamental to a successful foray into a challenging field of research which had arguably remained largely unexplored was interpersonal engagement within a structured but flexible framework of inquiry. It was 'partnerships' with a range of stakeholders that helped develop and sustain the comprehensive framework required to engage and support participants. Furthermore, it was a particular quality of engagement with nurse and consumer participants that enabled collaborative construction of data concerned with a very personal, significant and sensitive issue and experience. Engagement at these levels identified and countered something of the problematic 'silence' and fear around suicide.

It must also be noted that implementing a project sustained by my coordination of so many relationships and processes, while a great strength of the project, consumed a lot of time and energy within the constraints inherent to a PhD project. Furthermore, this level of complexity, combined with the possibility of adverse outcomes for participants, presented the possibility that the project might suffer serious setbacks. Challenges were also inherent to construction, analysis and interpretation of data. These factors were taken as serious concerns not only because valid and credible findings are essential as part of any worthwhile research,

but also because of the nature of the subject at hand, and the intention that findings might be used to inform clinical practice. In particular, I felt a great obligation to represent the participants faithfully, and to ensure that any findings which might ultimately affect people around suicidality or nursing care were optimally relevant and trustworthy. I feel confident that my foray into the research field created a 'pathway' that may be utilised and developed by others in comparable contexts, that generated positive and interesting processes and experiences, and that did yield valuable data.

## **Chapter 5 – Suicidal and alone: suicidal crisis, intersection with services, and lack of therapeutic engagement**

This chapter draws upon consumer and nurse participant data to highlight the multidimensional (holistic) nature of consumer suicidal crisis, and to identify consumers' mental health service-related needs in that context. As a first step in revealing something of the consumers' service 'journeys', a particular focus is given to initial intersection with services around suicidal crisis.

The participant data reinforces that suicidal crisis typically involved an experience of intense suffering and desperation, and then pursuit of death as an escape from that experience. In line with a holistic construction, the chapter identifies that the principle needs, understood by both nurses and suicidal people to exist at a time of suicidal crisis and intersection with mental health services, revolved around gaining access to service, the provision of physical care and safety, treatment of psychiatric symptoms, and appropriate interpersonal engagement with others (including family and friends, nurses and other healthcare staff). It is argued that intrapersonal and interpersonal factors were of primary concern in respect to these needs and that the nature of engagement between nurses and consumers was of particular importance.

The data also indicates, however, that needs were only partially met, particularly as meaningful engagement between nurses and consumers was experienced as minimal. This implies that consumers remained overly isolated as they entered inpatient unit settings and were not fully engaged in respect to their intrapersonal experiences. From the nurses' perspectives it is evident that some nurses also felt 'isolated' in that their colleagues did not share their goal of more fully

interpersonally engaging with consumers. This lack of engagement is amplified as being problematic because the data suggests that consumer suicidal crisis presented very real risk of harm or death and was something that nurses regularly encountered in their practice. In exploring these issues the chapter serves as an introduction to further consideration of the 'gap' between the rhetoric of therapeutic engagement (encompassing holism, recovery and alliance), and the medicalised, difficult to navigate, and sometimes coercive model of care that participants' predominately experienced.

### **5.1. The participants' understandings of suicidal crisis**

This section draws upon the participant data to reinforce that suicidal crisis may be understood as a multidimensional (holistic) experience (Shneidman 1993; Silverman et al. 2003; De Leo et al. 2006; Maris et al. 2000b, p. 50; Leenaars 1999; Lieberman 2003; LIFE 2007; Tasmanian Government 2010a; IASP 2008; DOHA 2007) and that, within such a construct, intrapersonal and interpersonal dimensions are of particular relevance (Shneidman & Leenaars 1999; Van Orden 2010, p. 280; Hjelmeland & Knizek 2010; Lester 2010; Rogers & Lester 2010; Rogers & Apel 2010). Illustrating this firstly using the consumers' interview accounts introduces the consumers and helps establish something of their biography and 'voice'. Nurses' accounts are then considered to highlight their understandings of consumer suicidal crisis. It is concluded that the nurses and consumers presented similar conceptualisations but that the nurses, having interacted with multiple consumers in the context of suicidal crisis, also focused on the potential diversity of suicidality, including in respect to risk and intent. Consideration of the holistic nature of suicidality also points to the principle consumer needs of access to service, provision of physical care and safety, treatment of psychiatric symptoms, and appropriate interpersonal engagement. The data also suggests that consumer suicidal crisis was seen as something of a common event within the nurses' practices.

#### **5.1.1. 'Better off dead': consumers' understandings of suicidal crisis**

The consumers' accounts reveal that their suicidal crises involved holistic factors at the centre of which was a person pursuing suicide as an escape from an intrapersonal experience of suffering or predicament perceived as intolerable. Various social, psychiatric and interpersonal issues were suggested to be relevant to the experience. These themes, and the consumer-participants themselves, are introduced here in relation to their crisis points and initial intersections with mental health services.

**Ben**, a man in his 20s diagnosed with schizophrenia, intentionally overdosed on his anti-psychotic medication in the recent past (i.e. post-2009). Ben described this suicidal act as somewhat impulsive. However, he also suggested that it had been 'building' for some time in the context of social isolation, depressed mood, and the emergence of symptoms of schizophrenia. Ben explained that:

*I was just really depressed. I had no motivation or energy and I was just depressed...I've been feeling like this for about 10 years...I had an appointment with a doctor [a MHS psychiatrist] and I just got extra pills and just took them all (Ben).*

Following the overdose Ben was admitted to a MHS inpatient unit as an involuntary patient. As with several of the consumer participants Ben acknowledged that he had some trouble recalling all of the events around his suicidal crisis and MHS treatment. His first memory after overdosing was waking up in the psychiatric inpatient unit, where he then spent approximately two weeks.

**Kate**, a woman in her 30s diagnosed with depression, attempted to electrocute herself in the recent past, with this leading to an initially voluntary (and later involuntary) admission to a MHS psychiatric inpatient unit. Kate indicated that her suicidal act occurred in the context of a combination of social, psychological and physical health-related factors. Kate expressed that even though she had close relationships with family and friends at the time she did not feel able to share with

them the extent of her suffering or her thoughts and plans of suicide. Kate spent approximately two weeks in the inpatient unit.

**Lucy**, a woman in her 50s diagnosed with bipolar affective disorder, intentionally overdosed on medication in the recent past and was involuntarily admitted to a MHS in-patient setting (with that later becoming a voluntary admission). Lucy's account highlights, again, that a combination of social, psychological, and psychiatric factors contributed to, and mediated, suicidal crisis. Reflecting this, Lucy recounted that following her overdose:

*I went in an ambulance to emergency... and I was just thinking at the time, 'oh I'll die in a minute'. I was in a hyper state, because I've got bi-polar apparently, and I was not concerned about dying at all...I just thought it would be great because I would be with my husband. That's the reason: I was trying to get to him...that was the only way that I could see that I could...even though I've got a fantastic family, that was the only way I could see out (Lucy).*

Lucy spent approximately one month in the inpatient unit.

**Andrew**, a man in his 20s diagnosed with schizophrenia, had experienced ongoing suicidality for several years, often coinciding with 'psychotic episodes'. During one such period in the recent past Andrew was involuntarily admitted to a MHS inpatient unit experiencing serious suicidal ideation. He described some of his thoughts and behaviours prior to admission:

*I was suicidal and I had these thoughts...like I thought I should throw myself off a cliff. So I drove all the way from [his home town] to [a nearby cliff], but by the time I got there the thoughts had sort of passed (Andrew).*

Similarly to Kate, Andrew described how, despite positive relationships with members of his family, he felt that when he was suicidal he could not discuss what he was thinking or feeling with them. He expressed that to do so would impose too



much of a burden on them. Thus, as with other consumers, it was highlighted that direct communication of suffering and suicidality with family and friends did not occur. Andrew spent approximately two weeks in the inpatient setting around that experience of suicidal ideation.

**John**, a man in his 50s diagnosed with schizophrenia and depression, had experienced ongoing suicidality for several decades. He recounted a past experience of suicidal crisis that involved withdrawal from a drug of addiction in a psychiatric inpatient unit:

*I was really scared because I knew I'd end up stabbing myself or something stupid like that. I was so depressed...I stuck a knife in my gut and it came out my back...the nurse found me and said, 'you're bleeding!' (John).*

John described feeling suicidal more recently as being '*depressed as...not happy*', and as involving serious suicidal ideation. John expressed that economic, social and relationship factors, in relation to his family and with potential employees in particular, were experienced as contributory to feelings of hopelessness, injustice, marginalisation, despair and suicidality. John explained that over time he had learnt to seek, and was now more able to receive, voluntary access to care when he felt suicidal (although he indicated that he was also sometimes involuntarily admitted). He noted that his inpatient unit admission around such times usually lasted around two weeks.

**Claire**, a woman in her 20s diagnosed with obsessive compulsive disorder and depression, attempted to starve herself to death in the recent past and was admitted to a MHS inpatient unit on a voluntary (and then later involuntary) basis. As with other consumers, Claire described how psychological, social and physical factors combined to reflect and shape an experience of suffering and wanting to die. She explained that:

*I got so down and so depressed that I just stayed in bed and I wouldn't eat, I wouldn't drink. I just thought I deserved to die because I'm diseased, I'm contaminated, and so things just went downhill and mum and dad called the ambulance (Claire).*

Claire spent approximately one month in the inpatient unit.

**Tracy**, a woman in her 40s diagnosed with depression, described how her suicidality had been ongoing for several years preceding 2010. Tracy's account again highlights the holistic nature of suicidal crisis and reinforces that social and interpersonal elements were particularly important. Tracy described how, in conjunction with experiences of '*psychotic depression*', she had experienced multiple social stressors including physical and emotional abuse. Her suicidality was expressed through ideation, starvation and drug overdose. Tracy explained that:

*it was a vicious circle. I'd be lonely and getting involved with these people thinking they were my friends...I was raped and bashed and stuff, and everything...it still lives with me...and I was so traumatised. I was just thinking, 'when's it ever going to end?' I was so broken-hearted at what happened to me...I felt that down I couldn't go any lower and no one would listen to me. 'I'm just no good, I'm just nothing, I'm better off dead' that was all I was thinking, 'I'm just better off dead, I'm better off gone, I'm a failure to my kids, I'm just no good'. So I did it. I remember going down to the bedroom and I took all of [her then partner's] heart pills, all of them, every single pill I could find of his, and I can't remember after that (Tracy).*

Tracy's multiple admissions to a MHS in-patient setting were at various times on a voluntary or involuntary basis, and lasted an average of two weeks.

**Lisa**, a woman in her 50s diagnosed with schizo-affective disorder, described how her suicidality had been ongoing for several years. Lisa explained that her suicidal thoughts and behaviours coincided with periods of psychosis and '*feeling really*

*unwell...depressed*'. During such periods Lisa was routinely admitted to a MHS inpatient setting. Lisa explained that, when suicidal:

*you feel like you're the worst of humanity and you're at rock bottom and there is nowhere else to go and you think about hurting yourself and you think 'this is the end, I've just had enough of it' (Lisa).*

Lisa noted that she spent approximately two weeks in the inpatient unit around such suicidal crises, usually admitted on an involuntary basis with that later changing to voluntary status.

**Candice**, a woman in her 30s diagnosed with depression, described how she was voluntarily admitted to a MHS in-patient setting during her recent suicidal crisis (with that later becoming an involuntary admission). Candice described her suicidal crisis as involving overwhelming thoughts of worthlessness and the belief that *'everyone would be better off without me'*. Candice noted that she spent approximately two weeks in the inpatient unit around that crisis.

As discussed in Chapter 4, the interviews with consumers were not principally concerned with the experience of being suicidal *before* intersecting with services. Nevertheless the consumers all chose to share something of what the initial experience of suicidal crisis – and, for most of them, serious suicide attempt – entailed. Appreciating that it is indeed difficult to convey in words the suffering that someone who would kill themselves feels (Goldsmith et al. 2002, p. 17), their accounts suggest that a complex combination of factors came together around their crises – including interpersonal difficulties, bereavement, abuse, social marginalisation, and mental ill-health.

Notably, it is indicated that overarching such factors were intrapersonal experiences of intense suffering and desperation reflecting, in unique examples, what may be analogous to 'psychache' (Shneidman 1996a), 'predicament' (Pridmore 2010), and/or thwarted belongingness (Van Orden et al. 2010), perceived as intolerable. It

is also indicated that suicidal crisis could involve interpersonal isolation including the reluctance or inability to directly communicate suicidality to others. Indeed it is highlighted that the first clear communication of suicidal intent was, for most of the consumers, via their suicidal behaviour, which then led to intersection with mental health services (MHS) and admission to acute mental health/psychiatric hospital inpatient units. This infers the importance of being engaged by others in relation to their intrapersonal experience at that point of intersection with services, if not before.

#### **5.1.2. *'They just want the pain to stop': nurses' views of consumer suicidal crisis***

The nurses' interview accounts reinforce the notion of suicidal crisis as a holistic experience at the centre of which was, typically, an intrapersonal experience of intense suffering and desperation. Accumulation and interplay of factors, including mental ill-health and social or environmental stressors, was suggested to be relevant in this regard. It was noted, for example, that:

*there may be drug and alcohol issues, there may be trauma, or abuse, the person might be facing jail...there's all these different things that may be going on in a person's life...so that might build up or something else might happen – say a relationship break-up – and then it's just too much (AcuteRN3).*

As with the consumers, the nurses expressed an appreciation of intrapersonal suffering being the primary factor within the holistic experience. As one nurse explained this may involve *'a sense of desperation and of sadness and a pain that they can only see one way out of'* (AcuteRN2).

Another nurse noted that when someone killed themselves, or attempted to do so, *'they just want the pain to stop'* (CommRN6). Within that view of suicide as an escape from suffering, hope was noted by some of the nurses to be a central concern in that the suicidal person *'can't see any light and they can't see any hope'* (AcuteRN2).

Further reinforcing the importance of the intrapersonal dimension of suicide, the majority of the nurse interviewees also highlighted their understanding that there could be a great range and variation in consumer suicidality, particularly in respect to risk and intent. Several nurses made a point in this regard of differentiating non-fatal consumer suicidal crisis from fatal suicide. It was expressed, for example, that:

*in some ways you could say 'ok we've got nothing to worry about because when they turn up and ask for help they're the ones that actually aren't going to kill themselves' (CommRN6).*

Another nurse explained, too, that:

*they want to be heard...The person who makes themselves known that they are suicidal, it's a plea for help: 'I want help!' They don't really want to die (AcuteRN2).*

Furthermore, several of the nurses expressed their belief that sometimes suicide was inevitable:

*There are some people you can help, and there's some people you can't (CommRN8);*

*It's a terrible thing to say, it's tragic that she died, but there was an inevitability that she could never live with what had happened in her life (AcuteRN2).*

Such comments may be taken to suggest a problematic perception by the nurses of the level of risk and of the potential for services to effectively respond to suicidal crisis. However, they may also be seen to indicate the nurses' perceptions that there can be great variation in the nature of suicidality, particularly in regards to intent and risk. Appreciating and responding appropriately to such diverse intrapersonal experiences of suicidality reinforces the importance of understanding the meaning that accumulated 'risk factors' might have for an individual.

Amongst the factors seen as contributory to suicide, the majority of the nurse interviewees were keen to express their understanding that interpersonal factors were often highly relevant. One of the nurses, for example, expressed that:

*suicide's a lonely thing to do...There might be a lot of causes or reasons given but a person moving towards suicide is disconnecting...they're disconnecting from the world and being...from their humanness...it's a total disconnect (AcuteRN11).*

Examples of interpersonal difficulty prior to completed consumer suicide were recounted by several nurses:

*His brother came in and said that he wasn't part of the family anymore...The whole family wiped him...Everyone just turned their back on him...and he was just sick of it (AcuteRN1).*

*Apart from almost a secondary problem of his psychosis becoming a bother for him and tormenting him a little more than usual, was his pain at this relationship loss (AcuteRN11).*

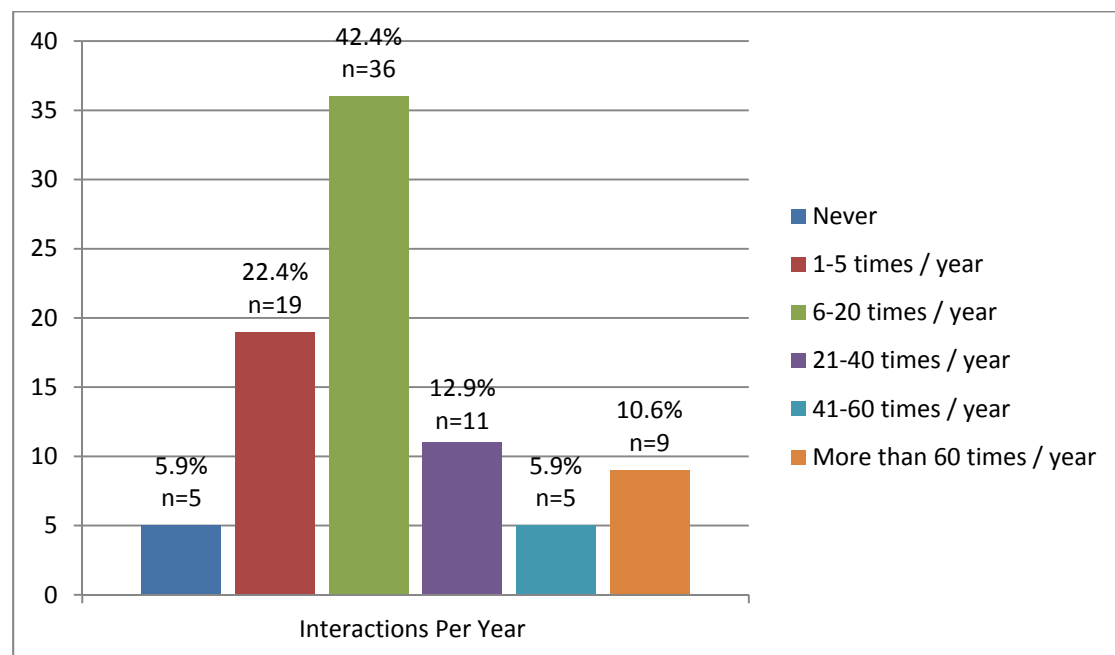
*She'd actually suffered a fair bit of sexual, physical and emotional abuse over quite a period of time during her childhood...she had been quite damaged by the experiences, and these were still permeating into her current thinking (AcuteRN2).*

While intrapersonal and interpersonal factors were most clearly noted by the nurses, it must be appreciated that a more implicit (but still highly significant) relevance was also attributed to the contribution that mental ill-health – in particular depressed or elevated mood, psychosis, or personality disorder – could make towards consumer suicidality. Thus, from the nurses' perspectives the central importance of intrapersonal and interpersonal factors, within a holistic framework, was reinforced.

### 5.1.3. Rates of suicidal crisis within MHS

One of the relevant understandings the nurses conveyed regarding consumer suicidal crisis was that it was something they regularly encountered in their practice. In the survey, for example, 42.4% (n=36) of the nurses indicated that they interacted with a consumer experiencing suicidal crisis 6-20 times per year, 22.4% (n=19) 1-5 times per year, 12.9% (n=11) 21-40 times per year (see figure 5.1 below), and 10.6% (n=9) more than 60 times a year.

**Figure 5.1. Survey question 7: Reported rates of RN interaction with consumers considered by RNs to be in suicidal crisis**



Interview data reflects marginally higher rates of interactions with consumers in suicidal crisis than does the survey data. This discrepancy may be attributable to differences in interpretations of the definition of 'suicidal crisis', sample bias (whereby nurses with more experiences of interaction with suicidal consumers were possibly more likely to volunteer for interview), and perhaps, too, that the experience of going further 'in-depth' in the interviews prompted recollection or recognition of more instances of suicidal crisis.

When I asked the nurses in interview to estimate how often they interacted with a consumer who was experiencing suicidal crisis nine clear responses were given (see Table 5.1. below). These ranged from *‘every day...every day I go to work’* (AcuteRN1) to *‘probably one every couple of months’* (CommRN8). It is apparent that, generally speaking, nurses who worked in acute settings perceived slightly higher rates, nurses who worked in community crisis assessment teams mid-range rates, and those working in community case-management roles the lowest rates.

**Table 5.1. RN interview participant reported rates of contact with consumers in suicidal crisis**

Nurse	Frequency	Quote frequency is calculated from
AcuteRN1	5 per week	<i>‘Every day...every day I go to work’</i>
AcuteRN2	2-3 per week	<i>‘Two or three times a week’</i>
AcuteRN3	1 per week	<i>‘Once or twice a fortnight’</i>
AcuteRN4	1 per week	<i>‘Pretty much weekly’</i>
CommRN6	2 per week	<i>‘Two a week minimum I think’</i>
CommRN7	2 per week	<i>‘I’d probably say five or ten times a month’</i>
CommRN8	1 per 2month	<i>‘Probably one every couple of months’</i>
AcuteRN9	1 per week	<i>‘Oh, definitely weekly’</i>
CommRN10	2 per week	<i>‘Regularly, at least a couple a week’</i>
	<b>Average = 1-2 per week</b>	

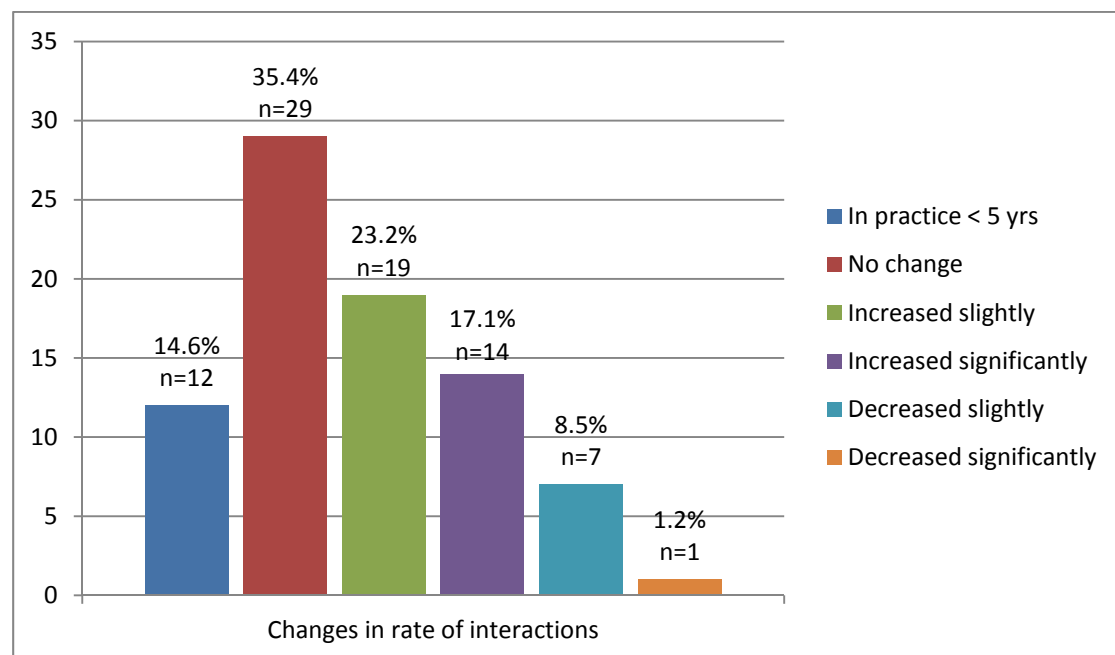
The data thus suggests that most of the nurses perceived they had regular interaction with consumers experiencing suicidal crisis. Considering both data sets, I have conservatively estimated the rate of interaction to average around one interaction per week per nurse. In reflecting on my own previous practice as a MHS nurse (in both inpatient and community case-management settings) I support the view that suicidal crisis within MHS inpatient settings is something that a nurse could expect to come across on a weekly basis, with the frequency less in a community mental health team case-manager role.



Data accessed as part of my engagement with SMHS supports the notion that consumer suicidality is a significantly common issue. For example, in relation to non-fatal suicidal behaviour, data reflects that in the month of April 2010, 19.2% of the 1633 (n=313) active MHS clients were formally assessed and recorded during the period as having non-accidental self-injury or suicidality as an issue (ranging from suicidal ideation to non-fatal suicidal acts) (SMHS 2010). There were 1371 occasions of service (18.1% of total occasions of service) recorded as having occurred with those 313 people in that month (SMHS 2010). In addition, during the same month suicidality was identified as an issue in 24% of all calls (n=127) to the MHS run mental health helpline (SMHS 2010). Furthermore, the MHS data notes that for the years 2008 and 2009 combined there were at least 10 deaths by suicide identified amongst people who were current MHS clients at the time of their death (SMHS 2010).

The survey data also suggests that, as a group, the nurses perceived the frequency of MHS consumer suicidal crisis to have increased over the period 2005-2010 (see figure 5.2. below). While 35.4% (n=29) of nurse survey respondents reported that from their perspective the number of interactions had stayed the same, 40.3% (n=33) said there had been an increase ('significant' and 'slight' increase combined), and only 9.7% (n=8) said there had been a decrease ('significant' and 'slight' decrease combined).

**Figure 5.2. Survey question 8: RN reporting on perceived changes of rates of RN interaction with consumers considered by them to be in suicidal crisis 2005-2010**



The notion of an increase in the frequency of nurse interactions with MHS consumers who were experiencing suicidal crisis was not part of the interview schedule, however it was raised by one nurse interviewee who expressed that *'there's been a definite increase'* (AcuteRN3).

The indication that nurses interacted, on average, with suicidal consumers on a weekly basis, and that the rate of interactions with suicidal consumers may be increasing, reinforces the importance of service in this context. Furthermore, in attempting to estimate the rates of suicidal crisis and nursing interactions with consumers experiencing suicidal crisis, something of the complexity of suicide and the challenges of identifying and exploring it are highlighted. For example, memory and/or interpretation bias (i.e. interpretation of the wording or meaning of questions, and interpretation of intent or degree of suicidality) is suggested to play a part in the recognition of suicidality. Reflecting this, CommRN7, for example, noted a range between *'five or ten times a month'* for suicidal crisis according to the definition that I discussed with him. However he suggested that the figure rose to

*'twenty or thirty people a week'* in regards to suicidal ideation. As well as reinforcing the complexity of identifying and understanding suicidality this points to the fact that, while suicidal crisis was perceived to be common, the presence of suicidality of some lesser degree is likely to have been extremely common.

#### **5.1.4. Summary**

The participants' accounts reinforce that suicidal crisis may be understood as a holistic experience, within which an accumulation and interplay of social, psychiatric and psychological factors results in an experience of intense suffering and desperation with the idea of death as an escape. It is indicated that intrapersonal experiences analogous to 'psychache' were an over-arching factor and of central relevance to decision making at times of suicidal crisis. These findings are consistent with previous findings that suicidality is typically aimed at cessation of an intolerable intrapersonal experience (Shneidman 1996a). The findings also reinforce that the presence of mental disorder or illness is typically understood as an important contributing factor in this context (Ghio et al. 2011, p. 213). The importance of interpersonal factors is also suggested to be highly significant, and it is reinforced that such factors may be contributory to suicidality and also present the opportunity for the intrapersonal experience of suicidality to be understood (Maris et al. 2000a). It was also suggested in this regard, however, that understanding of consumer suffering and suicidality often remained hidden from others, with suicidality expressed by some to be too much of a 'burden' to share with those closest to them.

These understandings of suicidal crisis point to the major mental health care needs that consumers have at such a time, namely: access to service, the provision of physical care and safety, treatment of psychiatric symptoms, and appropriate engagement with staff (particularly engagement concerned with the consumer's unique intrapersonal experience). The available data also indicates that consumer suicidality was, on average, encountered on a weekly basis by the nurses. By considering how suicidal crisis was experienced and conceptualised the significance of service in this important context is highlighted.

## **5.2. Access and understanding at a time of suicidal crisis**

This section explores experiences of access and initial intersection with services around consumer suicidal crisis. The relevance of a holistic conceptualisation of suicide, within which intrapersonal and interpersonal factors are of particular importance, is reinforced. It is also made explicit that gaining access to service was an essential prerequisite to receiving physical care and safety, treatment of psychiatric symptoms, and appropriate engagement. It is highlighted that a particular quality of engagement (with staff and/or significant others) was essential towards enabling the person to be understood and to gain access in this initial intersection.

### **5.2.1. *'It's sort of set up to dissuade access': access to service***

The consumer interview data highlights challenges and limitations around gaining access to service. It is noted that advocacy by significant others and engagement by staff was essential at this time. Kate, for example, explained that her first interaction was with the triage nurse in the hospital emergency department and that the nature of this was less than ideal. Kate recounted explaining to the nurse exactly how she had tried to kill herself, noting that:

*then the nurse said, 'You can't kill yourself like that!'...so I had to stand there in the Emergency Department with a lot of people listening and explain the whole thing...there was no privacy, but it was also that accusation. She treated me as though I was lying (Kate).*

Kate's experience, along with several of the other consumers, supports the argument that consumers may experience 'stigma or dismissiveness' in relation to non-fatal suicidal behaviour (Mendoza & Rosenberg 2010, p. 45), or that their views may be minimised, denied or 'disrespected' (Lakeman 2007, p. 152, 2010a). Kate pointed out that she did not think that she could have navigated access to service via the emergency department without the advocacy of her mother and a friend.

Revealing another potential challenge to access, Lucy expressed that she '*didn't want help at the time*' (Lucy). Such ambivalence – known to be a common feature of suicidality (Maris et al. 2000a, p. 509) – may have further challenged access to service. As with Kate, Lucy expressed that staff had to be 'convinced' to admit her to hospital. She explained in this regard that:

*my daughter was starting to get worried because they were talking about sending me home and she was saying to them the last thing she wanted was me coming home in that state...I didn't really care what happened, but luckily I ran around the hospital a fair bit and convinced them...so they decided to put me into the psychiatric section (Lucy).*

Lucy also noted that during her time in the emergency department, the nurses:

*were nice to me but they were flat out and worked off their feet. They just gave me charcoal and put me out close to the main desk and just kept an eye on me (Lucy).*

Thus, both Kate's and Lucy's accounts exemplify how access via an emergency department medical triage system may be challenging, particularly when, as with Lucy, the person is ambivalent about receiving service. Notably, it is suggested that advocacy by 'significant others' was crucial to access being gained. Clearly, in both of these examples too, the nature of interactions with nursing staff was suggested to be less than ideal – from Kate's accusatory interaction to Lucy being essentially observed rather than engaged. These accounts reinforce that access and assessment difficulties may dissuade or prevent people from receiving help via the public health system (Szasz 1999; MHCA 2005, 2009), particularly when traditional service models such as medical triage are relied upon (ABC 2010; Dawtrey 2010; Cutcliffe & Stevenson 2008b), and when problematic staff approaches or attitudes are encountered (Mendoza & Rosenberg 2010, p. 45; Lakeman 2007, p. 152, 2010a).

The suggestion that appropriate engagement and support from others (particularly staff and/or family and friends) was essential to gaining access to service – and to service being experienced positively – is further reinforced in respect to most of the other consumers' experiences of their initial admission to the psychiatric inpatient units. Claire, for example, described gaining access to the psychiatric inpatient unit at night time when much of the unit was in a darkened state. Claire had never before been in such a unit and she explained how her fears about being 'locked up' were overwhelming:

*The nurse said that I couldn't be let out and there was nothing I could do about that. I just felt trapped...The nurses put me in my room and then they went away, and then I slowly got up and started to walk around...I was scared because there were other people there and the thought of being locked up with people with schizophrenia...I felt like I was with all these mental people and it freaked me out - you know, they might hurt me...I was looking around the place for a couple of hours trying to find a way out, and I was scared. Even the nurses walking around checking on people scared me because it was someone moving around and I'd run away and hide around the corner. I don't know how long until I went to sleep, if I did go to sleep (Claire).*

Claire's account of entering into the locked psychiatric inpatient unit is similar to numerous other consumers' accounts in suggesting that this experience potentially compounded pre-existing feelings of fear, anxiety and distress. This was apparently particularly so for those people, such as Claire, who had not spent time in such a unit previously. Thus it is affirmed that the person who is suicidal and hospitalised, and potentially already isolated and distressed prior to admission, 'may feel even more isolated as a result of psychiatric admission' (Lineberry 2011, p. 345). Such experiences reinforce the importance of a particular quality of interpersonal engagement by staff in order to promote access and the therapeutic potential of initial intersection with services.

Lisa's account highlights that consumers who *did* have prior experience of admission could also find admission problematic. In addition to ambivalence around receiving service, and the need for advocacy, Lisa described how previous admissions had been involuntary and usually involved her being initially placed in the 'high dependency unit' (HDU) [this is a high-security, low-stimulus section of an inpatient unit which is designed to enable fuller observation and maintenance of physical safety of consumers considered to pose particularly high risk to themselves and / or others]. Lisa expressed that being placed initially in the HDU '*makes me worse...it's terrible...one of the worst feelings I've ever felt, being locked up alone out there*'. For Lisa, the limitations to such treatment centred around a lack of human interaction, as from her perspective:

*the more you have human interaction, the better. You become more stable as you listen and you're talking to somebody and interacting' (Lisa).*

Thus, the importance of appropriate interpersonal engagement at times of initial intersection with services was reinforced.

Several of the nurse interviewees also spoke about the challenges and service limitations consumers could face around gaining access to care. One nurse, for example, recalled the suicide of a consumer which occurred after she assessed him in the hospital emergency department but was unable to successfully 'admit' him:

*It was very busy and he was meant to stay back in the queue. I had to give a rationale for him jumping the queue and seeing me. So I walked away to do that. I talked to a doctor, I got the file organised, I argued for a room. All that took time – five, ten minutes...I came back and he had gone [and he died by suicide several hours later] (AcuteRN11).*

It was also noted that someone ambivalent about receiving care may not be 'embraced' by the system as, even if access was initially gained, service might be withdrawn prematurely. One nurse explained, for example, a scenario where a

colleague had informed the consumer that: *'if you're not prepared to accept treatment from us we will discharge you'* (AcuteRN1). Given issues such as consumer ambivalence around suicidal crisis such features of service can be seen as potentially problematic. In regard to limitations such as those noted above it was asserted by several nurses that:

*there's obviously some system issues...it's set up to probably wipe out the person who is in two minds about suicide; it's sort of set up to dissuade access in a way* (AcuteRN2).

Thus it was inferred that *'what a lot of services are doing is closing the door rather than opening the door'* (CommRN6).

The participants' accounts highlight, then, that access to service and admission to inpatient units were important and often challenging experiences. It is reinforced, furthermore, that interpersonal engagement with others (advocacy from significant others and appropriate engagement from staff) at this initial stage was absolutely essential, particularly as it promoted access by countering some of the ambivalence, fear, and isolation potentially experienced by the suicidal person at that time. Thus, interpersonal engagement was seen as essential to enabling the suicidal person to navigate a system that could be difficult and daunting to access. The incident recounted by one nurse regarding the suicide of a person who sought help, but was not enabled to receive access to service, is a stark reminder that suicidal people other than those able to participate in this research may fail to have the most basic need of access to service met.

### **5.2.2. 'Not just a question': the imperative of understanding**

Further highlighting the importance of interpersonal engagement with others around access and initial intersection with services, the majority of the nurse interviewees described the absolute importance of gaining meaningful understanding of the person in suicidal crisis as soon as possible (and then maintaining and building upon that). Because, as noted, suicidality was appreciated



to be a complex, holistic and unique experience, gaining understanding of the individual consumer's intrapersonal experience was seen as central to gaining meaningful understanding. The majority of the nurse interviewees noted that generating such understanding required a particular quality of engagement. For example, it was noted that:

*assessing suicide is not just a question of 'are you suicidal? Do you have intentions of suicide?' Of course they're going to be part of what you're talking about but I need to know the context, what they're actually thinking...I need them to trust me and be honest with me (AcuteRN3).*

Generating understanding of the consumer's intrapersonal experience was thus seen as essential to understanding the nature and meaning of relevant risk factors, and also to planning and enabling quality care. Towards this it was expressed, for example, that:

*I'm trying to find out if they've got a plan, how long they've had the plan for and all that, but also what sorts of things they can try do to....what do they like doing, what are they able to do...what is an alternative to committing suicide? (AcuteRN1).*

Thus the nurses strongly appreciated that gaining understanding via meaningful engagement with consumers was essential to assessment which could ensure short term needs such as physical safety, as well as promote further care. This acknowledges that assessment is only of use if it leads to appropriate and effective intervention (Cutcliffe & Stevenson 2008a, p. 343), as 'risk assessment itself never saved anyone's life' (Maris 2007, p. vi). Of particular relevance is the indication that engagement which enables appreciation of the consumer's intrapersonal experience may have particular value in this regard. This is pertinent to consider given the suggestion that inadequate evidence exists to assert that risk assessment is actually effective in reducing self-harm or suicide within mental health care contexts (Wand 2012, p. 2).

### **5.2.3. Summary**

The participants' accounts affirm and nuance previous findings that the immediate care aims for an acutely suicidal person are 'protection, safety' and 'connectedness' (Maris et al. 2000a, p. 515). Importantly, participants' accounts suggest that interpersonal engagement (encompassing connectedness) was a need of primary importance as it promoted the potential for access, admission, and assessment, to occur appropriately. How, ultimately, service underpinned by interpersonal engagement may help restore or generate in consumers hope and empowerment enabling resolution of crisis and the fuller realisation of recovery has been alluded to here, and is explored in depth in subsequent chapters. It is evidenced thus far, however, that interpersonal engagement which enabled adequate understanding of the suicidal person's intrapersonal experience was seen to be vital to accessing care, admission to inpatient settings and initial assessment and care planning.

### **5.3. Lack of engagement between consumers and nurses**

This section highlights the participants' appreciation that, while interpersonal engagement between consumers and nurses was understood to be central to meeting consumer needs, such engagement was not seen to exist to the extent that either nurses or consumers desired. The principle problem resulting from a lack of appropriate engagement in this context was suggested to be the continuation of consumer isolation in respect to their intrapersonal experience, and of nurses being unable to achieve the quality of care they aspired to. It is also noted that the majority of the nurse interviewees expressed that they themselves felt isolated in their 'teams' in that their aspirations to achieve appropriate engagement (the nature of which is explored in-depth in Chapter 7) did not seem to be widely appreciated or supported. In discussing the under-realisation of engagement this section also introduces the notion that service was seen to be heavily reliant on medical, custodial and observational interventions (explored in-depth in Chapter 6), and that

the nature of care was seen to be attributable to a complex interaction of consumer, nurse and contextual factors (explored in-depth in Chapter 8).

### **5.3.1. 'It can be the difference between life and death': nurses' perspectives on frustrated intentions to engage**

The nurses indicated a strong appreciation of the importance of appropriate interpersonal engagement with consumers who were in suicidal crisis. Indeed, engagement was commonly seen to be the most important element of quality care. As one nurse, noted, for example:

*it's about engaging with that client...I can't see that there's any other reason....other than you're custodial and you sit there and observe and I don't see that as particularly therapeutic (Acute RN4).*

Thus, it was appreciated by some nurses that:

*the opportunity to interact is the ultimate...it's a really important interaction....It can be the difference between life and death (AcuteRN2).*

Concerningly, both the nurses' survey and interview data indicate a significant gap between the aim to engage and the realisation of that aim. For example, when asked via the survey to classify their *ideal* approach as primarily 'observation' or 'engagement', 83.4% (n=65) nominated 'engagement', 7.7% (n=6) 'observation', and 9% (n=7) 'other'. However, when classifying what their *actual* approach primarily was, 61.8% (n=50) nominated 'engagement', 30% (n=24) 'observation', and 8.6% (n=7) 'other'.

Open-ended survey responses that asked the nurses to describe their typical *actual* approach further suggested an under-realisation of engagement. In descending order of frequency responses were described as being primarily assessment (n=19), creation of treatment plans (n=10), ensuring physical safety (n=9), active listening (n=8), building therapeutic alliance (n=7), and mobilising support and resources

(n=7). As asserted previously, care in the context at hand is a complex experience best not reduced to such discrete categorisation. Additionally, it is possible that engagement may have been combined with various other interventions noted here. Nevertheless, the survey data suggests that the nurses felt they were not achieving engagement-based care to the extent that they would have liked to.

The interview data further reinforces the suggestion that engagement was not achieved to the extent that nurses desired. Interestingly, the nurses' interview accounts indicate their perception that, in relation to their own practice, the under-realisation of engagement was attributable to a range of consumer and contextual limitations which essentially thwarted the nurse's best intention to engage. In critique of their colleagues, however, the nurse interviewees were critical of nurses themselves, implying that their colleague's inappropriate intentions and attitudes, as well as their lack of knowledge and skills, were the key factors resulting in the under-realisation of engagement.

Most of the nurse interviewees suggested that a lack of engagement was reflective of, and shaped by, over-reliance on a reductive, medical-psychiatric model of care. One nurse noted, for example, that:

*the emphasis here is on biological psychiatry where if you have schizophrenia we have medication that can treat that, we can alleviate the symptoms and we can discharge you...Anyone else – your OCD, anxiety, depression – they're tolerated. But personality disorders are dismissed out of hand (AcuteRN4).*

Such a model of care arguably reinforces the suggestion – a key concern within the Tasmanian suicide prevention strategy – that services may, problematically in the context of suicidality, be best suited to dealing with specific disorders such as schizophrenia rather than with complex psycho-social issues and suicidality (Tasmanian Government 2010a, p. 36).

Within the critique of their colleagues and the service model the nurse interviewees also suggested that the attributes of consumers themselves could sometimes prevent the realisation of therapeutic engagement. This was suggested to potentially have a legitimate basis as sometimes there was a '*personality clash*' (AcuteRN4), or consumers were perceived to have actively '*burnt their bridges with everybody*' (AcuteRN2).

However, it was the reduction of the suicidal person and their crisis to 'personality disorder' that was suggested to be most problematic. For example, a common approach to certain suicidal consumers was recounted as follows:

*Some nurses just say, 'they're a PD [personality disorder] we won't deal with them anymore – yeah whatever' and they just push them aside (AcuteRN1).*

Thus it was inferred that '*an air of cynicism can grow around a particular client...and a lot of people, they just get wiped*' (AcuteRN2).

Related to such reductionism and dismissiveness, several of the nurses argued that their nursing colleagues did not seem to prioritise or pursue the aim of therapeutic interpersonal engagement. Indeed, most of the nurses recounted disengaged approaches by their colleagues. AcuteRN4, for example, explained that:

*if you were to go around the various [nursing] stations now you would see the majority of the staff sitting in the staff stations and the patients sitting out...I don't think somehow they're getting what their role is as a therapeutic agent (AcuteRN4).*

Indeed it was claimed that, commonly:

*suicidality is seen as a difficult issue to work with – it's the most difficult of all interactions to have with a client. So if a worker can get out of being involved in that...a judgement of mine is that they do just that! (AcuteRN3).*

This meant that, in practice, engagement was seen to not be sought by many nurses, with the result potentially being, for example, that:

*he doesn't move out of that [office] chair anymore...he's one of the ones that talks to people from the chair. I mean he doesn't get off it! He'll move the chair to the door and answer the door! (AcuteRN1).*

Furthermore, it was claimed that, often:

*a nurse's response is essentially to tell them [the suicidal person] to pull their socks up! 'Stop that!' (AcuteRN4).*

Additionally, a disengaged approach was seen to reflect and shape a focus on medication, in particular. For example, it was noted that:

*a lot of them just go 'oh well, I think you need some PRN' [PRN is medication prescribed to be administered 'as required']. I try and keep away from the PRN... But I mean a lot of the older staff are 'oh I will just whack 'em with some PRN' (AcuteRN1).*

The lack of engagement was also seen to reflect and shape a custodial focus, whereby:

*they'll just put them back in the HDU and just get medication into them...which some people find the easy scenario, but I don't find it easy at all, I find it awful, if it ends up like that (AcuteRN2).*

Further to the notion of some nurses failing to promote engagement, and other nurses feeling isolated in their attempts to engage, it was asserted by several nurses that they themselves were sometimes negatively evaluated for pursuing a more

engagement-based approach to care. For example, AcuteRN3 explained that the greatest obstacle to him being able to therapeutically engage with consumers was:

*being judged! Me being judged by other staff...i.e. 'where abouts is [AcuteRN3]?' 'Oh he's been in a room with so and so for the last hour!' 'What's he doing?' 'Oh I don't know, prob'ly nothin!' [said in derogatory tone] (AcuteRN3).*

Thus it was suggested that some of the nurses themselves felt isolated within the 'team', with that potentially limiting their own ability to more fully realise engagement-based care.

Reinforcing the broader context (see Chapter 1), and specifically in relation to mental health nursing and mental health nursing care of suicidal people (see Chapter 2), the findings indicate that nurses (as a whole) were not achieving engagement with consumers to the extent that many nurses desired and felt was necessary. Furthermore, the nurses' accounts suggest that this problematic scenario resulted in a focus on medical, custodial and observational interventions. Additionally, the nature of service was suggested to be mediated by a complex combination of consumer, nurse and service-related contextual factors. Importantly, the intentions, attitudes and actions of nurses were seen as a particularly significant limitation amongst those related factors.

### **5.3.2. 'No one's really interested in hearing the story': consumer perspectives on lack of engagement**

As noted, the consumers' accounts indicate that appropriate interpersonal engagement was chief amongst their needs, particularly as it enabled their holistic and intrapersonal experiences to be understood and responded to. Such engagement, however, was perceived by the consumers to be absent or minimal, particularly in initial stages of service.

Ben was amongst the majority of consumer interviewees who expressed that there was very little appropriate interpersonal engagement with the nurses throughout admission. For example, Ben recalled that *'there was really no interaction with the nurses... they just left me there in bed'*. He explained further that he was still feeling suicidal when first admitted to the unit, that nobody asked him directly whether that was the case, and that he did not feel that he could initiate conversation concerning how he was feeling.

As noted, Ben acknowledged that he had some trouble recalling all of the events around his hospital care. While his account must be considered in light of this, it is nevertheless clear that, from Ben's perspective, on his most recent admission to hospital following his suicide attempt, he did not experience that which he perceived to be most important, that being:

*someone to sit down and talk with and go through it all...to just support you and ask you about it and how you're feeling...someone to make contact with you about it (Ben).*

Indeed, from Ben's perspective, the only contact he remembered having with the nurses during his admission following his overdose was around the administration of medication [the same form of medication, incidentally, that he had intentionally overdosed on when suicidal]. From his point of view, then, the focus of care was principally on medication and containment, which, as noted, is argued to be the dominant mode of care in comparable contexts (Cutcliffe & Stevenson 2008b; Marsh 2010).

Reinforcing the notion of a medicalised approach lacking appropriate engagement, Kate explained that:

*there was no-one I was able to tell the story of why I was suicidal. Like they go to a lot of trouble to make sure you're properly medicated...but no one's really*



*interested in hearing the story of why you did it or why you're in that sort of shape (Kate).*

Kate felt that she was, in a sense, reduced to depression to be treated by medication, and to an at-risk 'object' to be observed and contained. Kate expressed that she was actually seeking to be somewhere where she would be 'controlled' from harming herself in her crisis. However, she also felt the need for (and lack of) someone to engage with more deeply about what she was experiencing. Kate explained that:

*when you're in that sort of situation you need to discuss it as much as possible to sort out in your own head what you were thinking...to get better you need to discuss it. Isolation is what you don't need (Kate).*

As noted, Kate did 'share' something of her story with the triage nurse. That she experienced that initial interaction as accusatory highlights that it is not interpersonal interaction per se that is needed, but rather a particular *quality* of engagement – with this obvious but important point having been noted by others (Talseth et al. 1997; Cutcliffe & Stevenson 2007). Indeed, It was evident that, while consumers including Kate welcomed the physically safe environment, it was problematic for them to remain largely alone with their intrapersonal experiences of feeling suicidal, of having survived an attempt to die, and of having entered an unusual institutional environment.

Candice, too, expressed that she experienced a lack of meaningful engagement with staff, and an overreliance on medical and custodial approaches. She explained that upon admission she soon realised that she '*didn't want to be there*' as she '*just didn't believe in the whole 'taking medicines and I'd be okay' thing*', and felt that that was all that was being offered to her. She noted further that '*no one really spoke to me about how I was feeling or what I was thinking*'. Candice, as with most of the consumers, thus felt strongly that her experience of crisis – her very 'self' – was problematically reduced and oversimplified to a psychiatric diagnosis (in her case

depression). For Candice, and most of the other consumers, the framework of 'illness' did not capture what she was experiencing and reflected and reinforced a limited model of care.

Andrew also expressed that it was problematic that his interactions with nursing staff did not feature meaningful engagement directly concerned with his intrapersonal experience. Indeed, Andrew expressed that even over multiple admissions when suicidality had been an issue for him, *'no one has ever asked me about it. Like, none of the nurses have ever talked to me about it'*.

As noted, Andrew was amongst the consumers who expressed they could not directly communicate their suicidality to family and friends. He explained that:

*I wouldn't want to upset my family. It's too much for them to handle...talking to professionals is better...they're trained to deal with it (Andrew).*

Andrew's apparent lack of engagement is particularly concerning in this regard, then, as he saw professionals such as nurses as amongst the only people he could share his suicidality with.

Lucy, too, explained that the depth and quality of her engagement with inpatient nursing staff was limited. Lucy noted that, while the nurses were:

*all very nice and very caring...nobody talked to me about what I'd been through, about feeling suicidal and about the attempt (Lucy).*

As with Kate, Lucy thus reinforced the notion that appropriate engagement concerned with consumers' intrapersonal experiences was both desired and lacking. Lucy and I discussed this further:

*Lucy: It would be nice just to have a person that you'd feel was there for you, that you could talk to...I think that would have been beneficial.*

*D: How would that have been beneficial?*

*Lucy: It would have been more personal and somebody understanding what you're going through.*

*D: Was that need met?*

*Lucy: No, not really, no. I think they do a tremendous job with what they've got. Everywhere you go they're short staffed though, especially in emergency.*

Lucy's experience reinforces, then, that service lacked the desired quality of engagement, particularly as it was not directly concerned with her intrapersonal experience. Lucy's account also suggests that consumers may justify the lack of engagement as something understandable given some of the mediating factors at play, such as perceived staff shortages.

Claire, too, expressed that there was a lack of meaningful engagement with staff. Reinforcing the suggestion that consumer, nurse and contextual factors may come together to limit engagement, and that consumers may seek to justify not being engaged, Claire attributed her lack of engagement in the initial phase of service in part to her state of mind and behaviour. She recounted that:

*I remember getting angry, and I didn't feel like the nurses understood me and knew why I was in there...I was on my own, but that could've been because of the state I was in...I was scared and that portrayed as being angry, so that was not very good (Claire).*

Claire's account reinforces that there was a lack of engagement and that a complex interaction of factors, including consumer characteristics such as fear or aggression, may have been contributory to that.

As noted, Lisa, too, felt that service could be isolative at the very time that she required appropriate interpersonal engagement. However, she also noted that, over numerous admissions, she had built relationships with staff such that each new admission seemed to feature greater and more meaningful engagement with nurses. John and Tracy, too, presented relatively positive views of service. While it would seem that engagement was, as for the other consumers, still 'superficial' for these three consumers in that it had limited or no explicit or direct focus on accessing and positively constructing intrapersonal meanings around suicidal crisis, service was seen to entail positive interpersonal interaction. For John service was positively experienced because:

*there's a lot more people [referring to case manager] come and see you now, but years ago they didn't...there's help for you now (John).*

For Tracy, too, particularly in the context of her considerable social stressors, access to service which involved relatively positive interpersonal interaction was something she described as very helpful. Tracy noted that interactions with nurses were, typically '*just normal, just, 'Hi, how are you?' and stuff like that. Helpful like that*'.

Positive, 'normal' interaction was experienced by John and Tracy, in particular, but also by others, as significantly therapeutic. Thus it is inferred that appropriate engagement could entail both 'deeper' and more 'superficial' interaction, but that both could be welcomed and useful. Tracy noted that such 'lighter' conversation reflected a type of professional-friend relationship and that:

*they're my friends, the nurses – I mean I know they're not really friends – but they're like friends...if it wasn't for them I wouldn't be where I am today and they've just been wonderful (Tracy).*

In this respect it is affirmed that 'ordinary chat' might be highly therapeutic in such mental health nursing contexts (Burnard 2003, p. 682). Interestingly, Lisa, and in particular John and Tracy, had considerably longer-standing involvement with

services than the other consumers. The more positive views of service for these consumers seems largely attributable to the fact that they had established and predominantly positive relationships with staff, and that service was a welcome resource and refuge in times of crisis which could involve relatively severe social stressors.

While, then, the majority of consumers reported predominantly friendly and positive interactions with nursing staff – and it is notable that such interaction within a place of relative physical safety was seen as valuable – it was also the case that engagement did not extend to a ‘deeper’ level – that which was concerned with the consumer’s intrapersonal ‘world’ as it directly related to crisis and care. Importantly, it is clear that such a quality of engagement was seen by the participants to be essential to quality care.

### **5.3.3. Summary**

This section has highlighted that therapeutic engagement, appreciated by both nurse and consumer participants to be vital, was under-realised. This was seen to be problematic as consumers’ intrapersonal experiences remained largely hidden and consumers thus overly isolated. For the nurses this meant an inability to more fully understand the consumers and thus be optimally responsive to their needs. For many of the nurse interviewees this under-realisation of engagement was seen to infer that nurses themselves could feel isolated in their ‘teams’ if they were amongst the perceived minority who wished to prioritise a focus on engagement. The section has also reinforced that, in the absence of appropriate interpersonal engagement, service may be heavily reliant on more reductive medical and custodial approaches. It is also reinforced that the nature of care may be seen as attributable to a complex interaction of consumer, nurse and contextual factors.

## **5.4. Conclusion**

This chapter has explored the participant data to affirm the relevance of a holistic understanding of suicide, and to identify the related consumer needs of access to service, physical care and safety, treatment of psychiatric symptoms, and appropriate interpersonal engagement. The imperative for these needs to be met is reinforced by the appreciation that suicidal crisis entailed experiences of extreme suffering and desperation with the very real risk of death, and, furthermore, by the indication that suicidal crisis was something that nurses, on average, reported encountering on a weekly basis.

Within the holistic construction of suicidal crisis, the intrapersonal dimension was suggested to be particularly significant. This is because the intrapersonal experience can be seen to reflect the meaning that various holistic elements (risk factors) held for the consumer as central to the decision to pursue suicide, and to both reflect and shape subsequent experiences of service. The interpersonal dimension was also seen as significant because suicidality invariably arose in interpersonal contexts, and, furthermore, because interpersonal interaction was essential towards enabling the suicidal person and their intrapersonal experience to be understood and affected.

This chapter has also highlighted, however, the perception of serious limitations to the quality of service. In particular, the participant data indicates that gaining access to service, and initial entry into emergency departments and mental health/psychiatric inpatient units, was potentially a difficult, daunting and sometimes distressing and alienating experience (as noted previously by Mendoza & Rosenberg 2010; De Leo 2011, p. 238; Tasmanian Government 2007, 2010a). At the core of these limitations was a failure to comprehensively realise and integrate consumer needs into the care approach. This meant that, as has been noted (Cutcliffe & Stevenson 2008a; Ghio et al. 2011, p. 515; Tasmanian Government 2010a, p. 36), care could be characterised as largely custodial and medical. Medical and custodial elements of service were acknowledged to be potentially useful, particularly as they provided a place of physical safety and the chance for treatment

of psychiatric symptoms. The principle limitation to service was strongly suggested to be the under-realisation of a particular quality of interpersonal engagement between consumers and nurses.

While a superficial form of interaction with nurses was noted by the consumers to be common and to be of potential value, engagement on a deeper level directly concerned with consumers' intrapersonal experiences was problematically and commonly under-realised. While something of the consumers' intrapersonal experiences was revealed through their suicidal behaviour, it is evident that they were largely alone with their intrapersonal experience prior to their crisis. It was suggested that reluctance to communicate their suicidality may have been related to ambivalence about seeking help and also out of concern that it would be too much of a burden for their family or friends. Concerningly, it is indicated that this inability to share their suicidality via interpersonal engagement was largely maintained as they entered service. In this sense it would seem that a recognised 'window of opportunity' to more appropriately and effectively engage at the point of crisis (Michel 2011, p. 17) may not have been well utilised, nor, as shall be further explored in the following chapter, built upon. Thus the participants' accounts suggest that intrapersonal and interpersonal isolation was, in a sense, maintained, and the potential for optimal understanding and response thereby potentially limited.

The nurses indicated that they were aware of the central importance of interpersonal engagement which was concerned with the consumers' holistic and intrapersonal experience. However, they expressed being frustrated in their intention to enable such engagement to the extent they wanted. Numerous nurse interviewees indicated, furthermore, that they themselves felt 'isolated' as their colleagues did not appear to support nor pursue a model of care based around engagement. Indeed the nurses were highly critical of the standard of care in this regard. The nurses expressed feeling frustrated – arguably even angry or guilty – that they were not able to more fully meet the needs of people who they recognised to be in acute need of a holistic form of care which would be most fully promoted on a foundation of engagement.

The findings suggest that medical-psychiatric treatment was appreciated to be of potential value by most of the participants, as has been found previously (Ghio et al. 2011, p. 514). However, they also reinforce previous assertions that service may be overly reliant on treatment of mental illness (Tasmanian Government 2010a, p. 36) and on medical and custodial interventions (Ghio et al. 2011, p. 514). The lack of engagement is highlighted as a serious concern, particularly given that both nurse and consumer participants affirm its importance. As noted, the importance of engagement is also reinforced in the literature, including that concerned with mental health nursing (Barker et al. 1997; Cleary et al. 1999a; Walsh 1999; Hummelvoll & Severinsson 2001; Cutcliffe & Stevenson 2008b; ACMHN 2010a; Barker & Buchanan-Barker 2011a), care of suicidal people (Mishara 2008a, p. 2; Ghio et al. 2011, p. 510; Maris et al. 2000a; Leenaars 2006; Michel et al. 2004; Reeves & Seber 2004), and mental health nursing care of suicidal people specifically (Talseth et al. 1999; Hewitt & Edwards 2006, p. 666; Cutcliffe & Stevenson 2008a, p. 942; Barker & Buchanan-Barker 2011a, p. 356; Billings 2004, p. 191; Cardell & Pitula 1999; Jones et al. 2000; Bowers et al. 2011, p. 1464). Additionally, the consumers' accounts further reinforce that a complex interplay of factors may contribute to the under-realisation of engagement. Appreciation by the participants of the importance of engagement also reinforces the notion that the quality of service may be evaluated by those with first-hand involvement directly in respect to the human relationships it entails (Ghio et al. 2011, p. 516).



## **Chapter 6 – Watching and waiting: inpatient unit service and the value of engagement**

This chapter draws upon the participant data to identify and explore the principle interventions and practices understood to constitute inpatient unit service in the context of consumer suicidal crisis. In focusing on this central period of consumers' service 'journeys', it is indicated that nursing care most evidently revolved around a combination of detention, observation, medication, and management within a multifaceted social and physical inpatient unit environment. These interrelated elements of service are suggested to have had value towards meeting the consumers' needs of physical care and safety, treatment of psychiatric symptoms, and appropriate interpersonal engagement. It is notable that, for the consumer participants in this research, this period of service was associated with a reduction or resolution of suicidal crisis.

The findings reinforce however, that as with experiences of initial intersection with services, appropriate interpersonal engagement was experienced as minimal. This indicates the limited therapeutic potential of the predominant interventions, and of service overall. In this regard it is suggested that consumers and nurses found themselves within a system which was overly reliant on some potentially useful medical and custodial interventions but which did not optimally manage issues of isolation, (loss of) control, distress and objectification. Thus, this chapter generates an understanding of a central period of the consumer experience. It also reinforces the notion that a particular quality of engagement may be key to more fully integrating the range of useful interventions and promoting an optimal quality of holistic, recovery-oriented service.

## **6.1. Detention as a primary response to people experiencing suicidal crisis**

This section explores 'detention' in mental health/psychiatric hospital inpatient units around participants' experiences of suicidal crisis. The term 'detention' is used because the inpatient units to which all of the consumer participants were admitted are secure (locked) units, staff within them exercise discretion around when a person is discharged or has leave, and staff have the power to invoke involuntary treatment and detention orders, even in respect to people admitted to the units voluntarily. Consumers' admissions averaged approximately three weeks and all participants reported that 'involuntary' legal status was invoked for some or all of their admission. Thus, admission effectively constituted detention.

The findings suggest that detention provided the required time and space to potentially meet the consumers' needs for access to service, treatment of psychiatric symptoms, physical care and safety, and appropriate interpersonal engagement. However, it is evident that the effects of detention were varied and potentially problematic because of the under-realisation of appropriate engagement. Engagement is highlighted to be important in promoting the therapeutic potential of detention particularly as it could help address issues of isolation, loss of control, and distress, which could be generated or compounded by detention.

### **6.1.1. '*You're locked away*': detention and the importance of engagement**

The majority of the consumers expressed that, in hindsight at least, detention was a necessary and potentially valuable intervention. The degree to which it was perceived positively is suggested to relate to how well it was understood to meet the needs that consumers felt were most important to them. Tracy and John, for example, expressed that they essentially welcomed detention in the inpatient unit. In part this was indicated to be the case due to their existing negative social circumstances, which rendered the inpatient unit a place of relative physical and

social safety. John, for example, expressed that, *'I feel safe in there'*, and Tracy noted that *'they're my friends in there'*. For John and Tracy, then, detention provided an essentially welcome refuge.

Most of the other consumers indicated their belief that detention was of value. However, it was predominantly seen positively only in hindsight, yet experienced at the time in mixed and sometimes problematic ways. Kate for example – who, as noted, did express wanting to be somewhere where she was *'controlled'* against pursuing further suicidal behaviour – explained that soon after realising she was detained she thought that she *'should be allowed to go home'*. Kate soon realised, however, that she could not leave. This led her to feel that the inpatient unit was *'a bit like prison'*. Kate explained, however, that her desire to be *'controlled'*, coupled with her perception that staff *'were kind and friendly'*, helped ameliorate some of the isolation and loss of control that she described feeling as a result of detention.

Similarly, Lisa explained that, for her, detention entailed:

*just feeling trapped. Feeling like you couldn't leave. Like wanting to go home and feeling like you couldn't...losing control...not knowing how long it is before you'll be home again and it sometimes going into months before you do get home (Lisa).*

While Lisa explained that feeling *'trapped'* and *'losing control'* was problematic as it heightened her isolation and distress, it is apparent that there were also positive aspects to detention. For example, in hindsight at least, Lisa and others noted that detention did provide a valuable feeling of safety. Lisa explained in this regard that:

*it's a very secure feeling...It's a good place to be [HDU]. I don't like being locked up out the back. I get very upset and I get very angry about it. But it's still the best place to be...at least I'm safe (Lisa).*

Thus it was inferred that, in hindsight at least, detention was seen as valuable, particularly as it promoted physical safety and enabled the potential for further treatment.

Reinforcing Kate's suggestion that positive interaction with staff could go some way to ameliorating the possible negative effects of detention, Lisa described being escorted by nurses from the emergency department to the inpatient unit:

*They told me where they were taking me and why. They started interacting with me and were chatting to me all the way down [to the HDU]. Those nurses and that first talking really helped me (Lisa).*

Thus the importance of positive interactions with nurses around experiences of detention was reinforced, even if the interactions described by Kate and Lucy may be considered superficial (in that they were not directly concerned with the 'deeper' intrapersonal experience, as noted in the previous chapter to be important).

For Lucy, too, detention was seen positively in hindsight, although experienced at the time more negatively. She described being detained as '*horrible, just awful*', noting that:

*I used to walk around the walls looking for a place where I could climb out. Yeah I hated it (Lucy).*

Lucy reflected, however, that detention had value in that it met her need for physical safety and protection, enabled treatment of psychiatric symptoms, and also gave her a chance for intrapersonal reflection. She explained in these regards that:

*because you're in there and you know you can't leave you're forced to just spend time on your own and think about things...I was complaining because I thought I was only going in there overnight and had convinced myself of that, and so I was writing complaints all the time that I should be allowed to go*

*home. But obviously I shouldn't [have been allowed to leave] because I really wasn't safe and they needed to get the drugs into me (Lucy).*

Claire, too, described feeling very distressed upon initially being detained:

*As soon as I walked in there I was so scared. I was actually petrified...I went in, they shut the door...I didn't know anything about [the inpatient unit] or what it was like, and they took me to my room and that was all locked up, and that freaked me out because I thought you were like put in a cell; unlock it, chuck you in, lock it, yeah and so I thought, 'Geez I may be locked away', and I said, 'Are you going to lock the door?' and they said, 'No we just keep it locked while it's clean'. So that was a relief...I couldn't sleep though because it was at night and she said, 'Go to sleep and you'll be interviewed in the morning'. But there was no way I was sleeping (Claire).*

However, Claire also reflected that:

*it's a scary thing going somewhere where you feel like you're locked away, but in the end it was alright...Actually towards the end I didn't want to leave...I wanted to stay in because I felt safe there (Claire).*

Thus, numerous consumers suggested that, in hindsight at least, detention was a necessary and potentially valuable intervention, particularly as it provided physical care and safety and the possibility for further treatment. It is suggested, however, that detention could be an isolating, distressing and potentially disempowering experience. Such effects are particularly concerning given that consumers were already highly distressed and vulnerable before entering hospital. As Kate and Lisa suggested, even generally 'friendly' (if somewhat superficial in terms of direct engagement with consumers' intrapersonal experiences) interactions with nurses could go some way to making the experience of detention more therapeutic. Therefore it seems likely that the fuller engagement nurses and consumers identified as important may have been of great benefit in respect to detention. As noted in the

previous chapter, however, this was largely absent.

Reinforcing the importance of appropriate engagement around detention, several of the consumers expressed that detention was a negative experience, even in hindsight. For example, both Andrew and Candice explained that they thought detention was not justifiable as the treatment they perceived it to entail (physical protection and safety and treatment of psychiatric symptoms with medication) was inadequate. One of the most problematic aspects of this was an associated diminished or adversarial relationship with clinicians. This meant, for example, that both Candice and Andrew expressed misinforming staff about their level of suicidality in order to hasten discharge from the inpatient unit. Candice explained in this regard that:

*I convinced them to let me out. And I needed to be in there. I still felt suicidal. But it just freaked me out, being locked up like that (Candice).*

Andrew, too, explained that, towards hastening his discharge from hospital, he modified his behaviour to project what he thought was required:

*It didn't matter what was going on in my head. It was what they saw and the impression that they got that mattered...I mean I was completely 'tripping out' but I made sure I was seen to be doing the right things so they let me go (Andrew).*

Regarding Candice and Andrew in particular, then, it was indicated that there may be a problematic – indeed very risky – association between detention and service which did not see nurses and consumers engage openly and constructively at the level of intrapersonal experience.

The importance and complication of integrating appropriate engagement with detention was reinforced by some of the nurses. AcuteRN3, for example, noted that:

*some clients are particularly at risk because they're scared that if they discuss any suicidality they're going to be kept in hospital for a month. When, as with anyone else, they're looking for help...so things escalate (AcuteRN3).*

This highlights the conundrum that some consumers may be discouraged from engaging because they do not perceive service as adequate and do not wish to be detained or treated involuntarily. Towards enhancing the adequacy of service it was recognised by a number of nurses that:

*the suicidal client needs a place where they can feel safe...not just physically safe, but where they are able to talk through what the issues are that they confront, why they feel the way that they do, and why they've made the decision that this [suicide] is the only option available to them (AcuteRN4).*

As noted in the previous chapter, however, it is indicated that such a quality of engagement-based service was largely absent.

### **6.1.2. Summary**

The findings suggest that how detention was experienced related to how well it was perceived to enable the needs each consumer understood to be most important. Thus, those who prioritised the need for a relatively safe and welcoming environment, and who prioritised the need for medical-psychiatric treatment, saw detention as less problematic, particularly in hindsight. For those who were not comfortable with the isolation and loss of control that detention could entail, and who were seeking a more holistic model of care and fuller engagement, however, detention was seen as unjustified and was experienced more problematically. The current findings thus support the notion that inpatient care can be both 'prison-like', but also potentially a valuable place of safety, and that the quality of therapeutic relationships is of central importance to defining how it is experienced (Lineberry 2011).

It is concerning to note that, for the majority of consumers, detention did not entail the desired extent or quality of engagement. This was seen to potentially compound issues of isolation, loss of control and distress. It was also evident that detention could sometimes lead people to seek to avoid service or hasten their discharge from care. This reinforces findings that coercive practices in psychiatry may have adverse effects (Sibitz et al. 2011), including creating aversion to service (Webb 2005; Szasz 1999), increasing distress and incidences of self-harm (James et al. 2012, p. 301), and, regarding detention specifically, potentially further stigmatising consumers, 'deepening' their depression, increasing rates of self-harm (Bowers et al. 2008) and feelings of isolation (Lineberry 2011, p. 345), and being perceived as threatening, depersonalising (Jones & Crossley 2008), and sometimes preclusive of engagement (Cutcliffe & Stevenson 2008a, p. 29-35). This association between detention and such experiences may go some way to explaining previous findings that increased suicidal behaviour is associated with admission to and discharge from inpatient units (De Leo & Svetcic 2010; Appleby et al. 1999; Meehan et al. 2006; Ghio et al 2011, p. 514).

It is acknowledged that detention did, for the consumer participants, accompany a reduction or resolution of suicidal crisis. However, while definitive conclusions are not possible to draw, it is suggested that the fuller realisation of a particular quality of engagement could have helped address issues of loss of control, isolation and distress, around detention. Indeed, it is reinforced that detention without appropriate engagement may run counter to recovery principles, most notably, empowerment and maintenance of rights (Anthony 1993, p. 17; Onken et al. 2002; Mancini 2008; Coleman 1999; Burgess et al. 2010; Barker & Buchanan-Barker 2011a; Pilgrim 2008). Thus the participants' accounts reinforce and nuance previous findings that the therapeutic relationship may be the key medium for effectively integrating 'coercive' features of service (Lineberry 2011) in a more holistic and recovery-oriented model of care.



## **6.2. Observation as a primary response to people experiencing suicidal crisis**

This section explores 'observation' in the hospital inpatient units around experiences of suicidal crisis. Every client in a MHS inpatient setting is subject to formal observation, and it was indicated to be a particularly prominent intervention in the context of consumer suicidal crisis and related nursing care. Observation sees the location and activity of consumers documented at intervals of 15, 30 or 60 minutes depending on their assessed risk level. Additionally, people assessed as being at very high risk may be placed under 'constant/special observation' where they are in immediate proximity of a nurse at all times. As well as such formal observation, informal observation occurs via interaction and other means of surveillance, sometimes including the use of cameras.

As with detention, the participants' accounts indicate that observation provided the opportunity for consumer needs to be met, particularly as it could promote physical care and safety and the potential for further treatment. Again, it was also suggested that observation could create feelings of safety and promote positive intrapersonal change. However, it is reinforced that, amongst the range of experiences, the therapeutic potential of observation was associated with the quality of interpersonal engagement between nurses and consumers. This was indicated to be particularly so in that fuller engagement could help address issues of isolation, loss of control, distress and objectification which, particularly without engagement, could be generated or compounded by observation. Again, concerns are raised given the suggestion that such engagement was experienced as minimal.

### **6.2.1. *'It's freaky being observed like that': observation and the importance of engagement***

The nurses expressed that observing consumers at risk of suicide was a practical and legal necessity, essential towards understanding and responding to risk and consumer needs. They reported collaborating with medical and nursing colleagues to establish and adjust formal observation levels. One nurse, for example, explained

that:

*a guy at the moment, he's really frightened and he had an attempt on his life before he came in here so we keep a close watch on him...we have identified him as at real risk. I have spoken to the other nurses about him and we think we should be looking at him regularly – so we've put him on 15 minute obs. (AcuteRN9).*

Many of the consumers, too, expressed a view that observation was a necessity, particularly in regards to promoting physical safety. Lucy, for example, explained that *'if you've got somebody that's suicidal you need to be able to watch them and make sure they don't hurt themselves.'*

Both the nurses' and consumers' accounts suggest, however, that observation without appropriate engagement was limited in therapeutic potential and sometimes highly problematic. Kate, for example, described an experience in which she was being observed via camera and felt a distinct *'separation'* between her and staff. She noted that this was:

*a bit tricky...that separation, that 'us and them', between the patients and the nurses. It reminded me of the 'fish bowl' in the mall where the police are [a glass police booth]...like they could see me but I had to go get them if I needed anything (Kate).*

As well as creating practical obstructions to having needs met, Kate felt that such remote observation was *'freaky...a bit invasive'*. As noted, Kate had actively sought out the imposition of control that admission to service entailed. Her account suggests that her desire to be controlled, as well as the feeling that staff could be trusted to use the cameras *'for the right thing'* (Kate), meant that, for Kate, observation was acceptable. Her account thus suggests that observation may be problematic, but that features of appropriate engagement – such as trust and the *'kind and friendly'* (Kate) nature of nurses – were important to ameliorating some of

the problematic aspects of being observed.

Lisa's account reinforces the notion that the therapeutic potential of observation was understood to be enhanced when accompanied by certain elements of engagement. Lisa explained, for example, that the nurses '*watch you and they make notes about your behaviour*'. Lisa recounted an experience when her nurse had been completing Lisa's 'observation chart' in front of her and Lisa asked to read what had been recorded. The nurse allowed her to do so and they discussed what had been written. Lisa explained being able to see what had been written:

*made it all right, but if I hadn't have been able to see it, though, it would have been different. I mean you never know what they're writing and it puts you on guard... but, yeah, she let me see them (Lisa).*

It is not common practice within service to share and discuss written observations or notes like this. This experience highlights, however, that elements of appropriate engagement (such as collaboration or trust in this example) may enhance the therapeutic potential of observation and ameliorate some of its potentially problematic aspects.

Most of the nurses' interview accounts reinforce the importance of engagement to observation. It was noted, for example, that formal observation which involved periodic sighting but did not include engagement was potentially highly problematic, not least of all because '*they can do it [suicide] in between a 15 minute observation*' (AcuteRN11). An instance when this had happened and a consumer had died by suicide in the inpatient unit was recounted:

*She [the nurse] just looked in on her and then walked away...and she [the consumer] just waited...because she knew she was being looked at...you know at a certain time...and [the nurse] went back ten minutes later...[voice breaking] and she was hanging on the door knob (AcuteRN1).*

Thus engagement was indicated to be vital to observation, both as it provided more sustained and effective observation resulting in fuller understanding, and also as it helped address issues of isolation, control and distress that the consumer might be feeling and which might be generated or compounded by more 'distant' observation.

Regarding the notion of more fully integrating engagement with observation one nurse described the importance of just being in the ward environment (as opposed to being in the office or 'off the floor'):

*If you're there then you can see it and you generally go and get help and say 'oh look such and such is winding up or spinning out so I'll just need some time with them' (AcuteRN2).*

Thus it was reinforced that, indeed:

*it's about engaging with that client...I can't see that there's any other reason....other than you're custodial and you sit there and observe and I don't see that as particularly therapeutic (Acute RN4).*

As noted, however, the participants indicated that engagement was minimal, as Lisa, for example, noted:

*they were watching me from the office...they only came out more or less at the times to give you your medications...but I think more interaction would be better and yeah to ask directly about it [what the consumer was thinking and feeling in regards to their suicidal crisis] would be good (Lisa).*

The participants' accounts indicate, then, that observation was necessary and at least partially effective towards identifying and meeting consumers' needs, particularly in regards to physical care and safety. However, they also indicate that observation without fuller engagement was limited in therapeutic potential.

### 6.2.2. Summary

The findings give partial support to previous claims that observation may be an effective intervention (Libberton 1996; Stuart 2001; Stewart et al. 2012; Bowers et al. 2008) and that some consumers do feel safe and supported under observation (Jones et al. 2000). However, the findings most strongly support the argument that the therapeutic potential of observation is undermined if it exists without engagement (Cardell & Pitula 1999; Jones et al. 2000). Indeed, it is reinforced that observation without engagement can be ineffective or even counter-therapeutic (James et al. 2011, p. 38; Dodds & Bowles 2001), potentially exacerbating feelings of isolation (Temkin & Crotty 2004, p. 78), contributing to a 'prison' like environment or, as noted by Cutcliffe and Stevenson (2008a), constituting a modern day version of Bentham's Panopticon (Bentham 1995). This reflects the possibility that 'observation without interaction is a cold comfort', as noted by Campbell (2006, p. 276) who is a 'suicide survivor' / consumer researcher.

As with detention more broadly, one of the key ways that engagement was suggested to enhance the therapeutic potential of observation was by enabling greater understanding to be generated, and more effective and appropriate responses to be enacted, within the process of observation. It was also reinforced that engagement could help ameliorate issues of isolation, loss of control, distress and objectification which observation (and service more broadly) could generate or compound. Even discrete elements of engagement such as trust enabled Kate and Lisa, for example, to experience observation more therapeutically and to embrace the feeling of safety that it offered.

The notion that elements of engagement can enhance observation suggests that observation and engagement need not be mutually exclusive but that, under the right conditions, may co-exist, as noted by Billings (2004, p. 191). Nevertheless, it is also indicated that observation was a dominant intervention and that engagement was minimal. Embracing the point that observation may exist without engagement, whereas observation is inherent to engagement (Barker & Buchanan-Barker 2005, p.

545), the findings thereby point to the need to more fully promote engagement within observation.

### **6.3. Medication as a primary response to people experiencing suicidal crisis**

This section explores the use of medication in hospital inpatient units around experiences of suicidal crisis. All of the consumer participants reported that they took (and, for some, were forced to take) at least one, if not two or three, psychotropic medications during their admission. The use of anti-depressant, anti-psychotic, mood-stabiliser and anti-anxiety medication was particularly prominent. The use of such medication was generally implied to have value, particularly towards reducing psychiatric symptoms. However, appropriate interpersonal engagement was suggested to be an important complement to medication therapy as it could help provide more accurate and appropriate indication for, and administration of, medication, and also enhance the perception of medication as an appropriate therapeutic intervention within a holistic model of care. Related to such benefits it is further reinforced that engagement may be important in addressing issues of loss of control and objectification which could be generated or compounded by medication therapy. Further concerns are raised, however, given the suggestion that appropriate engagement was experienced as minimal.

#### **6.3.1. *'I have to take meds'*: medication therapy and the importance of engagement**

Lisa, Lucy and Tracy, in particular, indicated that they accepted the framework of 'mental illness' in regards to their suicidality and MHS treatment. Their accounts suggest that acceptance of that framework included acceptance of the appropriateness of a focus on medication therapy. Lucy, for example, explained that she attributed, as a key aspect of her resolution of crisis, the fact that her admission *'gave the chance to get the drugs into me so that I could control the head'*. She reflected further that the drugs:

*were absolutely necessary because I was so 'out there'...I probably have to take medication for the rest of my life, but so what? (Lucy).*

Ben's account also suggests acceptance of the framework of mental illness and the value of medication therapy. However, he, as with most of the other consumers, expressed that service was problematically over-reliant on medication therapy. Notably, Ben's only memory of contact with nurses involved the nurses delivering, and ensuring that he ingested, medication. Importantly, medication for Ben, as for most of the other consumers, was not seen as problematic in itself. It was seen as problematic to the extent that it was not more fully complemented by other elements of service including engagement.

A minority of consumers explicitly rejected the framework of mental illness in regard to their suicidality and related MHS treatment, and with that came a strong rejection of the usefulness of medication therapy. As noted, Candice, for example, *'just didn't believe in the whole 'taking medicines and I'd be okay' thing'*. The focus on medication was most problematic for Candice because she felt that it oversimplified her experience and the complex issues she faced. The problematic dimensions of that were heightened because she felt that medication therapy was essentially all MHS was offering (see section 5.3.2.). Candice explained in this regard that:

*I had lots of things going on. I thought I was a terrible mother and that I just wasn't worth being alive....and I didn't think a pill would fix that...They thought I was just having delusions or something, that I was trying my best and that it was just the depression that was clouding my thoughts. But I wasn't trying my best and it wasn't that simple (Candice).*

Candice did also explain, however, that even brief moments of superficial or partial interpersonal engagement with nurses around the administration of medication could have a positive impact:

*Most of the nurses just gave you your medicine and said goodnight. But a handful of them would have a chat and that made you feel like they weren't just there to give out medication and get information to give to the doctors...That helped me get through it (Candice).*

Thus it was suggested that even minimal engagement could enhance the therapeutic potential of service which was largely focused on medication therapy – or at least ameliorate some of the problems associated with over-reliance on that intervention.

Most of the nurses, too, described medication as a predominant intervention and acknowledged its potential value, particularly in respect to the treatment of psychiatric symptoms. As with the consumers, the nurses appreciated that medication therapy ideally involved therapeutic engagement. AcuteRN2, for example, recounted an experience demonstrating how engagement and medication therapy could be effectively integrated:

*She had this sense of desperation that nothing was working and nobody was doing anything to help her...I just asked her If I could talk to her about how she was feeling and out of the interaction I had with her she did settle, she did take some medication that helped her, and while that took time to work we just sat and kept on talking (AcuteRN2).*

Several of the nurses reinforced that medication therapy without appropriate engagement could be highly problematic. CommRN7, for example, recounted that:

*we nursed a fellow diagnosed with schizophrenia. He was put on a drug called Clozaril [an anti-psychotic]...over a number of months he gained insight and when he gained insight he took his whole week's dose and successfully suicided. None of us saw that coming (CommRN7).*

In this instance, as more generally, a greater understanding of the intrapersonal experience of the individual – for example what the gaining of insight meant for the



person – may have given the chance for more appropriate and effective intervention.

The interviewees were thus very conscious that medication was commonly over-relied upon in the absence of fuller engagement. As noted, AcuteRN4, for example, reflected that *'the emphasis here is on biological psychiatry where if you have schizophrenia we have medication that can treat that'*. The implication of such a focus was seen by AcuteRN4 and other participants to be a limited potential to respond to the complex personality, situational, and psycho-social challenges that consumers at risk of suicide typically faced. As noted, this was reported to sometimes result in nursing responses such as *'oh I will just whack 'em with some PRN'* (AcuteRN1). Furthermore, it was noted by several nurses that timely and collaborative administration of a PRN medication required a closer understanding of the person. Thus it was appreciated that, while *'the tendency is to kind of find a magic pill'* (AcuteRN2), medication without fuller engagement constituted a limited response.

### **6.3.2. Summary**

As with detention and observation, experiences of medication therapy were varied. The findings give partial support to the suggestion that certain psychotropic medication may be an effective element of treatment around suicidality (Isacsson & Rich 2005, p. 153; Mann et al. 2005; Goldney 2005, p. 134; Meltzer 1996; Potkin et al. 2003). It is reinforced, however, that appropriate engagement may be vital to optimise the therapeutic potential of medication therapy that could otherwise be experienced as limited or problematic. In particular, the findings support previous assertions that engagement may be vital towards enabling the proper selection of psycho-pharmacological agents (Glod 1998, p. 93; Wall et al. 2010) and promoting adherence to them (Dolder et al. 2003). It is also reinforced that positive benefits from medication therapy may, in part at least, arise from the act of engagement around that therapy (Goldney 2005, p. 134).

The suggestion that appropriate engagement was minimal around medication

therapy can be seen to have reflected and reinforced isolation, loss of control, objectification, and additionally, the false belief and 'conceptual confusion' that suicidality essentially *is* a mental illness. Furthermore, as has been noted by authors in the broader mental health care context, a focus on psychopathology and pharmacological therapy may have involved deferring responsibility and treatment to the medical system and 'experts' (Szasz 1970; Ahmed 2010), potentially pathologising and objectifying the person and promoting a 'victim role' (Karp 1996, p. 73). As with detention and observation, it is further indicated that appropriate engagement may be a key factor in reconciling tensions between a focus on potentially reductive and medicalised approaches and the fuller realisation of a recovery approach which works to understand and empower consumers. Further concerns are raised, however, given the suggestion that appropriate engagement was experienced as minimal.

#### **6.4. Management within the inpatient unit milieu**

This section explores elements of service within inpatient unit environments, around experiences of suicidal crisis, which were additional to the principal interventions of detention, observation and medication already discussed. The participants' accounts highlight that interrelated aspects of the inpatient milieu – including the physical and social environment, activities of daily living, both unstructured and structured therapy and recreational activities – impacted on experiences of service and resolution of crises. In exploring these 'other' elements of inpatient unit service the extent and quality of nurse-consumer engagement is, again, indicated to be a crucial factor reflecting and shaping experiences and the therapeutic potential of service. In particular, it is reinforced that engagement was important towards addressing issues of control, isolation, distress and objectification around the various elements of service. It is also further suggested that a complex interplay of consumer, nurse and contextual factors mediated the potential for such engagement and the quality of care overall.

#### **6.4.1. ‘Trapped inside a building’: the physical environment of detention and observation**

The participants’ accounts highlight that the physical environment of the inpatient units played an important part in defining their experiences. This is exemplified in respect to detention and observation. Detention was enabled via the physical environment in that the units are securely locked and virtually impossible to ‘escape’ from. Observation was enabled by various environmental features including the use of cameras, centrally-located and glassed-in nurse’s stations, tinted glass which allows one-way viewing of court-yards, open communal living spaces, and viewing ‘portholes’ into interview rooms. It is suggested that, while such features of the physical environment provided the opportunity for important needs to be met, their therapeutic potential was associated with the quality of engagement between nurses and consumers.

As noted, Kate, for example, felt that the physical environment – including the nurses remaining in their ‘fish bowl’ (the nurse’s station/office) and their use of cameras – accentuated ‘*that separation, that us and them, between the patients and the nurses*’. It is indicated that some of the problematic dimensions of this were ameliorated by elements of engagement such as trust between Kate and the nurses. Limitations were nevertheless apparent as the physical environment reinforced isolation. Lucy, for example, noted that:

*you have to go and find a nurse if you want to go to the laundry or something...you have to request things, stand out in the foyer [in front of the nurse’s ‘station’] and try and get somebody’s eye. Sometimes they’ll leave you there for five or ten minutes (Lucy).*

Several nurses also noted that the physical environment could reinforce a lack of engagement. AcuteRN1, for example, explained that:

*a lot of [the nurses] will stay in that damn office and will not move out of the office. I don't know how they can write proper notes...because [laughs] they're in the office all day (AcuteRN1).*

Candice also described a separation between the patients and the nurses, and reinforced that some of this was built into the physical structure of the unit and some related to other consumer and nurse factors. She expressed, for example, that *'there were no nurses that I felt like I could talk to. They were always in their office'* (Candice). Thus the notion of isolation accentuated by the physical environment – in particular the nurses' glass-walled office – was highlighted. Clearly implicated as important in this context, too, is the manner in which the nurses used the environment.

The physical nature of the bedrooms was also seen as reflecting and shaping the nature of care and interactions between staff and consumers. Several of the participants explained that often the best place available to talk with nurses was in the relative privacy of the consumer's bedroom. Tracy, for example, noted that if she was to have a 'deeper' conversation with a nurse it would occur *'mostly in the bedrooms, if I talked to them about stuff like that'*. It was indicated by both nurses and consumers, however, that usually people shared rooms and that privacy could be difficult to achieve. Indeed it was strongly suggested that opportunities to talk in private had to be sought out amidst various challenges to do so, not least of which was finding a place conducive to private communication. It is notable that there is typically no designated private area for inpatient unit nurses to engage with consumers.

Numerous nurses supported the notion that the physical environment could be associated with a lack of engagement. CommRN6, for example, explained that:

*when it's noisy, the light is bright, the furniture is old and dirty...I can tell you, when you're trying to get someone in a space where they're comfortable to talk*

*to you and it's like that, it's not conducive to good therapeutic relationship (CommRN6).*

CommRN7 agreed that '*a noisy environment or a chaotic environment*' was not conducive to engagement, and suggested that '*outside*' the building, or at least somewhere quiet was preferable.

Several of the consumers also commented further, regarding potential limitations of the physical environment, that the inpatient unit was overly isolative, clinical or 'sterile'. Kate, for example, expressed that:

*it's a shame they don't have a garden or an open area, like there's nowhere outdoors where you can go. It's not healthy! There's nowhere you can get exercise. They have this tiny little area outside where you can 'shoot hoops', but that's it...You really are trapped inside a building (Kate).*

Implicit in the participants' accounts, too, was an appreciation of the effects that the physical environment could have on social integration and routines that are discussed in section 6.4.2 below.

While it was indicated that the physical environment of the inpatient units could potentially support the meeting of consumer needs – particularly in regards to detention and observation – it was also indicated that the physical environment could reflect and shape limited engagement. Indeed, the findings support previous assertions that consumers may effectively be 'hermetically sealed' within particular inpatient environments and that this may actually restrict the potential 'of a caring staff' (Lineberry 2011, p. 345). Furthermore, it is suggested that the physical environment may have sometimes been inappropriately or unwittingly employed by the nurses to avoid engagement. Thus, concerns are reinforced that the physical hospital environment could have powerful and problematic effects on the people within them (Foucault 1979) as reductive practice became integrated in the 'architectural' features of 'the closed institution' (Habermas 1987a, p. 245). It is

suggested in this regard that the physical environment both provided opportunity, and additional need, for appropriate engagement. As noted, this was suggested to have been largely unmet.

#### **6.4.2. ‘I was with all these mental people’: the social inpatient unit environment**

The impact of being with a diverse range of people within the inpatient units was significant for most of the consumers. Interactions between consumers involved varied experiences, ranging from fear and discomfort to something positive and helpful. It was suggested that nurse-consumer engagement affected the therapeutic potential of interactions between consumers, and that, indeed, the lack of engagement between nurses and consumers sometimes necessitated that consumers engage with each other.

For several consumers, interactions with other consumers were indicated to be less than therapeutic. Candice, for example, felt that:

*it’s hard because they’re not necessarily the type of personalities that I wanted to be interacting with, and their attitudes – complaining and moaning – they weren’t in a very good frame of mind (Candice).*

Lucy also explained that, for her, interactions with other consumers were sometimes problematic. She recalled that:

*they put me into a room and I was horrified because I was in with a girl that was in there for drugs and I was just a horrible snob because I thought ‘oh god I’m going to have to watch all my gear’...and I did have to watch all my gear because she was going backwards and forwards being allowed out and she’d take my stuff and sell it and get what she could (Lucy).*

Lisa also noted that interacting with other consumers could be less than therapeutic in that ‘it brings you down more’ (Lisa).

Several of the nurses agreed that interactions between consumers could be problematic. They also inferred that nursing management of the interactions was important. One nurse asserted, for example, that:

*it's just not a good mix and I don't think it helps clients who are actively suicidal to be around other clients who are aggravating them with their behaviour...sometimes it can be hard for us to manage that (AcuteRN3).*

Managing consumer interactions implies and reinforces the need for appropriate engagement with the consumers in order to understand and positively influence the interpersonal dynamics at play.

Interestingly, numerous consumers expressed that interactions with other consumers were something that tended to become more positive over time. As noted above, Claire was extremely uncomfortable when she was first admitted to the inpatient unit, not least of all because of the other consumers and the fear that '*I was with all these mental people and it freaked me out, you know, they might hurt me*'. Claire explained further that:

*I sort of stayed away from everyone. I was so scared that I'd put myself into a corner and curl up into a ball because there was no way out and I was scared and these were all new people (Claire).*

However, Claire recalled that she gradually built positive relationships with some of the other consumers. Indeed, it seems that her relationships with other consumers may have been significantly therapeutic, particularly in the absence of adequate therapeutic engagement from staff. As Claire noted:

*I began to talk to other patients and that was quite good, just listening to them. I wasn't scared of them after all...They would really listen and... yeah, because they're going through their own sort of thing and they sort of understand how hard it is...like, we're a team...Everyone was still in trouble in*

*their life...and I ended up having a good time. There were people I could chat to and I started to laugh (Claire).*

Kate supported the notion that interactions between consumers could be positive, explaining that:

*sometimes it's nice to have other people around because you do feel like you're being watched because of the monitors and the cameras and the 'fish bowl'...there's a bit of unity with the other patients (Kate).*

As in relation to the nurses, Tracy, in particular, described her interactions with other consumers as very positive and valuable. She noted too, however, that building relationships with other consumers could be problematic given issues such as the relatively high rate of completed suicide within the consumer population. Indeed, Tracy specifically chose to talk about two consumer 'friends' who had died by suicide in recent times:

*That time I tried to do myself in, she was just coming out [of the inpatient unit] and she said, 'I'm going home'. A week later she actually killed herself...she hung herself. She...was beautiful. And [another consumer] I knew him quite well too. He's gone now too [he also hanged himself]...they were my friends (Tracy).*

Thus, while interactions between consumers were experienced in varied and sometimes problematic ways, the findings reinforce previous assertions that consumers engaging with other consumers regarding their 'shared experience' might provide significant benefits (Lineberry 2011, p. 346; Nolan et al. 2011; Bowers et al. 2008). Furthermore, the findings support the argument that this may sometimes occur because the consumer 'didn't feel they were getting the help they needed from the nurses' (Stenhouse 2011, p. 74; Shattell et al. 2008). The notion of consumers supporting each other is also congruent with recovery, as 'other people who are recovering may be a key stimulant to recovery in others' (Anthony 1993, p.



24). Thus, overall, it would seem that consumer interaction within the shared inpatient unit environment was a positive aspect of service.

While this study has focused predominantly on the relationships between nurses and consumers, rather than between consumers, it is suggested that nurses – the milieu managers – have the potential to influence and positively affect consumer-consumer relationships. It would seem reasonable to assert that avenues to promoting more therapeutic consumer-consumer interactions might be enabled by appropriate nursing engagement with individuals to, for example, generate greater understanding of that person and their needs, and to promote positive interactions in both formal and informal interactions and settings, particularly group activities and therapies. The potential value of consumer-consumer engagement thus reinforces the importance of a particular quality of engagement in the context at hand.

#### **6.4.3. ‘You’re really reliant’: practical assistance and activities in the inpatient unit**

Other aspects of the inpatient unit milieu which were indicated to both impact upon, and necessitate, appropriate engagement included practical ‘activities of daily living’, and both unstructured and structured ‘therapy’ and recreational activities. Many of these elements of service – particularly as they were interrelated within service as a whole – had potentially huge impacts. Numerous consumers highlighted, for example, that they were dependent on nurses for all manner of ‘activities of daily living’. As Kate noted, for example, *‘you’re really reliant on the nurses if you want clothes or if you want anything really, like food’* (Kate).

Lisa, similarly to most of the other consumers, suggested that assistance with activities of daily living could be of vital importance towards promoting a good quality of care. Lisa recounted, for example, that:

*they start taking care of you and getting you to take care of yourself. They encourage you to shower and things like that...things that have just lapsed or things that you just can’t be bothered with any more. They just remind you*

*again, 'come on, shower time'. So you go and you have a shower, and you feel brighter and fresher (Lisa).*

Exemplifying that the promotion and enabling of 'basic' needs was best underpinned by appropriate engagement in order to minimise issues of isolation, loss of control, objectification and distress, Claire explained that:

*because I wasn't eating they would come into my room and say, 'Come on you haven't eaten yet, you've got to eat this'. The nurse would stand there and wait until I would eat so it made me feel like I'm going to have to eat otherwise she's not going to go away. And she said that if I didn't eat then they'd stick a tube down my throat anyway. So I started eating (Claire).*

Claire inferred that encounters such as this involved a mixture of coercion and caring which was usually effective. She also indicated that the manner in which the nurse engaged with her at such moments was very important. Claire explained in this regard that some nurses were *'firm but caring'*, whereas others were *'a bit intimidating or would get frustrated'*. The difference between such approaches was suggested to be significant for Claire, particularly given that, as noted, she did experience significant isolation, fear and distress while in hospital.

Lucy's account reinforced the notion that 'activities of daily living' could become the context for engagement, and that such activities were experienced as more therapeutic if they were integrated with engagement. She explained, for example, that *'some would take time, like at morning teatime, to have a cup of tea with you and a chat, and that was good'*. While Lucy indicated that even an element of engagement such as 'chat' could be experienced as therapeutic this did not constitute the desired 'depth' of engagement. Thus Lucy added that:

*they were just flat out getting through their work though and nobody was really offering to talk. It really is strange that they didn't talk about it [her suicidality] because I was in hospital for a month (Lucy).*

It is thus reinforced that many nurses did not seem to prioritise fuller engagement. Indeed, it would seem that many 'activities of daily living' were managed in a more detached and routinised manner. Nevertheless, it was clear that the nurses could have positive effect through many of their 'basic' actions and interactions. Lisa noted in this regard that:

*they tend to be as caring as they can and it's good to get that sense that they care Some of them are really, really patient, I tell you, with a lot of the things they go through with us (Lisa).*

Further highlighting the importance of appropriate engagement within the inpatient unit milieu, many of the consumers' accounts also highlighted the relevance of more structured 'therapy' or recreational activities. Kate, for example, noted that '*the activities are good...the art and the relaxation*'. Kate explained further that:

*there were a few nurses who did indoor bowls and stuff like that with us. They joined in which was really, really good (Kate).*

The nurses, too, noted the important association between such activities and appropriate engagement. AcuteRN2, for example, explained that:

*I keep going back to them, and I might say 'would you like to play a game of ping pong or something?'...just to show them I care (AcuteRN2).*

Thus it was suggested that various activities had the potential to reflect and shape valuable experiences of engagement, even if such engagement might seem superficial in that it was not directly concerned with 'deeper' intrapersonal experiences.

Some of the consumers, however, expressed that there was a lack of such activities in the unit, with this reinforcing the notion of minimal engagement. Lucy, for

example, noted that one of the worst things about inpatient unit admission for her was:

*boredom, nothing to do. Not that I probably would have done it anyway. I mean they were trying to get us to watch films and things like that (Lucy).*

This also reinforces that a complex interaction of consumer, nurse and service factors was indicated to come together to affect engagement – in this case, for example, Lucy may have been invited to participate but declined to do so.

Despite the suggestion that activities within the units were generally beneficial, and could both reflect and shape engagement, it was also appreciated that they had the potential to be experienced less therapeutically. Lucy, for example, noted that:

*they have all these rules. Like you can be in the middle of a TV programme and they'll turn it off. I don't understand about the television. I guess they have set rules and they've just got to stick to them (Lucy).*

It was also suggested that sometimes 'encouragement' to participate in activities could actually be inappropriate. AcuteRN11, for example, questioned such practice:

*Why would you say to someone who's had schizophrenia for 15 years 'you must be up at nine to go to this or that group'? It's a part of the disease that they sleep more than your average person. So why are we trying to inflict that level of control? (AcuteRN11).*

Thus, the importance of a *particular quality* of engagement – one able to more fully understand the experience and needs of individuals – was reinforced.

The findings highlight, then, that positive 'shared experiences' might arise from inpatient unit activity and group activities and therapies (Lineberry 2011, p. 346). The potential for them to be experienced positively was suggested to relate to the

expression of such elements of therapeutic engagement as genuine interest, concern and the desire to understand. In addition to the practical and therapeutic value that various activities and therapies could have for individuals, it was suggested that they could be both enhanced by fuller engagement and offer a context within which engagement could occur. Given the collective opinion that appropriate engagement was limited, however, it is reinforced that the therapeutic potential of management within the inpatient unit milieu may have been limited.

#### **6.4.4. *'Alliance against their suicidality': no-suicide contracts***

Another intervention indicated to feature as part of service, and which reinforces the importance of appropriate engagement, is that of 'contracting' against suicide. Several of the nurses mentioned 'no-suicide contracts' (McMyler & Prymachuk 2008) specifically, and the wider notion of 'contracting' was raised by both consumers and nurses. Contracts are made with a nurse or supportive other, and are agreements to not suicide and to seek help when required. As with detention, observation, medication, and other elements of service within inpatient units, no-suicide contracts were associated with diverse experiences of care: from highly problematic to very valuable. Contracts were problematic if over-relied upon or relied upon outside of a therapeutic relationship, yet suggested to be very valuable within such a relationship and a possible means of enhancing the generation, maintenance and potential of appropriate engagement.

It was highlighted by several nurses that a no-suicide contract could be employed primarily as a means for nurses to legally protect themselves and as a poor substitute for engagement. AcuteRN4 expressed that such contracts are *'not worth the paper that they're written on'*, in both a legal and practical sense. AcuteRN4 described, however, that within a therapeutic relationship he sometimes utilised no-suicide contracts if he and the consumer felt that it could help promote what he described as *'an alliance against their suicidality or illness or whatever problems they're facing'*.

Similarly, beyond a written contract, AcuteRN3 described how:

*sometimes with people you can actually get them to give like a 'gentlemen's agreement' that they won't harm themselves, or that they'll speak to you before they harm themselves...that agreement is actually part of an attempt to gain trust, to actually get them to a point where they would approach me or another member of staff rather than harming themselves...that is the ideal (AcuteRN3).*

Effectively 'contracting' or agreeing with a suicidal person that they will not harm themselves, or if they feel like doing so they will seek help, thus reinforces the value of a particular quality of engagement. Many of the nurses expressed that gaining the level of trust and quality of communication required to underpin an effective 'contract' was what they were aiming to do when they engaged with consumers.

It was also suggested that nurses were potentially able to help build protective relationships between the consumer and significant others within which verbal 'contracts' could be employed and alliances against suicide formed. CommRN6, for example, recounted one such scenario:

*Because his wife was very supportive I helped put in place plans that he discuss his issues with his wife, keep her informed, and basically have her as his 'safety person'...so at the end of that we had an agreement...that if he felt suicidal that he tell his wife and she would phone the mental health line (CommRN6).*

Exemplifying a similar approach, Tracy explained that she had been engaged by her community case-manager (a nurse) towards constructing an agreement which she shared with her family. By her account this was very useful in helping her be open to seeking and receiving intervention when she was suicidal and, typically, ambivalent about receiving help. Such contracts and plans are, anecdotally and also in my experience, valuable as part of discharge planning from inpatient settings and in community case management.

The findings thus give partial support to the notion that no-suicide contracts may reflect an inappropriate (Jobes 2006, p. 4) and oversimplified approach to a very complex problem, possibly constituting 'yet another form of psychological pressure that the person has to bear' (Cutcliffe 2002, p. 35). Indeed it is reinforced that such contracts may represent an 'ineffective' tool (McMyler & Prymachuk 2008, p. 520). However, the findings also highlight that 'contracting' as part of appropriate engagement may be very valuable. Thus the findings suggest that, as with detention, observation, medication, and milieu management, the quality of the relationship between the 'contractees' may both reflect and shape the therapeutic potential of the intervention.

#### **6.4.5. Summary**

The findings highlight that the physical and social environment of the inpatient unit, as well as practical 'activities of daily living', both unstructured and structured activities and therapies, and no-suicide contracting, impacted on experiences of service and resolution of crises. The potential for these interrelated elements of service to generate or compound issues of loss of control, isolation, distress and objectification was significant and may have been ameliorated by fuller engagement. Furthermore, it was indicated that these elements of service were potentially suitable contexts within which to foster engagement. Amidst the complex interplay of consumer, nurse and contextual factors suggested to mediate the quality of care, it is evident that a more concerted and explicit intent on the part of nurses to therapeutically engage may have been valuable.

#### **6.5. Conclusion**

This chapter has identified and explored the principle interventions and practices understood to constitute inpatient unit nursing care in the context of consumer suicidal crisis. These interventions were indicated to most prominently include detention, observation, and medication, as have been found to be dominant in comparable contexts (Cutcliffe & Stevenson 2008b; Cutcliffe & Barker 2002). Broader

management within the physical and social inpatient unit environment, practical 'activities of daily living', both unstructured and structured activities and therapies, as well as no-suicide contracting, were also indicated to be significant aspects of service. It is noted that these interrelated elements of service were seen to have potential value towards meeting the consumers' expressed needs of physical care and safety, treatment of psychiatric symptoms, and appropriate interpersonal engagement. For the consumer participants in this research at least, the prominent interventions noted did accompany resolution or reduction of suicidal crisis.

The chapter has indicated, furthermore, that fuller engagement between consumers and nurses was associated with more positive experiences regarding the interrelated elements of service, and that a lack of engagement was associated with more problematic experiences (with a notable exception to that being the potential for meaningful intrapersonal reflection and positive consumer-consumer interactions to arise in the absence of engagement by nurses). In particular, it is suggested that the potential for the interrelated elements of service to generate or compound issues of loss of control, isolation, distress and objectification was significant and may have been ameliorated or addressed by appropriate engagement. Moreover, it is suggested that these elements of service were potentially suitable contexts within which engagement might be fostered.

Amongst the issues that the various interventions raised, and which appropriate engagement was suggested to potentially address, the issue of loss of control is particularly pertinent. In this regard, service may be understood as the sharing or deferring of control by the consumer – or the involuntary imposition of control on the consumer – at a time when they were at acute risk of suicide. Furthermore, the resolution of suicidal crisis may be seen to involve a regaining of control. The present findings reinforce that inpatient settings and staff therein may exert control over where a person is, what they are doing, when they are doing it, who they are doing it with, and even who they are (how and what they are thinking) (Webb 2005b). The findings suggest that the application of such pervasive control in response to suicidality may have positive benefits. However, it is also suggested that the



application of control may limit the seeking of help, reflect and shape a diminished quality of care, and sometimes disempower those who would be controlled (Webb 2005b, p. 27; Lineberry 2011; Cutcliffe & Stevenson 2008b).

It is acknowledged that recovery may firstly involve a period of releasing control (Barker & Buchanan-Barker 2011b, p. 353). However, the present findings suggest that if control is managed via the various elements of service in the absence of appropriate engagement, issues of isolation, distress, objectification and disempowerment can be generated or compounded. There is a possibility, too, that this might result in an adversarial and potentially deceptive and dangerous 'relationship' with service, or on the other hand a form of institutionalisation or dependence. Alternatively, it is suggested that appropriate engagement may help render the elements of service more acceptable, may enable consumers to retain as much control as possible, and may help transfer control back to consumers in the most responsive and therapeutic way possible. In this sense it is reinforced that the therapeutic relationship may be the key medium for effectively integrating coercive features (Lineberry 2011) in a more recovery-oriented service. This reflects that service need not be either wholly reductive (medicalised and custodial) *or* engagement-based, but rather an integration of such elements.

This chapter has reinforced that limitations arose, in particular, as the consumers remained largely alone with their intrapersonal experiences regarding crisis, care and recovery. Admittedly, the potential limitations of this intrapersonal isolation is complicated by the fact that the consumer participants in the present study did avert death, with some of them explaining that being left largely alone did drive them to their own resolution of crisis or to achieve positive engagement with fellow consumers. Nevertheless, it is suggested that consumer experiences could have been more positive and therapeutic had nurses engaged more fully with them. As with experiences of access and initial service outlined in Chapter 5, then, the therapeutic potential of the various interventions, and the fuller realisation of a recovery-oriented approach, is suggested to have been undermined by a diminished quality of interpersonal engagement between nurses and consumers.

# Chapter 7 – The nature and role of therapeutic engagement in care of suicidal people

This chapter draws upon the participant data to explore in greater detail the nature and role of therapeutic engagement in the context of consumer suicidal crisis and related mental health nursing care. Although, as noted, fullest therapeutic engagement was reported by the participants to be minimal, the data does provide ‘glimpses’ of therapeutic engagement occurring. The data also provides insight from the participants about the nature and role of the engagement they *desired* to be realised and felt would be most effective and appropriate. This chapter thus speaks to the potential of nursing care, particularly as it may help address issues of isolation, distress, loss of control and objectification, and thereby promote a more holistic and recovery-oriented model of care.

The data indicates that therapeutic engagement may be understood as constituted of interrelated elements including: rapport, active listening, empathy and boundaries, relating as equals, genuineness, compassion and unconditional positive regard, trust, and time and responsiveness. The co-occurrence of (at least most of) these elements was seen as essential towards an optimal quality of engagement. It must be appreciated, however, that therapeutic engagement was suggested to be more than just the sum of those elements. In particular, it is indicated to be a collaborative, psychotherapeutic, experience, which had a reciprocal impact on nurses and consumers and reflected and shaped positive narrative constructions.

The chapter also extends appreciation of the consumer ‘journey’ by discussing consumers’ ‘turning points’ from a death-oriented trajectory to a life-oriented trajectory. By providing insight into the nature and role of therapeutic engagement

in the context of recovery from suicidal crisis, the chapter contributes to understanding around the recognised association between the quality of clinical relationship and the ability to help the person at risk of suicide (Lineberry 2011, p. 345; Maris et al. 2000a; Leenaars 2006; Michel et al. 2004; Reeves & Seber 2004). This reinforces that therapeutic engagement may be critical to bridging the gap between the rhetoric and reality of care.

### **7.1. Elements of therapeutic engagement**

This section outlines the elements indicated to constitute therapeutic engagement in the context of consumer suicidal crisis and related mental health nursing care. Towards identifying these elements, open-ended survey question 11 asked the nurses: *How do you define therapeutic engagement?* Listed in descending order of frequency the following elements were central to their definitions:

- Collaboration (n=18)
- Building rapport (n=15)
- Demonstrating empathy (n=14)
- Enabling positive outcomes (n=13)
- Being honest and creating trust (n=12)
- Validating and being non-judgemental (n=12)

The notion of engagement constituted of these elements is congruent with Rogers' (1961) theory of therapeutic relationships, which feature respect, genuineness, empathy, and unconditional positive regard. They are also congruent with more specific concepts of therapeutic alliance between clinicians and suicidal people which highlight the importance of understanding, openness, involvement, continuity (Michel 2011, p. 15) and trust (Rudd et al. 2001).

The interview data affirms and adds to the survey data and existing literature by highlighting the relevance to therapeutic engagement of interrelated elements

including: rapport, active listening, empathy and boundaries, relating as equals, genuineness, compassion and unconditional positive regard, trust and time and responsiveness. It is suggested that, even though individual elements of engagement could be therapeutic in themselves, an optimal quality of engagement was more than the sum of these elements. Indeed it is suggested that the elements came together to provide therapeutic effect as they enabled collaboration which revealed and positively affected consumers' intrapersonal experiences within a psychotherapeutic form of care that implicitly embraced recovery and holism.

#### **7.1.1. Rapport**

Rapport – 'relation marked by harmony' (Merriam-Webster 2011) – was expressed by the participants to be an essential element of therapeutic engagement. A key function of rapport was recognised by nurses to be its potential to enable understanding and collaboration. CommRN6, for example, noted that:

*rapport is key...if I've got good rapport with them I can get the information I need, they're more likely to actually tell me whether they will kill themselves or not, and then from there, with the client, we can work out what they need (CommRN6).*

Thus it was suggested that good rapport indicated greater likelihood that a consumer would talk with the nurse '*about what was on their mind*' (AcuteRN4). This led some nurses to assert that '*your assessment's only as good as your rapport*' (CommRN7) and that, as such, '*If I didn't have good rapport with someone I'd ask someone else to do the interview*' (CommRN8). However, noting the need for elements additional to rapport, AcuteRN11 explained that '*rapport is no guarantee though...you might be getting along well because they've decided [to suicide]*'.

For the consumers, too, rapport was highlighted as essential to engagement as it enabled them to be understood and involved in their own care. Lisa, for example, expressed that rapport that had developed over time meant that, more lately, she was less likely to be placed in the HDU section of the inpatient unit. She attributed

this to staff being able to understand more clearly what her state of mind, needs and risks were, via their relationships with her. As Lisa explained:

*When they didn't know me very well they would stick me out in the HDU. Now, the last couple of times, I went straight on the ward, not out into HDU and I feel that was because they got to know me better. They worked at them [the relationships] and they developed over time (Lisa).*

Rapport was suggested to be best established, initially at least, through 'lighter' and less structured interactions. Lucy, for example, suggested that nurses should:

*build up a relationship before they attempt to talk about anything too heavy by keeping it light: 'what would you like for lunch?', just casual stuff like that, 'how many children do you have?', very casual light stuff (Lucy).*

Further reinforcing the importance of building rapport, possibly through 'lighter' interaction, AcuteRN11 expressed that:

*The nurses that actually have some success with their interactions, they take the time to establish rapport...I mean, I've gone weeks, 'hello, hello Joe, goodbye Joe, going home now Joe', never hear a word, and then you'll walk in one morning, 'good morning [nurse]', and it's Joe! It might take three weeks, but I've established something (AcuteRN11).*

The use of humour was also described by several participants as a potentially important way of building and maintaining rapport. Claire noted, for example, that:

*there was a couple of them that used to make funny jokes that sort of took your mind off what was going on and helped us all get along and to get through it (Claire).*

AcuteRN3 recounted an example of when he had employed humour to try and reinforce rapport as a consumer described an elaborate suicide plan:

*I responded to that straight off by saying 'that's quite original!' You know, in a humorous way (AcuteRN3).*

CommRN6 noted further that sometimes humour, as well as being a way to establish and maintain rapport, could help to build understanding. He explained that:

*for some people the way 'in' is humour...I also use humour a lot because it lets me know if they're reactive (CommRN6).*

Rapport can also be seen as related to collaboration. Highlighting the perception amongst the nurses that, above all, therapeutic engagement was something that enabled collaboration towards positive outcomes, AcuteRN4, for example, noted that therapeutic engagement inferred that:

*I'm not doing something to them and they're not having something done to them...we're working on a problem together to reach a resolution (AcuteRN4).*

AcuteRN4 explained further that rapport which enabled collaboration could, as noted, constitute:

*an alliance against their suicidality or illness or whatever problems they're facing...us against whatever the issue or the illness is (AcuteRN4).*

The inference that collaboration could underpin understanding and help address suicidality was further reinforced by CommRN6 who explained that collaborative engagement involved metaphorically saying:

*'come along with me in this direction'....it's like saying 'come on, here's a hand, let's walk down this path, this path could be safe' (CommRN6).*

Although it was highlighted that rapport in and of itself did not constitute a level of engagement able to ensure an optimal quality of care, rapport was highlighted to be essential in enabling understanding, collaboration, and also for various interventions and aspects of care to be experienced more therapeutically. While 'lighter' interactions were seen as an essential part of building and maintaining rapport, 'deeper' collaboration was also seen to potentially arise from good rapport. Thus it is affirmed that therapeutic engagement (alliance) is 'the basis of a therapeutic process in which patient and therapist become allies against mental illness and distress' (Michel 2011, p. 13).

#### **7.1.2. Active listening and inquiry into the consumers' 'inner worlds'**

The participant data indicates that 'active listening' (Glod 1998:673) which entailed inquiry into the consumers' intrapersonal experience was central to the fullest therapeutic engagement. Indeed, active listening was suggested to be '*the most important thing that you can do*' (AcuteRN1). The importance of listening to both '*what they're saying...and what they're not saying*' (AcuteRN9), and also taking into account cues such as body language which could tell the nurse '*an awful lot*' (AcuteRN1), was highlighted.

As with each of the elements of therapeutic engagement, it was noted that active listening could be therapeutic in and of itself and also as it supported various interventions and service as a whole. AcuteRN1, for example, noted that by being actively listened to, a consumer might think:

*'oh shit, she is listening to me! Someone cares!' And then they'll open up a bit more and then the next day they'll tell you more and then they'll start coming up to you and telling you how they feel (AcuteRN1).*

This suggests that active listening could be therapeutic by, for example, providing an experience of being understood. It also reinforces that active listening could be therapeutic as it underpinned other elements of service such as the nurse's

assessment of risk and needs.

The participants' accounts strongly suggest that active listening was experienced as therapeutic, in part at least, because it entailed engagement directly concerned with the consumer's intrapersonal 'world' of meaning and narrative. This involved '*acknowledging someone's story*' (CommRN7) and '*bringing it [suicide] out into the open*' so that '*it doesn't fester away in a dark place*' (Lucy).

For Andrew, deepening engagement towards direct consideration of his intrapersonal experience was important in identifying and ameliorating suicidality via a form of 'reality testing'. Lisa, too, suggested that it would be appropriate that the nurses engage her directly, within a therapeutic relationship, about her intrapersonal experience, because:

*sometimes if they wait for you to bring it up, you may not bring it up, especially if you're planning it. You'll be as quiet about it as you can be and maybe if they ask, it wouldn't seem so unusual (Lisa).*

Claire also noted that it was important to speak directly about her intrapersonal experience '*because then you know that they understand what you're thinking*'. The importance of engagement directly concerned with the person's intrapersonal experience was reinforced by John who recommended that nurses '*ask them straight out what they're thinking and what they really need*' (John), and by Kate who suggested that:

*they should ask them about it...you need to discuss it as much as possible to sort out in your own head what you were thinking...to get better you need to discuss it (Kate).*

Thus the findings affirm that people who are suffering want to share their feelings (Holm et al. 2009b) and tell and understand their story (Warner & Wilkins 2004). As has been found previously, the opportunity for consumers to talk and be understood



was of central importance (Talseth et al 1997;1999; McLaughlin 1999; Samuelsson et al. 2000; Cutcliffe et al. 2006; ACMHN 2010b), and it was suggested that nurses may be in a position to access and affect consumers' 'secret knowledge' (Holm & Severinsson 2011, p. 849). Indeed, the findings reinforce that therapeutic engagement which involves understanding the person and their narratives has the potential to help the person re-establish 'life-oriented goals' (Lineberry 2011, p. 350). It is such engagement that may make the person an active partner in understanding and enacting treatment and recovery, as noted regarding various models of care (Michel 2011; Cutcliffe & Stevenson 2007; Barker 2001). Despite its importance, however, if the consumers were asked directly about suicide, the data suggests that such 'inquiry' tended to be part of a formal and more superficial risk assessment rather than as an attempt to actively engage in the comprehension and (re)construction of intrapersonal meaning and narrative. Alarming, it is also reinforced that some of the nurses did not necessarily believe that talking directly about suicide with consumers was an appropriate or safe thing to do, as has been found previously (Meerwijk et al. 2010).

### **7.1.3. Empathy and Boundaries**

The participant data indicates that empathy – the act of 'understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another' (Merriam-Webster 2011) – was essential to therapeutic engagement. Andrew, for example, expressed that *'I need there to be that empathy otherwise the whole thing's meaningless'* (Andrew). Similarly Tracy noted that *'the nurses have just got to have a lot of empathy'*.

Many of the nurses also acknowledged the importance of empathy. In discussing it, several of them revealed different interpretations of empathy, with some inferring that it was necessary to balance 'close' empathy with the maintenance of boundaries and a particular 'distance'. CommRN6, for example, described a more distanced form of empathy:

*With this girl we had the other week, I remember saying to her 'that's really sad, that even makes me sad.' But I wasn't really sad...I mean I use empathy but I don't really join with them! 'Cause if I was joining with them I might start thinking 'gosh my life's not too good either!'* (CommRN6).

CommRN6 noted further, regarding such a form of empathy that engagement was *'a one way passage...a ticket to go there and help them...not a ticket to join with them'*. Thus, it was suggested that engagement could be *'not a true joining...not real'* and that the nurse was thus *'almost an actor'* who sought to *'dis-engage personally and pretend'* (CommRN6).

CommRN8, too, described something of a 'distanced' empathy:

*You don't get personally involved. You know your boundaries...so you sort of try not to let that affect you...you know not to become emotionally involved* (CommRN8).

Such an interpretation of empathy reflects something of the recognised tension between 'distance' and 'closeness' in mental health nursing care of suicidal people (Talseth & Gilje 2011, p. 8; Talseth et al. 1997; Larsson et al. 2007). Furthermore, it may exemplify the (potentially misguided) search for emotional and ontological security that more distanced approaches promise. Arguably, such empathy may deny the necessity that clinicians 'imagine in themselves their patients' thinking, feeling, will, and memory – their patients' selves' (Maltsberger 2011, p. 32). Indeed, such an interpretation of empathy may fail to appreciate the importance of 'truly sharing the patient's world with all its experiences', particularly suffering, and incorporating that into 'communion between patient and nurse' (Eriksson 1997, p. 10).

It is acknowledged, however, that 'close' empathy may actually be very challenging. CommRN8, in particular, grappled with the tension between achieving genuine empathy and not being over-involved or potentially 'engulfed' by the suicidal person,

as is noted by Akiskal (2007, p. 395) to be possible. CommRN8 reflected regarding this that:

*it's a hard one. You try not to get emotionally involved, but you have to get involved to talk to them. But you don't make it personal (CommRN8).*

I asked CommRN8 whether empathy was then, as previously asserted by CommRN6, something of an act. CommRN8 explained that for him it was not an act, and that:

*if you are acting the client will know straight away. But if you're there nursing them as someone who feels for the client then the client will know that and they will respond better to someone who's not there feeling as though they have to put on an act (CommRN8).*

Thus it was suggested that a nurse could establish boundaries around how 'close' they would get, but could still realise empathy.

A less conditional empathy was appreciated by several of the other nurses, however, to be more congruent with therapeutic engagement. AcuteRN11, for example, noted that empathy entailed 'reciprocity', and her being 'exposed' and potentially deeply impacted, both positively and negatively. Her focus was on the need to 'bear witness' and then deal with what that might entail (such as being confronted).

The concept of boundaries was, nevertheless, inferred to be important towards promoting therapeutic engagement. Tracy explained, for example, that nurses for her were:

*just like my friends. I know that they're not my friends...I know it's a professional thing. But they're just like my friends (Tracy).*

Clearly, management of such ‘professional friendship’ would require very explicit relational boundaries which nurses would be responsible for clarifying and maintaining.

AcuteRN3 framed the establishment of boundaries as the laying of ‘*ground rules that protect you but also protect the client*’ (AcuteRN3). It was noted that one of the important ‘rules’ involved establishing that certain information may have to be shared within the treating team, should, for example, risk be revealed. AcuteRN2 explained in this regard that:

*I told her, before we even started talking, that I had to share the information, but that it would just be with the team. She was happy with that (AcuteRN2).*

AcuteRN3 recounted a similar instance, which suggests that such boundaries or ‘rules’ – which may potentially seem obstructive to empathic engagement – could actually function therapeutically in certain contexts:

*I told him that it couldn’t just be something between the two of us, that I have an obligation to talk to his treating team about how he’s feeling...I got the feeling that that’s what he wanted me to do anyway...so there was no animosity or I didn’t feel that he felt that I was letting him down. I think he felt relieved, that he possibly wasn’t able to talk, or hadn’t been given the opportunity to talk about his suicidality, and he now had someone else being able to bring it up with his treating doctor (AcuteRN3).*

AcuteRN9 suggested further, regarding the balancing of ‘professional distance’ and ‘closer empathy’, that perhaps professional boundaries could actually facilitate a better quality of engagement as, ‘*because I’m tied to that professional role they look to me for support and I try to be strong for them*’.

It is highlighted, then, that empathy was absolutely central to therapeutic engagement. Empathy is suggested to require (and reinforce) good rapport, active

listening and direct inquiry into the consumer's intrapersonal 'world', negotiated boundaries and, in addition, a certain attitude and approach from the nurse. Importantly, it is clear that empathy may be very challenging and confronting for nurses to achieve, requiring them to mediate 'professional and personal demands and boundaries' (Gilje et al. 2005, p. 520). Thus it is indicated that genuine empathy is essential to therapeutic engagement which seeks to connect with consumers' intrapersonal 'worlds'. It is also indicated that nurses require preparation, support and expertise to achieve such empathy.

#### **7.1.4. Relating as equals**

The participant data highlights that, as part of direct and empathic engagement with the consumer about their intrapersonal 'world', it was important to relate as fellow humans who had not dissimilar hopes, experiences and struggles. It was noted that this may involve the exchange of stories.

Regarding relating as fellow humans, AcuteRN4 noted, for example, the need to:

*forget the patient label and just engage with the person as another person who might find you interesting as much as you might find them interesting (AcuteRN4).*

Similarly, AcuteRN2 explained that ideally:

*you're trying to build something that means that they're not isolated and they're not feeling like it's them and us, that we're all human beings together (AcuteRN2).*

AcuteRN11, too, inferred that therapeutic engagement required the honest belief that:

*I'm just as human as they are...I don't believe I'm any different to the person sitting in the chair across from me (AcuteRN11).*

The majority of the participants (in particular the consumers) explicitly noted that appropriate self-disclosure involving the sharing of personal stories could be a key element of relating as fellow humans within therapeutic engagement. Claire, as with several other consumers, expressed that such sharing involved the nurses '*talking with me, not down to me*' (Claire). Lisa explained how it made her feel to share stories with a nurse:

*That makes you feel really good. It just builds you up, makes you feel better...you can see what they're going through, too, and it reminds you for a while that everybody's going through the same sort of things – or different things – but we're all going through something (Lisa).*

Claire explained that interaction with one nurse in the inpatient setting was therapeutic because, amongst other elements of engagement, '*he talked about his personal life and his children*'. Claire reported finding this helpful, particularly in helping resolve anger towards her parents.

Tracy, too, described the potential therapeutic impact of sharing stories:

*Some of them would let you know they had kids and they had families, too, and some of them were studying and stressed out. Some of them had different things happening in their lives and it wasn't all roses for them either (Tracy).*

Lucy also highlighted that sharing stories in such a way had the potential to reflect and shape a deepening of the therapeutic relationship. Indeed, her account suggests that the sharing of stories might create the context in which she felt able to reveal her intrapersonal experience. Lucy explained that:

*I remember thinking it was all right to talk to her...that she understood because she'd been through a few bad things herself...but they need to build up a relationship before they attempt anything like that (Lucy).*

Lucy noted further the potential value of relating as fellow humans and how this was interrelated with other elements of engagement and aspects of care:

*The more you know about the people you're interacting with the more confidence you have in them. When I know that a nurse has nursed for so many years in one area and is now back at uni, and I know that she's got exams coming up or she's tired and stressed, she's got kids to get off to school and things like that, it helps...it makes them more human (Lucy).*

As noted in section 6.4.2., Claire also highlighted that 'therapeutic sharing' could occur with other patients in the inpatient setting who, later in her admission, she related to as '*a team*'. Thus the value of sharing stories – potentially involving the dissolution of, for example, status, age, and various personal or social differences – was suggested to be potentially highly therapeutic. Self-disclosure is, however, something that needs to be carefully managed to protect both parties (Ashmore & Banks 2002), and so the importance of appropriate boundaries is reinforced. Rather than a blanket rule not to self-disclose, as was suggested by CommRN8, however, there may be value in relating as equals and sharing stories as part of a therapeutic relationship, as has been noted to be relevant in mental health nursing contexts more broadly (Holm & Severinsson 2011, p. 849; Peplau 1991 [1952], p. 9; Walsh 1996, p. 328).

#### **7.1.5. Genuineness, compassion and non-judgemental and unconditional positive regard**

The participant data indicates that nurses' attitudes and actions, which reflected genuineness, compassion and non-judgemental and unconditional positive regard, were essential complements to rapport, empathy and engagement that encompassed concern with the consumer's intrapersonal experience. Expanding on his understanding of the necessity of empathy, Andrew noted in this respect that:

*if I am going to open up to someone and talk about suicidal thoughts or stuff like that the most important thing is that I feel like they genuinely care about me...like they are really interested...otherwise I just wouldn't tell them anything (Andrew).*

Claire, too, highlighted that the perception of genuine care for the consumer was an important element of therapeutic engagement. Exemplifying this Claire recounted one instance of engagement in her inpatient unit admission that stood out:

*There was one nurse who was good. I would stay in my room and sit there and wait and he would come in and chat to me. He was genuine. There were some nurses that you feel like they're just doing their job sort of thing...but I felt that he really cared [long pause]....him caring...it showed me that I'm worth something [voice breaking]...that I'm worth being alive (Claire).*

Tracy also indicated the importance of perceiving that a nurse genuinely cared. She indicated that this enabled her to see herself more positively and also gave her an ally to work towards recovery with. Tracy explained that:

*if you get a nurse and they're just nice and they've got that nice nature about them, you're not talking to someone judgmental...they don't have the stigma about different things...and they make me feel wanted (Tracy).*

Kate also recalled that a genuine, caring attitude and approach was essential and underpinned the one instance of therapeutic engagement she recalled within the inpatient unit:

*I remember one nurse. I had a chat with him and he just seemed really emotional, you know like he really cared...and I was glad somebody cared (Kate).*



Several of the nurses expressed, too, the importance of attitudes and actions reflecting genuineness, compassion and non-judgemental and unconditional positive regard. AcuteRN3, for example, noted that:

*if they think you're going to be judgemental there's no way in hell they're going to talk to you about feeling suicidal (AcuteRN3).*

CommRN6, too, highlighted the importance of a non-judgemental, caring approach:

*You have to be focused on their pain and let the other things go out the window. Like I've nursed paedophiles who were really suicidal and I just figure that at this point this is where I'm at. I'm there to help them not judge them (CommRN6).*

In the same vein, AcuteRN4 explained that genuineness, compassion and non-judgemental and unconditional positive regard were essential to maintaining a therapeutic relationship in response to repeated suicide attempts. He recounted, for example, that following a repeated suicide attempt a consumer said to him *'I'm sorry, I've let you down, you probably won't want to see me again'*. AcuteRN4 explained, however, that *'that's never an issue for me. They will choose to leave me before I will give up on them'* (AcuteRN4).

Similarly, AcuteRN2 recounted an experience when:

*I valued her, and I didn't judge her...that judgement can be a real problem at times...the attempt on my part was to be with her to say that she is worthwhile, to say that it is ok to feel the way she does (AcuteRN2).*

The nurse interviewees thus appreciated the importance of genuineness, compassion and non-judgemental and unconditional positive regard. Crucially, this is suggested to extend to non-judgmental attitudes towards suicidal behaviour - even within the context of trying to prevent it. In line with the findings that therapeutic

engagement was under-realised, however, it is possible that the consumers may have perceived that the nurses felt it was *'not ok to feel the way she does'* (AcuteRN2) – i.e. suicidal. It must be noted, however, that explicit negative judgement was not strongly suggested in the participants' accounts although, as noted, the nurse interviewees were critical of some of their colleagues in respect to some of their attitudes and approaches. Thus, the findings affirm that less judgmental and more compassionate responses to suicidality are necessary and valuable (Mendoza & Rosenberg 2010, p. 45). This is in keeping with previous findings regarding therapy relationships in general (Rogers 1961), and in mental health nursing specifically (Happell et al. 2008; Cutcliffe & Stevenson 2007).

#### **7.1.6. Trust**

Trust was also indicated by participants to be essential to therapeutic engagement, and interrelated to the elements of rapport, empathy, relating as equals, genuineness, compassion and unconditional positive regard. Trust was established within certain boundaries and, along with the other interpersonal elements, was concerned with direct and active engagement with consumers' intrapersonal narratives. Highlighting an appreciation of the interrelatedness of elements, including trust, AcuteRN1 noted that:

*you can't talk meaningfully unless you have a relationship and the only way you're going to have a relationship with anybody is to be honest...plant the seed by telling them that you care, acknowledge what their saying and don't lie to them...gain their trust and they will open up (AcuteRN1).*

AcuteRN2 also noted the necessity of trust and how it was interrelated with other elements of therapeutic engagement:

*They need to be able to trust me....and for that to occur I need to be non-judgemental as to the circumstances that they're in, I need to set up the right environment, tell them 'yes I do need to pass on some of this information, but please trust me' (AcuteRN3).*

Lucy suggested that, from the consumer perspective too, trust was essential to therapeutic engagement. Reinforcing the need to build a relationship which moved appropriately towards engagement concerned with her intrapersonal experience, Lucy noted that:

*it would have to be the right person. It would have be someone that I trusted...Trust is what you want...so I think it's necessary that they do the light stuff and then try and get into the heavy stuff because it's got to be talked about and dealt with. When they feel that they're trusted they can go on with it (Lucy).*

Several of the nurses reflected on experiences where they had developed trust to the extent that they could understand and affect the consumer's intrapersonal experience. AcuteRN4, for example, described engagement with one consumer, noting that:

*she has responded well to my honesty. She trusts me to be open and transparent, to not judge her, and so she is brutally honest with me too. That means that I can challenge her ideas, her reasons...she benefits from that because I'm honest (AcuteRN4).*

As with therapeutic engagement as a whole and its other constitutive elements, it is clear that trust was seen to be therapeutic both as it had therapeutic effect in and of itself (for example via the experience of trusting and being trusted) and as it could enhance the therapeutic potential of various elements of service (such as assessment). Regarding the direct value of experiencing trust within a relationship, Tracy, for example, expressed that the most helpful thing about nursing care for her was that:

*they believed in me. Because I had no family support, no friends, no one to talk to...It was the nurses that believed in me...because I've got trust issues after*

*what I've experienced...I find it really hard to trust people with what I say, and I can trust them [the nurses] (Tracy).*

Furthermore, as noted regarding Kate, for example, trust was also seen as essential to underpinning interventions such as detention and observation. It is thus affirmed that, ideally, a consumer would collaborate in treatment with 'someone they trust' (Holm & Severinsson 2011, p. 847). Indeed it is reinforced that it may be trust which makes it possible for a suicidal person to take the necessary 'risks' to connect with others, develop new skills, and realise positive change (Rudd et al. 2001).

#### **7.1.7. Time and responsiveness**

The fundamental need to spend time with consumers was also noted to be vital to therapeutic engagement. Time, being available, and responsiveness to consumer readiness to engage, interrelates with the elements of rapport, empathy, relating as equals, direct engagement with narratives, genuineness, compassion, unconditional positive regard, and trust. Beyond the obvious point that '*they need people's time*' (AcuteRN4), AcuteRN2 elaborated on how spending time with someone may entail a particular quality of 'being with':

*I have come to value the importance of just 'being with' a person. Not necessarily saying anything, but just being with the individual. The value of it can be profound...even in silence it gives hope...there have been times when nothing else could be said, but being with that person and valuing them in the moment somehow changed things (AcuteRN2).*

Beyond the value of 'being with', it was noted that the management of time, and the maintenance of other elements of engagement in relation to that, was important. AcuteRN1, for example, explained that, in a pragmatic attempt to make the most of the demands on her time she would often give '*little chunks*' of time to a suicidal client. AcuteRN1 argued that the potential for this to be experienced as superficial was ameliorated by other elements of engagement including rapport and honesty, in

particular. From AcuteRN3's perspective, however, such an approach was suggested to be potentially problematic. He noted in this regard that:

*I've seen other mental health nurses give lip service to suicidal clients...so a five or ten minute discussion, a pat on the back, 'you'll be alright' (AcuteRN3).*

Reinforcing the importance of longer periods together (at least at some point) it was expressed further that consumers:

*have got a story they need to tell and they don't want to be disrupted, they don't want to have the feeling that they're being fobbed off, they don't want to have the feeling that you're listening to them until you have something better to do (AcuteRN2).*

While the consumer who AcuteRN1 was giving 'little chunks' of time to may have found that experience to be therapeutic, it was also noted that there was a need for more extended periods together. Indeed some nurses noted that to be effective they might devote an hour or more to an interaction. AcuteRN4, for example, explained that:

*I will pretty much give them as much time as I can afford to. You know an hour, an hour and a half, two hours (AcuteRN4).*

Lucy, too, noted the importance of nurses devoting adequate time to interactions. Interestingly, Lucy expressed in this regard that interactions with student nurses were often most therapeutic because the students spent more time with her (and within that context also often had particularly positive attitudes). Lucy explained that:

*the [registered nurses] have so many other chores to do and they're just racing around to do them and just hoping to god that you keep your lid down so they can get through their shift. Whereas the students are all fresh and ready to*

*learn stuff, they're available, and they're trying really hard to find out what the story is with each patient (Lucy).*

Lucy, while perceptive of service and time constraints, nevertheless highlighted that what would have made a positive difference for her was:

*having the nurses available, so when you feel as though you could really talk you could just go in and talk. I know that's practically impossible though because everybody's got their own schedules (Lucy).*

Related to the importance of spending adequate time together, and engaging therapeutically within that time, the need for responsiveness to consumer needs was highlighted. For example, many of the consumers expressed that there were certain times when 'deeper' engagement would not be appropriate, and others where it would be welcomed. Thus the notion of creating and capitalising on 'windows of opportunity' was nuanced. Ben, for example, expressed that, while he would have liked to talk directly about his intrapersonal narrative at some point, the timing would have to be right and it would thus be best if *'they could check in with me once a day'*.

In respect to *'giving someone a choice'* (Kate) to talk when they were ready, Kate noted the importance of nurses appreciating when that might be. Kate reflected on why she experienced the desired therapeutic engagement with one nurse on one particular occasion:

*Maybe it was just me. Maybe he thought I was just ready to talk to someone, whereas before I hadn't been. Or maybe he was not in too much of a hurry. Like the rest of them, you know, in a hurry, rushing in and out (Kate).*

Reinforcing the need for responsiveness around the time spent together, Lucy noted that engaging in respect to her intrapersonal narrative may have been difficult because *'you wouldn't be able to cope with it for too long, you'd get too tired when*

*you're in that situation'* (Lucy). Thus, consumers felt that nurse responsiveness was not simply about interaction, but involved appropriate evaluations of when to engage or disengage, based on consumer readiness and intrapersonal state.

Thus it was appreciated that time together was an essential aspect of therapeutic engagement, and that responsiveness and the presence of various other interrelated elements of engagement was important within that time of being together. The findings reinforce, then, that nurses need the intent and ability to therapeutically engage, as well as the time and opportunity within which to do so (McLaughlin 1999; Talseth & Gilje 2011). Reinforcing the importance of nurses' availability and the quality of interaction within time spent together, it was notable that several consumers commented on the therapeutic potential of students who spent more time with consumers and showed genuine interest in understanding the consumer. This affirms that patients may prefer the approaches of less trained and less experienced 'therapists' (Hersoug et al. 2001) as the giving of time within a relationship constituted of the elements outlined may be more important from the patient perspective than, for example, a clinician's experience and knowledge.

#### **7.1.8. Summary**

This section has outlined the interrelated elements suggested by the participants' to be constitutive of therapeutic interpersonal engagement, namely: rapport, active listening, empathy and boundaries, relating as equals, genuineness, compassion and unconditional positive regard, trust, and time and responsiveness. It has been highlighted that these elements constituted therapeutic engagement particularly as they enabled consumers' intrapersonal 'worlds' to be understood and potentially positively affected, whether that was via direct and explicit discussion or was the outcome of experiences such as that of being trusted, understood, cared about, or even just 'being with' someone who conveyed such relational qualities. It is notable that most, if not all, of these elements were seen as necessary, but alone not sufficient, for therapeutic engagement. The result was seen to be collaboration in an alliance against suicidality and optimal progress towards recovery.

## **7.2. Therapeutic engagement as fundamental to recovery**

This section looks further at how engagement may have had therapeutic effect as, underpinning various elements of service and in and of itself, it allowed intrapersonal experiences (reflecting and shaping personal narratives) to be understood and positively affected. This continues exploration of how engagement may enhance the therapeutic potential of the dominant service interventions of detention, observation, medication, and management within the inpatient unit environment. Understanding is extended by focusing more broadly on how engagement may underpin a psychotherapeutic / interpersonal model of mental health nursing, how it may empower consumers, and lead to both consumers and nurses experiencing positive change reflected in evolving narratives. Thus, understanding is extended regarding how therapeutic engagement may help address issues of isolation, distress, loss of control and objectification, thereby promoting recovery-oriented and holistic service.

### **7.2.1. Psychotherapeutic engagement**

The participant data highlights that, as well as potentially optimising the primary interventions of detention, observation, medication, and management within the inpatient unit milieu, therapeutic engagement could be associated with a psychotherapeutic model of nursing. This psychotherapeutic dimension of engagement was seen to be important in positively affecting consumer experiences and narratives. AcuteRN2 described such a model of nursing as:

*a Rogerian type of counselling – that warmth, that immediacy, and honesty – those basics are really important and then I go for more specific techniques like CBT on top of that (AcuteRN2).*

CommRN10 described, additionally, the potential of ‘a goal-focused type of therapy to build some hope’ (CommRN10). It was suggested that this might involve:



*helping them try and establish some goals and trying to find out what it is they want and how they might try and achieve it and what kind of things might be blocking their ability to achieve their goals (CommRN10).*

CommRN7 described a similar approach, whereby she would be:

*trying to get an accurate perception of where they are now – grounded in reality – without misconceptions – so there’s a bit of CBT in there – and then a solution-focused approach more than anything else – looking at what was causing the stressors, looking at their supports, developing a future plan (CommRN7).*

The consumer responses also reflected the importance of such interpersonal psychotherapeutic approaches. Kate, for example, explained how a nurse engaged to help her understand how she was thinking and to establish some future goals:

*We talked about how all your thoughts get tangled up in your head...and then he asked me something like, ‘Will the problems that brought you in here still be there when you go home?’ It was a question like that. And then we just talked about what I needed to do to face those problems...it was really good (Kate).*

I asked Kate what she thought the nurse was trying to do via this conversation, and she replied that:

*the doctors are interested in medication; they want to get you on the right medication. And I think he [the nurse] was trying to fill the space of a counsellor kind of thing because I didn’t get to speak to a counsellor or a psychologist or anyone while I was in there. So maybe he was trying to take that role (Kate).*

Kate asserted that the nurse filled the role of ‘counsellor’ quite well in that one 15 minute interaction with him. She expressed that it led her to ‘*deciding to change the way I think about some things that have been troubling me*’ (Kate).

Candice, too, noted the nature and benefits of a psychotherapeutic approach that she had experienced with her community mental health care case manager:

*For me, it was thoughts and ways of thinking that have been there since I was born basically...I didn't really know any different. I'd never had any sort of question about my thinking, because I didn't know any other sort of way of thinking....talking with [case manager] has created sort of 'movement', if you know what I mean (Candice).*

The participants' accounts thus reflect the importance and potential of psychotherapeutic approaches. However, it would seem that consumers did not think that mental health nurses were necessarily expected to provide such counselling or psychotherapy. Furthermore, nurses themselves inferred that there was a lack of structure to support and guide them in such approaches and that doing so was dependent on their individual motivation and ability. Again, the nurse interviewees expressed a lack of faith in their colleagues' motivation and ability to fill such a role. Thus psychotherapeutic engagement was seen as valuable, but uncommon and unstructured, particularly in the context of inpatient unit service. Furthermore, it was indicated that when nurses did provide such care it largely went unacknowledged within the broader context of service.

The findings thus arguably support the assertion that Peplau's vision of interpersonal psychotherapeutic nursing care may be threatened (1952, cited Barker 2002, p. 22). Indeed, it is affirmed that such a model of nursing may be 'at risk of becoming less important' than interventions such as psychopharmacology (Happell et al. 2008, p. 131), and eroded from the practice and education of mental health nursing (Delaney & Handrup 2011). Nevertheless, the findings clearly assert that psychotherapeutic approaches are an important element of therapeutic engagement. Findings also support previous research which has found that some mental health nurses want to provide such therapies (Brimblecombe et al. 2007).

### 7.2.2. Empowering engagement

Extending previous discussion of how elements of therapeutic engagement may contribute to recovery by helping address issues including loss of control, the participant data highlights that one of the most significant outcomes of therapeutic engagement would be consumer empowerment. As noted in the previous chapter, suicidal crisis and related mental health service raised issues of loss of control around potentially coercive and reductive elements of service. It is argued that therapeutic engagement may be key to negotiating the tension between autonomy and control in a way that maintains and returns consumer autonomy as quickly, effectively and appropriately as possible.

Inferring the importance of therapeutic engagement to promoting autonomy, it was suggested that:

*ideally consumers are more involved. They identify the goals they want, how long they need to achieve them, what they want from our service, what they expect us to do for them, and how they can participate in their plan to get well (AcuteRN1).*

AcuteRN1 expressed that promoting such involvement meant enabling the consumer to take responsibility, as:

*a lot of the times nursing staff over-protect and do most of the stuff for them – taking their responsibility away from them...We need to bring responsibility back to them and tell them that they need to do this for themselves. We will help them but we won't do it for them (AcuteRN1).*

Expanding on how empowering engagement may function, AcuteRN4 described the importance of:

*trying to get them not to be the victim, not to be just subject to the illness or their thoughts or whatever...and trying to impart mechanisms where they can see that they have control (AcuteRN4).*

This was noted to potentially occur via:

*an alliance against the illness that we're engaged in...not me telling them how to live their life. I try and empower them to understand that I can't give them control, that control must come from them (AcuteRN4).*

CommRN6 conceptualised empowering engagement as working to help suicidal people gain 'focus' to see the 'big picture' and raise insight such that they could appreciate their resources, goals and potential for living. Shneidman (1996a, p. 60-61) suggests, similarly, the value of raising insight and widening 'the blinders' so the person can 'see new angles' and so the therapeutic relationship can then proceed to challenge the person's suicidal intent. CommRN6 explained to this end how:

*sometimes I'll say to them, 'tell me what you need to make sure that you're safe?' I'll put it back on them and ask them to tell me what they need, sort of empower them to make those choices (CommRN6).*

Thus it was suggested that empowerment may involve the consumer gaining, or taking back, control to direct their care (and their life). The nurses clearly felt that empowerment was important, although several of them noted that negotiating and promoting this was not necessarily simple or without risk.

Despite the finding that therapeutic engagement was minimal, several consumers' accounts support the suggestion that therapeutic engagement may be essential to experiencing empowerment. Candice, for example, explained how gaining 'an understanding of what was really going on' (Candice) was valuable to her and occurred by engaging with nurses and other consumers. Lucy, too, framed her resolution of crisis as a learning experience and suggested that this 'learning' was

promoted via interaction. Tracy also noted that she had '*learnt a lot*', felt more in '*control*', and had '*more options that are really good*' (Tracy).

It was suggested that consumer empowerment was promoted by essential elements of therapeutic engagement such as unconditional positive regard. Tracy, for example, explained that:

*the nurses would just say, 'you are a good person', and they made me feel like I'm wanted somewhere. So then I thought, 'Oh, maybe I could do that', and then...I started to believe in myself (Tracy).*

Further highlighting that various elements of service and engagement could come together to promote empowerment, Lisa described how:

*sometimes the nurses help me understand what's happening with me, grounding me a bit, because I'm often manic...and they make me feel like I'm not alone, that I'm not isolated, that somebody's listening, that I can get a handle on things (Lisa).*

It is thus reinforced that, central to recovery, is promoting personal autonomy and internal motivation which may otherwise be limited by service that is experienced as controlling, or, indeed, by mental ill-health (Mancini 2008, p. 359) or suicidality. The notion of empowering engagement is accentuated by various authors including Shneidman (1996a, p. 6), who suggests that, within the boundaries of the therapeutic relationship, a therapist should help the person to understand the source and location of their 'pain' and what they require to address that. Similarly inviting the person to an empowered position, Jobes (2006, p. 41) suggests an ideal initial response to a suicidal person:

*The answers to your struggle lie within you – together we will find those answers and will work as treatment partners to figure out how to make your*

*life viable and thereby find better alternatives to coping than suicide (Jobes 2006, p. 41).*

The present study highlights the challenges of promoting the consumers' wishes and preferences at a time often accompanied by ambivalence, when they may be experiencing a preference for suicide and non-participation in treatment. During this period it may be that principles of recovery including empowerment are most difficult to realise, yet important to promote as they are intimately linked to an optimally successful resolution of crisis. While consumers' accounts do suggest an ability to sometimes regain control themselves – even in the absence of therapeutic engagement – it is strongly suggested that engagement may greatly benefit the negotiation and reclamation of control as part of the resolution of crisis and meaningful recovery.

The findings thus support the notion that empowerment may be at the heart of interpersonal nursing (Peplau 1991 [1952]), mental health nursing (Barker & Buchanan-Barker 2011), the recovery model of care (Onken et al. 2002), and therapeutic engagement with suicidal people (Cutcliffe & Stevenson 2007). The participants' accounts affirm that therapeutic engagement, recovery and empowerment are interrelated. In this sense it is highlighted that therapeutic engagement is a medium through which responsibility and control could be both given back to, and received by, the consumer.

### **7.2.3. Nurses realising positive change from therapeutic engagement**

The participant data highlights that therapeutic engagement may, ultimately, promote intrapersonal change which is reflected in positive narrative development. For the nurses, the potential for positive intrapersonal change was suggested to arise from understanding and helping (or attempting to understand and help) another person, and, within that, embracing and 'growing' from the challenges that therapeutic engagement might entail.

As noted, at least one nurse interviewee expressed that empathising too closely with a suicidal person could threaten the nurse's own existential security. Some of the nurse interviewees expressed that reluctance to get close to the consumer's intrapersonal experience might arise from a reluctance to confront one's own fears and limitations, as:

*people find it difficult to engage because suicidal people provoke strong emotions in them and they [the nurses] don't like being out of control (AcuteRN11).*

This reinforces that there were challenges – even perceived risks – for the nurses in engaging more fully with suicidal people. This was suggested to be particularly so should a consumer with whom a nurse had engaged with go on to complete suicide. However, several nurses also noted that even if outcomes were positive, therapeutic engagement could still be very confronting and challenging. As CommRN6, for example, expressed, *'even if you do it properly, it's pretty draining'*. The personal challenges around engagement may go some way to explaining why it was sometimes not pursued by the nurses.

Despite the potentially confronting and challenging nature of therapeutic engagement with a suicidal person, however, it was also appreciated that:

*if you don't try and understand that person and build that relationship then you're doing a wrong to the patient and you're doing a wrong to yourself (CommRN6).*

Such a statement reflects the possibility that both nurses and consumers stood to benefit from therapeutic engagement. Benefits for the nurses are suggested to potentially arise directly from the act of connecting with another person in a meaningful and hopefully helpful way. Benefits are also indicated to potentially arise as, within that act, the nurse could come to face personal limitations in a way that may foster self-awareness and personal and professional development. CommRN10,

for example, explained that helping a suicidal person via therapeutic engagement may be rewarding:

*To be able to connect with that person and help them find alternatives – to think I’ve actually helped this person to stay alive and perhaps to find a better way – is enormously satisfying, when it happens (CommRN10).*

Similarly, AcuteRN11 noted that:

*my payback is that I get to interact with them, assist if I can, but it’s just interesting to really ‘meet’ other people. It’s just an interesting way to be with other human beings (AcuteRN11).*

AcuteRN2 expressed further that:

*I really do love those moments when you know you’ve reached that person and you think how privileged you are to – I feel a bit emotional about it [voice breaking] – to have that connection. Those words....they can be the lifesaving words (Acute RN2).*

Regarding the potential that nurses could also benefit from having to face personal limitations within therapeutic engagement, it was noted that ‘*in mental-health nursing your main tool is your own personality*’ (CommRN10). It was inferred by several nurses that pursuing and practicing engagement-based care could be embraced as a means to understand and develop that ‘tool’ (self). AcuteRN2, for example, noted that:

*engaging teaches you that you have to learn to love those things about yourself [potential for self-destruction, low self-esteem, fear, etc.]. It is kind of diving into and acknowledging and actually embracing some of those things (AcuteRN2).*



AcuteRN4 reinforced the notion that therapeutic engagement may prompt consideration of one's own potential for self-destruction, noting that *'I think everybody has probably contemplated suicide, if only to reject it as an option'* (AcuteRN4).

Further highlighting the potential of developing self-awareness via engagement, AcuteRN11 asserted that:

*it's confronting...but the subjective use of self requires you to be completely aware of your subjectivity, so you have to embrace that (AcuteRN11).*

Furthermore, it was implied that benefits might arise because professional skills such as those developed around engagement with suicidal people could become integrated into one's personal life:

*Being a mental health nurse, the skills you learn integrate into your life, they shape your way of thinking and being (CommRN8).*

One of the key avenues to positive 'growth' was suggested to be the need to confront one's own mortality and potential for self-destruction as part of engaging closely with the suicidal person. This may well be rewarding as:

*Contemplation of death and dying makes that much more vibrant a participation in life and living...one's knowledge that life will end enhances one's enjoyment of the moment, and all the moments past and future related to it (Shneidman 2005, p. 117).*

Thus, it was implied that, additional to the direct rewards of helping another, therapeutic engagement with a suicidal person – or intent towards that – could be embraced as an opportunity to foster self-awareness and self-development, as well as to gain and practice the range of therapeutic and interpersonal skills that engagement with a suicidal person might entail.

The findings thus reinforce that embracing a context which demands the confronting of one's own potential for self-destruction may address a problematic tendency for humans to suppress exploration of such matters (Webb 2005; Shneidman 1996a). This may, indeed, 'awaken' the nurses' personal insight and prompt them to reconcile 'inner dialogue about suffering' (Gilje et al. 2005, p. 522), such that:

*The nurse's sense of self is renewed and reawakened each and every time she [sic] meets existential despair (Gilje et al. 2005, p. 522).*

The broader and more specific implications of gaining insight in these respects, and responding to what one 'learns' may, I would argue, be contributory to the notion of 'learning to live better' via the study of suicide (Maris et al. 2000a). Thus, therapeutic engagement may remind us that we all, at some point, seek 'recovery' from life's catastrophes (be they larger or smaller) (Anthony 1993, p. 20; Barker & Buchanan-Barker 2011b, p. 352).

Clearly, getting close to a suicidal person via therapeutic engagement may confront nurses (and people in general) in very powerful ways. Indeed, it has been noted that mental health care therapists (Alexander 2007; Wurst et al. 2010), psychiatrists (Lafayette & Stern 2004), and nurses (Cutcliffe & Stevenson 2008a, p. 947; Talseth & Gilje 2011) may find interactions with suicidal clients very demanding. Numerous nurses in the present research, however, note that these demands can be embraced with positive effect. This affirms that in 'interpersonal nursing' a nurse 'both expands her [sic] own insights and helps the patient to grow' (Peplau 1991 [1952], p. xii). Thus, as Holm (2009) points out, personal and professional growth may be realised in the nurse because, as they are forced to face their own qualities and limitations as they appreciate the consumer's experience, they may evolve their own understanding and ability to face challenges. The notion of reciprocal change highlights that, indeed, mental health nurses may be affected by the experiences and outcomes of patients (Walsh 1996, p. 219). In respect to suicide this has very important implications, principally for the consumer but also for the nurse who may

be deeply confronted by people's suicidality, particularly if outcomes are poor. Some of the nurse interviewees embraced the challenges that therapeutic engagement presented, and it was clearly suggested that doing so could have benefits for the nurse. However, the potential enormity of embracing this challenge is also apparent.

#### **7.2.4. 'Turning points' and the value of engagement**

For the consumers, the data suggests that the ultimate value of therapeutic engagement may be the promotion of hope and the successful realisation of a 'turning point' from wanting to die to wanting to live. As noted, all of the consumer participants did realise a resolution, or at least reduction, of suicidal crisis, and yet therapeutic engagement was indicated to be minimal. As such it is difficult to definitively demonstrate that greater engagement would have enhanced realisation of a 'turning point' and an optimal recovery experience. Nevertheless, given the findings thus far it is likely that elements and 'moments' of therapeutic engagement were contributory to turning points and resolution of crises. Furthermore, it is suggested that fuller realisation of therapeutic engagement may have been of further benefit, as the participants themselves expressed. The consumers' turning points are discussed now, then, in the interests of reinforcing the potential importance of therapeutic engagement towards realising positive intrapersonal change, and also towards extending understanding of the consumer 'journey' of (resolution of) suicidal crisis.

Several of the consumers reflected on their turning points from wanting to die to wanting to live:

*I thought that dying would be the most wonderful thing that could happen to me, I really did. But then the next day when I was awake and it didn't happen I thought how could I do that to the family? How could I do it? I just couldn't believe it. I really could not believe that I did it (Lucy).*

*I remember realising that it just wasn't worth it. That it's a really hard thing to do, to pull off, and that it upsets too many people. Yeah, that it leaves a tremendous mess (Kate).*

*I got a second chance. I woke up and I just thought to myself, 'I've got a second chance...I've got a second life, I've been given a second chance' (Tracy).*

It is notable that all of the above turning points occurred immediately upon the person realising they had survived their suicide attempt. Clearly, this reflects a crucial 'window of opportunity' when therapeutic engagement may underpin a holistic and recovery-oriented response.

Several other consumers noted that their turning point happened gradually or almost imperceptibly. Candice, for example, explained that:

*there was a turning point somewhere in [the psychiatric inpatient unit] of not wanting to die. That was a big thing...but it happened gradually, particularly my thoughts and attitude (Candice).*

Indeed, Candice expressed that she '*didn't even really notice*' the turning point. She felt, however, that some of the nurses and the doctors did notice the change. Candice explained further that it was only upon reflection that she could see the '*most dramatic*' change of:

*going from really thinking that I wasn't worth being here, I wasn't really worth anything, to sort of...just not thinking that anymore (Candice).*

Despite Candice expressing that her care did not entail the fullest therapeutic engagement, as has been discussed, Candice's account does suggest that staff reflected back to her that she was resolving her crisis. Thus, despite the lack of fuller engagement, the personal turning point did occur in a context where interpersonal

interaction was still important. Furthermore, as with the other consumers, it was indicated that the resolution of crisis involved a changing intrapersonal narrative.

Lucy, too, explained that upon surviving her overdose she realised very quickly that *'the voice in the head'* telling her to kill herself *'wasn't right, you know, it was absolutely wrong'*. Thus a radical intrapersonal and narrative change is suggested to have begun from that point. Lucy expressed that it took *'probably three weeks'* for staff to reflect their realisation to her that she was no longer suicidal. Thus the need for fuller engagement in order to make the most of Lucy's recovery was reinforced.

Similarly to the other consumers, Lucy noted that, while the turning point may have been reached quickly in the inpatient unit, her narrative of suicidal crisis and care was continuing to evolve. As with many of the other consumers, all of whom were at the time of interview receiving community case management, Lucy was actively developing her narrative, due in part to an apparently positive therapeutic relationship with her community case-manager.

Lucy explained further that she had thought about *'what to do'* with her experience of suicidal crisis and care *'a lot, actually'*. It was apparent that Lucy's ongoing therapeutic relationship with her case-manager [a psychologist] involved a psychotherapeutic approach within which narrative (re)construction was a feature. Lucy was very positive about her recovery and this was reflected in her positive account. Lucy expressed, for example, that:

*I just think this is my journey and I'm fine about it...I've learnt to be more compassionate about people that have mental illness and to understand when people are depressed that it's really, really dreadful. It's a journey. It's for a reason. That's what I think and I've come out understanding a bit more...It's been a journey, a change (Lucy).*

Hope may be seen as central to consumers' narratives of recovery from suicidal crisis. CommRN7 supported the notion that hope was of central importance, noting that:

*it's a good sign for me that the person may be able to get to that area where they have some hope and some future planning (CommRN7).*

AcuteRN2 reflected further that:

*it's very important that you help them see that there is actually light at the end of the tunnel and that this is just a situation that will change (AcuteRN2).*

There is a strong and clear association between hopelessness and suicidality (Goldsmith et al. 2002, p. 2), and restoration of hope is identified as necessary for the resolution of suicidal crisis (Akiskal 2007; Cutcliffe & Stevenson 2008a; Cutcliffe and Barker 2002). Hope is concerned with a restoration or realisation of meaning and is closely aligned with resolution of suicidality and the concept of recovery in mental health care more broadly (Schrack et al. 2008, p. 7). The findings affirm that, indeed, the fostering of hope may well be a central process in effectively responding to a suicidal person (WHO 2000; Schrank et al. 2008; Cutcliffe & Barker 2002).

Similarly to other elements and outcomes of therapeutic engagement, hope was seen by various participants as something that could arise directly from the experience of engagement, as well from the various other interventions. Thus, again, a complex interrelatedness of elements was suggested. Kate, for example, noted in regard to her one experience akin to therapeutic engagement that it made her feel 'optimistic'. Thus, reinforcing the centrality of hope to recovery, it is affirmed that therapeutic engagement may provide a 'secure base' within which hope can be generated (Michel 2011, p. 18).

For the consumer participants, then, recovery from suicide was shaped by, and reflected in, positive development of intrapersonal narratives. The crucial change

from a trajectory to death, to a trajectory to life, involved versions of the narrative themes of learning from the experience, of being happy to have survived, and of having hope for a worthwhile future. Interestingly, the current findings differ from previous findings that people who survived a suicide attempt experienced anger and disappointment at realising they had survived (Ghio et al. 2011, p. 514). The current findings do, however, support the assertion that people who survive an attempt may experience guilt (Ghio et al. 2011, p. 514). They also affirm previous findings that people who survive a suicide attempt are commonly happy they did survive (Bowers 2006; Blaustein & Anne 2009). It is reinforced that (even elements of) therapeutic engagement may have helped make the most of consumers' turning points and subsequent recovery, and indeed these turning points were central features of community case-management post-discharge from the acute units.

The consumers' turning points involved narrative changes that occurred largely without direct interpersonal engagement concerned specifically with the consumers' intrapersonal experiences. Nevertheless, these changes also occurred, to some degree, in interpersonal contexts subsequent to admission. Furthermore, when direct engagement with their intrapersonal narrative did occur care was arguably experienced more positively. This was suggested, for example, by Kate's experience of engagement later in her admission, and more generally by the fairly consistent experiences of therapeutic engagement that most of the consumers had with their case managers at the time of interviews. Thus it is evident that the construction of narratives around such important events as the actual turning away from suicide may have been experienced more positively and productively had therapeutic engagement been more consistently and fully enabled.

#### **7.2.5. Summary**

This section has explored how therapeutic engagement may promote the potential for intrapersonal narratives to be understood and positively affected. The participant data has indicated that this may occur as engagement can support a psychotherapeutic model of mental health nursing, empower consumers, and lead

to both consumers and nurses experiencing positive 'growth' and change reflected in evolving positive narratives.

### **7.3. Conclusion**

This chapter has further detailed the nature and role of therapeutic engagement in the context of mental health nursing care and resolution of consumer suicidal crisis. The interrelated elements that constitute therapeutic engagement have been outlined, with those being: rapport, active listening, empathy and boundaries, relating as equals, genuineness, compassion and unconditional positive regard, trust, and time and responsiveness. It has been noted that a combination of these elements was necessary for therapeutic engagement to occur. Furthermore, it has been argued that these elements constituted therapeutic engagement particularly as they enabled a collaborative effort to reshape consumer narratives, and positively affect their intrapersonal worlds.

The collaborative nature of therapeutic engagement contributed to reshaping the intrapersonal narratives of both consumers and nurses. Positive effects arising from the promotion of a psychotherapeutic model of nursing included empowering consumers, which in turn challenged nurses towards greater self-awareness and personal and professional development. These aspects of engagement may have contributed to consumers' turning points from wanting to die to wanting to live, as well as their subsequent resolution of crisis and recovery. While definitive claims in these regards are difficult to make given the under-realisation of therapeutic engagement, the current findings do affirm the notion that therapeutic engagement may be the most important factor in the treatment of suicidal people (Krupnick et al. 1996, p. 536; Maris et al. 2000a; Leenaars 2006; Michel et al. 2004; Reeves & Seber 2004; Mishara 2008; Billings 2004).

The argument that therapeutic engagement may be crucial to understanding and positively affecting intrapersonal narratives supports the notion that narrative



construction is the central element of the caring process (Barker 2001, p. 236), the promotion of hope, and the realisation of recovery (Kaiser 2009). In these regards, the current findings support the assertion that people with mental health problems 'are calling for care and treatment to re-emphasize the relationships between themselves and their carers' (Barker 2001, p. 237). Clearly, therapeutic engagement has the potential to promote empowerment and hope as, within an experience of reciprocal narrative development, positive intrapersonal change may be enabled allowing consumers to turn away from suicide and experience optimal recovery.

Despite the clear value of therapeutic engagement towards narrative (re)construction, however, it is clear that such engagement may not necessarily come 'instinctively' to mental health nurses (Stuart 2001) and may be deeply confronting (Talseth & Gilje 2011, p. 7). Indeed, it is clear that engagement concerned with consumer suicidality 'can be difficult both for the nurse and the person suffering from emotional pain' (Holm & Severinsson 2011, p. 848). It is recognised that many nurses may feel uncomfortable in this area of practice and may construct 'elaborate defence mechanisms in order to avoid' engagement (Cutcliffe et al 2006, p. 801). Nevertheless, while the challenges inherent in engagement-based nursing may create a 'vicious circularity' denying engagement and reciprocal change, for other nurses it may also promote a cycle of growth or 'becoming' (Walsh 1996). This was reflected in the suggestion that nurses may develop self-awareness and realise personal and professional development as they faced the challenges of pursuing and realising therapeutic engagement.

Nursing has long sought to understand 'what interpersonal conditions are required in order that health may be experienced' (Peplau 1991 [1952], p. 15). While therapeutic engagement with suicidal patients has not been well understood (Cutcliffe & Stevenson 2008), the current findings provide some clarity. In essence, the present findings highlight that engagement provides an interpersonal experience which is of vital importance in and of itself, and is fundamental to the promotion of recovery principles around interventions which may otherwise be experienced as objectifying, distressing, disempowering or alienating. It is indicated that therapeutic

engagement has great potential benefits for both consumers and nurses as, together, they may learn how life may be lived more successfully. However, it is important to appreciate that therapeutic engagement (alliance) is necessary but, alone, 'not sufficient for change' (Michel 2011, p. 17). Thus, while therapeutic engagement has value in and of itself it too must be considered as an approach that is part of a larger model of holistic care. The complex care process is influenced by various consumer, nurse and contextual factors, and some of these act as barriers to therapeutic engagement. It is these aspects to which Chapter 8 turns in more detail.

# **Chapter 8 – Factors affecting realisation of therapeutic engagement**

This chapter draws upon the participant data to explore the interrelated consumer, nurse and service-related contextual factors suggested to affect, and ultimately limit, the realisation of therapeutic engagement. The chapter reinforces that modification of these factors may enhance the realisation of therapeutic engagement. Consumer factors identified are ambivalence and intent, fear, aggression, lack of trust, limited ability to access and communicate intrapersonal experience, perceived or actual personality disorder, and diagnoses and symptoms of mental illness. Nurse factors identified are professional identity, attitudes and reactions, reflection and development of expertise, and knowledge, skills and training. Service-related contextual factors identified are teamwork and support, professional supervision, resources including time, the service setting, and the dominant model of care. These various factors are best considered to be interrelated.

It is argued that nurse and contextual factors are of particular relevance as they may be the most readily and appropriately modifiable aspects of service. Indeed, it is argued that modification of nursing and service factors may be crucial to positively affecting some of the consumer factors. Thus the chapter reinforces that conditions in acute mental health care may indeed challenge nurses to achieve the therapeutic aims to which they aspire (Hummelvoll & Severinsson 2001, p. 156). It also highlights that nurses themselves must more actively articulate, develop and promote their own practice in order to more fully realise their aspirations and potential (Barker & Buchanan-Barker 2011). Identifying and exploring the interrelated factors mediating therapeutic engagement fosters an understanding of how such engagement might be more fully developed in the context at hand.

## **8.1. Consumer factors affecting the potential for engagement**

This section considers the consumer factors indicated to affect the realisation of therapeutic engagement. While consumer agency is relevant, this section does not intend to shift responsibility for limitations of care to consumers. Factors identified must be considered as interrelated to other nurse and contextual factors discussed subsequently in this chapter. The consumer factors identified are ambivalence and intent, fear, aggression, lack of trust, the difficulty that consumers may have in accessing and expressing their intrapersonal experiences, perceived or actual personality disorder, and diagnoses and symptoms of mental illness.

### **8.1.1. Ambivalence and intent**

The participant data suggests that consumer ambivalence and intent to die challenged the development of therapeutic engagement. This was essentially because:

*if they're really truly at that point when they want to kill themselves, you're not their ally, you're not their friend. In fact you're their enemy! You're the person that's going to stop them doing what they want. You're stopping them from getting peace! You're causing them to continue the pain (AcuteRN6).*

Thus it was appreciated by the nurses that *'someone who wants to kill themselves doesn't want to ally themselves with you'* (AcuteRN5).

As noted in the previous chapters (see for example section 5.2.1. regarding ambivalence and intent around access to service), most of the consumers confirmed that at certain points they were indeed resistant to receiving help or to talking about their thoughts and experiences. Lucy, for example, expressed regarding her initial intersection with services that *'I didn't want help at the time.'* Clearly such ambivalence may present challenges to the realisation of therapeutic engagement.

The potential for intent to be hidden was appreciated as a related factor mediating the realisation of therapeutic engagement. It was noted in this regard that *'suicide can be a master of disguise'* (AcuteRN5). CommRN10 recounted an event that demonstrates how intent may be hidden (and suicide sometimes pursued impulsively):

*A gentleman spoke to me about attending the day centre at the time, which on that day was moving premises. I said 'look, they're moving the furniture this morning. I'll pick you up this afternoon' and he said 'okay then'. And after that he took himself down to the park with a .22 and shot himself through the head. I didn't see that coming at all (CommRN10).*

AcuteRN11 also described an instance when intent was not revealed, despite an established relationship with a consumer:

*He was really quite talkative that day. He spoke to me, then he saw the doctor, and the next day the doctor came to me on the point of tears. He'd gone home and within the hour of that appointment had hung himself. I didn't see it. Just didn't see it (AcuteRN11).*

It is crucial to appreciate that, as well as potentially obstructing engagement, issues of ambivalence and intent were seen by some participants as providing an impetus and context *for* engagement. As noted, most of the consumers in the present study initially revealed their intent through suicidal behaviour, and some nurses took these revelations as a direct impetus for therapeutic engagement. CommRN7, for example, described being driven to engage in order to deeply understand, or *'to be as sure as possible'* (CommRN7) about intent. As noted in the previous chapter, however, consumer ambivalence and intent could also drive nurses to avoid engagement – to *'get out of it'* (AcuteRN2) – if they could. It was further suggested that intent could remain hidden or be incorrectly assessed when, for example, certain consumers were labelled *'attention seeking'* or *'personality disordered'*, and these labels acted to prevent initial or sustained engagement.

Ambivalence about living, and thus about seeking or receiving help, is a recognised characteristic of suicidal people (Maris et al. 2000b; Leenaars 1996; Berman 2006). This means that suicidal people can reject 'the very nurturance that might save their lives' (Maris et al. 2000b, p. 43). Furthermore, it is appreciated that intent to die can be both confronting and sometimes difficult to detect and understand (De Leo et al. 2006, p. 8; Lebacqz & Engelhardt 1980; Cholbi 2009). Despite the challenges that ambivalence and intent may pose to therapeutic engagement, however, some of the nurses expressed trying to embrace those issues as impetus to engage.

#### **8.1.2. Fear, aggression, lack of trust, and difficulty accessing intrapersonal experience**

Related to the challenges of ambivalence and intent, certain other emotional and cognitive characteristics of suicidal people can impede the development of therapeutic engagement. These were indicated to include lack of trust, aggression, fear, and the difficulty that consumers may face in accessing and expressing their thoughts, emotions, needs and experiences, around their suicidal crises.

Regarding lack of trust, AcuteRN2, for example, noted that sometimes people may be *'so suspicious that they think you've got a hidden agenda and they just close right up'*. It was suggested that symptoms of mental illness or negative perception of services (regarding, for example, the potential for involuntary detention and treatment to be invoked) could also limit the establishment of trust. Additionally, as evidenced by Tracy's narrative, difficulty in trusting others had arisen from her experiences of dysfunctional interpersonal and social circumstances. It was suggested that a lack of trust could result in consumers actively or passively resisting therapeutic engagement with nurses.

It was also indicated by several participants that consumer aggression or anger could challenge the formation and maintenance of therapeutic relationships. AcuteRN11, for example, referred to some of her interactions with one particular consumer who later went on to complete suicide:

*I'd been intimidated by him, I'd been stood over by him, I'd been threatened by him (AcuteRN11).*

Claire suggested, too, that actual or perceived aggression or anger could be a potential obstacle to engagement. Claire reflected that:

*I don't think I was very pleasant to be around. I think I was very scared and angry and, I don't know, mixed emotions...They thought there was something that was making me really angry, because I was expressing it to everyone, but I was just scared (Claire).*

As Claire highlighted, anger was potentially conflated with other emotions including fear. It was also suggested that anger could arise from frustration around involuntary detention, the model of care provided, or the thwarting of suicidal intent. The present findings thus support the notion that emotions including fear may create significant obstructions to therapeutic engagement in psychiatric units (Lineberry 2011, p. 345).

Another consumer characteristic that could restrict therapeutic engagement was the consumer's ability to access and express their intrapersonal experience. Candice, for example, noted that:

*at the time I couldn't sort of say exactly what I needed...I didn't know what I needed....I sort of just knew that I needed help (Candice).*

The degree to which consumers could access and share their intrapersonal experiences was a factor difficult to fully understand. Clearly, a whole range of interrelated factors affected their ability and desire to clearly articulate the complex, personal and confronting experience of suicidality, and related mental health care. Even in the research interviews post-crisis it was obviously difficult to do so, although the participants did meaningfully express themselves. It can be expected

that accessing and sharing their intrapersonal experiences would be even more difficult around the time of the suicidal crisis, as has been noted by Goldsmith et al. (2002, p. 17).

As with other consumer factors, it is suggested that issues of trust, aggression, fear, and difficulty in accessing, understanding and articulating experiences and needs, presented both potential challenges to engagement as well as potential impetus and opportunity for engagement.

### **8.1.3. Personality disorder**

The nurses' accounts suggest that consumer personality and behaviour traits – particularly associated with the psychiatric diagnosis of 'borderline personality disorder' (BPD) – were experienced by nurses as challenging to therapeutic engagement. AcuteRN1, for example, expressed her view regarding people considered to meet the criteria for borderline personality disorder [commonly referred to by some nurses as 'PDs' or 'borderlines']:

*PD's are the worst! They say 'I'm going to kill myself' and you feel like saying when they're cutting, 'This way! Deep! This way!' [gestures cutting of wrist] but you can't because you don't know if they're just screaming out for attention or they're serious...they're so hard to engage (AcuteRN1).*

Related to the frustration apparent in AcuteRN1's account around understanding and working with someone seen to fit the criteria for BPD, it was expressed by numerous nurses that engagement with such a consumer could be difficult in personal, professional and legal terms.

The challenges associated with people exhibiting BPD traits included the tendency for the person to be 'oppositional', 'sabotaging' (CommRN7) of the therapeutic relationship; or manipulative or 'splitting' (CommRN10) of staff. It was asserted, for example, that consumers associated with the diagnosis of BPD are often:



*not open to developing solutions.....and that causes problems in the context of developing agreement and understanding and working together toward a common goal – it makes it very difficult (AcuteRN5).*

It was further expressed that:

*it's tricky because these people will often draw you into their stories and will have loose boundaries and that can be very hard sometimes (CommRN10).*

Exemplifying this, AcuteRN1 described an incident of manipulative behaviour intended to divide the nursing team:

*[The consumer with BPD] told [another nurse] that 'I told [AcuteRN1] I was going to commit suicide today and she just said 'oh yeah, whatever''. And that's not the case. You know...they play games amongst the nurses...And they get you in a lot of shit! (AcuteRN1).*

AcuteRN4 also noted that nursing someone exhibiting BPD traits could entail professional risk, recalling an incident when a consumer had 'threatened' to kill herself and 'to take, in a legal sense, as many people with her as she could'.

Thus it was highlighted that, because nurses could 'get burnt' (AcuteRN2) personally and professionally while attempting to engage with people perceived to fit the BPD diagnosis, 'an element of cynicism' (AcuteRN2) could arise in relation to those consumers. AcuteRN4 noted this regarding one particular consumer:

*She is now seen only in relation to her personality issues...that means...how can I put this politely? Shall we say that the staff here are less sympathetic to her plight perhaps than they otherwise would be if she was 'clean', you know, fresh, unknown (AcuteRN4).*

The nurses' accounts thus highlight that not only were personality traits associated with BPD potentially obstructive to engagement, but that the perception or inference of the BPD 'label' may have further impeded nurse's intent towards engagement. AcuteRN4 explained that this was essentially because of *'squeaky wheels'* and the *'philosophy'* of acute settings. The term *'squeaky wheels'* was made in reference to particular patients with the potential to *'split'* staff and to create greater professional and legal risks, and who were generally *'more imposing on staff time'* (AcuteRN4). The term *'philosophy'* refers to the belief of many of his colleagues that *'personality disordered people are not seen as warranting an admission because it's not something we can fix...this is not the place for them'* (AcuteRN4).

It was also suggested that suicidality was commonly reduced by some nurses to *'just a borderline carrying on'* (AcuteRN3), while at the same time those with personality disorders were *'dismissed out of hand'* (AcuteRN4). This is highlighted as particularly problematic because, as noted, there is a very strong association between BPD and suicide with, for example, approximately 70% of people diagnosed with BPD attempting suicide (Gunderson 2001) and 5-10% completing it (Black et al. 2004).

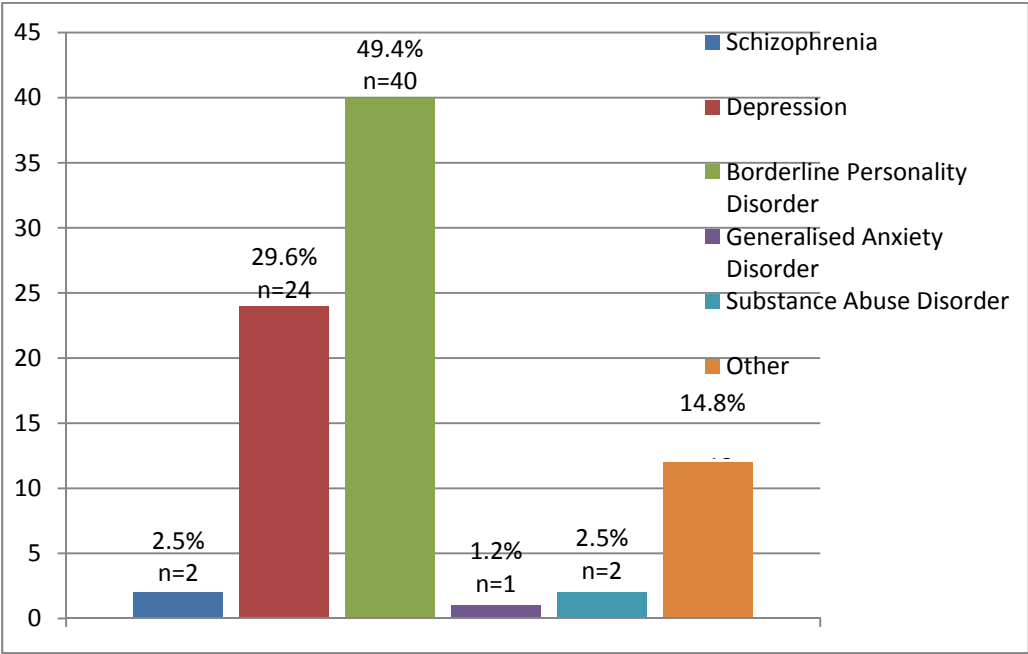
Recurrent suicidality or self-harming behaviour, along with impulsivity, anger, and relationship difficulties (including around attachment and abandonment) are amongst the criteria for a diagnosis of BPD (Keltner et al. 1999, p. 437). Indeed, BPD is the only psychiatric diagnosis with a criterion for recurrent suicidal behaviour (McGirr et al. 2007, p. 721). While many of the elements of BPD may pose serious and legitimate challenges to engagement, it is clear that engaging with the person exhibiting BPD behaviours may be absolutely essential towards understanding their intent and also towards addressing issues such as those around attachment and abandonment. As with the other consumer factors noted, it was clear that some nurses recognised the potential for personality issues to be impetus for engagement. However, it is concerning that negative perceptions of this diagnosis and of those perceived to fit this diagnosis – and indeed the possible mis-use of the *'borderline'*

diagnosis by some nurses – reflected and shaped additional challenges to engagement.

**8.1.4. Symptoms of mental illness**

The findings suggest that certain psychiatric diagnoses and symptomology were associated with suicidality. As noted in regards to BPD, these were indicated to sometimes challenge therapeutic engagement. Nurse survey question 10 asked the nurses: ‘what was the most common primary psychiatric diagnosis of the people in suicidal crisis with whom you have interacted?’ As represented in the graph below, the nurses reported the most common primary diagnosis to be BPD followed by depression. The third most common response – ‘other’ – related primarily to ‘situational crisis’ or to a combination of the other diagnoses listed.

**Figure 8.1. Nurse survey question 10: What was the most common primary psychiatric diagnosis of the people in suicidal crisis with whom you have interacted?**



As noted, suicide is strongly associated with mental illness or disorder (De Leo 2005; Pirkis et al. 2001, p. 31; De Leo & Svetlicic 2010), in particular depression (Moller 2003, p. 73), and to a lesser extent BPD (Gunderson 2001; Black et al. 2004) and

schizophrenia (Meltzer 1999). The current findings highlight a nursing perception that BPD was a considerably more common primary diagnosis in suicidal consumers than depression. This could be an accurate assessment and reflect a high level of service-use by suicidal people with BPD characteristics or diagnosis. On the other hand, and in light of the suggestion above that nurses potentially misused the label of BPD, this finding could be taken to indicate that nurses applied the BPD label more commonly than was appropriate. While sample bias may be a factor (for example people associated with BPD may have been less likely to meet the selection criteria) it is interesting to note that in this study the consumer participants' actual primary diagnoses were most commonly depression (n=4) and schizophrenia (n=3) (with the other two being schizoaffective disorder (n=1) and obsessive compulsive disorder (n=1).

As noted regarding BPD, the participant data highlights that certain symptoms of mental illness could limit the potential for nursing engagement and, furthermore, that over-reliance on the psychiatric-diagnostic model may itself prove obstructive. The consumer characteristics already noted – including ambivalence, suicidal intent, lack of trust, fear, aggression, and reduced ability to access and communicate intrapersonal experiences – were seen by most of the nurses and some of the consumers as potential symptoms of mental illness and as sometimes challenging engagement. It is reinforced, however, that several consumers explicitly rejected such a framework.

Lack of trust or paranoia, in particular, was a consumer characteristic associated by numerous participants with mental illness. Lisa, for example, explained how:

*I can get psychotic depression. I can go down...I could take a fair bit for a week or so but then I can go down really quick and I start getting paranoid (Lisa).*

Kate, too, suggested a link between mental illness and characteristics potentially obstructive to engagement. She recounted that:

*I remember being scared to get on the scales because I think I was psychotic at the time. So yeah, I wouldn't get on the scales. I just remember not trusting any of them (Kate).*

Another potentially challenging consumer characteristic associated with mental illness was a lack of insight. Lisa, for example, explained how:

*often you don't realise you're feeling depressed. You realise you're planning on killing yourself, but you just don't make the connection that you're depressed. It's not until someone says 'you've got depression' that I realise. I know when I get manic, but I don't realise when I get depressed (Lisa).*

Other characteristics linked to mental illness and highlighted to potentially challenge engagement included anxiety, delusion and hallucination. AcuteRN11, for example, noted that, in the presence of delusions and hallucinations, a consumer diagnosed with schizophrenia '*wanted to engage but his illness prevented him from doing it*' (AcuteRN11).

It was also appreciated by the nurses that consumers' lived experiences of mental illness – involving, for example, the 'torment' of certain hallucinations – could actively drive suicidal intent, thus affecting the consumer's motivation to engage. Furthermore, it was appreciated that high or rising insight could also drive suicidal intent, again potentially affecting the consumer's motivation to engage. AcuteRN11 recounted in this respect how a person resisted engagement and:

*they died knowingly because they gained partial insight into their illness and their fear or whatever was so high that they committed suicide (AcuteRN11).*

The participant data also suggests that the way psychiatric diagnoses were employed by the nurses may itself have been a potential obstruction or disincentive towards engagement. As noted, for example, it was asserted that some nurses '*will just give people a diagnosis and sit back and watch*' (AcuteRN2).

Further complicating the impact that psychiatric diagnosis could have on nursing care, it was suggested by one nurse that other nurses may not be aware of the potential for suicide when someone was *not* diagnosed with, for example, depression or anxiety. It was inferred that in the absence of such a diagnosis some nurses may be less inclined to engage. AcuteRN3 noted in this regard that:

*some nurses think if they're not depressed, not anxious, that they're obviously not suicidal, and that's not necessarily the case (AcuteRN3).*

Thus it was indicated that symptoms and experiences of mental illness, as well as prompting over-reliance on a diagnostic and medicalised framework by nurses, could negatively impact therapeutic engagement. Conversely, understanding and responding to issues around mental illness could also, for some nurses, provide the impetus for therapeutic engagement.

#### **8.1.5. Summary**

This section has affirmed that people in suicidal crisis commonly have symptoms, behaviours, and personal and interpersonal characteristics which may both explain their suicidality and challenge the realisation of therapeutic engagement (Maris et al. 2000a). Consumer factors identified as potentially challenging engagement were ambivalence around seeking and receiving help, intent to die, fear, aggression, lack of trust, difficulty accessing and expressing intrapersonal experience, perceived or actual personality disorder, and diagnoses and symptoms of mental illness.

While the current findings highlight the potential for nurses to see challenging consumer characteristics as an impetus for engagement, the overall impression derived from the data is that nurses found certain consumer characteristics obstructive to engagement. In many instances particularly challenging characteristics may be legitimately difficult to overcome. However, the labelling and negative perceptions of these behaviours may have further diverted nurses from pursuing engagement-based nursing.

## **8.2. Nurse factors affecting the potential for engagement**

This section considers the nurse factors indicated to affect therapeutic engagement. Interrelated to many of the consumer factors noted above (and the contextual factors noted in the subsequent section), the current findings position the nurse as the principle element in determining the nature and potential of nursing care. Nursing characteristics identified in this respect include professional identity, attitudes and reactions, and the ability to practice reflexively, in order to develop and utilise expertise and knowledge.

### **8.2.1. Professional identity**

Nurses' professional role and identity was an overarching feature of the nurse-related factors that impacted on engagement. As noted, the nurse participants were able to articulate a professional identity and role based around therapeutic engagement which would be highly suited to care of suicidal people (see Chapter 7 in particular). However, the participant data also indicates that nurses were struggling to realise such an identity and role. Several of the nurses conceptualised this 'gap' between the rhetoric and reality of nursing practice as an '*identity crisis*' (AcuteRN11). This was seen to involve '*a vagueness about what mental health nurses do...an erosion of knowledge and skills*', as well as an appropriation by other disciplines of positions, such as '*suicide counselling*' (CommRN10), that mental health nurses had in the past more comprehensively occupied. In this regard it was expressed that '*we're pretty much a dying breed*' (CommRN10).

The lack of articulation, development and promotion of the aspirational nursing identity was indicated to be central to a limited realisation of therapeutic engagement. CommRN6, for example, expressed that, because it was not obvious what mental health nurses could do in respect to engagement with suicidal people, their role was dominated by managerial, administrative and other 'tasks'. It was thus

inferred that, in practice, the interpretation and management of their role hindered the consistent realisation of therapeutic engagement.

Several nurses indicated that an inability to foster a clear and esteemed identity reflected that their practice was still tied to historical notions of custodial and 'handmaiden' roles, that nurses were seen to be outperformed or subsumed by other disciplines, and that mental health nursing was stigmatised. In these regards it was asserted that:

*the problem with psychiatric nurses is sometimes they're looked down upon or the skills are belittled or minimised by other clinicians, and I think that's problematic and that becomes a sort of almost like a self-fulfilling prophecy and a professional lowness of self-esteem (CommRN10).*

Thus a need to more clearly articulate and positively promote the aspirational identity and role of mental health nurses was highlighted. AcuteRN2 noted in this regard that:

*I think a bit of positive kudos about psych nurses and the sort of work they do would be a good thing. You know there's not much going on that actually says how marvellous psych nurses are (AcuteRN2).*

The nurse interviewees attributed much of the identity and role dilemma to nurses' own attitudes or complicity, which maintained the status quo and reliance on reductive models of care. AcuteRN3, for example, suggested that:

*there's often a growing cynicism of what you do over time...nurses get burnt out by what they do, they go in there with some level of enthusiasm and they come out cynical (AcuteRN3).*

It was, then, suggested that nurses not only experienced consumer and contextual barriers to best practice, they also encountered nurse attitudes and practices that



presented a similar barrier. Thus it was indicated that some nurses were reinforcing the discipline's limitations (Barker & Buchanan-Barker 2011). AcuteRN11 noted, for example, in this regard that:

*you'll have people sitting in front of computers for years on end – not interacting with patients for years on end – and it's because they've used the system to create their 'autonomy' and it's like three bricks thick. They've got no hope and they're completely and utterly protected. Are they appearing to be nurses? Yes, they are. Are they nursing? No they're not. Can the management do anything about it? No, because every time you open a [consumer's] file you'll read 'nil management problems'. It covers all the bases, but what does it mean? Nothing! (AcuteRN11).*

The nurses' accounts suggest that the quality of care was associated with the potential for nurses to articulate, develop and promote an identity and role which optimally supported therapeutic engagement. In this regard the current findings support previous assertions that mental health nurses may be struggling to articulate and achieve their aspirations of therapeutic engagement in a general context (Barker & Buchanan-Barker 2011), as well as specifically in relation to care of suicidal people (Cutcliffe & Stevenson 2008a, p. 942). The barriers against developing the nursing identity more in line nurses' stated aspirations were related to conditions of practice including historical precedent, stigma, and disciplinary competition within a particular service model. Furthermore, it is highlighted that, as with care more broadly, a principal mediating factor may have been the attitudes and actions of nurses themselves.

### **8.2.2. Nursing attitudes and reactions**

Related to identity and role, it was indicated that the attitudes and reactions of nurses could also affect the development of therapeutic engagement. In particular, adverse reactions to the challenges at hand, including not knowing what to do or say towards engagement, or not valuing therapeutic engagement, were restrictive. Such attitudes and reactions were in response to the potential for negative outcomes

including death by suicide, as well as the very real possibility that nurses might be confronted by suicidality in both practical (see also section 8.1.1) and more personal ways (see also section 7.1.3.).

Capturing something of how adverse outcomes and the personal and professional challenges of engaging could occur, yet be overcome, AcuteRN11 asserted that:

*you'll never know if they're going to do it [suicide] and that's why there is a reticence to engage. But to me it's like the sun coming up in the morning. It is there. It will happen. You will do your best and it will happen anyway. And that's difficult to sit with. I mean everybody wants to be successful (AcuteRN11).*

In addition to the potential for adverse outcomes, the actual nature of the consumers' suicidality was indicated by the nurses to be something they could find 'disheartening' or 'scary' (CommRN8), or as something that could make the nurse 'nervous' (AcuteRN2), 'afraid' (AcuteRN11), or leave the nurse 'drained' (CommRN7), 'teary' (AcuteRN9), 'dumbfounded' (AcuteRN1) or feeling like a 'failure' (AcuteRN4). AcuteRN3 noted further in this regard that:

*if someone does suicide...it can very, very, very strongly affect your mental health for some time afterwards (AcuteRN3).*

AcuteRN1 described how the various challenging aspects of engagement with suicidal consumers could come together for her:

*Sometimes I don't know what to say next...I get a blood rush and think 'oh God am I going to put my foot in it...am I going to make things worse'...and there have been times when I've come home just drained, and I just go over the whole day in my head, and there have been nights where I haven't been able to sleep because I've thought 'oh maybe I've done that wrong'...I didn't, but I'd think about it a lot (AcuteRN1).*

Thus it was inferred that certain emotional reactions meant that engagement was not only challenging, but that it could take a toll on nurses' personal lives. The price nurses paid was not just the emotional trauma of engaging with volatile emotions, but also the uncertainty around the appropriateness of their attempts to engage.

It was noted by several nurses that their colleagues could justify a lack of engagement by arguing that it was not appropriate, or was harmful to engage. AcuteRN2, for example, explained that:

*there is the suggestion that sometimes when we talk to someone you make it worse by talking about it...that by talking about it they can act worse because that's the secondary gains they want (AcuteRN2).*

Indeed it was noted that:

*a lot of clinicians that I've come across, because either they're not well trained, they have old ideas, or they're simply disinterested, believe that if you're engaging with a suicidal client – particularly if you spend a fair bit of time with them - the client - that you're just wasting your time or probably making it worse (AcuteRN3).*

Thus it was suggested that nurses could be both deeply confronted by, and quite dismissive of, engagement. Overall, it was asserted by most of the nurse interviewees that their colleagues were often '*not interested enough in either the job or the patient*', or did not understand or appreciate '*their role as a therapeutic agent, and the potential they have in the fairly powerful position that they now find themselves in as nurses in a psychiatric facility*' (AcuteRN4). Thus the findings infer that nurses require a particular attitude, fortitude, as well as skill-set, to motivate them to embrace the challenge to more fully engage.

The participants' accounts affirm that nurses may be deeply confronted by consumer suicidality (Gilje et al. 2005; Talseth & Gilje 2011) and that the greatest threat to therapeutic engagement may be the adverse reactions of clinicians (Maris et al. 2000a, p. 512). They also reinforce that some nurses may not think engaging directly with consumers about suicidality is a safe or appropriate thing to do (Meerwijk et al. 2010). It is also evident, however, that some nurses may embrace these personal and professional challenges as impetus to engage. It is proposed in this regard that nurses need further training, and possibly personal and professional support to foster a belief '*that they might make a difference*' (AcuteRN4). It is in this context that nurses may foster a commitment to the principles of therapeutic engagement as an opportunity to help someone who is suffering and to achieve personal and professional growth.

### **8.2.3. Self-awareness and reflective practice**

Interrelated with issues of professional identity and the attitudes and reactions of nurses, self-awareness and 'reflective practice' (Johns & Freshwater 2005) were important mediators of therapeutic engagement. Such awareness and reflection was suggested to be important to the management of adverse emotions (such as guilt), the successful negotiation of clinical conditions and models that constrained engagement, and moving towards developing a sense of expertise.

AcuteRN11 described how being self aware, and constructively reflecting on interactions with suicidal people – particularly when adverse outcomes occurred – was essential to managing her reactions and sustaining an approach centred on therapeutic engagement. It was noted in this regard that:

*when people die or things like that I bear witness to it. That's the price I have to pay. I sit with the pains and they pass...I sit and reflect on it and I let it be. But a lot of nurses don't do that (AcuteRN11).*

Similarly CommRN6 explained the importance of consciously reflecting, and particularly thinking constructively, about the engagement:

*If I've done all I can with the knowledge and skills I have, and I've applied that and I'm not negligent and that person kills themselves that's not my fault, and people need to know that (CommRN6).*

AcuteRN4 highlighted that reflecting on personal reactions to consumer suicidality was also important in the face of frustrated efforts to help, as *'it can be very disheartening when you can't move that person from that thinking'*. AcuteRN4 explained that constructive reflection was essential in such instances:

*Because if you internalise that, the word failure comes up in neon lights...but my expectation is not to shift or change them. So I reflect that this might be a constant ongoing dilemma for that person, but it's not my responsibility. So then if you accept that, it's a risk that you have to take in that alliance that you're trying to form (AcuteRN4).*

Numerous nurses indicated that, by reflecting in such a way, they would either accept the inevitability of what had happened or what was happening, or they would decide to go about things differently. AcuteRN2, for example, explained that:

*if I realise that if I'm not able to reach someone then I think someone else might, and I don't carry the burden of guilt for that...I do my best and then I get someone else to help (AcuteRN2).*

It was noted further that reflection could also be valuable when facing system-related challenges. AcuteRN11, for example, explained that reflection enabled her to:

*get better at 'pushing away the system', so to speak...Trying to influence the system in a positive way, but if I can't then accepting that and thinking about what I could have done better as I participated in the system (AcuteRN11).*

For AcuteRN11 'pushing away the system' entailed moving towards engagement despite the dominant (difficult to access, medicalised and coercive) model of care. Thus, reflective practice for her meant that when her practice was limited by the system she was able to constructively analyse that and accept it, or consider how to overcome the limitations.

An outcome of effective reflection was noted to be development of a sense of expertise, or greater mastery of engagements with consumers. AcuteRN1, for example, explained that she would often *'think how I can do it better....I just think, 'I did what I could...but could I have done it any better?'*" She expressed further that:

*we're always learning...you go home and you think 'oh god I should've asked this or I should've done that!' And the next time your do, you remember. You go in and you think 'oh yes I didn't do this last time, is that appropriate to do now?'* (AcuteRN1).

Nurses' reflections on their practice can enhance the care context in several ways. Essentially, it was indicated to underpin the management of negative personal reactions, to help the nurse to minimise system constraints against engagement, and to facilitate the development of a sense of expertise. Clearly, these three outcomes are interrelated with issues of professional role and identity, and the attitudes and approaches of nurses. It is notable that several nurses argued that, when it came to reflective practice, *'a lot of nurses don't do that. A lot of people don't do that* (AcuteRN11).

The need to identify and reflect on one's own responses to suicidality, such as fear and failure or guilt, is supported by previous research highlighting the sometimes painful need for nurses to confront their own 'desires, needs and frustrations' towards enabling quality care with suicidal people (Talseth & Gilje 2011, p. 7). The current findings affirm that meeting such challenges required nurses to reflect, and foster self-awareness and a sense of expertise or 'intuition' around the appropriate approach to care (Holm & Severinsson 2011, p. 848). More broadly, fostering self-

awareness in the nurse is seen as a crucial aspect of enhancing the potential for engagement (Happell et al. 2008, p. 133) and better assessment and response. This reflects the notion that 'self-insight operate[s] as an essential tool and as a check in all nurse-patient relationships that are meant to be therapeutic' (Peplau 1991 [1952], p. 11). Thus, promoting reflective practice and self-awareness is key to optimising nurses' experiences of engagement.

#### **8.2.4. Knowledge, skills and training**

It was indicated that the knowledge and skills of nurses were of crucial importance in relation to the realisation of therapeutic engagement. The nurse-participant data, in particular, reveals that, although nurses valued the knowledge and skills they had, they also strongly desired additional knowledge and skill in engagement, and also felt that this was true for mental health nurses more generally.

Regarding formal educational qualifications, the majority of the nurse interviewees reported having a specialist (graduate diploma or masters degree) mental health nursing qualification, as did 45.3% (n=38) of the survey respondents. Of the survey respondents, 6% (n=5) also reported that they were studying towards a specialist mental health nursing qualification, and a further 6% (n=5) reported that they held diploma or degree qualifications in psychology. Furthermore 36.9% (n=31) of survey respondents reported that they had been trained in a psychiatric hospital prior to nursing education entering the university sector. The majority of participants thus reported having formal mental health nursing qualifications, with approximately half of them receiving that education in more recent times and via university.

Additionally, 63.4% (n=52) of survey respondents reported that they had undertaken training, education or professional development specifically regarding the management of clients in suicidal crisis. A further 61.5% (n=32) reported that they had received training in their 'workplace' (i.e. within MHS), 38.5% (n=20) in their 'post-graduate course', and 28.8% (n=15) in their 'undergraduate course' (with some having received training in more than one context). Additionally, 78.3% (n=65) of the nurse survey respondents reported familiarity with the recovery model, 53% (n=44)

reported familiarity with the LIFE framework, and 49.4% (n=41) reported familiarity with the national standards for the mental health workforce. Thus the majority of the nurse participants reported having both formal mental-health care training and training specifically regarding care of suicidal people.

It must be acknowledged that some of the consumer and nurse interviewees claimed that nurses did have adequate skills and knowledge (although, as was the case more generally, the nurses were less positive in this respect regarding their colleagues). Lisa, for example, expressed that:

*I find here they're pretty competently trained. They're better than most people think they are...I mean, the better trained they are, the better. But here, I like the way they're trained (Lisa).*

Many of the nurses reported that they personally had adequate skills and knowledge to therapeutically engage with suicidal consumers. In the survey, 67.5% (n=54) reported that they 'usually' felt they had adequate skills and knowledge, although only 15% (n=12) reported they 'always' felt competent, while 13.8% (n=11) were 'unsure', and 3.8% (n=3) reported they 'rarely' felt that they had adequate skills and knowledge to therapeutically engage with suicidal consumers. Upon examination, the data suggests that the extent and quality of both formal and informal education and training may have been inadequate to optimally support the realisation of therapeutic engagement. Indeed, overall, it was commonly suggested that the education and training received had given nurses '*little preparation for dealing positively with people in suicidal crisis*' (survey respondent). Further to this, it was indicated by several nurse interviewees that suicide had been mentioned in training regarding risk assessment, but that this had not prepared them to engage with the suicidal person. It was suggested, that:

*most nurses are not trained to intervene other than to use the mental health act to section clients. Alternate solutions and the experience and strength to implement these are needed (survey nurse).*



Additionally it was asserted that:

*I haven't seen any therapeutic guidelines around interacting with suicidal people...There's mandatory training around risk but it's not very good for building more advanced therapeutic skills (CommRN7).*

The assertion that nurses had not received effective training specific to the care of suicidal people was reinforced by the team leader of the MHS Workforce Development Unit which oversees workplace training for staff of mental health units. She expressed to me that:

*There is no specific training here...except for assessment, which doesn't address the problem specifically...we need to be able to respond (Team Leader MHS Workforce Development Unit, pers. comm. 2010).*

Notwithstanding that some nurses felt they had adequate skills and knowledge, the data suggests the need for development in this area. This is supported by the finding that 50% (n= 40) of nurse survey respondents agreed with the statement that 'additional specific suicide prevention and treatment education/training' would enable them to provide better outcomes. Furthermore, 80% (n=64) of respondents reported that additional workplace training would enhance their practice in regards to the care of suicidal consumers.

The survey results suggest an association between formal training specific to the care of suicidal consumers, and more positive experiences and outcomes. For example, 82% (n=41) of nurses who reported having received specific training reported that they were 'satisfied' or 'very satisfied' with the outcomes of their interactions, as opposed to 55.2% (n=16) who reported having not received specific training. Additionally, 59.1% (n=29) of nurses who reported having received specific training reported that they thought the consumer was 'satisfied' or 'very satisfied' with service, compared to 41.4% (n=12) who reported not having received specific

training. Furthermore, 89.7% (n=44) of those who reported receiving specific training reported that they felt they 'always' or 'usually' had adequate skills and knowledge, compared to 70% (n=21) who reported not having specific training; and, 75.5% (n=37) of those who reported receiving specific training reported 'little or no change' or 'positive' impact to their own mental health and well-being around interactions with suicidal consumers, compared to 55.1% (n=16) who reported not having specific training.

Linking the notion of training, education and professional development with the previously highlighted essential elements of attitude and developing expertise, CommRN10 noted that education and training which improved knowledge and skills could enhance practice by increasing the nurse's confidence. It was noted in this regard that:

*we see enough people with suicidality and self-harm that we need to be trained better...and through my experience I've found that people, once they're trained, have higher self-esteem, they feel better about themselves, and they feel more confident in their practice (CommRN10).*

The knowledge and skills suggested to enhance nurses' abilities to therapeutically engage with consumers included 'assessment, management and counselling' (survey nurse). It was noted in this regard that both experienced and inexperienced nurses needed their 'basic' skills and knowledge extended, and that more experienced nurses 'could do with a refresher' (CommRN6) to validate and refine their approaches. Communication, counselling and specific modalities such as CBT were noted to be particularly relevant.

Further to the notion of learning to better engage with consumers, the importance of appreciating the consumer perspective was also indicated. AcuteRN4, for example, noted the need to gain:

*a better understanding of the person....moving it from words or textbook knowledge to real application of an understanding of what it means for an individual to make a decision to end their life....more insight into their experience (AcuteRN4).*

Thus nurses' recognised that understanding consumer experiences was an important skill to acquire and could provide crucial information.

In terms of how knowledge and skills could best be acquired, nurse participants noted that learning happened in a variety of ways, including via experience and both formal and informal learning, particularly in collegial contexts. For example, it was expressed that *'it takes years of experience to deal with suicidal crisis clients in a competent, comfortable manner* (survey nurse). Additionally, AcuteRN1 noted that she learnt by:

*talking to someone and working it out...if I can't figure it out I'll talk to [nurse] 'cause I can relate to them...if I'm really stuck I'll say 'how do you think I can do this better?' I learn from that, and I think they learn from me too (AcuteRN1).*

Regarding the notion of 'team learning', AcuteRN4 suggested that *'modelling would probably be more powerful'* than other forms of education or training. There was also indication from the nurses that formal education and training was best delivered via interactive, case-study and role-playing approaches.

The current study thus supports previous findings that nurses perceived a need for further skills and knowledge regarding their nursing care of suicidal consumers (Talseth & Gilje 2011, p. 13-14; Rooney 2009; Meerwijk et al. 2010; ACMHN 2010b). Clearly, knowledge and skills can be seen as interrelated with issues of professional role and identity, the attitudes and approaches of nurses, and the ability to practice reflectively. Furthermore, the findings suggest that specific education programs may indeed improve the ability of staff (Samuelsson & Asberg 2002; Ramberg & Wasserman, 2004) and may be valuable in the context of nursing care of consumers

at risk of suicide (Talseth & Gilje 2011; Samuelsson et al. 2000). The findings thus affirm that people may need to be trained to provide the trusting and empathic interpersonal engagement necessary (Anthony 1993, p. 24). However, reinforcing the importance of considering the quality of any education and training and how that is delivered, it has been noted that training programs aimed at teaching therapeutic alliance (not specifically in relation to nursing) may lead to an improved alliance less than half the time (Horvath 1994). What has been shown to be successful in terms of training programs is alliance training within individual supervision arrangements (Michel 2011, p. 17), thus the role of supervision is considered below.

#### **8.2.5. Summary**

The current findings indicate that nurses' professional identity and role, attitudes and reactions, ability to practice reflectively towards developing expertise, and knowledge, skills and training, were of central importance in promoting therapeutic engagement. Overarching the nurse factors suggested to affect the realisation of therapeutic engagement was an identity and role 'haunted' by historical precedent and stigma, subject to disciplinary competition, and sometimes undermined by nurses' personal and professional response to the challenges, and opportunities, of their role and of therapeutic engagement.

Reflecting on practice has been shown to be a key strategy nurses use to embrace the challenges and opportunities of engagement. However, nurses may not recognise the importance of reflection. Knowledge, skills and training were also seen as vital to being able to more fully and effectively engage with suicidal consumers. While participants valued the skills and knowledge some nurses had – and they were associated with better quality care – the nurses also strongly expressed their need to enhance their skills and knowledge. Indeed, it was indicated that the extent and quality of their skills and training was not sufficient to optimally guide them in practice. It was suggested, furthermore, that practically-oriented approaches to skill and knowledge acquisition would be most appropriate, yet is currently lacking. Thus

it is suggested that nurses were not optimally inspired, prepared or supported to therapeutically engage.

### **8.3. Service-related contextual factors affecting the nature and potential of engagement**

This section considers the service-related contextual factors indicated to affect the realisation of therapeutic engagement. The contextual factors identified are teamwork and support, professional supervision, resources including time, the service setting, and the model of care. Considering these factors reinforces the interrelatedness of elements, and highlights both where limitations were seen to exist, and where reform could be directed towards greater realisation of therapeutic engagement.

#### **8.3.1. Teamwork and support**

The functioning of the multidisciplinary and nursing teams was indicated to be an important factor affecting the potential for therapeutic engagement, particularly as it could support nurses' personal and professional needs and development. While it was noted that, even as a somewhat 'autonomous' practitioner, *'you belong to a group and you have to work as a team'* (AcuteRN11), for many nurses the functioning of the team was less than ideal in supporting therapeutic engagement.

Teamwork was seen to support care of suicidal consumers in the immediate sense in that, *'if there's a suicidal crisis people sort of drop everything and help'* (CommRN8). In this regards it was noted that, *'it's nice to know I've got staff around me who I can rely on...that makes a big difference'* (CommRN10). Having a team to draw upon was also seen as valuable towards planning care and *'working out new ways and new techniques'* (AcuteRN1). In addition to lending assistance and expertise to an individual nurse's attempt to engage with a suicidal consumer, having other staff to *'talk to about these experiences'* (CommRN10) as part of reflective practice, was also seen to be important, particularly in the case of adverse outcomes.

The nurses' survey responses, too, highlight the perception that team work could provide important support to individual nurses. For example, collaboration with the multidisciplinary team (MDT) ranked as third (50.6% - n= 40) after 'knowledge and training' and 'availability of time' in nurses' responses to what most positively influenced their interactions. Thus it was appreciated that *'being supported by other nurses and doctors is very important'* (AcuteRN11).

The data indicates the perception that the level of support provided by 'the team' was substantial, but less than it could have been. For example, 66.3% (n=53) of the nurses indicated that they 'always' or 'usually' received adequate support around their interactions with suicidal consumers. However, 18.8% (n=15) reported 'rarely' or 'never' receiving adequate support. Furthermore, 51.2% (n=41) of survey respondents reported that they 'usually' or 'always' had a chance to talk with colleagues about their care of suicidal consumers. However, 48.8% (n=39) reported that they 'never', 'sometimes', or were 'unsure' about whether they had the chance to talk. Additionally, of the nurses who reported receiving support in relation to their interactions with suicidal consumers, 55.3% (n=42) reported that to be helpful, 19.7% (n=15) 'very helpful', with 23.7% (n=18) saying they were 'unsure' whether it was helpful, and 1.3% (n=1) saying it was 'unhelpful'. Thus it is suggested that the extent and quality of support was less than ideal.

It was noted, furthermore, that support from 'the team' usually occurred *'after the event'* (survey nurse). This was suggested to be important, however it was also seen as a limitation in that *'the moment – the emotions you feel then – it's gone...support needs to be more instantaneous'* (AcuteRN2). While, then, some form of team support was experienced by most of the nurse participants, the nature and timing of that support was suggested to have been less than optimal. It was also argued by several respondents that support was aimed primarily *'on how to protect the organisation rather than providing support to the worker'* (survey nurse).

Overall, as noted (for example in section 5.3.1.), the nurses highlighted that they could feel a sense of isolation and a distinct lack of teamwork and support in respect to their intention to therapeutically engage with consumers. It was noted, for example, that:

*some of them scoff....but I don't mind if they're critical of me for trying to engage, because, you know, they're the ones that will just give people a diagnosis and sit back and watch (AcuteRN2).*

Concerningly, it was also suggested that nurses could be directly undermined by colleagues in their attempt to engage. For example, AcuteRN3 expressed that:

*if I'm engaging with somebody other staff may actually undermine and criticise my work to the effect that it's not worth spending time with the person, or maybe that I'm in some way colluding with the person (AcuteRN3).*

AcuteRN11 recounted an example of when she felt that her intention to engage had been under-supported by her colleague:

*We went together to assess him in [the hospital emergency department] and my off-sider never uttered a word to him, never went near him. I interacted with him. I wasn't stopped from doing that, but having another professional right beside me who chose not to just made it that much harder (AcuteRN11).*

Teamwork was, then, seen as potentially very valuable in supporting the nurses to engage with suicidal consumers. However, the extent, quality and timing of that support was suggested to commonly be less than ideal. Furthermore, it was noted that a lack of team work and support could directly or indirectly undermine engagement attempts. Indeed, it was inferred that, to some extent, nursing teams involved 'a bunch of people standing in the room and they all feel alone' (AcuteRN11).

### 8.3.2. Professional supervision

Professional (clinical) supervision was indicated to be an important specific form of support that could promote personal and professional coping and development of expertise around engagement with suicidal consumers. However, as with education, training and teamwork more broadly, participants highlighted that adequate supervision was under-realised.

Regarding the potential for supervision to promote coping and the ability to engage AcuteRN3, for example, explained that consumer suicidality:

*can bring up a lot of emotion in the clinician [sighs loudly]...having adequate debriefing and supervision is extremely important, particularly if the person does suicide and you spent time with them (AcuteRN3).*

The nurses' accounts highlight, however, that supervision was not commonly provided. For example it was expressed that '*we are meant to get supervision, but it's not happening (AcuteRN1)*, and similarly that, '*I don't get supervision at the moment. I've got to find someone*' (CommRN6). Yet another nurse noted:

*I've never been offered supervision once, and it's quite amazing really how we're expected to perform these tasks, and we understand the nature and the importance of debriefing and talking about things, and yet when it comes to clinical staff like psychiatric nurses, that just doesn't happen a lot of the time, it's just paid lip service to (CommRN10).*

While it was reported by the majority of nurse interviewees that formal supervision was not occurring it is important to note that the nurses saw informal support as a form of supervision, and this was reflected, as noted in section 8.3.1., to be a very important element towards promoting therapeutic engagement. In this sense it was noted that, for the most part:



*there's no formal practice of supervision...it happens though, informally, and that's pretty important (CommRN7).*

Notably, 65% (n=53) of survey respondents reported that 'yes' they felt that additional clinical supervision would enhance their practice in regards to care of suicidal consumers. Thus the nurses clearly saw the potential of formal clinical supervision and they indicated directly their perception that it may enhance their ability to therapeutically engage.

As well as the need for greater supervision, numerous nurses commented that the usefulness of supervision depended on the supervisor. Further highlighting the potential for the nurses to have diverse – and sometimes oppositional – approaches, AcuteRN1, for example, noted that she would only be interested in supervision if she felt she could be open and honest with the supervisor and if she respected their practice. Similarly, AcuteRN3 expressed in this regard that:

*clinical supervision would be helpful...but, again, everyone needs to be reading from the same 'hymn book'. It's no use having supervision with someone who is diametrically opposed to the way you deal with suicidality, or your feelings on the topic. That's going to be a waste of time (CommRN10).*

AcuteRN11 used the issue of supervision to reinforce the need for a clearer evidence base, and clinical guidelines around care of suicidal people, so that:

*when it comes to issues of supervision everyone's working from the same training, everyone's working from the same ideas (AcuteRN11).*

Thus the importance of not just ensuring that all nurses were participating in supervision, but of also supporting the nature and quality of the supervisory relationship – including the content or aims of supervision – was highlighted. Additionally, several of the nurses expressed that having choices as to the supervision arrangements – in effect enabling 'ownership' of the process – may be

vital. The findings thus affirm the potential value of supervision to impact the nature of nursing care (Samuelsson et al. 2000), and to provide effective training to promote therapeutic engagement (Michel 2011, p. 17).

### **8.3.3. Resources including time**

The nurses highlighted that the availability of time, the effective use of time, and appropriate staffing levels and nurse-patient ratios, were crucial factors mediating the potential for therapeutic engagement. The fundamental value of time together and staff availability has been explored in previous sections (see in particular section 7.1.7.), and it is clear that a lack of time spent together was experienced by nurses and consumers to reflect and shape a diminished quality of care. This was evidenced by nurse responses to questions about what would help them provide a better standard of care. The nurse interviewees invariably responded that *'time is the big one'* (CommRN10). Thus it is reinforced that nurses needed:

*more time to spend with individuals, plus the appropriate utilisation of the time you have available to get to know the patients in your care (AcuteRN4).*

The survey responses support the notion that availability of time to engage was of crucial importance. For example, 54.4% (n=43) of respondents reported that 'availability of time' most positively influenced their interactions. Additionally, 64.1% (n=50) of respondents reported that 'lack of time' most negatively influenced their interactions with suicidal consumers. Furthermore, 53.8% (n=43) of respondents reported that 'more available time' would enable better outcomes for clients in suicidal crisis.

Reflecting the view that availability of time could impact on the potential for therapeutic engagement, it was noted that:

*in the acute in-patient setting time and support are lacking. Often interventions in this setting are aimed at prevention of self-harm/suicide in the short-term*

*and containment is the most practical intervention offered due largely to time constraints (survey nurse).*

The availability of time was linked by the nurses to staffing levels and nurse - patient ratios. AcuteRN4, for example, stated that:

*you have people who are on regular observation every 15 minutes. If I've got say six clients that I have to see every 15 minutes then that really limits what I can do with one person (CommRN10);*

Thus it was noted that '*multiple, conflicting responsibilities*' (AcuteRN3) within limited time and with multiple consumers meant that adequate time could not always be allocated to an individual. As such it was argued that, '*what would help me in that role is greater resources – more time and more people so that it's not just me doing it*' (AcuteRN4). Several participants also asserted, however, that time needed to be more carefully used, in that '*it's not just having more time, it's utilising time as well*' (AcuteRN4).

McLaughlin (1999) and Talseth and Gilje (2011) make the obvious yet crucial point that nurses require both the intent and ability to therapeutically engage with consumers, as well as the time and opportunity within which to engage. The present findings clearly indicate the view that there were great demands on nurses' time in inpatient units in particular, and it was obvious to numerous participants (for example Lucy) that this could result in a pervasive 'busyness'.

The concept of the 'busy nurse', who is unable to spend time engaging with the patient, has been linked to the historical conceptualisation of nurses as 'handmaiden' within a medical model which sees the patient cast as a passive recipient of care (Street 1992, p. 49). The legacy of this is argued to be the view that a 'good' nurse is a 'busy nurse' (Robinson 1995). The current findings affirm that the 'busy nurse' may remain 'distant' from the intrapersonal experience of patients, as has found to be problematic in general nursing (Bowles et al. 2001) and

psychiatric/mental health nursing contexts (Cutcliffe & Stevenson 2008a). Indeed, the notion of the busy nurse who does not engage with the intrapersonal 'world' of the consumer sits in stark contrast to the consumers' expectations that they would receive 'help through talking with the nurses while on the ward' (Stenhouse 2011, p. 74). Thus, not only did limited time restrict nurses' ability to engage, it reinforced constructions of the nurse role which impeded therapeutic engagement.

#### **8.3.4. The model of care**

As asserted throughout this thesis, the participants' accounts highlight the ways in which the dominance of a reductive, medical model of care diminishes therapeutic engagement. As noted, this model is characterised by custodial, observational, diagnostic and pharmacological interventions (see Chapter 6). AcuteRN11 was amongst other nurses who felt that her intention to therapeutically engage towards recovery was undermined by such a model of care. She expressed in this regard that:

*you cannot just marry a nursing and a recovery model to a business and medical model...The patient chose to come and see me – that's part of recovery – but we can't do what we need to do. No, the system says we have to do this, this and this (AcuteRN11).*

The reductive model of care was seen to potentially mean that:

*we don't provide nursing care; we give them a bed, food, drugs, some time out, and wait until they're ready to say they're no longer suicidal (AcuteRN3).*

In addition to failing to meet the holistic needs of consumers, the reductive model of care was also seen to offer consumers 'a number' and a seat, rather than 'full intervention', which one nurse explained could be potentially difficult to access: :

*This is not a system that is designed to fulfil what people are told it will fulfil. If the system says present to [the hospital emergency department] for your mental health issues or suicidal feelings, provide the access, don't just say*

*'here's a number, sit down'...What we're telling people is that when you get to the end of your tether you can go there and you'll get full intervention. Well, you bloody well won't. You won't even get to step one half the time (AcuteRN11).*

Thus it is indicated that the dominant model of care presents a limited range of services, within which the potential for therapeutic engagement is sidelined. This model of care has limited scope to meet consumer needs, as Pilgrim notes:

*A reductive model may (generally speaking) be unduly optimistic about a focus on risk minimisation, pharmacology and psychological 'technologies' (Pilgrim 2008, p. 296).*

As noted by the nurse interviewees, there were attempts to *'influence the system in a positive way'* (AcuteRN11). However, the overall dominance of a more reductive model of care was seen to challenge the best intentions and the potential of nurses to realise a model of care based more fully upon therapeutic engagement (which encompassed holism, recovery and alliance).

### **8.3.5. The differences between community and inpatient settings**

By considering some of the differences in experiences of care between the community and inpatient settings, the argument that elements such as time, physical environment, service model, as well as consumer factors, may impact on the realisation of therapeutic engagement, is reinforced. As has been noted, most of the consumer participants felt that they were more likely to experience therapeutic engagement with their community mental health team case manager than with nurses in the inpatient units.

The survey findings reinforce the notion that therapeutic engagement was more prominent in community-based care than in inpatient units. For example, 94.4% (n=17) of the respondents who worked in community settings reported that their primary approach was usually to 'engage' with the consumer in suicidal crisis,

compared to 54.2% (n=26) of inpatient respondents. It followed, too, that longer interactions were reported by the respondents to occur in the community. For example, 12.5% (n=6) of inpatient nurse respondents reported that on average each interaction with a suicidal person was 'more than 60 minutes', compared to 38.9% (n=7) reporting the same in the community. Additionally 45.9% (n=22) of inpatient unit nurse respondents reported spending 'less than 20 minutes' interacting with a suicidal person on average, compared to 11.1% (n=2) in the community.

While care was suggested to be more engagement-based in the community the data also indicates that community settings could be particularly challenging. This was arguably due to the relatively high degree of autonomous practice experienced in the community-based roles. The result was, for example, that 74.5% (n=35) of inpatient unit nurses reported 'little or no' or 'positive' impact on own mental health around interactions with suicidal consumers, compared to 33.4% (n=6) of community-based nurses. Furthermore, 12.8% (n=6) of inpatient nurses reported that their own mental health was negatively affected around interactions, whereas the figure was 50% (n=9) for community nurses.

Thus it was suggested that the setting, interrelated with various other factors, could play an important role in determining the nature of care and the potential for therapeutic engagement to occur. While care experiences in the community were arguably expressed to be more positive, and while the community context may enable longer interactions in more private settings and with a more psychotherapeutic approach, it must be remembered also that community case-managed consumers were in a very different state of mind, stage of recovery or degree of suicidality than when they were in the acute setting. Case-managed consumers in this study, for example, were not in suicidal (or any other type of) acute crisis. That case management was, apparently, more engagement-based than inpatient unit nursing speaks to the potential for an optimal model of care to occur when various consumer, clinician and contextual elements align. It also highlights the potential for service to be more comprehensive and not just focused on episodic intervention, as is recognised to be vital (Mendoza & Rosenberg 2010, p. 17).

#### **8.3.6. Summary**

This section has highlighted that the realisation of therapeutic engagement was influenced by service-related contextual factors including the functionality of the service team, the provision and quality of professional supervision, the availability and utilisation of time, the dominance of a reductive model of care, and whether the nurse worked in a community or inpatient unit setting. As with the other factors noted, it is suggested that some nurses saw the challenging contextual factors as impetus towards attempting to enable therapeutic engagement. Overall, however, it is indicated, that the service-related contextual factors noted did not optimally prepare or support nurses to therapeutically engage. It is also reinforced that the actions and intentions of individual nurses may be seen as a crucial element in reflecting and shaping such factors.

#### **8.4. Conclusion**

This chapter has identified and explored the consumer, nurse and service-related contextual factors indicated to affect the potential for therapeutic engagement around consumer suicidal crisis. This has reinforced that ‘there are many challenges to developing a therapeutic alliance with the hospitalised suicidal person’ (Lineberry 2011, p. 350). It is evident that the interrelated factors identified represented potential barriers to engagement, although some nurses also framed them as impetus and opportunity to engage. The findings thus do not assert that the model of care was wholly reductive or medicalised. Indeed, there was a degree of therapeutic engagement involving elements and ‘glimpses’ of holism and recovery, particularly in community case-management contexts. Furthermore, it is acknowledged that, while the dominant (reductive) model of care may have imposed limitations, it may be positively shaped by staff philosophy and care approaches.

The potential to respond more positively to the significant challenges at hand was argued to relate, most relevantly, to the preparation, attitude, skills, knowledge, and

support of nurses. In this sense, the potential for engagement was seen to be reflected in the nurse's level of participation in the aspirational model of therapeutic engagement (which embraced holism, recovery and alliance). However, there is a clear finding that an overly reductive, medicalised model of care was seen to be predominant, and to limit the realisation of therapeutic engagement.

The findings affirm that the realisation of therapeutic engagement may be challenged by various symptoms, behaviours, and characteristics of the person in suicidal crisis – for example the person's likely ambivalence about living and possible resistance to seeking and receiving 'help' (Maris et al. 2000a; Berman 2006). It has also been reinforced that conditions in acute mental health care may challenge nurses to achieve the therapeutic aims to which they aspire (Hummelvoll & Severinsson 2001, p. 156); that the attitudes and reactions of clinicians may be the biggest obstacle to therapeutic engagement (Maris et al. 2000a, p. 512); that nurses may not respond well to the challenges inherent in engagement with suicidal people (Berman 2006, p. 171); and that nurses may indeed be complicit in reinforcing the limitations of their practice (Barker & Buchanan-Barker 2011).

Clearly, the consumer, nurse and service-related contextual factors affecting the potential for therapeutic engagement are interrelated. Therefore, just as poor nursing attitudes, for example, may undermine systems which support therapeutic engagement, the performance of the best intentioned nurse could be expected to be undermined by, for example, a lack of preparation and poor or non-existent clinical supervision and support. In considering how therapeutic engagement may be more fully realised it is thus particularly relevant to focus on nursing and service-related factors. This is not to apportion blame to systems or nurses (or indeed to diminish the importance of consumer agency). Rather it is to acknowledge that consumers are in a most vulnerable position, and is aimed towards making the most of the good will and significant potential that services and nurses are indicated to have. Considering the interrelated factors in this way highlights both where limitations were seen to exist and where reform could be directed towards greater realisation of therapeutic engagement.



# **Chapter 9 – Realising the potential of therapeutic engagement**

This chapter summarises the findings in relation to the research questions and discusses recommendations aimed at promoting therapeutic engagement between consumers and nurses. It also discusses some limitations of the study, identifies areas for further research, and concludes the thesis with a reflection on the research process and findings.

## **9.1. Findings summary**

This section summarises the literature review that gave rise to the research questions, and then discusses the findings in relation to research questions 1-3.

### **9.1.1. Introduction**

This thesis has highlighted that limiting the occurrence and burden of suicide is a pressing and widely appreciated concern to which significant efforts have been directed. Relevant efforts include an ever-expanding literature base in suicidology, the implementation of suicide prevention strategies, the development of mental health care recovery theory and practice standards for mental health nurses, and social campaigns that have arguably reduced stigma and promoted help-seeking behaviour. However, despite such developments, suicide rates remain alarmingly high, and in many regions are increasingly high. Although suicide will likely always accompany humankind (Hawton 1994, p. 76), it is believed that it is largely preventable (McGorry 2010a). Therefore, appreciating the challenges inherent to this issue, and the ongoing and valuable efforts of many people working to limit the occurrence and burden of suicide, it is argued that suicide has thus far not received

the degree or quality of attention that it warrants (McGorry 2010 in Drape 2010; Mendoza 2009 in Pollard 2009; Brogden 2010 in Agius 2010).

Mental health care is believed to be integral to suicide prevention (Goldney 2005; McGorry 2010 in Drape 2010; Mendoza 2009 in Pollard 2009; Mendoza & Rosenberg 2010; WHO 2009; IASP 2008) and publically funded mental health care services are positioned as key respondents to people at heightened risk. Indeed, people are encouraged, and sometimes forced, to seek and receive mental health care in response to suicidal crisis. In particular, hospital-based psychiatric inpatient units regularly provide service to people experiencing suicidal crisis. Clearly people deserve the best possible quality of care in this important context. However, there is a lack of evidence that inpatient unit care prevents suicide (De Leo & Svetlicic 2010) and the quality of service has been criticised (Michel 2011; Marsh 2010; Cutcliffe & Stevenson 2008a; Lieberman 2003; Dodds & Bowles 2001; Szasz 1999; Lineberry 2011; Cutcliffe & Stevenson 2008a; Lakeman & Fitzgerald 2008; Leenaars 2006; Goldsmith et al. 2002; Mendoza & Rosenberg 2010, p. 93). There is, therefore, an ongoing need to meaningfully explore the nature and adequacy of current systems (Mendoza & Rosenberg 2010, p. 168) in order to address limitations and develop better models of care.

Within inpatient units, registered nurses make up the largest discipline group with the greatest consumer contact. It is argued that such nurses can provide effective care for suicidal people (Lakeman & Fitzgerald 2008; Samuelsson et al. 2000; Carrigan 1994). Concerningly, however, there is a lack of evidence informing nursing practice in this context (Valente & Saunders 2002; Gilje et al. 2005; Cutcliffe & Stevenson 2008b). Reflecting and shaping the broader field of mental health care, evidence which does exist consistently points to limitations and significant 'gaps' between the rhetoric potential and reality of nursing care. This highlights that the aspirations and potential of mental health nurses are under-realised (Barker & Buchanan-Barker 2011a). Thus, while service limitations remain unaddressed, the critical role of nursing care to appropriately support consumers in suicide crisis, and to successfully avert suicide, remains seriously under-developed.

Theoretical concepts exist which provide insight into how nurses may best care for someone at risk of suicide. For example, *in theory* mental health nursing embraces the value of holistic or multidimensional care that takes into account all of the interrelated aspects of a person's life (Cutcliffe 2003, p. 97; Procter 2005, p. 200). It also theoretically aims to realise a recovery-orientation which provides more than just symptom reduction, and which empowers people within their intrapersonal and interpersonal contexts (Barker 2001). Mental health nursing also appreciates, in theory, that the therapeutic relationship is the foundation of quality care (Barker et al. 1997; Cleary et al. 1999a; Walsh 1999; Hummelvoll & Severinsson 2001; Cutcliffe & Stevenson 2008a; ACMHN 2010a; Barker & Buchanan-Barker 2011a).

Nursing models that encompass principles of holism, recovery and therapeutic alliance do exist (Barker 2001), including in the context of mental health nursing care of suicidal people (Cutcliffe & Stevenson 2007). There are also mental-health models specific to therapeutic engagement with suicidal people (Michel 2011). However, such theory is somewhat abstracted from practice settings; it focuses predominantly on what an effective model would look like could it be realised, rather than on what might more commonly occur; and it does not provide the understanding needed to translate evidence into practice. Crucially, these models are not sufficiently constructed from knowledge which incorporate the contextual knowledge and lived experiences of both consumers and nurses in an adequately critical approach. Therefore, while the existing literature highlights that mental health nursing is vital in the care of suicidal people, neither generalist nursing or mental health models provide an adequate evidence base for 'best practice'.

The present study aimed to generate a new set of understandings around an important yet little understood and relatively undeveloped area of practice. Given the established understanding that principles of holism, recovery, and therapeutic alliance, are fundamental to mental-health nursing care and suicide, these elements were central to the investigation. Nursing practice encompassing these essential principles was operationalised in the current study as 'therapeutic engagement'. The

study was thus partly focused on extending and nuancing understanding of how therapeutic engagement might function and be promoted in the context at hand. In order to access rich data, and prioritise the experiences, knowledge and particular meanings that exist for the people in the context, an interpretive qualitative methodology was crucial.

Methodologically, parallels may be drawn between clinical and research contexts, in that limitations in both areas can be associated with a tendency towards over-reliance on reductive, (medicalised and positivistic) approaches. This may be seen as part of a misguided search for legitimacy and ontological security. Towards redressing bias towards such reductive approaches, and given the importance of intrapersonal and interpersonal dimensions in the care of mental health-care consumers in suicidal crisis, first-person narratives were imperative to this study. It was also evident that a critical focus was vital to identify areas for reform and closer application of theory. The result was this study which explored the experiences and needs of mental health care consumers around suicidal crisis; the degree those needs were met; the role that mental health nurses played in meeting those needs, particularly via their clinical relationships; the factors which were seen to impact on the quality of care experienced; and the implications for the practice, preparation and support of nurses.

#### **9.1.2. Research question 1**

*What are the experiences and needs mental health service-users have around suicidal crisis and to what degree are these needs met?*

The findings highlight that people in suicidal crisis were largely isolated within a multidimensional and intrapersonal experience of extreme suffering involving the view of death as an escape. Intrapersonal and interpersonal factors were identified by consumers to be of central importance around the time of their suicidal crisis. At this time, consumers indicated that the risk of completed suicide was high to extreme. While the possibility of death was acknowledged by nurses to be potentially very high, they also felt that people who purported to be in suicidal crisis

were often not necessarily at imminent risk of death. While most participants expressed that consumers in suicidal crisis were usually experiencing what may be understood as symptoms of mental illness, some consumers explicitly rejected such a framework and many nurses noted that there could be a problematic over-reliance on such a model. Corresponding to the holistic conceptualisation, suicidal people's mental health service needs around suicidal crisis were indicated to be access to service, physical care and safety, treatment of psychiatric symptoms, and interpersonal engagement.

The findings indicate that inpatient unit service was characterised by the medicalised interventions of detention, observation, medication and management within a multifaceted 'social' and physical inpatient unit environment. These interrelated elements of service were noted to have value, particularly towards meeting the consumers' needs of physical care and safety and treatment of psychiatric symptoms. However, therapeutic interpersonal engagement was the most important need expressed by consumers, yet was also the need most notably under-realised. This was seen to be problematic in that understanding of holistic contexts and intrapersonal experiences remained limited. This meant that the design and implementation of various interventions was undermined by a lack of shared understanding and collaboration between consumers and nurses. It also inferred that consumer isolation, distress, loss of control and objectification was not fully addressed, and in some cases could be compounded by the lack of therapeutic engagement. Nevertheless, for the consumer participants in this study, service was associated with a reduction or resolution of suicidal crisis.

The findings also highlight that some people seeking help around suicidal crisis were not able to receive service or that service was ineffective in helping them. For example, both nurse and consumer participants recounted experiences of other consumers who had completed suicide, including after seeking service and not receiving it, whilst in the inpatient unit, or post-discharge from the inpatient unit. This is not to assert that services did not have the capacity to respond to people in suicidal crisis. They clearly did, as the experiences of most of the consumer

participants, in particular, demonstrate. However, it may be argued that, overall, needs were only partially met. This was suggested to be due, in large measure, to the limited realisation of therapeutic interpersonal engagement (encompassing holism, recovery and alliance). It is notable, however, that some of the consumers explained that being left largely 'alone' did lead them to drive their own resolution of crisis. Additionally, it is evident that consumers' experiences were generally seen to become more positive throughout their hospital admission and that some consumers did not want to leave the setting (although others did find inpatient unit unacceptable and remained focused on how to achieve discharge, even when they were still feeling suicidal). While this may point to a problematic 'institutionalisation' (Wing 2000; Priebe 2004; Salize et al. 2008) it also suggests that people were able to realise a degree of recovery within the settings. As well as involving valuable introspection, this may be associated with the development of positive relationships between nurses and consumers, and also between consumers and consumers.

It is also evident that, for most of the consumer participants in this study at least, the period post-crisis which featured MHS case-management in the community was a generally positive, although still challenging, time. It is evident that most of the consumers valued their experience of case-management, particularly as it provided ongoing support more closely linked to their actual living environment, as well as the experience of fuller therapeutic interpersonal engagement that they felt was largely lacking in the inpatient units. The marked difference in service in this respect points to the way that interrelated consumer, nurse, and service-related contextual factors, may define the nature of care and the potential for therapeutic engagement. For example, in community contexts the consumer participants no longer had serious suicidal intent, their symptoms of mental illness were diminished or absent, case-managers (some of whom were nurses) arguably had more experience and were more focused on psychotherapeutic intervention than inpatient unit nurses, and there was more privacy and extended time together available, usually in the consumers' own homes. Thus, therapeutic interpersonal engagement was able to occur more consistently in community case-management contexts. This raises the

crucial point that, at the very point of crisis, therapeutic engagement was arguably at once most vital yet most challenging to realise.

Overall, the findings support previous assertions that people in suicidal crisis are commonly understood and responded to in limited and potentially problematic ways within mental health care contexts (Talseth et al. 1997, 1999; Samuelsson et al. 2000; Meerwijk et al. 2010; Michel 2011; Marsh 2010; Cutcliffe & Stevenson 2008a; Lieberman 2003; Dodds & Bowles 2001; Szasz 1999; Lineberry 2011; Cutcliffe & Stevenson 2008a; Lakeman & Fitzgerald 2008; Leenaars 2006; Goldsmith et al. 2002; Mendoza & Rosenberg 2010, p. 93). Indeed the findings exemplify that the needs of consumers in such contexts, as well as the needs and aspirations of mental health nurses (Barker & Buchanan-Barker 2011a), may be similarly and inseparably under-realised. In particular, the findings highlight that nurses and consumers shared an understanding of the importance of therapeutic interpersonal engagement. This affirms that therapeutic relationships may be of primary importance in responding to people at risk of suicide (Michel 2011; Maris et al. 2000a; Leenaars 2006; Michel et al. 2004; Reeves & Seber 2004; Mishara 2008; McLaughlin 1999; Talseth et al. 1999; Samuelsson et al. 2000; Sun et al. 2004; Carlen & Bengtsson 2007; Cutcliffe & Stevenson 2008a, p. 29; Talseth et al. 2011).

However, nurses and consumers also shared a concern that the vital therapeutic engagement was lacking, particularly in emergency department and inpatient unit service contexts. At the centre of these concerns was, for the consumer, the extension of their intrapersonal isolation, and for the nurses a frustration of their intention to realise an optimal professional role and identity and, ultimately, quality of care. The findings thus point to the potential for nurses to help people survive and resolve suicidal crises (Lakeman 2010a; Lakeman & Fitzgerald 2008; Samuelsson et al. 2000). However, they also reinforce previous findings reflecting that the aspirations and potential of nurses were under-developed and under-realised (Talseth et al. 1999; Cardell & Pitula 1999; Samuelsson et al. 2000; Gournay & Bowers 2000 Cutcliffe et al. 2006; Cutcliffe & Stevenson 2007; Reid & Long 1993; Duffy 1994; Long & Reid 1996; Talseth et al. 1997; Cleary et al. 1999b; Fletcher 1999;

Vrale & Steen 2005; Gilje et al. 2005; Carlen & Bengtsson 2007; Rooney 2009; Meerwijk et al. 2010; McLaughlin 1999; Fletcher 1999).

### **9.1.3. Research question 2**

*What role do mental health nurses play in this context, particularly in regard to their interpersonal interactions with service-users?*

The findings indicate that the main role for nurses in the context of consumer suicidal crisis was that of clinician and inpatient unit milieu manager. Within those roles, nurses were attempting to understand and meet the consumers' needs and their own professional responsibilities. Thus, the role was perceived to encompass the provision of access to service, physical care and safety, treatment of psychiatric symptoms, and therapeutic engagement. Reflecting the under-realisation of therapeutic engagement, and the related 'gap' between the rhetoric and reality of care, it was indicated that the nursing role centred on coordinating and enabling the interventions of detention, observation, medication and management within the inpatient unit environment.

Despite its under-realisation, the participant data does provide understanding of the nature and role of therapeutic engagement in this context. This data was drawn from participants' accounts concerning elements or 'glimpses' of therapeutic engagement. It was also drawn from data concerning the standard of care that the nurses were trying to achieve and that the consumers wanted to receive. It was indicated that therapeutic engagement was constituted of a range of interrelated elements including rapport, active listening, empathy and boundaries, relating as equals, genuineness, compassion and unconditional positive regard, trust, and time and responsiveness. Most, if not all, of these elements were seen as necessary, but alone not sufficient, for the optimal quality of therapeutic engagement. Central to such engagement were the principles of holism, recovery and therapeutic alliance. The importance of a nursing role based upon such engagement was that it could enable collaboration around understanding and potentially positively affecting consumers' intra-personal experiences. This collaboration was suggested to involve



addressing and limiting issues of isolation, distress, loss of control and objectification. It was also indicated to be reciprocal in nature and potentially beneficial for nurses as it challenged both consumers and nurses to realise personal and professional development.

Therapeutic engagement between consumers and nurses was associated with more positive experiences of service, and a lack of engagement was associated with limitations to service. Thus therapeutic engagement was suggested to have the potential to make the most of a system which might otherwise be problematically reductive, medicalised, objectifying, alienating and coercive. Indeed, it is proposed that therapeutic engagement as outlined may be conceived as the key catalyst to an optimal quality of care. In this sense it is argued that greater realisation of therapeutic engagement is central to integrating the various elements of service, bridging the 'gap' between the rhetoric and reality of care, and, ultimately, promoting more effective and appropriate service. It has been suggested that nurses have the potential to fulfil such a role, but that they require enhanced preparation and support to achieve that.

#### **9.1.4. Research question 3**

*What are the contextual factors which likely impact the quality of care experienced?*

Factors indicated to impact the realisation of a nursing role which more fully embraces and realises therapeutic engagement were identified. By exploring these factors it is hoped that means to address the significant 'gap' between the rhetoric and the reality of care may be developed. The mediating factors were conceptualised as interrelated consumer, nurse and service-related contextual factors. Consumer factors identified were ambivalence and intent to die, fear, aggression, lack of trust, and limited ability to access and communicate intrapersonal experience, perceived or actual personality disorder, and diagnoses and symptoms of mental illness. Such factors can be seen as both helping explain the person's suicidality and as factors potentially limiting the realisation of therapeutic engagement, as has been noted to be the case more broadly (Maris et al. 2000a). In

particular, these factors can be seen to potentially limit the consumers' and nurses' intent and ability to engage. Alternatively, however, it is noted that the nurse may respond to such challenges as impetus to apply themselves towards engagement (although the former outcome was indicated to be more common than the latter). The consumer factors may be considered modifiable largely through modification of the other nurse and service-related contextual factors.

Nurse factors identified were professional identity, attitudes and reactions, reflection and development of expertise, and knowledge, skills and training. These factors may be considered the most central of the mediating factors as they represent the nurses' intent and ability to engage, and their potential to compound or ameliorate other limitations at hand. Service-related contextual factors identified were teamwork and support, professional supervision, resources including time, the service setting, and the dominant model of care. These factors were important in that they could affect the consumers' and nurses' abilities to engage. The nurse and service factors may be considered of primary importance in terms of modifiability.

The potential to respond more positively to the significant challenges at hand was argued to relate, most relevantly, to the preparation, attitude, skills, knowledge, and support of nurses. In this sense, the potential for optimal care was seen to be reflected in the nurse's realisation of an identity and role which corresponded with the aspirational model of therapeutic engagement (which embraced holism, recovery and therapeutic alliance). However, as noted, this contrasted with the finding that nurses' professional aspirations were largely frustrated, and that an overly reductive, medicalised model of care was seen to be predominant.

By focusing on the primary relevance of the nurse and service-related contextual factors the findings reinforce that conditions in inpatient units can make it difficult for nurses to achieve the therapeutic aims to which they aspire (Hummelvoll & Severinsson 2001, p. 156). They also reinforce that nurses may be confronted (Talseth & Gilje 2011) and challenged in caring for suicidal consumers (Berman 2006, p. 171), and that nurses themselves may limit their own practice (Barker &

Buchanan-Barker 2011a). This points to the importance of better preparing and supporting nurses to realise their professional aspirations which would see them more fully participate in a model of care underpinned by therapeutic engagement.

## **9.2. Recommendations**

This section discusses the findings in relation to research question 4: *What implications do the findings have for the practice, preparation, support and development of nurses?* From the findings that therapeutic interpersonal engagement (as it has been defined) was central to an optimal model of care, recommendations are made in respect to the interrelated consumer, nurse and service-related contextual factors, relevant in that regard.

### **9.2.1. Consumer recommendations**

Although consumer factors affecting the realisation of therapeutic engagement may best be addressed by first modifying nurse and contextual factors, some recommendations can still be drawn from the findings specifically regarding consumers. Firstly, consumers desire a greater level of interpersonal engagement with nurses, particularly engagement which sees the nurse genuinely care and engage with them in respect to their intrapersonal narratives. It is notable in this regard that consumers perceived therapeutic engagement to be more under-realised than the nurses did. This reinforces that therapists can misjudge the quality of therapeutic alliance (Horwath & Luborsky 1993), with that being significant because patients' ratings of alliance tend to be better correlated with outcome in therapy than do therapists' ratings (Piper et al 1991). Thus it is exemplified that consumer perspectives represent vital knowledge and that their participation in service should be enhanced. Central to enhanced participation is incorporating the consumer experience and voice into mental-health nursing service-provision and training. Because consumer participation is clearly vital towards promoting a recovery-oriented service (Happell 2010), it may also be a useful part of formal research endeavours. Thus it is recommended that consumer participation, in both individual

clinical scenarios and in the broader design and delivery of service, be actively promoted.

Also congruent with notions of recovery (Anthony 1993, p. 24), and an important finding of the current study, is that consumers can often support each other around experiences of suicidality and related mental health care (Lineberry 2011, p. 346; Nolan et al. 2011; Bowers et al. 2008). The current findings affirm that this may occur, for example, in the absence of adequate nursing engagement (Stenhouse 2011, 74; Shattell et al. 2008). Therefore, supporting consumers to optimally engage and support each other is potentially very valuable and it is recommended that this is given further attention in the context at hand.

An additional and most challenging recommendation that I can draw from the data concerns the broad topic of how interpersonal, familial and social conditions might be affected to limit the occurrence and burden of suicidality and also help support people's interactions with services including MHS. This is clearly a topic warranting major ongoing research and reform.

Although the recommendations noted may be implicit priorities within therapeutic engagement, it is important to explicitly highlight that nursing policy and practice can be improved by greater consumer involvement in designing, implementing and evaluating service. This is in line with findings that consumer insight – previously lacking from the predominately quantitative reports on the sector (Tasmanian Government 2007) – is important to understanding the successes and failures of mental health nursing for those in suicidal crisis.

### **9.2.2. Nurse recommendations**

Recommendations regarding nurses can be related directly to the identified mediating factors. It is recommended that the education, training, supervision and support of nurses be enhanced to promote nurse's professional identity and role, their ability to practice reflectively towards developing a sense of mastery over their own intrapersonal worlds, and the confidence and skills to engage with consumers. It

is suggested that this, in turn, could enhance realisation of fuller therapeutic engagement with consumers.

The articulation and development of a nursing identity and role in line with aspirations of therapeutic engagement is a highly significant and ongoing project. An identity encompassing such broad principles is pursued in regards to general nursing (Benner 1984; Peplau 1991 [1952], 1992; Eriksson 1997; Moyle 2003) and mental health nursing (Barker et al. 1997; Cleary et al. 1999a; Walsh 1999; Hummelvoll & Severinsson 2001; Barker 2003; Cutcliffe & Stevenson 2008a; ACMHN 2010a; Barker & Buchanan-Barker 2011a). However, this study has reinforced that such an identity was struggling to be realised in clinical settings. The findings also suggest there is room for supervision and team culture to be developed towards alliance approaches, which point to the potential value of grounding identity and role development in individual services, settings and teams. It would seem that such a 'ground up' approach may be a vital complement to continuing development and appreciation of theory espoused in research and academic contexts.

Developing an appropriate identity and role within mental health services mandates that nursing reconcile a humanistic, holistic, recovery-oriented role based on engagement, with the more medical and coercive features of service. Claims that such diverse features of service may be mutually exclusive (Cutcliffe & Stevenson 2008a; Barker & Buchanan-Barker 2011a), or indeed that coercive services might do more harm than good (Szasz 1999) – for example by dissuading help seeking or compounding issues of isolation, distress, loss of control and objectification – may have validity (Webb 2005a). However, while much might be done to prevent the need for coercive interventions (for example bolstering social supports to avert suicidal crisis, and providing service in community or in unlocked inpatient units) rejection of medical and coercive practices – effectively a 'divorce' from medical-psychiatry (Barker & Buchanan-Barker 2011a) – is an unrealistic and undesirable option. Furthermore, some people do seem to welcome and benefit from medical-psychiatric and/or custodial interventions. Therefore, what is required is greater collaboration between clinicians, disciplines and consumers towards a shared goal of

recovery and therapeutic engagement. This would involve provision of service which integrates appropriate interventions within a least-restrictive model of care and which is responsive in maintaining and returning consumer self-determination to the greatest degree possible.

It is recommended, then, that nurses, individually and collectively, enhance their efforts to move beyond Barker and Buchanan-Barker's (2011a) assertion that we are *either* 'mental health nurses *or* 'psychiatric nurses'. While that dichotomous construction provokes valuable debate, moving beyond bias or reductionism demands that mental health nurses fill more than just one of those roles, or provide more, even, than the sum of both those 'parts'. Instead, an attitude should be fostered that we are a discipline that can draw together whatever elements of 'mental health' or 'psychiatric' practice are useful, acceptable and appropriate – and do so in ways underpinned by principles encapsulated in the notion of therapeutic engagement. This may help diffuse the rigid framework of current services involving coercive practices and over-reliance on medical-psychiatry into a broader holistic, recovery-oriented service. Thus the system may lose nothing and gain much as it evolves from within.

As noted, the findings affirm that nurses perceive having a lack of skills and knowledge regarding their nursing care of suicidal consumers (Talseth & Gilje 2011, p. 13-14; Rooney 2009). The nurses' desire to learn and develop in this regard can be considered a valuable asset towards making the most of the recognised potential for education programs to improve the attitudes and abilities of nurses in relation to care of suicidal people (Talseth & Gilje 2011; Samuelsson et al. 2000). In the current study, nurses have strongly expressed a desire to improve their skills and knowledge via academic and, in particular, formal and informal workplace learning and development contexts. It is suggested that the nurses especially want to learn by interacting and experiencing. As such, education and training cannot just be a theoretical supplement. It is recommended, therefore, that nurses be enabled to participate in education and training which includes their expressed desire for learning via interactive, case-study and role-playing approaches. The findings

indicate that it would be useful to cover topics including assessment, counselling, and more specific psychotherapeutic techniques such as CBT. It is also suggested that knowledge and skills specifically concerning suicide risk and protective factors, and communication and engagement, would be useful.

Such a focus on education and training acknowledges that people may need to be trained to provide the trusting and empathic interpersonal engagement necessary (Anthony 1993, p. 24); it is in line with government recommendations that nurse training at the under- and post-graduate level include awareness of suicide prevention strategies (DHHS 2009a); and it embraces the potential for specific training to reinforce better attitudes in health professionals (Brunero et. al 2008, p. 588), and to promote the potential for ‘gatekeeper’ training to reduce further suicidal behaviour (Mann et al. 2005). It also appreciates that the preparation and ongoing development of nurses may be central to the nature of service provision, including definition of the nursing role and the dominant model of care. Such a focus also reflects the belief that ‘increased knowledge about suicide allows for more effective prevention’ (Tasmanian Government 2007, p. 76). Furthermore, it supports the Tasmanian Suicide Prevention Strategy’s point that:

*Clinicians in specialist facilities need to be trained to a high level to both assess and support distressed patients (Tasmanian Government 2010a, p. 36).*

Thus it is recommended that steps be taken to help articulate, develop and promote a particular nursing identity and role that is conducive to engagement, and to promote learning and development through reflective practice, fostering team work, and both informal and formal education and training. This builds on the broader government recommendation that clinical settings develop new ways of working that reduce feelings of stress and alienation (Tasmanian Government 2010a, p. 51).

### **9.2.3. Service context recommendations**

Recommendation regarding the service context can also be related directly to the identified mediating factors. Thus, recommendations involve enhancing ‘teamwork’

and support, providing appropriate professional supervision, improving the availability and utilisation of resources including time, considering how limitations attributable to both community and, in particular, inpatient unit settings could be ameliorated, and, ultimately, addressing the dominance of overly reductive, medicalised and coercive models of care.

Findings reflect government acknowledgement that hospital admission and discharge processes are inadequate (DHHS 2009a). Given the difficulties consumers experienced in their attempts to be 'admitted', it is recommended that issues of access to service be more fully addressed. The Tasmanian Suicide Prevention Strategy has pledged to respond to problematic access issues in part by ensuring that 'mental health trained professionals are present in general hospital emergency departments, at all times to identify people at risk of suicide' (Tasmanian Government 2010a, p. 48). The strategy has also proposed that ambulance workers and various other primary health care and first-responders are trained in suicide awareness (Tasmanian Government 2010a, p. 49). As the findings indicate, however, the presence of a mental health professional in the emergency department may not necessarily be enough to ensure quality service and timely admission. Limitations were suggested to exist because of system, rather than (or as well as) staffing shortcomings. This research demonstrates that initial contact with emergency settings is a critical period in which experiences of negative evaluation by staff and of bureaucratic and systems-related delays may have detrimental and even fatal effects. It is hoped that community members, government and health care professionals – and in particular the mental health professionals who will now staff emergency settings – are willing and enabled to provide sensitive and timely individualised care to people who present to emergency settings.

It is recommended that the length and quality of time that nurses in different settings (particularly emergency department and inpatient units) have to devote to therapeutic engagement with suicidal consumers is given serious consideration. In addition to considering staff-patient ratios, the potential for inpatient unit nurses to be relieved of responsibility for other patients in order to provide sustained and



timely periods of engagement to a consumer for whom suicide is an issue may help make the most of staffing and budget constraints in this respect. It may also be beneficial to consider, in terms of the physical environment, how engagement could be promoted – for example the provision of a specific, quiet, private space may be appropriate. It is also suggested that enhancement of the inpatient units be considered in respect to activities and therapies, and towards making the settings more ‘natural’ or ‘healthy’.

It is strongly recommended that the extent and quality of clinical supervision be reviewed regarding its potential to prepare and support nurses’ intent and ability to therapeutically engage. This adds to the more general government recommendation that clinical settings require new ways of working, including enhanced internal support systems, in order to reduce stress and reduce ‘compassion fatigue’ (Tasmanian Government 2010a, p. 51). Michel (2011, p. 23) suggests that supervision towards enhancing therapeutic alliance with suicidal people may ideally involve actual video or audio taping of encounters. Michel (2011) speaks in reference to counselling professions more generally and his suggestions reflect more sophisticated and invasive methods of supervision than nurses in the current study were experiencing, if indeed they were experiencing any supervision at all. Nurses in the present study indicated their desire for ‘ownership’ of their supervision, particularly around having a supervisor whose approach to care they respected.

The issue of leadership is also crucial to consider here. Effective clinical leadership is recognised to be an essential element of workforce development (Graham 2003) which has the potential to improve client outcomes (Ennis et al. 2011). Indeed it is noted that:

*effective nursing leadership is one of the most important factors influencing the retention of nurses and the maintenance of quality nursing care (Mass 2005, p. 18).*

According to Hughes (2008, p. 9), leaders must achieve voluntary commitment to shared values, they must broker and concurrently enable the needs of multiple stakeholders, and set the ethics and norms that function in a given context. Thus the importance of individual, as well as collective and agency leadership, is noted (Hughes 2008, p. 9). Clinical leadership may be particularly important to consider in respect to bringing about the practical and cultural change in services required to drive orientation to a model of care more fully underpinned by therapeutic engagement.

The importance of academic leadership can also be seen as relevant towards promoting therapeutic engagement, particularly in regards to the building of commitment and capacity by universities to teach quality mental health nursing (Happell 2007, p. 296). More specifically, nursing curriculum may need to be considered in respect to how it prepares nurses to engage with suicidal health care consumers. My own experiences of having completed the Bachelor of Nursing and Graduate Diploma Degrees since 2003, working as a mental health nurse since 2004, and teaching within a Bachelor of Nursing course, reinforce that, while suicide and interpersonal engagement may have been considered briefly in numerous education and training contexts, these topics are arguably not explored and incorporated into practice in ways that effectively improve nurses' potentials to therapeutically engage with suicidal health care consumers. Indeed, it may be that neither the university or health service gives adequate attention to nurses' skills, abilities, attitudes and intentions, relevant to the fundamentally important nurse-patient relationship. It is best recognised that leaders and educationalists at all levels have an impact on the nurse's potential to realise therapeutic engagement.

Thus it is reinforced that nurses, and the contexts they work in when interacting with consumers in suicidal crisis, require significant additional preparation, development and support, to enable greater therapeutic engagement. The positive news in this regard is that many nurses appear to have a solid understanding of the nature and importance of therapeutic engagement and, most importantly, to appreciate it as central to an appropriate role and identity which they aspire to.

#### **9.2.4. Summary of recommendations**

##### **Consumers:**

- Enhance consumer participation in designing, implementing and evaluating service.
- Include consumer experiences and insights into service evaluations, training and policy.
- Support consumers to positively engage and support each other.
- Promote broader conditions which help reduce suicidality, encourage help-seeking, and support ongoing recovery.

##### **Nurses:**

- Develop and implement education, training, and professional supervision to promote therapeutic engagement.
- Implement activities aimed towards developing, articulating, and promoting identity and role, attitudes and reactions, reflective practice, knowledge and skills, conducive to therapeutic engagement.
- Develop and implement academic and case-based and interactive learning concerned with enhancing psychotherapeutic and communication techniques including counselling, CBT, and solution/goal-focused therapy, and which increases knowledge of risk and protective factors and suicide prevention strategies.

##### **Service-related context:**

- Review processes and personnel concerned with intake to service via emergency departments.
- Enhance team-work approaches, such as group reflective practice and supervision that increase the interpersonal support available in inpatient units.

- Change ways of working by fostering inter-sector engagement and more collaborative ways of working, such as peer learning which includes workers in more isolated community settings.
- Provide appropriate professional supervision which sees nurses actively engaged in supportive supervisory relationships with someone they respect and with whom there is a clear and shared understanding of a specific and relevant model of care.
- Improve the availability and utilisation of resources including time.
- Consider how limitations attributable to physical nature of settings could be enhanced, for example by making private spaces conducive to therapeutic engagement available within inpatient units.
- Further explore issues of academic and clinical leadership and how that might support fuller realisation of therapeutic engagement.
- Further explore how over-reliance on medicalised and coercive features of service can be redressed via therapeutic engagement (encompassing holism, recovery and alliance).

### **9.3. Limitations, further research and concluding remarks**

This section notes some potential limitations of the study, reflects on the study process, and offers some concluding remarks.

#### **9.3.1. Limitations**

One of the potential limitations to suicide-related research is that the population of people who experience non-fatal suicidal behaviour may only partially overlap with the population who complete suicide (De Leo 2002, p. 372). Thus caution must be taken in applying the findings of this study more generally in relation to people for whom suicide may be an issue. At the same time, however, it must be appreciated that suicide is inherently an individual experience. Thus, in order to generate understanding and develop a more comprehensive evidence base it is important to

find ways to appropriately utilise the information which may be gained from people who survive suicidal crisis.

The interviewee sample size in this study was relatively small and the inclusion criteria for consumers did preclude some consumers participating (including those for whom suicide was a current issue of concern). Similarly the nursing samples were non-random and must be considered in light of the aims of qualitative research for rich data, rather than representative samplings.

Because the data was gathered throughout 2010 it must also be acknowledged that service provision within MHS settings may have changed in some ways. For example, clinical supervision may have become more fully realised, the suicide prevention strategy may have been more fully implemented, and other workforce and service setting conditions may have changed.

### **9.3.2. Further research**

This exploratory research points to the need for further and ongoing research and evaluation. As noted, the evidence-base for mental health nursing is particularly under-developed, and lacks clear pathways for translating research findings into practice. The current findings reinforce that further work is required to help nurses articulate, develop and promote the aspirational model of care encapsulated in the notion of therapeutic engagement. This involves continuing to address the tension between therapeutic engagement (encompassing holism, recovery and alliance) and more reductive, medicalised and coercive models of care. One avenue to this may be to construct action-research around the recommendations I have outlined above, in order to 'test' and refine how indeed therapeutic engagement may be more fully realised in practice. This could help contribute to the broader goal of refining the knowledge required to clarify and articulate specific clinical guidelines to support mental health nursing care of suicidal consumers. As was recommended to me at a conference presentation, it may also be useful to look at the same issue using case-study or observation methods in order to more directly compare the nurse and consumer experiences of the same event.

Given that service is multidisciplinary it would also likely be beneficial to incorporate exploration of the other disciplines involved in mental health care around consumer suicidal crisis. Particularly valuable in this regard may be consideration of how different disciplinary perspectives can be combined and teamwork enhanced. A project to help raise public awareness and involvement, and help promote help-seeking behaviour may also be appropriate. The larger (and arguably most challenging) social project is that around understanding and modifying the determinants of suicide and mental ill-health with a view to reducing the occurrence and burdens of suicidality.

This study has also indicated that there is a dearth of literature exploring how to conduct research within mental health services, particularly when that involves research engagement with consumer participants and clinicians around a sensitive topic such as suicide. It is thus important to extend knowledge and practice around how to involve key stakeholders – such as consumers, nurses, and consumers’ ‘significant others’ – within effective, ethical and adequately critical inquiry. Further inquiry into how research may be undertaken – and incorporated more fully into evaluation and development of services – should be a priority. Translational and action research approaches may be particularly useful towards meeting these research and practice development priorities.

### **9.3.3. Reflections and concluding remarks**

This study was both deeply rewarding and greatly challenging to undertake. This was exemplified most profoundly in my engagement with the research participants. Engaging with the participants was a privilege and I greatly appreciate how each person willingly, but not necessarily easily, retrieved and described very significant and sometimes confronting experiences. They did this with the implicit expectation that I would faithfully represent their experiences within a sound research process. I believe that part of the participants’ motivation to contribute their stories arose from an appreciation that a great deal of good will and potential exists in the context of mental health nursing care of people at risk of suicide. One of the survey

respondents captured well, I think, how myself and I believe many of the participants – and indeed the other research ‘partners’ – felt about the research:

*I’m really glad that you’re doing this David; that some of these things are being highlighted - the things that we knew and understood for years in the profession of mental health nursing. It’s clearly a job we do and in some ways it is poorly understood by others, but we’ve always known what we do and a lot of us have been dedicated to this area of nursing for many years and would like to see the profession and this specialist area develop (survey nurse).*

I take this to reflect that nurses can and do provide very valuable care to people at risk of suicide, that this important area of practice is one that deserves and requires further and ongoing support and development, and that the knowledge around how best to structure and implement these changes can be found in these same nursing contexts.

This study highlights that, in clinical, research, and broader social contexts, the issue of suicide all too often remains shrouded by a cloud of fear, confusion and silence. Clearly, suicide and suicidal people can be challenging and confronting to understand and respond to. Additionally, health services are fiscally constrained, particularly in Tasmania, and there are limits to what they might achieve given the complex nature of suicide. However, avoiding the issue, or not striving to provide the best possible attention to the issue and those affected by it, is highly problematic: it reinforces a lack of understanding and, thereby too, a limited ability to effectively respond. This unfortunate scenario is reflected in research and mental health care practices which may reduce the complex experience of suicidality to individual causal or risk factors such as mental illness, and exclude and alienate people at risk of suicide. Such practices reflect and produce an ongoing failure to adequately acknowledge and engage with the complex individual and their context and constructions of meaning and narrative. Alternatively, fuller therapeutic engagement with suicide, and individuals affected by it, may disperse fear, confusion and silence.

Fortunately there is a great deal of good will and potential at hand, and nurses aspire to a model of care that is highly suitable for the care of suicidal people. Yet they are currently under-prepared and under-supported to fully realise such a model. It is evident that the lives of consumers could be enhanced and potentially even preserved, and the professional lives of nurses greatly improved (and broader individual and collective benefits more fully realised), if a greater degree and quality of therapeutic engagement could be realised. This research has generated understandings and highlighted steps that may help achieve this, and these and related issues clearly warrant further and ongoing attention. At the core of efforts aimed at realising therapeutic engagement is the belief that sometimes people need other people in order that our intrapersonal 'worlds' and stories will be understood and positively affected. It is in such engagement that we lose our isolation, we feel supported, we learn about ourselves, and together we do the best we can to live more successfully.



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## Interactions between Registered Nurses and suicidal clients within MHS

Dear Registered Nurse,

Mental Health Services (MHS) Registered Nurses are potentially significant contributors to suicide prevention when they interact with clients at risk of suicide.

It is likely that interactions in this context will be enhanced with a greater evidence base. The subjective accounts of nurses and clients are considered absolutely essential to enhancing this evidence base.

This survey is one part of a University of Tasmania PhD study titled:

Nurse-client engagement and suicide:

An exploration of therapeutic engagement between mental health nurses and clients who at the time of engagement were in suicidal crisis.

You are warmly invited to share your valuable insights by completing this survey. The information gathered will remain completely anonymous and will be used to inform and positively influence current practice, educational and reform activities.

The study is being conducted by the following University of Tasmania (UTAS) research team:

Principal Researcher: David Lees – Registered Psychiatric Nurse and PhD candidate at the University of Tasmania (UTAS) School of Nursing & Midwifery.

Primary Supervisor: Prof. Denise Fassett – Head of UTAS School of Nursing & Midwifery.

Co Supervisor: Adjunct Professor Nicholas Procter – Mental health promotion and suicide prevention researcher and consultant and senior lecturer at University of South Australia.

Research Monitor: Christine Handley – Senior UTAS lecturer and mental health nurse therapist.

Your participation is voluntary and the survey takes 5-10 minutes to complete.

Your participation is greatly appreciated.

Please feel free to contact me regarding any aspect of this survey and/or if you would like to be involved in the in-depth interview phase of this study.

Yours sincerely,

David Lees

PhD Candidate  
School of Nursing and Midwifery  
Launceston Campus,  
Locked Bag 1322  
Launceston, Tasmania 7250 Australia  
Tel: 03 6324 3318  
Mobile: 0408133278  
Fax: 03 6324 3952  
Email: leesd@utas.edu.au

**1. For how many full-time equivalent years have you always or mostly practiced psychiatric/mental health nursing as a Registered Nurse?**

- ☐ Less than 1 year
- ☐ 1 - 4 years
- ☐ 5 - 9 years
- ☐ 10 - 15 years
- ☐ 15 years or more

**2. In what region do you always or mostly practice psychiatric/mental health nursing?**

- ☐ North
- ☐ North East
- ☐ North West
- ☐ East
- ☐ West
- ☐ South
- ☐ South East
- ☐ South West

**3. In what type of setting do you always or mostly practice psychiatric/mental health nursing?**

- ☐ Inpatient
- ☐ Outpatient
- ☐ Community
- ☐ Other (please specify)

**4. How often on average have you interacted with a MHS client or clients considered by the inter-disciplinary treating team to be at serious risk of suicide?**

**Note: If you have engaged with the same client on multiple occasions please include every interaction in your estimation; Please rate your answer according to full-time equivalent workload**

- ☐ Never
- ☐ 1 - 5 times per year
- ☐ 6 - 10 times per year
- ☐ 11 - 15 times per year
- ☐ 16 - 20 times per year
- ☐ 21 - 25 times per year
- ☐ 26 - 35 times per year
- ☐ 36 - 51 times per year
- ☐ 52 or more times per year

**5. How often on average have you interacted with a MHS client or clients who YOU consider to be at serious risk of suicide?**

**Note: If you have engaged with the same client on multiple occasions please include every interaction in your estimation; Please rate your answer according to full-time equivalent workload**

- ☐ Never (go straight to question 16)
- ☐ 1 - 5 times per year
- ☐ 6 - 10 times per year
- ☐ 11 - 15 times per year
- ☐ 16 - 20 times per year
- ☐ 21 - 25 times per year
- ☐ 26 - 35 times per year
- ☐ 36 - 51 times per year
- ☐ 52 or more times per year

**6. How often have you interacted with a MHS client or clients considered to be at serious risk of suicide specifically ABOUT THEIR ISSUE OF SUICIDE?**

**Note: If you have engaged with the same client on multiple occasions please include every interaction in your estimation; Please rate your answer according to full-time equivalent workload**

- ☐ Never
- ☐ 1 - 5 times per year
- ☐ 6 - 10 times per year
- ☐ 11 - 15 times per year
- ☐ 16 - 20 times per year
- ☐ 21 - 25 times per year
- ☐ 26 - 35 times per year
- ☐ 36 - 51 times per year
- ☐ 52 or more times per year

**7. Which of the following treatment approaches best describes your interaction(s) with a MHS client or clients at serious risk of suicide?**

- ☐ Primarily observation/risk management and/or medication management
- ☐ Primarily rapport/alliance building and/or therapeutic discussion
- ☐ Observation/risk management/medication AND rapport/alliance building and/or therapeutic discussion
- ☐ Other (please specify)

**8. Which of the following treatment approaches best describes how you would IDEALLY interact with a MHS client or clients at serious risk of suicide?**

- ☐ Primarily observation/risk management and/or medication management
- ☐ Primarily rapport/alliance building and/or therapeutic discussion
- ☐ Observation/risk management/medication with rapport/alliance building and/or therapeutic discussion
- ☐ Other (please specify)

**9. What was the most common outcome for the client(s) specifically in relation to your interaction(s) with them?**

- ☐ Became less suicidal
- ☐ Became more suicidal
- ☐ Mental state improved
- ☐ Mental state declined
- ☐ No change noted
- ☐ Other (please specify)

**10. When you interact with a client at risk of suicide do you feel able to meet their needs?**

- ☐ Always
- ☐ Very often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

**11. Overall how satisfied were you with the outcome of your specific interaction(s) with the client(s) at serious risk of suicide?**

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Undecided
- ☐ Unsatisfied
- ☐ Very unsatisfied

**12. How satisfied do you believe the client(s) at serious risk of suicide was/were with the outcome of your specific interaction(s) with them?**

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Undecided
- ☐ Unsatisfied
- ☐ Very unsatisfied

**13. In relation to your role what, if anything, do you believe may enable better outcomes for clients at serious risk of suicide?**

- ☐ Nothing
- ☐ Decreased nursing client load
- ☐ Enhanced professional supervision/reflective practice
- ☐ Additional specific suicide prevention and treatment education/training
- ☐ Additional psychiatric/mental health education/training
- ☐ Other (please specify)

**14. How is your own mental health typically affected when you interact with clients at serious risk of suicide?**

- ☐ Very positively
- ☐ Positively
- ☐ Little or no change
- ☐ Negatively
- ☐ Very negatively
- ☐ Other (please specify)

**15. Do you receive adequate support to stay mentally healthy yourself when you are required to nurse clients at serious risk of suicide?**

- ☐ Always
- ☐ Very Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

**16. Please briefly outline one or more changes that you believe may enhance the interaction experience for yourself in relation to your professional interaction(s) with MHS clients at serious risk of suicide**

**17. Please briefly outline one or more changes that you believe may enhance the interaction experience and outcomes for MHS clients at serious risk of suicide**

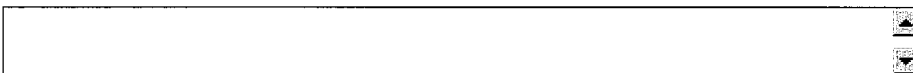


**18. Do you receive adequate support to enhance your ability to care for suicidal people?**

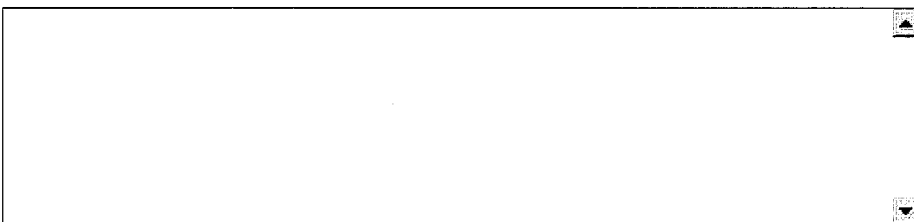
- ☐ Always
- ☐ Very often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

**19. What educational qualifications relevant to psychiatric/mental health nursing do you have?**

- ☐ Certificate of Nursing
- ☐ Certificate of Nursing (psychiatric/mental health)
- ☐ Bachelor of Nursing Degree
- ☐ Bachelor of Nursing Honours Degree
- ☐ Graduate Diploma of Nursing (psychiatric/mental health)
- ☐ Masters Degree (psychiatric/mental health)
- ☐ Other - e.g. Masters or Graduate Diploma in another field you feel is relevant, PhD, or any other formal qualification that you feel is relevant (please specify)



**20. Please feel free to make any other comment regarding the issue of MHS Registered Nurse interaction(s) with a client or clients at serious risk of suicide**





## **Appendix 2**

### **NURSE PARTICIPANT INFORMATION SHEET**

**Dear colleague,**

My name is David Lees and I am a Registered Nurse (Authorised Psychiatric Nurse) employed with Mental Health Services (MHS). I am currently undertaking a PhD at the University of Tasmania and this letter is to give you information about my research and to invite you to be a participant. You may choose to participate by completing and returning the survey included with this letter and/or you may choose to contact me with a view to being interviewed.

The research is about the role that mental health nurses have in enhancing client outcomes and reducing client suicidality when they engage professionally with clients in suicidal crisis.

#### **Research Title**

A retrospective exploration of engagement between clients experiencing suicidal crisis and Registered Nurses

My candidature is through the UTAS School of Nursing & Midwifery and my supervisors are:

- Professor Denise Fassett - Head of UTAS School of Nursing & Midwifery; and
- Adjunct Professor Nicholas Procter - University of Tasmania and Associate Professor – University of South Australia. Professor Procter has an extensive background in mental health nursing and research, and was a consultant to the Australia's National Suicide Prevention Strategy (LIFE, 2007).

#### **Research Approval & Support**

This research has been approved by:

- UTAS Graduate Research Unit; and
- Tasmanian Health & Medical Human Research Ethics Committee.

This research has the support of:

- MHS Tasmania Statewide Directors; and
- Dr Michael Dudley, Chair Suicide Prevention Australia.

### **Context of the research**

Suicidal behaviour results in significant human and financial burdens, and in 2006 Tasmania's suicide rate was reported to be the highest in the nation. Mental health care is recognised to be an integral component of suicide prevention. I am exploring the interaction between nurses and clients in MHS because nurses have a high level of contact with clients relative to other disciplines, and because the therapeutic engagement that is proposed to underpin psychiatric/mental health nursing is widely regarded to be of relevance in suicide prevention.

Data will be analysed in relation to current national and international knowledge about the issue as well as in relation to Australia's latest National Suicide Prevention Strategy (LIFE, 2007).

More specifically, this research aims to contribute to suicide prevention by:

- Informing suicide prevention reform agendas;
- Informing mental health nursing education and workforce development;
- Providing understanding regarding the needs and experiences of suicidal mental health clients to mental health care professionals, clients and consumers, as well as to the broader community, and by;
- Providing relevant stories of resolution of suicidal crisis.

The research data will be gathered via:

- A survey of MHS nurses;
- Individual in-depth interviews with MHS nurses; and
- Individual in-depth Interviews with MHS clients.

I am hoping that you will participate in both the survey and the interview. A high return rate for the survey is of particular importance to this research.

### **To participate in this research**

- Please complete the attached survey.
- Return the survey using the reply paid envelope.
- If you wish to participate in the interview, or would like more information about this research, please contact me using the supplied contact details.
- The survey takes approximately 10 minutes to complete.
- Interviews will take approximately 1 hour.

### **Please be aware of the following**

- MHS agreed to distribute this invitation and survey on my behalf to all MHS Registered Nurses.

- Your participation is completely voluntary and confidential, and is in no way linked to professional performance management.
- In certain circumstances a mental health tribunal or coronial inquiry may be able to request interview transcripts that arise from this research.
- Completion and return of the survey indicates your consent for me to use your survey data. Any possible identifying information will be omitted, but because the surveys are anonymous withdrawal of data will not be possible.
- You may choose to participate in the survey and/or the interview. Survey participation is particularly encouraged as a high return rate is essential for generating information useful to this project's aims.
- To participate in the interview it is necessary for you to have engaged with at least one MHS client who has been in suicidal crisis, and for this to have occurred since 2000.
- Interview data will be de-identified and participant confidentiality and wellbeing will be prioritised at all times.
- Nurse interview participation will be limited to 15 people.

**I know your time is valuable and I appreciate you reading this. I hope that you can take the time to complete the attached survey and return it using the reply paid envelope, and also to think about contacting me regarding being interviewed.**

**Your views are of immense value and are central to the success of this research. I hope that together we can contribute to suicide prevention.**

#### **Further information and/or to participate in the interview**

For further information about this research and/or to nominate for participation in the interview please contact me using any of the following contact details:

David Lees  
 School of Nursing and Midwifery  
 Launceston Campus, Locked Bag 1322  
 Launceston, Tasmania 7250  
 Tel: 03 6324 3318  
 Mobile: 0408133278  
 Fax: 03 6324 3952  
 Email: leesd@utas.edu.au

I will also be conducting information sessions at the following locations with my supervisor Professor Procter:

- .....

- .....
- .....
- .....

If you have concerns or complaints about the conduct of this research you should contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. You will need to quote Ref No: H001075.

**This information sheet is for you to keep.**

Thanks for your time,

David Lees RN (Authorised Psychiatric Nurse), PhD candidate

## **Appendix 3**

### **NURSE INTERVIEW PARTICIPANT CONSENT FORM**

**Title of Project:**

**An exploration of therapeutic engagement between Registered Nurses and clients who at the time of engagement were experiencing a suicidal crisis**

1. I acknowledge that the nature, purpose and contemplated effects of the project so far as it affects me, have been fully explained to my satisfaction by the research team and my consent is given voluntarily.
2. The details of the proposed interview process have also been explained to me, including the anticipated length of time it will take, and an indication of any discomfort, which may be expected. I understand that my involvement means:
  - I agree that the researcher will respond to any significant health and wellbeing and/or safety issues that may arise, or if I request that they do so, by providing me with help-seeking information and/or referral.
3. I understand that there are the following risks or possible discomfort:
  - Possible psychological distress as a result of recalling experiences of engaging with clients in suicidal crisis.
4. Although I understand that the purpose of this research project is to improve the quality of mental health care, it has also been explained that my involvement may not be of any immediate benefit to me.
5. I have been given the opportunity to have a member of my family or friend present while the project was explained to me.
6. I am informed that no information regarding me will be published so as to reveal my identity.
7. I understand that my involvement in the project will not affect my relationship with Mental Health Services (MHS) or the University of Tasmania (UTAS). I also understand that I am free to withdraw from the project at any stage and withdraw my interview any time prior to

publication. My withdrawal will not affect my legal rights, or my relationship with MHS or UTAS.

8. I understand that I will be given a signed copy of this consent form. I am not giving up my legal rights by signing this consent form.

9. I understand that the research will be conducted in accordance with the latest versions of the *National Statement on Ethical Conduct in Human Research 2007* and applicable privacy laws.

10. I would like another person to be informed about my participation in this project yes / no

Name of other person: \_\_\_\_\_

Name of participant \_\_\_\_\_

Signature of participant \_\_\_\_\_ Date \_\_\_\_\_

The following section regarding the witness is not essential but you may choose to discuss your participation with another person and record them as a witness.

Name of witness (if appropriate) \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

10. I have explained this project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

Name of researcher \_\_\_\_\_

Signature of researcher \_\_\_\_\_ Date \_\_\_\_\_

## **Appendix 4**

### **Interview Guide and Questions for MHS nurses**

#### **Introduction**

My project is about understanding from your perspective the nature and scope of encounters you have had with clients who were considered to be in suicidal crisis. To help me understand your perspective I wonder if you could think back to clients in suicidal crisis who you have been with, who you have talked with, and just talk me through what sorts of things happened. Through this process I hope it will be possible for me to understand from your perspective what you say, think and do when interacting with a suicidal client.

#### **Questions to guide the interview**

In formulating your answer think back to a client/ clients you have interacted with.

- How did you know that suicide was a significant issue for your client?
- When you interacted with the client, how did the issue of suicide come to be acknowledged?
- What form did their suicidal expression take (for example - was the client recovering from a suicide attempt, had they been exhibiting suicidal behaviour and/or thoughts, were they considering suicide – how was suicide an issue for them)?
- Did the client agree that suicide was an issue for them or was it an opinion of others? If so who?

I am also interested in the approach and context of your interactions...talk me through your approach

- What happened and why?
- How did the interaction begin?
- Did you take a particular model or therapeutic approach to the interaction?
- What was the quality and nature of the interaction and how was it maintained?
- Have you felt pressures (work/ social/ professional) or necessitating factors to do other than engage with the client?
- What are you trying to do when you engage? Inspire hope? If so how?
- For example, do you try to have the client recall memories of successful problem-solving?
- How would you rate the appropriateness and effectiveness of those approaches?
- Do you think that engagement/alliance and observation/defensive/custodial approaches are mutually exclusive or can they be complementary?
- What were you attempting to do when you engaged with the client?
- How did the interaction finish?
- What was the outcome?
- Where you satisfied with the outcome (and the effect of your engagement)?

- How do you think the client was affected by the engagement with you?
- How were you affected by the engagement with that client?
- What do you think are the main needs of a client when they are or have been suicidal?
- Reflecting back on the situations, if you could have been supported in the workplace in any way, what form would that take?
- What role do you think that engagement with people other than yourself played in that person's experience in relation to suicide and what else do you think was significant in their experience and in their recovery?

Prompting may include asking nurses how often (if at all) they provided care mostly made up of the following approaches, or of a specific mix of such approaches:

- Building good rapport and engaging with the person to build hope and raise insight about reasons for their behaviour and options for the future;
- Assessing and advocate for the most effective and appropriate use of medication;
- Developing and implement a 'no-harm' contract with the person;
- Carefully and consistently observing the person and ensuring their physical safety;
- Or some other intervention(s)?



## **Appendix 5**

### **PSYCHIATRIST/ CASE MANAGER INFORMATION SHEET**

#### **An exploration of engagement between mental health nurses and clients who at the time of engagement were experiencing a suicidal crisis**

Dear Colleague,

I am writing to brief you on a PhD research project that aims to examine therapeutic engagement during suicidal crisis from the perspectives of Mental Health Services (MHS) nurses and clients. I am also seeking your assistance where possible to identify potential client-participants for the research.

#### **Principal Researcher**

David Lees - Registered Psychiatric Nurse and PhD candidate at the University of Tasmania (UTAS) School of Nursing & Midwifery

#### **Supervisors**

- Professor Denise Fassett - Head of UTAS School of Nursing & Midwifery,
- Adjunct Professor Nicholas Procter - University of Tasmania and Associate Professor, University of South Australia

#### **Participant support person**

- Christine Handley – Senior UTAS lecturer and senior mental health nurse therapist

The research involves interviewing current MHS clients who have previously interacted with Registered Nurses when they were in suicidal crisis (now resolved).

The main focus of the proposed study is to seek understanding of what was said/ done by the nurses at the very moment of contact/ interaction with the client(s), with the view to finding out as much detail on what was helpful to the client and why.

At the same time we will be interviewing registered nurses about their experiences of engagement with mental health clients at a time of suicidal crisis, asking them specific detail on what they think is useful/ what has helped them in the past. From there the PhD will set about analysing data and move to making specific recommendations for education and training of nurses and other health care workers. Data will be generated from both clients and nurses using interviews (clients) and interviews and questionnaires (nurses).

Data arising from the project will be analysed in the context of the Commonwealth Department of Health and Ageing latest National Suicide Prevention Strategy (LIFE, 2007). Specifically, it will seek to pinpoint what steps can be taken by nurses toward enhancing meaningful engagement (care) they have with people who are experiencing a suicidal crisis. More broadly the study hopes to:

- Inform suicide prevention reform agendas in Tasmania;
- Inform mental health nurse education and workforce development in Tasmania and nationally;
- Inform an understanding of the needs of mental health clients in the resolution of suicidal crisis;
- Provide information on successful resolution of suicidal crisis.

The project therefore has strong humanitarian and educational intent and orientation. We think there is much to be gained in in-depth knowing of the interaction between clients and nurses at the very point of need. We are therefore taking very special care in supporting people who volunteer for interview. There is a sensitive and rigorous recruitment and management plan in place to ensure support (if required) of all consumer participants who take part. Consumers will have support from an experienced senior mental health nurse (Christine Handley) employed in a conjoint position between UTAS and DHHS. We hope to generate interest from psychiatrist and case managers and support from them in their current role pre- and post-interview as may be required. Nurses who agree to participate will also have supports available to them through MHS.

### **Recruitment process**

If you believe that you may have a client or client(s) who meet the inclusion criteria below then you may pass on to them the client information sheet and consent form included with this letter. The information sheet will direct the client to contact the researcher directly. If the client is accepted for the study you will be notified and your authorization to proceed with the interview will

be sought within 48 hours prior to the interview taking place. In the unlikely event that the client is significantly adversely affected by the interview experience you will be contacted by the research team to provide appropriate intervention.

### **Inclusion Criteria**

Mental Health Services psychiatrists and case-managers are asked to anonymously invite participation in this project from any of their current clients who meet the following criteria:

- They received MHS care that included nurse-client engagement;
- They were in suicidal crisis during this engagement;
- The engagement during suicidal crisis was since 2000 and they were 18 or over at the time;
- They have clearly resolved being at risk of suicide and are presently not at any foreseeable risk of experiencing a suicidal, mental health, situational or any other type of crisis;
- They are not likely to be distressed or adversely affected by participating in an interview that will explore their experience of engagement with a nurse or nurses when they were in suicidal crisis;
- They wish to be interviewed in relation to their past experience of engagement with a MHS nurse or nurses during their now resolved suicidal crisis;
- They are able to provide informed and voluntary consent;
- They agree to consent to the participation in the interview of the principal researcher and participant support person, who will support the client-participant in the interview and ensure the health and wellbeing of the client-participant;
- They agree to consent to the principal researcher and/or participant support person taking appropriate action to protect the health and wellbeing of any person that may be identified as being at risk during the interview;

### **Questions about this research**

We have taken considerable care to ensure this research has both strong scientific merit and is conducted in a professional manner. If you would like to discuss any aspect of this study please feel free to contact me (principal researcher - David Lees) by phoning 0408133278, or my PhD supervisors Professor Denise Fassett (telephone 6324 3324) or Adjunct Professor Nicholas Procter (telephone 0417 080 630). We are only too happy to discuss any aspect of the research with you.

**If you wish to invite participation from one or more of your current MHS clients who you believe to be suitable please forward to them the CLIENT INTERVIEW PARTICIPANT INFORMATION SHEET and the CLIENT INTERVIEW PARTICIPANT CONSENT FORM provided.**

This study has been approved by the Tasmanian Health & Medical Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study should contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. You will need to quote [*HREC project number*].

**Thank you for taking the time to consider this research project. Your assistance is very much appreciated.**

**Yours sincerely,**

**David Lees**

**PhD Candidate / Principal Researcher**

## **Appendix 6**

### **CLIENT INTERVIEW PARTICIPANT CONSENT FORM**

#### **An exploration of therapeutic engagement between Registered Nurses and clients who at the time of engagement were experiencing a suicidal crisis**

3. I acknowledge that the nature, purpose and contemplated effects of the project so far as it affects me, have been fully explained to my satisfaction by the researcher and my consent is given voluntarily.
4. The details of the proposed interview process have also been explained to me, including the anticipated length of time it will take, and an indication of any discomfort, which may be expected. I understand that my involvement means:
  - I agree to the participation of the participant support person (Christine Handley) before, after and, if I request during also, the interview between myself and the researcher (David Lees);
  - I agree that the participant support person will provide briefing and/or supportive counselling, and/or help-seeking information before, during, and after the interview as is required or as I request;
  - I agree that the researcher and/or participant support person may contact my psychiatrist/case manager to inform them on my behalf of any significant health and wellbeing and/or safety issues that may arise or if I request that they do so, and that the researcher will communicate to me that my psychiatrist/case manager has been contacted;
3. I understand that there are the following risks or possible discomfort:
  - Possible psychological distress as a result of recalling experiences of a previous suicidal crisis.
11. Although I understand that the purpose of this research project is to contribute to suicide prevention, to improve the quality of mental health care, and mental health nurse education, it has also been explained that my involvement may not be of any immediate benefit to me.

12. I have been given the opportunity to have a member of my family or friend present while the project was explained to me.
13. I am informed that no information regarding me will be divulged and that all information given will be de-identified or excluded from the study if de-identification is not possible.
14. I understand that my involvement in the project will not affect my relationship with the University of Tasmania (UTAS), or with any Mental health Services (MHS) service or employee. I also understand that I am free to withdraw from the project at any stage and withdraw my interview data prior to publication. My withdrawal will not affect my legal rights, my mental health care or my relationship with MHS or UTAS.
15. I understand that the information that I provide will be securely stored in a de-identified form at UTAS for a period of 5 years before it is destroyed.
16. I understand that I will be given a signed copy of this patient information sheet and consent form, and that I am not giving up my legal rights by signing this consent form.
17. I understand that the research will be conducted in accordance with the latest versions of the *National Statement on Ethical Conduct in Human Research 2007* and applicable privacy laws.
18. I would like my GP or another person to be informed about my participation in this trial – Yes / No

Name of GP / other person

\_\_\_\_\_

Name of participant

\_\_\_\_\_

Signature of participant

\_\_\_\_\_ Date \_\_\_\_\_

Name of witness (if participant wishes to discuss this project with a support person) \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_

10. I have explained this project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

Name of researcher \_\_\_\_\_

Signature of researcher \_\_\_\_\_ Date \_\_\_\_\_

## **Appendix 7**

### **CLIENT INTERVIEW PARTICIPANT INFORMATION SHEET**

**An exploration of therapeutic engagement between Registered Nurses and clients who at the time of engagement were experiencing a suicidal crisis**

**Dear .....,**

My name is David Lees and I am undertaking the following project for my PhD at the University of Tasmania (UTAS).

The project aims to better understand, from the perspective of both clients and nurses, what happens when nurses engage professionally with clients in suicidal crisis.

The data generated during the project will be analysed in relation to current national and international knowledge about suicide prevention and support. The study aims to contribute to suicide prevention by:

- Informing suicide prevention reform agendas on the nature and significance of professional contact with mental health clients who may be experiencing a suicidal crisis;
- Informing mental health nursing education and workforce development in the areas of mental health promotion and suicide prevention;
- Providing understanding regarding the psychosocial needs and experiences of suicidal mental health clients to mental health care professionals, clients and consumers, as well as to the broader community, and by;
- Providing relevant stories of resolution of suicidal crisis.

#### **Principal Researcher**

David Lees - Registered Psychiatric Nurse and PhD candidate at the University of Tasmania (UTAS) School of Nursing & Midwifery

#### **Supervisors**

- Professor Denise Fassett - Head of UTAS School of Nursing & Midwifery,
- Adjunct Professor Nicholas Procter - University of Tasmania and Associate Professor, University of South Australia



### **Participant support person**

- Christine Handley – Senior UTAS lecturer and senior mental health nurse therapist.

### **1. 'What is the purpose of this project?'**

The purpose of this project is to examine and explore what happens when mental health nurses and clients in suicidal crisis engage professionally. The project aims to contribute to enhancing the engagement (care) experience by using the research findings to inform current practice, educational and mental health service reform activities.

### **2. 'Why have I been invited to participate in this project?'**

Mental Health Services psychiatrists and case-managers have been asked to anonymously invite participation in this project from any of their current clients who:

- Have received MHS care that included nurse-client engagement;
- Were in suicidal crisis during this engagement;
- Were 18 or over at the time and engaged since the year 2000;
- Have clearly resolved being at risk of suicide and are presently not at any foreseeable risk of experiencing a suicidal, mental health, situational or any other type of crisis;
- Are not likely to be distressed or adversely affected by participating in an interview that will explore their experience of engagement with a nurse or nurses when they were in suicidal crisis;
- Wish to be interviewed in relation to their past experience of engagement with a MHS nurse or nurses during their now resolved suicidal crisis;
- Who can provide voluntary and informed consent;
- Who agree to consent to the participation in the interview of the researcher and the participant support person who will support the client in the interview and ensure the health and wellbeing of the client;
- And who agree to consent to the researcher and/or participant support person taking appropriate action to protect the health and wellbeing of any person that may be identified as being at risk during the interview;

You have been sent this invitation because your psychiatrist and/or case manager believes that you may meet these criteria.

### **3. 'What does this project involve?'**

This project involves you being interviewed about your experience(s) of engagement with a MHS nurse or nurses when you were in suicidal crisis.

Nurses will also be interviewed and surveyed as part of this project, however they will not be asked about you or your experience and they will have no knowledge of your participation in the project.

The interview will be conducted in either a private, comfortable setting at the University of Tasmania (UTAS) or at a Mental Health Services location, or alternatively at your house if this is your preferred option. The most suitable location is one that provides optimum confidentiality, convenience, safety, and conduciveness to recalling the experience in a non-distressing and supportive way. You can discuss your preference for location with me before the interview is scheduled. On the day of the interview you will be welcomed by the participant support person (Christine Handley) and myself and briefed about the interview process.

The research team acknowledges that suicide is a sensitive issue, and your health and wellbeing is of the highest priority to us. As such you will be supported throughout the interview to share your perceptions and you will be required to provide prior consent for us to take appropriate actions with your full knowledge if any risk arises concerning your or anybody else's health and wellbeing. This means that in the unlikely event that you are adversely affected by the interview and require support we may contact your psychiatrist or case-manager and/or another supportive person that you can nominate. You will be fully informed if this is thought to be necessary.

The interview will be audio-taped and later transcribed into a word document. The research team will not judge you or your perception of events, however to gain clarity and to generate useful data the interview will be structured and guided in such a way as to gain the most useful information from you. To ensure confidentiality I may also direct you at times to express yourself without using specific names. If any names or other identifying information is recorded then this information will be erased before the interview is transcribed. The transcription will then be checked again and any further information that could possibly identify you or anybody else will be removed before the transcript is analysed.

This project will also involve the surveying and interviewing of MHS nurses. These nurses will have no intended relation to your current or previous care or engagement experiences and your identity will be protected from them and every other person other than your MHS psychiatrist and/or case-manager.

It is important that you understand that your involvement in this study is voluntary. While I would be pleased to have you participate, I respect your right to decline. There will be no consequences to you if you decide not to

participate, and this will not affect your current or future treatment / service. If you decide to discontinue participation at any time, you may do so without providing an explanation. All information will be treated in a confidential manner, and your name will not be used in any publication arising out of the research. All of the research will be kept in a locked cabinet in the office of The University of Tasmania School of Nursing & Midwifery.

#### **4. 'Are there any possible benefits from participation in this project?'**

You may derive some satisfaction from participating in this project with the knowledge that ultimately your unique and valuable insights into the issue will contribute to knowledge that in the future may improve how nurses engage with and help people in suicidal crisis.

Also, some people find that telling their 'story' in a supportive setting can sometimes be a beneficial process. The interview is not intended as therapy, however, so these are matters for you to consider. In making your decision as to whether to participate you may wish to talk with significant and supportive people in your life including your psychiatrist and/or case-manager. You may also wish to contact me using the information on the front page of this letter to gather more information before you make your decision.

#### **5. 'Are there any possible risks from participation in this project?'**

There are no specific risks anticipated with participation in this project. However, if you find that you are becoming distressed or adversely affected in any way during or after the interview you will be supported by the participant support person and myself. This may include brief supportive counseling, pausing, postponing or cancelling the interview, or withdrawing your interview data completely from the project any time before publication.

If you, the participant support person or myself believe that the interview is adversely affecting you in any way appropriate action will be taken. In the unlikely event that your or anyone else's health and wellbeing are at risk Ms Handley or myself will contact your psychiatrist and/or case manager.

#### **6. 'What if I have questions about this project?'**

If you would like to discuss any aspect of this project please feel free to contact me (David Lees) by phoning 0408133278 or my PhD supervisors Professor Denise Fassett 6324 3324 or Adjunct Professor Nicholas Procter (08) 8302 2148. My supervisors and I are only too happy to discuss any aspect of the research with you.

You may also wish to discuss your participation in this project with your psychiatrist and/or case-manager, and/or also with other supportive people who can help you make the best decision about whether or not to participate.

Once we have completed the project it will be submitted for marking and when it is published you will be contacted and a copy of the research thesis will be made available to you upon request.

If you wish to participate in this project then please complete and return the attached consent form.

This project has been approved by the Tasmanian Health & Medical Human Research Ethics Committee. If you have concerns or complaints about the conduct of this project you should contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. You will need to quote [*HREC project number*].

**This information sheet is for you to keep.**

**Thank you for taking the time to consider this study.**

**If you wish to take part in it, please sign and return the attached consent form.**

Yours sincerely,

David Lees  
PhD Candidate  
School of Nursing and Midwifery

## **Appendix 8**

### **Interview Guide and Questions for Client Interviewees**

#### **Introduction**

Thank you very much for taking the time to speak with me. As described in the information sheet, your experiences are important to me and this research project. An important part of the time we spend together is for me to learn from your experience. This means showing you respect. I am not here to judge you or anyone else for their actions or thoughts. So, on that basis I really just want to understand your experience of when you were in contact with nursing staff when suicide was an issue for you.

Remember, if you want to stop the interview at any time just say so – the last thing I want is for you to become distressed by the interview. Your health and wellbeing are important to me

#### **Questions to guide the interview**

So on that basis what can you tell me about your experience when you engaged with nursing staff when you were suicidal?

- How did your interaction with the nurse begin?
- What happened during your interaction with the nurse? (Some prompts include; closeness of the nurse to understanding issues and concerns, and exploring to what degree was the experience a therapeutic alliance or a more defensive/custodial experience or a combination of both, or does the person perceive and/or describe a different kind of experience).
- How did you feel?
- Were you able to speak freely with the nurse?
- Did you feel you could trust the nurse?
- Did you believe that the nurse could help you?
- Did your interaction with the nurse help you? If so, how? (Some prompts include; problem solving, remembering and reinventing successes from the past, examining goals, ideals, rules, and/or automatic thoughts, developing a plan for the future that created hope/belief, providing physical safety, referral, medication)
- What do you think that the nurse was trying to do when they interacted with you?
- Can you suggest anything that may have made the interaction better?

If the interview allows, the following questions may be utilised:

- Are you aware of suicide prevention activities – do they have any impact on you?
- What are the contributing factors that you're aware of in relation to suicide – warning signs, tipping points, risk factors?
- How do you perceive does suicidal behaviour impact on others?
- What has your experience been in accessing help/services?
- What support systems were significant when you were suicidal?