Suicide and Self-Harm

Note

Health and social care practice and knowledge are constantly changing and developing as new research and treatments, changes in procedures, drugs and equipment become available.

The authors, editor and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

Suicide and Self-Harm: an evidence-informed approach

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Chapter 10

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This book is dedicated to
Dr Maryla Cutcliffe, João Santos and Rita Santos

These individuals add meaning to our lives

CHAPTER 1

Introduction

> Suicide is functional because it abolishes painful tension…[it is a form of] intolerable suffering. (Murray, 1981, p. 216)

> Given intense and irremediable sufferings, there is nothing irrational about the act of suicide. It is irrational only to those who stand outside of it. (Murray, 1981, p. 491)

Introduction

For many people, suicide is bewildering. Why would a person – any person – wish to deliberately bring their existence to a premature end? How would a healthcare practitioner understand such a choice, let alone know how to bring about a change of view in the suicidal person? And even if I, as a healthcare practitioner, wanted to help the suicidal person, what evidence is there available to me to inform my practice? These are the principal questions and issues that we shall concern ourselves with in this book.

Take a moment to look back over human history and, regrettably, you will see suicide. You will see it occurring for people from all walks of life; people of every ethnicity, gender, race, socio-economic status or political persuasion. Suicide, it seems, is closely inter-twined with the human experience. However, despite its ubiquity, an honest appraisal of our understanding of why any particular individual takes his or her own life is that this comprehension is far from complete; it may only be just beginning. Or, more precisely, it is difficult to reconcile that we have a comprehensive understanding of suicide, and that this has led to global reductions in the rate of suicide, with the reality that, since 1950, the global trend in suicide rates has risen!

What most practitioners appear to be particularly lacking is evidence-informed literature that guides the practice of nurses (and others) in terms of day-to-day, hour-by-hour, minute-by-minute care of suicidal people. As a result, this book specifically focuses on theory and practice to help inform and guide the clinical interactions of healthcare professionals wherever they encounter suicidal

people. It hopes in some small way to provide comprehensive and contemporary literature that will act as a 'balm', helping practitioners to recognise and deal with the powerful emotional responses to suicide, ranging from anger, to fear, to bewilderment and to confusion.

Nursing-sensitive outcomes and suicide

Rightly or wrongly, the relationship between healthcare and evidence-informed or evidence-based practice is a reality that we all have to deal with. The epoch of evidence-informed practice is upon us and it has profound implications for the way(s) in which we carry out our business of caring for/with people. One such implication is the perpetual contentious need for, and associated efforts of, healthcare organisations to balance cost-effectiveness and quality of care, given the increased attention being given to identifying, measuring and reporting on outcomes for clients, healthcare professionals and employers. At the same time, within healthcare settings, there is a growing emphasis on evidence-based decision-making regarding staff mix and care delivery models, which has prompted considerable research on identifying outcome indicators sensitive to nursing interventions and staffing levels.

The discipline of nursing only started to have more robust scientific evidence to demonstrate the difference that it makes in healthcare since the 1990s, when studies were undertaken to bridge the gap in knowledge and identify nursing-sensitive outcomes (Doran, 2011). Despite the fact that nurses are the single largest discipline involved in healthcare[1] (Benner *et al*, 2009), but nursing is often absent from health policy decision and descriptions of healthcare. While some literature is available regarding nursing sensitive outcomes in acute (medical/surgical) care (Yang *et al*, 1999; Doran *et al*, 2006; Tourangeau *et al*, 2006; Blegen *et al*, 2011), and to a lesser extent in long-term care (Head *et al*, 2004; Castle, 2008), it is extremely limited in the area of psychiatric/mental health (P/MH) nursing. In some small way, this book attempts to contribute to rectifying this limitation by providing an evidence-informed approach (not least by considering nurse-sensitive outcomes) to caring for and working with suicidal people.

Identifying nursing-sensitive patient outcomes

What do we mean when we are referring to nursing-sensitive outcomes? When patient outcomes tend to focus on how people and their health problems are

1 In terms of numbers of clinicians; furthermore, the same 'picture' is evident when one examines international and global data on this issue.

affected by nursing interventions, then these (it can be argued) are references to nursing-sensitive patient outcomes. Maas *et al* (1996, p. 295) define nursing-sensitive patient outcomes as

> ...measurable changes in a patient's state of health or condition as a result of nursing interventions and for which nurses are responsible.

Nursing-sensitive patient outcomes are within the scope of nursing practice. They are coherent with the processes of nursing care and can be evidenced by an empirical link between nursing interventions and the patient condition (Given *et al*, 2004).

The need to move towards an international consensus on a set of measures to best capture the quality of hospital-based P/MH nursing care have been acknowledged in the extant literature and there are two predominant perspectives on the investigation of nursing-sensitive patient outcomes. The first involves the investigation of outcomes according to a process model of care, whereby

> outcomes are affected not only by the care provided but also by the factors related to the patient, to the interpersonal aspects of care and to the setting or environment in which care is provided. (Irvine et al, 1998, p. 58)

The second perspective encompasses P/MH nursing-sensitive patient safety outcomes which include the unintended effects of inadequate P/MH nursing care, such as medication errors, patient falls, nosocomial infections, violence, absconsion, and relapse (McGillis-Hall, 2004). Nursing's independent role concerns the functions and responsibilities for which only nurses are held accountable – activities initiated by nurses which do not require a physician's order (Irvine *et al*, 1998). They are interventions developed and initiated by nurses in response to a so-called nursing diagnosis, or also autonomous actions based on scientific rationale performed by the nurses to benefit the patient, ie. to obtain a nursing-sensitive outcome (McCloskey and Bulechek, 2000).

As a result, we present a great deal of material in this book that can be characterised as aspects of the nurse's independent role, function and/or responsibility, in addition to other material where there is perhaps, for want of a better expression, a shared or collaborative responsibility, function or role with other (mental) healthcare professionals.

Structure of the book

Many countries now have national prevention or action plans to attempt to combat and subsequently reduce suicide rates. For many nations, lowering rates of suicide

(and more specifically in certain groups or populations who hitherto were not known for being high risk groups – eg. young men) has become a national health policy target. These policy positions, prevention programs and action plans (such as they are), quite rightly adopt a broad and wide-ranging approach to tackling suicide, recognising that effectively combating suicide requires a comprehensive approach; it needs a more comprehensive response than 'tinkering' with formal mental health services. Reducing suicide rates also appears to require consideration of social services, family dynamics/support, education and training for young men, access to means, conceptualisations of and how suicide is portrayed in the mass media, atypical primary prevention programs (such as using formerly suicidal people and suicide survivors as a resource), and addressing societal-based stigma to name but a few. As a result, Chapter 2 focuses on National Suicide Prevention Strategy documents and suicide prevention policies (where they exist). Areas or themes that share commonality are identified and consideration of what direction these provide to healthcare professionals are included. While national suicide prevention strategies and polices are often more capacious and capture more than clinical practice *per se*, we pay particular attention to how such policies, plans and strategies inform and might impact upon the day-to-day, hour-by-hour clinical practice of caring for (with) suicidal people.

Leading logically from the examination of policies, plans and strategies, Chapter 3 is dedicated to risk assessment of suicide and self-harm. While there seems to be little or no debate regarding the necessity of thorough and accurate assessment as a prerequisite for or antecedent of effective care of the suicidal person[2,3], it is perhaps counter-intuitive to realise that the evidence indicates that we (mental health practitioners) often fall some way short of best practice when it comes to assessing suicide and/or self-harm. In the first instance, comprehensive assessment of suicide risk is merely the beginning of the care of the suicidal person; such assessments have to lead to meaningful and effective interventions. Secondly, such formal and informal assessments are bedevilled by conflating suicide with self-harm. Thirdly, some practitioners report that they do not believe that standardised instruments scales are clinically helpful, that scales take too much time to use, and that they have not been trained in the use of such measures. Moreover, despite the existence of a substantial body of work in this area, our assessments (and associated instrumentation) remain far from perfect. Accordingly, this chapter reviews and draws attention to a wide range of instruments and considers so-called

2 Indeed, an argument could be made that assessment is a prerequisite

3 Similarly, locating this chapter where we have, early in this book, also seems logical and in keeping with current approaches to organising care.

'up-stream' and 'down-stream' risk factors. We situate the use of risk assessment instrumentation in the broader, more comprehensive 'picture' of assessment *per se* and, importantly, link the identification of high-risk clients with different levels (intensities) of intervention, engagement and care.

In Chapter 4 we focus on suicide in hospital settings and pay particular attention to if/how the physical environment and unit/ward milieu (or atmosphere) can be managed to reduce the chance of suicidal acts. Particular attention is paid to recommendations for the possible prevention of suicidal behaviours in hospital settings through the means or medium of 'managing the physical environment and ward milieu'. And we draw attention to how families and significant others might be 'mobilised' as a further healing resource for suicidal people. Although nurses have significant responsibilities in this domain and should be mindful of how these phenomena might be managed to enhance care, environmental safety is only one piece of the puzzle (Sullivan *et al*, 2005).

Defensive practices are concerned with the physical integrity of the person and do little or nothing to address the genesis (and/or exacerbation) of the person's suicidal thoughts or feelings (Cutcliffe and Stevenson, 2008). In Chapter 5 we identify the most common defensive practices – containment, seclusion, observations, removal of objects and no-suicide contracts – and examine each of these approaches/interventions, especially as despite their lack of supporting evidence (in many cases), these remain common practices that nurses engage in on the ward/unit as a means to (purportedly) prevent suicide. In this chapter we analyse the efficacy and legitimacy of these practices based on evidence-based data and discuss some implications of these practices from the point of view of users and nurses. Finally, we address alternatives to these practices, as we believe that the evidence indicates that it is necessary for us to move away from defensive strategies as a matter of urgency.

Rather than discussing the issue of prescription of medication by nurses *per se*, or exploring/arguing/identifying the most appropriate pharmacological treatment for the prevention of suicidal behaviours, Chapter 6 aims to explore the existing evidence-based practice related to pharmacological 'treatment' for suicidal people. At the outset, it should be taken into account that medication is only one measure among many others to 'treat' or help suicidal people, and it may or may not be a priority. However, in certain parts of the world, even despite the evidence pertaining to the questionable efficacy of pharmacological interventions for treating suicide (see van Praag, 2003), pharmacological 'treatment' or intervention is the mainstay of 'care' offered to suicidal people, in some places being the only 'care' that suicidal people receive. So while the chapter does indeed consider the wider evidentiary context of pharmacology, we do also review and explore some

of the more common pharmacological 'treatments' provided to suicidal people. In this way, this chapter is expected to contribute to a more profound discussion about pharmacological interventions for suicidal people among nurses (and other formal caregivers).

The centrality of, for want of a better expression 'talk therapy', in helping suicidal people, leads logically to the focus of Chapter 7. The chapter begins by reviewing common elements and aspects of psychotherapeutic attempts to help suicidal people. Given the existing evidence (such as it is) pertaining to the efficacy of cognitive therapy (or approaches) for suicidal people, we examine such approaches in some detail. Similarly, the chapter then focuses on dialectical behaviour therapy (DBT) as a means for working with certain groups of suicidal people. We draw the chapter to a close by reviewing the empirical evidence pertaining to these psychotherapeutic approaches.

As we have pointed out in previous chapters, even a cursory survey of mental health facilities in most parts of the (so-called) 'developed' world will show that the current standard *modus operandi* for the nursing care of suicidal people is to place the person 'under observation'[4]. This book also highlights how woefully inadequate such practices often are; how they do little or nothing to help alleviate the suicidal person's psychache and/or genesis of his/her suicidal ideation. Further evidence previously provided also shows how observations often fail in even their most basic function: keeping the person physically safe. Yet it would be remiss of the authors of this book to point out the serious and significant limitations of this current practice without, at the same time, offering an alternative. Accordingly, Chapter 8 focuses on such an alternative; one that has been termed the 'engagement/inspiring hope – reconnecting the person with humanity' approach (see for example Cutcliffe and Barker, 2002; Cutcliffe and Stevenson, 2007). The chapter begins by drawing the reader's attention to the literature, which has repeatedly shown how suicidal people feel a sense of disconnection. It then proceeds to underscore this experience with reference to the literature linking suicide with isolation/loneliness and then highlights the links between a sense of disconnection and Shneidman's psychache. Following this, we present the findings of a recent federally funded study that explored how P/MH nurses work with suicidal people (see Cutcliffe *et al*, 2006; Cutcliffe and Stevenson, 2007). A summary of the three-stage process is provided, explaining how P/MH nurses work day-by-day, hour-by-hour and minute-by-minute with suicidal people.

4 Or whatever vernacular term is used to connote keeping the suicidal person under some form of surveillance.

While Chapter 8 introduces the reader to and provides an overview of the 'engagement – reconnecting the person with humanity' approach to caring for suicidal people, Chapter 9 provides a more comprehensive and detailed account of this approach. It provides a detailed account of each of the three stages and illustrates the key psychosocial care practices and the process therein by drawing on participant quotes (from formerly suicidal clients) which were procured during the study.

While much of this book focuses on the assessment, care and management of suicidal people during their 'acute' period of increased risk of suicide, often (but not always) involving some form of hospitalisation, there is a compelling body of evidence which indicates that people whose mental health problems lead them to require psychiatric hospitalisation are at a significantly increased risk of suicide (Appleby *et al*, 1999; Pirkola *et al*, 2005; Troister *et al*, 2008). However, hospitalisation for people at risk of suicide is only 'part of the bigger picture'; the period of time immediately following discharge after such hospitalisations appears to be a particularly high risk time (see Goldacre *et al*, 1993; Geddes and Juszczak, 1995; Geddes *et al*, 1997; Lawrence *et al*, 2001; Ho, 2003; Yim *et al*, 2004; Troister *et al*, 2008). Accordingly, Chapter 10 highlights how a number of variables have been shown to be significantly related to suicide after recent discharge, such as previous suicide attempts (Fernando and Storm, 1984; King *et al*, 2001a,b; McKenzie and Wurr, 2001; Yim *et al*, 2004); presence of affective disorder/depressive symptoms (King *et al*, 1995); unplanned discharge (Ho, 2006); and experience of negative life events following discharge (Pokorny and Kaplan, 1976). Conflicting findings exist regarding the link between duration of hospitalisation and increased risk (Qin and Nordentoft, 2005; Ho, 2006). It also shows that while there is consensus within the limited literature concerning the existence of this increased period of risk, our understanding of the particular experience(s) that contribute to this risk is far from complete. Accordingly, Chapter 10 reports on findings from a federally funded, mixed-methods study which sought to better understand the observed increased risk for suicide following discharge from an inpatient psychiatric service. Ultimately, the theoretical understanding of this specific high-risk period will lead to the development of selective prevention strategies that will decrease the risk of suicide and suicidal behaviour (Knox *et al*, 2004).

It is both interesting and disturbing to note that only a limited literature exists regarding practitioners' reactions to loss of a client due to suicide, very little of which focuses on P/MH nurses or general nurses. When one considers the worldwide prevalence of suicide and the estimates of how many people are affected

by a single suicide (numbers ranging from 6 to 28), the under-developed nature of this associated literature is a puzzle. The immaturity of this literature may be all the more counter-intuitive given the increasing attention since the 1980s to 'Suicide Survivors' *per se*. Conceptual and methodological limitations notwithstanding, the extant studies on mental health clinicians' exposure to suicidal behaviours indicate that P/MH nurses report rates of 58.3% (Itoh, 2006) and 32.4% (Itoh, 2005). For psychotherapists this exposure was found to be around 33%; and for psychiatrists a figure of 51% was discovered (Valente, 1994). However, some authors have advanced the argument that these figures may be significant understatements (see, for example, Ruskin *et al*, 2004).

There exists a widely accepted and fairly well developed body of work that shows how a completed suicide can lead to a variety of mental health challenges for 'survivors' of a suicide – including increasing the survivor's own risk of suicide (Jobes *et al*, 2000). So when one considers how practitioners working in mental health settings (e.g. P/MH nurses, psychiatrists, psychologists, ministers/priests, general nurses) can and do form close relationships with suicidal people, there is a logical intuitive position that the death by suicide of a person under one's care can have major effects on the (mental) health and wellbeing of the practitioner. Accordingly, Chapter 11 begins by examining and problematising the definitions and conceptualisations of Suicide Survivors and goes on to make the case for considering that mental health practitioners who lose a client to suicide can be thought of as Suicide Survivors. The chapter then focuses on embracing (and ultimately implementing) clinical supervision as one means to help such practitioners deal and cope with their reactions to client suicide. It closes by examining the case for regarding a client's suicide as a Critical Incident, and goes on to make the case for the potential utility in providing Critical Incident Debriefing in such instances.

Lastly, in Chapter 12 we focus our attention on what lies ahead: what are the challenges we might consider addressing in the future in order to enhance our care of suicidal people and ultimately save lives. We draw attention to the need for additional conceptual clarity, addressing the conceptual confusion *vis-à-vis* restricting our thinking to suicide as *exclusively* a mental health problem and the continuing problem of conflating suicide with self-harm. The chapter then focuses on the practice challenges and developments that lie ahead of us. It reminds us of the need to keep talking as the centrepiece of care of the suicidal person, of the need to move away from defensive, surveillance and containment-orientated measures. It looks at the need to pay more attention to what can/should happen *after* a risk assessment is completed, the need to re-examine our initiatives

regarding reducing access to lethal means, and (by no means least) what the evidence-informed options are before considering re-thinking and re-configuring mental healthcare service delivery for the suicidal person.

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