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FEATURE ARTICLE

Never the twain? Reconciling national suicide prevention strategies with the practice, educational, and policy needs of mental health nurses (Part two)

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ABSTRACT: *Suicide remains as a distinct global public health problem and the reduction of rates continues to be a major concern of the governments of many countries. This two-part paper focuses on national suicide prevention strategies; it highlights common policy directions that appear to speak directly to the practice and/or educational needs of mental health (MH) nurses and juxtaposes these against the realities of their practice and educational needs. Part one focused on two of these policy directions, whereas part two concentrates on the following policy directions: (iii) initiatives to reduce access to lethal means; (iv) improve surveillance systems; and (v) training for caregivers to improve delivery of effective treatments. The paper argues that while being mindful of the physical environment and its associated access to means, the national suicide prevention policy literature should consider reflecting that this should be an adjunct to the more central aspects of MH nursing care of people who are suicidal. Further, it is argued that the suicide policy literature should consider replacing 'improving surveillance systems' with 'improving the ability and capacity of MH nurses to engage with people who are suicidal'. Lastly, the paper asserts that the suicide policy literature might consider refining the policy direction on additional training to indicate the need for additional post-graduate (post-basic) education and training in care of the person with suicidal tendencies, which includes dialectical behavioural therapy; the work emanating from the University of Toronto; and the skills, attitudes, and knowledge perhaps captured with the terms, engagement, co-presencing, and inspiring hope.*

KEY WORDS: *critique, evidence-based practice, mental health nursing, national suicide prevention strategies, suicide.*

INTRODUCTION

This is the second of a two-part paper that draws on national suicide prevention strategy documents and summarizes what direction these provide to mental health (MH) nurses. Of these, five policy directions appear to speak directly to the practice and/or educational needs of MH nurses, and these are: (i) training for caregivers to improve recognition of at-risk behaviour; (ii) development and promotion of effective clinical and professional practices; (iii) initiatives to reduce access to lethal means; (iv) improve surveillance systems; and (v) training for caregivers to improve delivery of effective treatments. Given that Part one of this paper focused on the first two

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policy directions, part two concentrates on the remaining three directions, critiques and considers these, particularly in the context of the findings contained in the recent emerging literature that focuses on the MH nursing care of the person with suicidal tendencies.

3. Initiatives to reduce access to lethal means

Recently, a special supplement dedicated to exploring and/or controlling access to means of suicide was published with the journal *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. According to the editor (Beautrais 2007a; p. 1):

> There is now a large body of research literature suggesting that restricting access to a particular method of suicide may successfully reduce suicides by that method. However, the extent to which reductions in rates of suicide by one method that is restricted are paralleled by reductions in *overall* (original emphasis) suicide rates is less clear; and this has led to debates about the extent to which restriction of one method may lead to substitution through an equally lethal method.

In the light of this compilation of evidence, it is necessary to consider this aspect of the national suicide prevention strategies. For some, such as Hawton (2007), the utility of restricting access as a means to prevent suicide is beyond debate, although Hawton acknowledges that preventing access to means does not address the underlying cause(s) of suicide. The International Association for Suicide Prevention (2003) also contributes to the debate and purports that this method of suicide prevention has particular utility when such access can be readily controlled. Hawton (2007) rightly draws attention to the data that offer the most support for restricting access to means, namely changing from coal-gas to a non-toxic domestic gas supply in the UK. He argues that there was little evidence of an immediate compensatory increase in the use of other methods of suicide following the reduction in suicides by carbon monoxide poisoning. Interestingly though, the data reported by Charlton *et al*. (1994) also indicate that subsequent to the recorded reduction in the overall rate, the suicide rate for males later began to increase again as other means were discovered or became more 'popular'. Further telling and more longitudinal evidence are reported in Gunnell *et al*.'s (2000) study where it was found that following the change in domestic gas, for males aged 15–34 years, the overall rate of suicide increased by 37% between 1973 and 1975. There was a 34% decrease in suicides by gas but a 299% increase in suicide by drug overdose. Correspondingly, for females, there was a 54% increase overall in suicide rate. There was an 89% decrease in suicides by gas but a 305% increase in suicide by drug overdose. Accordingly, while it is accurate for Hawton (2007) to highlight, there was little evidence of an *immediate compensatory (substitution) increase*: the longitudinal data tend to indicate that there appears to have been a longer term substitution effect occurring.

Similarly, a number of studies have illustrated the apparent effect on suicide rates of controlling access to firearms (see e.g. Cantor & Slater 1995; Lester & Murrell 1982; Loftin *et al*. 1991). However, within the same body of work, there is evidence of the substitution effect: as access to means of one method of suicide is restricted or removed, (usually) following a period of time, the rate of suicide by alternative means rises dramatically. Recent evidence of this phenomenon can be found in the study undertaken by De Leo *et al*. (2003) wherein these researchers examined the increase in the rate of suicide by hanging and an apparently simultaneous decrease in the rate of suicide by firearm as hypothetical evidence that Australian males have substituted one method of suicide for another.

In terms of reducing access to means for people admitted to psychiatric facilities, some existing evidence indicates how the rate has reduced recently (National Institute for Mental Health in England 2007). In the UK, the data indicate that the number of mental health inpatients dying by suicide has dropped from 217 in 1997 to 154 in 2004.[1] One might speculate that this reduction has occurred as a result of the range of 'interventions' and strategies identified in the original national suicide prevention strategy (Department of Health 2002); including reducing the person's access to means (e.g. installing collapsible curtain rails as potential ligature points). However, no control group was used and thus, no comparative data is available.

There appears to be a particular utility in restricting access to means as a suicide prevention strategy for those people who would be categorized as having high 'impulsivity'. In such instances where the desire to die by suicide is an impulsive decision, being less or unable to access the means during the period of high impulsivity would seem like an intuitively logical prevention strategy. As a result, the authors would commend the logic of including 'initiatives to reduce access' in national suicide prevention strategies. However, there is evidence also that suicide as an

[1]Although the same reports shows that in the same time frame, the number of people in contact with the mental health services who die by suicide has increased; and it is perhaps notable that this finding is less prominent in the report.

impulsive act fails to account for many of the population that present to formal mental health care services (see Beautrais 2007b); and that correspondingly, for a larger number of people, suicide is a chronic problem.

While acknowledging its vintage (and for some in the international academe of suicidologists, highly significant) status, the work of Maris (1981), *Pathways to Suicide*, drew attention to the notion of suicidal careers. The central premise of his thesis was that individuals who took their own lives had long suicidal careers involving complex mixes of biological, social, and psychological factors. More recently, Joiner's (2005) illuminating book contains three central premises: (i) that people who make a serious attempt to end their own lives feel a real disconnection from others;[2] (ii) they feel that they are a burden on others; and (iii) the ability to enact the lethal self-injury is acquired. As a result of numerous studies, Joiner (2005; p. 63) concludes:

> suicide occurs because one instance of suicidal behaviour lays the groundwork for later instances and it does so specifically through the accrual of fearlessness and competence.

Relatedly, Beautrais' important work on looking at the trends and outcomes of all admissions for suicide attempts to a New Zealand hospital for over 10 years reports similar findings. Beautrais (2007b) argues that her results clearly show that suicidal behaviour, for many, is a chronic condition and not just a single, impulsive event; and rather worryingly is that, for many, the situation does not change much following a suicide attempt because people do not receive the help they need. Beautrais concludes that suicide is a complex response by vulnerable people who need extensive long-term treatment, care, and support.[3]

In the context of all this evidence, one is left thinking what an MH nurse should make of the policy direction regarding limiting access to means? It would be difficult to disagree with the view that reducing access to means is likely to have a positive impact (reduce the numbers) on those 'impulsive' suicides and consequently, this should be reflected in national suicide prevention strategies; however, this is an incomplete representation. In order to see the whole clinical picture, one needs to consider the body of evidence that speaks to the possibility of a (*ex post facto*) substitution effect and the evidence that shows how one can learn or acquire the 'ability' to enact lethal self-injury. One also needs to be cognizant of how most people who present to mental health care services with a high risk of suicide are likely to have a 'chronic suicide' problem and associated suicidal career, rather than suicide as a 'spur of the moment', impulsive act. One also needs to be mindful of the significant practical problems that exist with trying to create or ensure a 'means free environment'. With all these important contexts established, it seems that while MH nurses should be mindful of the physical environment and its associated access to means, this should be an adjunct to the more central aspects of MH nursing care of people who are suicidal. That in the light of the limited long-term efficacy of limiting access to means for the majority of the types of people who are suicidal who present to formal mental health care services, there might be more valuable and effective interventions that MH nurses can engage in than managing the physical environment. The authors purport that such environmental management should be one of the many 'interventions' that MH nurses should have available to them, and moreover, that the same nurses should be painfully aware that while reducing access to one method and/or means in the 'here and now' might prevent an impulsive suicide, much more MH nursing interpersonal work is needed to help the (more common) person with a chronic suicide problem. As a speculative rather than an empirically based finale to this section, the authors also wonder: does the MH nurse, who becomes focused (preoccupied?) with maintaining the elusive risk-free environment, simultaneously lose sight of the person?

4. Improve surveillance systems

Here, the authors are assuming that surveillance captures all of those practices that are concerned with 'observation' of people who are suicidal. It is not without a distinct sense of irony that the authors begin this section by noting the incongruence in national suicide prevention strategies that advocates the need for effective (evidence-based) practices and simultaneously improve surveillance systems; when the existing empirical evidence is consistent in showing just what a woefully weak and ineffective 'intervention' surveillance (ala observations) is (see e.g. the latest evidence reported by the National Institute for Mental Health in England 2007). Accordingly, before MH nurses adopt and support this policy direction, it is worth examining the evidence regarding surveillance and/or observations and a number of associated issues, namely: who undertakes observations; how expensive are observations; what are nurses' and clients' experiences

[2]Here, the authors will not belabour the obvious parallels with the key finding in Cutcliffe and Stevenson's (2007) research: 'Re-connecting the person with humanity'.

[3]Here, there is strong empirical support for the findings reported in the section 'Appropriate Time Frame', which was included in part one of this paper.

of close observations; and how efficacious are close observations?

Who undertakes close observations?

Some empirical and numerous anecdotal papers have been published, and these are unswerving in showing that there is a significant variation in who undertakes close observations, particularly when international data are examined. Close observations have been undertaken by the following groups: experienced, qualified psychiatric nurses (MacKay *et al*. 2005); inexperienced, qualified psychiatric nurses (Bowles *et al*. 2002; Dodds & Bowles 2001; Duffy 1995); licenced practical nurses (Moore *et al*. 1995); nursing students and/or medical students (Duffy 1995; O'Brien & Cole 2003); care aids (Fletcher 1999); volunteers (Bowers *et al*. 2000); family members (Heyman & Lombardo 1995); sitters (Cardell & Pitula 1999; Pitula & Cardell 1996); security guards (Cutcliffe 2003); and close circuit television cameras (Cutcliffe 2004; Holmes *et al*. 2004). There is also evidence of a strong degree of consensus within this literature that close observations are regarded as a 'low skill', unpleasant, and unpopular activity (Buchanan-Barker & Barker 2005; Duffy 1995; Jones *et al*. 2000; Stevenson & Cutcliffe 2006). As a result, close observations are often delegated to junior and/or untrained staff. Training for such observations, if provided at all, is sporadic, lacking any theoretical underpinning and/or evidence base, and inconsistent. There is no consensus, even with MH nursing educators, as to when and how much training and/or education for observations should occur, who should provide these, or indeed, how such training should be evaluated.

How expensive are close observations?

A number of papers have attempted to calculate the cost of providing close observations (e.g. Eastwood & Schectman 1999; Goldberg 1989; Green & Grindel 1996; Heyman & Lombardo 1995; Kettles & Bryan-Jones 1998; Moore *et al*. 1995) though these figures should be treated with a degree of caution given that the calculations are based on estimations. Indeed, precise calculations of the cost of close observations are beset with conceptual and methodological problems, for example the lack of conceptual and operational consistency of close observations (see Bowers *et al*. 2000). The cost of providing close observations is also going to vary across different clinical sites given the variation in how close observations are operationalized (Bowers & Park 2001). Precise cost calculations would need to take account of the nature of the staff that actually undertake the observations, the frequency of close observations, and the duration of each occurrence of close observations. Notwithstanding the imprecision of the calculations, there is ample evidence that indicates that close observations are a staff intensive activity; one that requires a high staff-to-client ration and therefore incurs a high cost (see e.g. O'Brien & Cole 2003).

Nurses' and clients' experiences of close observations

A small number of studies have attempted to investigate both the clients' and MH nurses' experiences of observations and have similarly tried to extrapolate that the experience is either therapeutic or non-therapeutic. The findings of these studies should be regarded with a degree of caution as a result of the methodological limitations found within the studies. *For example, tragically, the experiences of those people who were under observations and still managed to complete their suicide will never be available to us. Even the most junior researcher would thus recognize that this will skew any sample of clients who have been under observation* (our emphasis) (Cutcliffe & Stevenson 2007). However, critical examination and synthesis of this literature clearly indicates that the findings are equivocal.

A number of studies have identified and have repeatedly reported how 'being under' close observations is experienced as non-therapeutic (Barker & Cutcliffe 1999; Bowles *et al*. 2002; Cardell & Pitula 1999; Cutcliffe & Barker 2002; Dodds & Bowles 2001; Fletcher 1999; Jones *et al*. 2000; Moorhead *et al*. 1996; O'Brien & Cole 2003; Pitula & Cardell 1996; Younge & Sterwin 1992). This body of work purports that non-therapeutic aspects of close observation include: lack of empathy, lack of acknowledgement, disinterested practitioners, lack of information provided, lack of privacy, invasion of personal space, observers reading newspapers or books or magazines while observing the client, and confinement.

Interestingly, some of these studies also report that clients have identified some therapeutic aspects to close observations (Cardell & Pitula 1999; Fletcher 1999; Jones *et al*. 2000; Pitula & Cardell 1996). The therapeutic aspects have been described as observer intentions optimism, acknowledgement, distraction, emotional support, and protection. Further, this body of work has attempted to identify the characteristics and behavioural practices that are regarded as therapeutic. 'Therapeutic observers' are being described as caring, helpful, hopeful, acknowledges or recognizes the client as unique, known to the client (rather than being an unfamiliar face or stranger), and 'engage' with the client.

This body of literature also alludes to the purported relationship(s) between the effectiveness of close observations and a number of related variables including: who

undertakes the observations, how the observations are enacted, the extent of established familiarity between the observer and the client, and the overarching cultural perspective of the unit regarding the purpose and/or value of close observations (Buchanan-Barker & Barker 2005; Cardell & Pitula 1999; Duffy 1995; Fletcher 1999; Jones *et al*. 2000; Pitula & Cardell 1996; Stevenson & Cutcliffe 2006).

How efficacious are close observations?

As with other issues associated with close observations, the literature in this area is underdeveloped and is in a stage of relative 'infancy'. Indeed, perhaps the most important limitation of the extant literature is that no study has even tried to examine if 'being under' certain levels of observation actually reduces the number of suicide attempts, the person's suicide risk, or extent of suicidal ideation; there is no randomized control trial that has attempted to compare psychiatric care units that use close observation against units without constant observation.

The data that do exist provides a highly disturbing picture of the abject failure of observations to prevent people from taking their own lives. The UK Department of Health (2001) 'Safety First' report highlighted that 18% of all completed mental health inpatient suicides occurred while people were under observation. More recently, the annual progress report on the National Suicide Prevention Strategy for England (National Institute for Mental Health in England 2007; p. 66) reports that of the recorded cases of suicide of inpatients of mental health services:

> Twenty two percent of the patients (185 cases) were under special (non-routine) observation, similar to the 23% in the previous inquiry report. Of those who died on the ward, 48% (117 cases) were under special observation.

It continues:

> In this sample, 18 cases (3%) were under one-to-one observations. The number of deaths under observation has not fallen since 1997, which means that they have increased as a proportion of inpatient suicides.

Similarly, Goh *et al*.'s (1990) report indicated that 6 out of 57 completed suicides were under close or special observations. Gournay and Bowers (2000) report that of the 31 cases of suicide or self-harm that they reviewed, 23 of these were under an observation 'level' greater than the minimum level of observations for all the clients on the unit. Furthermore, a disturbing finding from Cardell and Pitula's (1999) study was that 10% of the study participants informed researchers that they lied about their degree of suicidality in order to hasten the termination of constant observation.

These consistent findings are perhaps even less encouraging when one considers the very high number of people who go on to take their own lives once the close observations have been removed and/or they are discharged (Canadian Association of Suicide Prevention 2004; Geddes & Juszczak 1995; Geddes *et al*. 1997; Goldacre *et al*. 1993; Gournay & Bowers 2000; Hawton *et al*. 2003; Ho 2003; King *et al*. 2001; Pirkola *et al*. 2005; Roy 1982). In the only published paper of practice development that was identified in the review, following the dismantling of observation and moving towards a more 'care' orientated system (Dodds & Bowles 2001), there was no increase of suicides during the corresponding period (18 months). Furthermore, although not an empirical piece, in the discussion paper arising out of this 'study', a number of compelling testimonies are evident as well as further confirmation that removing observations led to a reduction – not an increase – in suicide rates (Bowles *et al*. 2002). As a result, one can conclude with a degree of empirical confidence that while close observation may have maintained the physical safety of some clients, in no way is this physical safety guaranteed. More worryingly, close observation appears to lead some clients into deliberately misleading the clinician in order to have the observations 'lifted'.

To summarize the evidence, as a scientific and clinical community, we really do not know if placing a person 'under observation' or increasing the surveillance reduces his and/or her suicidality; we do not know if placing a person under observation makes him and/or her feel less suicidal. What we do know is that placing a person under observation does not guarantee his and/or her physical safety. Indeed, if the latest UK data is accurate, the efficacy of close observations as a means to prevent suicide has diminished since 2001. Furthermore, the findings pertaining to the experiences of those 'being observed' are equivocal with some data showing that clients experience observations as non-therapeutic and some showing that clients experience observations as therapeutic. Importantly though, there is a growing body of evidence that indicates that even when observations are carried out 'well', it is certain 'micro-skills' or 'micro-interventions' that some MH nurses use (and these are captured and described in the literature pertaining to the MH nursing care of people who are suicidal, see Cutcliffe *et al*. 2006; Cutcliffe and Stevenson 2007; Sun *et al*. 2005; 2006; Talseth *et al*. 1997; 1999) during the observations, and not

the observations *per se*, that appear to have some therapeutic effectiveness for people who are suicidal. Accordingly, the authors purport that the national suicide prevention strategies should consider replacing 'improving surveillance systems' with '*improving the ability and capacity of MH nurses to engage with people who are suicidal*'; and this segues our paper into the final policy point.

5. Training for caregivers to improve delivery of effective treatments

Given the alarmingly high rates of mental health inpatient suicide and the even more concerning rates of suicide in the period of time following discharge as pointed out earlier, it seems entirely appropriate for the national suicide prevention strategies to highlight the need for additional training. However, the issue is not whether or not additional training for 'effective treatments' is needed but what the nature of this additional training should and/or could be? Interestingly, perhaps the crux of this matter is whether this additional training should focus on tightening up current ineffective, defensive practices (such as observation) or if the training should be focused on the interventions and/or approaches that have some, albeit emerging, evidence regarding how MH nurses can work with people who are suicidal. Further, perhaps such an emphasis might be captured (or at least alluded to) in the national suicide prevention strategy documents?

Current preparation – what training?

It is worth looking at the current international situation regarding preparation of MH nurses and more specifically, preparing these practitioners to work with people who are suicidal. MH nursing curricula, whether pre- or post-graduation, and the vast majority of the MH nursing textbooks used in conjunction with such courses and/or programmes, commonly make reference (to a greater or lesser extent) to suicide. Differences are common and not surprising between specialist and generic pre-registration curricula (Younge & Boschma 2006). Restricted by constraints of time and space, and by the demands of competing areas of care and/or issues for nurses, generic programmes often have less attention to suicide (and still less devoted to care of the person with suicidal tendencies) than specialist programmes. Yet specialist mental health programmes have no case for complacency and arguably are still severely limited in their preparation of MH nurses to care for people who are suicidal. Almost inevitably, the focus in such curricula is an introduction to the principal theories of suicide (rightly so) and to the material on risk and risk assessment; very little attention is given to what MH nurses might do by way of caring for people who are suicidal once the risk assessment is complete (other than perhaps assigning and instigating various forms of defensive practice, administering medication, and some reference to non-suicide contracts).

It may well be, as with other specialist areas of practice, that the best one can achieve in basic mental health education is to equip students with risk assessment skills, familiarity with suicide risk tools, some intervention skills such as active listening, personal awareness raising of their own issues around death, dying and suicide, and the beginnings of the development of the required qualities. It may well be that additional specialist, advanced education and training would be required for those MH nurses who wish to focus on working with people who are suicidal. Just as one would not expect newly graduated MH nurses to take on a caseload of people requiring specialist psychotherapy, the authors suggest it would be clinically prudent not to expect newly graduated MH nurses to take on a case load 'heavy' with people who are highly suicidal. This appears to be particularly logical and sensible given the previously mentioned complexity of suicide and the emotional requirements such clients demand of their MH nurses. In the light of these foci, one might conclude that the current preparation of MH nurses to work with people who are suicidal is deficient in providing them with the skills, attitudes, and knowledge necessary for delivering adequate, therapeutic, transformative care for people who are suicidal. Hence, there is a clear need to provide additional education and/or training to address this matter.

Improving observations and tightening up policies

Some, such as Bowers and Park (2001), the Standing Nursing and Midwifery Advisory Committee (SNMAC; 1999), Gournay and Bowers (2000) and Bowers *et al*. (2007), indicate that the training emphasis needs to be on improving so-called special observations and tightening up observations policies (and ensuring strict adherence to these policies). For example Bowers and Park (2001) argue that what is needed is a clear, agreed, workable policy as this would facilitate basic training. However, in the same paper, they also acknowledge that there seems to be no agreement about what observers are supposed to do during special observations, and they find it hard to see what the content of such training should be. Perhaps Bowers and Park (2001) feel that training MH nurses how to undertake observations while reading a newspaper should be part of the training process as they also state:

TABLE 1: *Standing Nursing Midwifery Advisory Committee's essential components of adequate training in close observations*

Risk assessment;
Risk management;
Engagement of patients at risk of harming themselves and others;
Factors associated with self-harm and/or harm to others;
Indications for observation;
Levels of observation;
Therapeutic opportunities in observations;
Roles and responsibilities of the multidisciplinary team in relation to observation;
Making the observation safe;
Recording the observation; and
The use of reviews and audit.

> Although some authors decry the nurse who sits in the doorway of a patient's room reading a newspaper, even this might be appropriate at times and temporarily offers the patient a form of privacy of solitude.

Similarly, the SNMAC (1999; p. 6) advocate tightening up the observation policies and offer what they believe to be the essential components of adequate training to carry out observations; these are listed in Table 1.

It is noteworthy that of these 11 elements, only two (perhaps three) make any reference to what MH nurses might actually do while enacting observations. More importantly, they say nothing about how an MH nurse might ease a person with suicidal tendencies' psychache,[4] promote a person with suicidal tendencies' hope, or facilitate a person with suicidal tendencies' reconnection with humanity. Gournay and Bowers (2000; p. 131) argue that MH nursing staff need to more strictly adhere to (observation) protocols and policies. Despite the admonishments of the UK Department of Health (2001) regarding the use of intermittent observations, Bowers *et al*. (2007; p. 187) conclude their latest research with a number of recommendations, one of which states:

> Trusts should review their special observations policies to ensure that this form (intermittent observation) of containment is an available option for staff.

Each of these authors all purport that observation is not simply a custodial activity but an opportunity to interact with the patient and that encouraging communication, listening, and conveying to the patient that they are cared for are important components (SNMAC 1999). Yet at the risk of sounding incredulous, it is difficult to see how any MH nurse can interact, encourage communication, and listen to a person with suicidal tendencies when they are checking in on them intermittently; indeed if they are following the SNMAC's (1999; p. 3) guidance and checking the patient's location every 15–30 min.

Training in engagement and meaningful ways to respond to people who are suicidal

As an alternative to improving observations and tightening up policies, the authors suggest that national suicide prevention strategies might encourage practitioners to explore additional training in practices that have some supporting empirical evidence: dialectical behavioural therapy (DBT); and/or the approach that focuses on de-escalating an individuals' emotional (psychache) crisis; providing the person with an enhanced ability to identify and/or express their distressing emotions; and/or the approach that focuses on engagement, inspiring hope, and re-connecting the person with humanity.

Training in DBT (see Linehan 2007) and the approach that focuses on de-escalating an individuals' emotional (psychache) crisis and providing the person with an enhanced ability to identify and/or express their distressing emotions (Bergmans & Links 2002; Bergmans *et al*. 2007) have been covered previously. Therefore, the authors will concentrate on the approach that focuses on engagement, inspiring hope, and reconnecting the person with humanity. For those authors contributing to the empirical literature on the MH nursing care of the person with suicidal tendencies (see Cutcliffe & Stevenson 2007; Cutcliffe *et al*. 2006; Sun *et al*. 2005; 2006; Talseth *et al*. 1997; 1999), for key figures in the international suicidology academe (Joiner 2005; Maltsberger 1986; Maris *et al*. 2000; Shneidman 1997; 2001; 2004 to name but a few), and for many MH authors, researchers, and practitioners who have contributed to the debate, the practice of working with people who are suicidal is essentially an interpersonal endeavour; one that is inherently concerned with listening and talking. In order to do so, the MH nurse needs to be comfortable with co-presencing; needs to be able to sit with the suicidal patients' and with their own emotions that surround the experience(s) of death, suicide, and mortality. While some MH nurses may feel that they are already comfortable with this (and that may very well be the case), there is a body of evidence that shows how for many, dealing with emotionally charged experiences such as death and suicide is often problematic and is sometimes avoided altogether. Evidence of this dynamic is evident in both 'vintage' and more contemporary literature.

Altschul's (1972) seminal contribution on the importance of interpersonal relations as the foundation of effective MH nursing suggests that MH nurses largely

[4]Shneidman's (1997) classic description of the intense psychological pain that suicidal people experience.

shunned any contact with patients; consistently spending their time in the office and only 10% with patients. Altschul's conclusions about MH nursing are an echo of the earlier work of Menzies Lyth (1959/1961) in relation to 'general' nurses' response to suffering and death, namely having great difficulty and thus avoiding this. More recently, Sanon-Rollins (2006) drew attention to a survey made of three hospitals. The findings revealed that regardless of institutional or demographic characteristics, nurses use avoidance as a primary strategy to resolve conflict, including their own internal conflict.

Similarly, even a cursory examination of the bereavement counselling literature will show that dealing with the issues or topics of death and dying often provokes feelings of discomfort in the listener (Lendrum & Syme 1992; Raphael *et al*. 1993; Worden 1988). Accordingly, it is not surprising that some MH nurses still have significant discomfort when talking about situations that are synonymous with death and dying. Coupled with these emotionally charged issues is the qualitatively different nature of death (or attempted death) by suicide (Jordan 2001). Thus, MH nurses working with a person who has made a serious suicidal attempt need to be thoroughly prepared to hear about death, dying, and suicide, and moreover, not shy away from this; not be uncomfortable with the topic(s) nor discourage the person with suicidal tendencies from talking openly about his and/or her suicidality, psychache, and/or hopelessness. A similar argument has been postulated previously by Davidhizar and Vance (1993) who also stressed that when working with people who are suicidal, MH nurses need to consider their own attitudes towards suicide in order that they can ensure they do not distance themselves from the person with suicidal tendencies. Such consideration clearly demands and requires that the MH nurse needs to possess a high degree of self-awareness and needs to have come to terms with his and/or her own mortality. Without so doing, the process of providing meaningful caring responses to people who are suicidal would be hindered if not actually thwarted. As a result, any additional training would have to include some attention to these issues.

Co-presencing and listening

The authors would argue that additional training should include materials designed to help MH nurses become comfortable with and effective in co-presencing and listening. All too often and for a variety of reasons, some nurses are too quick to speak. Sometimes, nurses have a compelling need to be seen to be doing; to be active; to be making a difference (Cutcliffe 2004). Other times, nurses use their own (excessive) talk as a defence mechanism (Dombeck 2007); if the nurse is talking majority of the time, it is difficult for the person with suicidal tendencies to bring up emotive (and dangerous) issues. Sometimes, with every good intent, some nurses wish to find the erudite sentence; the 'pearl of wisdom' that will serve as an epiphany and solve all the person with suicidal tendencies' problems in one go.

Yet, sometimes the hardest thing to do is nothing! While this truism is used here purposefully to make the point, it should not detract from the message the authors are trying to make. The people who were suicidal in the study reported by Cutcliffe and Stevenson (2007) welcomed the chance to talk and be heard, to speak and be understood, and to gain a sense that somebody cared. This was brought about (in part) by the MH nurse saying little and hearing a lot. With the earlier point in mind, the MH nurse's willingness to really listen to the suicidal client is clearly prefaced by their high degree of comfort in hearing such disclosures. If the MH nurse is unable or unwilling to hear about the person's suicidality, then he and/or she is unlikely to listen.

For the person with suicidal tendencies recovering his and/or her life force, it is critical to have a space in which to make sense of what has happened to him and/or her. To some extent, this work takes place in the private domain, but for those people receiving care from MH practitioners, this also occurs in, and by means of, the interpersonal connection: the co-presence. Effective MH nurses ask questions that encourage the outward expression of psychache, hopes and fears, and demonstrate the capacity to listen to the person with suicidal tendencies' innermost concerns; they are able to ask, 'Where does it hurt?' and subsequently, hear the person's story.

The cadre of a training curriculum

The authors have stated previously that their belief is that the best that can be achieved in basic entry-level MH nursing preparation would be an introduction to caring for people who are suicidal. Further, through clinical mentoring, preceptorship, and working in combination with experienced, senior clinicians, student nurses ought to be able to grasp the basics. The authors concur with the view captured in the national suicide prevention strategy that additional training is necessary and argue that this needs to be specifically designed, post-graduate (post-basic) education and training in care of the person with suicidal tendencies. At the very least, in order to provide effective, meaningful caring responses to people who are suicidal, the authors believe that this education and/or

TABLE 2: *Minimum educational components for including in a post-basic programme in equipping MH nurses to provide effective, meaningful and caring responses to people who are suicidal*

Self-awareness training – Specifically, dealing with one's own mortality;
Cognitive re-framing techniques and skills;
Experiential work around being comfortable with stillness;
Monitoring one's self – Particularly one's own level of hope;
Experiential work around hearing about death, dying, and suicide;
Techniques and qualities associated with inspiring hope;
Techniques and qualities associated with co-presencing;
Listening (without prejudice or discomfort);
The use of gentle, implicit challenges;
Giving and receiving clinical supervision;
Creating a calming, peaceful external (physical) environment;
Experiential work on becoming comfortable with not having erudite answers;
Interventions and attitudes to build trust;
Interventions geared to explore and facilitate understanding of the meanings attached to the suicidal act (e.g. catalytic interventions, empathic building, selective reflection); and
Role modelling and the use of simulators.

training should contain the (minimum) elements described in Table 2.

CONCLUSIONS

The juxtaposition of national suicide prevention strategies with the realities of MH nursing practice and education indicates that some aspects of these are fitting, appropriate, and useful for informing the MH nursing care of the person with suicidal tendencies (e.g. development and promotion of effective clinical and professional practices, and additional training for caregivers to improve delivery of effective treatments.) Other aspects are perhaps difficult to reconcile with these realities and thus, the authors would argue that there would be merit in revisiting these strategies to include the following:

1. Consider a suicide policy literature that reflects a less defensive, less risk management-oriented position.
2. Consider a suicide policy literature that emphasizes and reiterates the need for MH nurses involved in care of the person with suicidal tendencies to receive appropriate clinical supervision.
3. Consider a suicide policy literature that while being mindful of the physical environment and its associated access to means, reflects that this should be an adjunct to the more central aspects of MH nursing care of people who are suicidal.
4. Consider a suicide policy literature that replaces 'improving surveillance systems' with 'improving the ability and capacity of MH nurses to engage with people who are suicidal'.
5. Consider a suicide policy literature that indicates the need for additional post-graduate (post-basic) education and training in care of the person with suicidal tendencies; includes DBT; the work emanating from the University of Toronto; and the skills, attitudes, and knowledge, perhaps captured with the terms, engagement, co-presencing, and inspiring hope.

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