




ORIGINAL ARTICLE

‘Promoting and preserving safety and a life-oriented perspective’: A qualitative study of nurses’ interactions with patients experiencing suicidal ideation

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ABSTRACT: Suicide prevention is an important imperative in psychiatric hospitals, where nurses have a crucial role in and make essential contributions to suicide prevention and promoting the recovery of patients experiencing suicidal ideation. The present qualitative grounded theory study aimed to uncover and understand the actions and aims of nurses in psychiatric hospitals during their interactions with patients experiencing suicidal ideation. Interviews were conducted with 26 nurses employed on 12 wards in four psychiatric hospitals. The data analysis was inspired by the *Qualitative Analysis Guide of Leuven*. The findings show that nurses’ actions and aims in their interactions with patients experiencing suicidal ideation are captured in the core element ‘promoting and preserving safety and a life-oriented perspective’. This core element represents the three interconnected elements ‘managing the risk of suicide’, ‘guiding patients away from suicidal ideation’, and ‘searching for balance in the minefield’. The enhanced understanding of nurses’ actions and aims can inform concrete strategies for nursing practice and education. These strategies should aim to challenge overly controlling and directing nursing approaches and support nurses’ capacity and ability to connect and collaborate with patients experiencing suicidal ideation.

KEY WORDS: nurse–patient relationship, psychiatric hospitals, qualitative research, suicidal ideation, suicide.

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INTRODUCTION

Suicide is a leading cause of death worldwide, accounting for at least 800 000 deaths each year (WHO 2018). The global lifetime prevalence is estimated to be 2.7% for suicide attempts and 9.2% for suicidal ideation (SI), which refers to thinking about, considering, or planning suicide (Nock *et al.* 2008). Given suicide’s profound impact at the personal, economic, and community

levels, suicide prevention strategies are increasingly being developed (Zalsman *et al.* 2016), such as the Zero Suicide Model in the United States and the Strategies to Prevent Suicide (STOPS) project in Asia (Brodsky *et al.* 2018; Hendin *et al.*, 2008).

Suicide prevention is an imperative in primary care and general hospitals (Hawton *et al.* 2015; Raue *et al.* 2014) and especially in psychiatric hospitals, given the high association of suicide with mental health problems (Cavanagh *et al.* 2003) and the high suicide risk during psychiatric inpatient admission (Madsen *et al.* 2012; Walsh *et al.* 2015). Regarding psychiatric hospitals, the literature suggests the crucial role of nurses in multi-disciplinary teams in preventing suicide and promoting patients' recovery from SI (Cutcliffe & Stevenson 2008; Sellin *et al.* 2017).

Reflecting this focus, the term 'nurses' is used throughout the present article to refer to nurses working in psychiatric hospitals. In addition, the formulation 'patients experiencing SI' is used to acknowledge the hospital context while recognizing and validating patients' individuality and the range of suicidal thoughts and feelings they can experience.

BACKGROUND

Their position proximate to patients has made nurses a particular target of suicide prevention policies encompassing the use of risk assessment tools, involvement in formal observations, removal of harmful items, and restraint and seclusion of patients (Bowers *et al.* 2011; Kontio *et al.* 2012; Manuel *et al.* 2018). In addition, their proximity to patients makes nurses ideally placed to develop a therapeutic engagement with patients experiencing SI that is underpinned by an interpersonal relationship, trust, acceptance and tolerance, and listening and understanding (Cutcliffe & Barker 2002; Lees *et al.* 2014). Nurses' capacity and ability to develop therapeutic engagement with patients experiencing SI provide a vehicle to inspire hope in patients, understand the nature of their needs and problems, address their loss of control and distress, validate them as human beings, and help them move from a death-oriented position to a life-oriented position (Cutcliffe & Stevenson 2008; Lees *et al.* 2014; Talseth *et al.* 1999).

Studies worldwide highlight that nurses' interactions with patients experiencing SI often lack therapeutic engagement and are even devoid of the basics of care, such as acknowledging patients as individuals and treating them with respect and empathy (Cutcliffe *et al.* 2015; Lees *et al.* 2014; Slemon *et al.* 2017). Several

authors argue that the fundamentals of nursing are under pressure, partly due to increasing requirements for nurses to conform to and uphold standardized and defensive practices for suicide prevention (e.g. formal observations, physical restraint, and seclusion) and growing demands for professional and public accountability with regard to ensuring patient safety inside and outside the ward (Hagen *et al.* 2017a; Higgins *et al.* 2016; Manuel & Crowe 2014).

This context largely dictates the actions and aims of nurses in practice. As an example, Manuel *et al.* (2018) uncovered conflicts between policy recommendations to increase the use and restrictive level of protocol-based interventions to ensure patient safety and the views of clinicians, including nurses, that such recommendations undermine their intentions to develop therapeutic engagement with patients. While such findings reflect the challenge for research and practice of integrating clinical knowledge into the evidence base of suicide prevention (O'Connor & Portzky 2018), they also reflect that nurses' perspectives are often overlooked and that there is no clear articulation of what nurses do and what contribution they (can) make (Browne *et al.* 2012; Santangelo *et al.* 2018).

Aim

The aim of the study was to uncover and understand the actions and aims of nurses in psychiatric hospitals during their interactions with patients experiencing SI.

METHODS

Design

A qualitative grounded theory study with systematic and constant comparison analyses was conducted. This approach was indicated as the most appropriate given the aim to uncover basic elements in human interactions (e.g. nurse-patient) and to understand 'how' and 'why' people (e.g. nurses) act in certain ways (Foley & Timonen 2015; Glaser & Strauss 1967). The data collection and data analysis interacted in a cyclical process to support the progressive identification and integration of concepts and relations between concepts (Glaser 2002; Hallberg 2006).

Participants

Nurses were recruited on 12 wards of four psychiatric hospitals geographically distributed across Flanders (the Dutch-speaking part of Belgium). The head nurses

on the wards acted as contact persons. They invited potential participants and facilitated the contact between the interviewer and the participants. The head nurses were fully informed about the study through an informed consent sheet and face-to-face interaction. In this process, the researchers had particular attention for explaining the aim of the study and clarifying the inclusion criteria. Nurses could be included if they were assigned to adult patients experiencing SI in the past year in a nursing model (e.g. primary or team nursing model). The interested nurses were contacted through the email address provided by the head nurses.

Data collection

The first author conducted individual semi-structured interviews with 26 nurses. He used an interview guide with open-ended questions, including the opening question 'What is it like for you to interact with patients experiencing SI?' The interviews were conducted in the hospitals, lasted between 61 and 120 min (mean 78), and were audio-recorded and transcribed.

The interviewer was a PhD candidate with three years of prior experience as a nurse in a psychiatric hospital. He used reflexivity to facilitate active acknowledgement and explicit recognition of how his position as a researcher and his experience as a nurse affect the data collection. The other researchers supervised his contributions to the study based upon their diverse backgrounds (e.g. different fields of nursing, mental health care, and qualitative research). This diversity supported the possibility to monitor assumptions or biases based on substantive, methodological, or personal background of the researcher(s) (Creswell & Miller 2000; Foley & Timonen 2015).

In accordance with grounded theory (Glaser & Strauss 1967), data were collected at different geographical locations and new data were collected based on the emerging insights obtained from the constant comparison analysis. As an example, the preliminary analyses of the first interviews showed a predominant focus of nurses on formal and defensive practices aimed at ensuring patients' safety. This focus seemed to be high relative to the attention of these nurses for relational elements in their interactions with patients (e.g. collaborating). Nuanced discussions of these preliminary insights within the research team highlighted the need for efforts to broaden and deepen the understanding of the various elements in nurse-patient interactions. One of these efforts was that head nurses were

asked whether they could also invite nurses who attach more importance to relational elements in their interactions with patients experiencing SI.

Ethical considerations

The study was approved by the Ethical Committee of the Ghent University Hospital and the local Ethical Committees of the hospitals (B670201630531). The participants were fully informed about the goal of the study, the nature of involvement, the voluntariness of participation, and the confidential treatment and anonymity of the data. This information was provided through an informed consent sheet and face-to-face interaction. All participants provided written and verbal informed consent prior to participation.

Data analysis

Systematic and constant comparison analyses were prioritized to support the progressive identification and integration of concepts and relations between concepts (Glaser 2002; Hallberg 2006). The Qualitative Analysis Guide of Leuven (QUAGOL) was considered particularly useful to support these evolving processes of analysis within a grounded theory approach (Dierckx de Casterlé *et al.* 2012). The first author repeatedly read the transcripts and listened to the audio recordings. In line with the QUAGOL, he wrote memos and developed a narrative report and a conceptual scheme of each interview to identify preliminary concepts while developing a holistic understanding of the context wherein the concepts acquire their meaning (Dierckx de Casterlé *et al.* 2012). The last author read all the transcripts and added memos. The first and last author engaged in open discussions about the emerging insights to elaborate the concepts and the relations between concepts. Three other researchers read some of the transcripts, made their own memos, and checked and verified the emerging conceptual understandings. Alongside this attention for investigator triangulation, reflexivity was prioritized and discussed in order for the researchers to remain open to varied interpretations and to monitor assumptions or biases (Creswell & Miller 2000; Foley & Timonen 2015).

The recurrent open discussions inspired the constant comparison analysis and the purpose of compiling a list of meaningful concepts. Then, the first and last author read the interviews again and used the QSR NVivo 10 software program (QSR International, Burlington, MA, USA) to code the data. These efforts

supported the process of shaping the essential analysis structure and describing the conceptual meanings and relations. Data saturation was confirmed based upon the cyclical processes of gradually deepening the analysis and the recurring discussions within the research team (Dierckx de Casterlé *et al.* 2012).

FINDINGS

The interviewed nurses ($n = 26$) were employed on adult wards with an open or closed entrance divided according to psychotherapeutic focus (e.g. mentalization-based treatment), age (e.g. ≥ 35 years), or psychiatric diagnoses (e.g. mood disorders). On average, the nurses were aged 36 years (range: 22–61) and had been employed for 12 years as a nurse (range: 1–39). They all had a degree in psychiatric nursing. While all the nurses had direct experiences of patients' suicide attempts, 18 nurses had at least one professional experience of a patient's suicide. The demographic data are summarized in Table 1.

Promoting and preserving safety and a life-oriented perspective

'Promoting and preserving safety and a life-oriented perspective' reflects nurses' actions and aims in their

TABLE 1: Demographic data of the nurses

	Age (years)					$n = 26$
	<25	25–34	35–44	45–54	≥ 55	
Gender						
Female	2	6	5	3	1	17
Male	1	5	1	1	1	9
Length of employment (years)						
<5	3	4	2			9
5–14		7	1	1		9
15–24			3	1		4
≥ 25				2	2	4
% FTE appointment						
100	3	9	3	2	1	18
75		2	3	2		7
50					1	1
Education level						
Undergraduate		3	3	3	1	10
Bachelor's	3	6	3	1	1	14
Master's		2				2
Ward type [†]						
Closed		4			1	5
Open	3	7	6	4	1	21
	3	11	6	4	2	

[†]Ward type: entrance of the ward is open or closed.

interactions with patients experiencing SI. This core element represents the three interconnected elements 'managing the risk of suicide', 'guiding patients away from SI', and 'searching for balance in the minefield'. Nurses emphasized other aspects depending on whether their interactions with patients experiencing SI are guided more by controlling and directing patients or by connecting and collaborating with patients.

Managing the risk of suicide

Nurses consider it important to use suicide prevention protocols. They explained that these protocols provide guidance to assess suicide risk, assign a level of risk to patients, and carry out actions such as removing suicide means, locking doors or enforcing seclusion, and performing formal observations by checking on patients, having standardized conversations with patients, or having patients sign an observation form. Some nurses use protocols primarily to ensure a secure environment. They conduct formal observations to check and control suicide risk, determine whether the assigned risk level to patients is sufficient, and intensify formal observations and protective measures accordingly.

If risk level two is assigned to patients, then we have one standard conversation with them before noon and one conversation after noon. We assign the third level of risk to patients if their suicidality is more serious. Then we also observe them every half hour and document their whereabouts. Finally, we have level four, which refers to very serious suicidality. Most of the time this means that we seclude patients, with or without fixation. (male, 25–34y, closed ward)

In the past, we would check patients once every hour, but now, based on the protocol, we check patients every fifteen minutes if they express suicidal thoughts or when we are suspicious of emerging suicidal ideation. (female, 35–44y, open ward)

Other nurses indicated that they are considerate towards using formal observations and protective measures. They emphasized that they only use these interventions in a way that still allows patients to feel that a human is interacting with them, a human who treats them as a valid person. They reflected that their main intention is not to control patients but rather to initiate caring contact with patients and to be sensitive and responsive to their needs. These nurses stressed their commitment to being present with patients in a way that conveys compassion, eases their burden, and gives them courage. Nurses perceive that this contact is

intense but worthwhile because it provides a foundation upon which to develop an emotional connection. They articulated that this connection facilitates patient–nurse contact, enables patients’ communication of their SI, and can serve as a secure base during suicidal crises.

There is a suicide prevention protocol, and everyone follows it like a robot. I strongly believe you should perform interventions so that patients feel that someone is interacting with them as a person and not as a professional who has to check patients every 15 minutes because that is expected! I believe it is far more important to be present with patients, listen to them, and establish that connection, even if you go to them every 15 minutes. (male, 25–34y, closed ward)

I try to make a connection with patients by being present, recognising them and their story, and avoiding the reflex to initiate quick solutions. I believe that connecting is the most important thing, being human in contact with patients, showing your willingness to understand how difficult it is for them. (female, ≥55y, open ward)

Nurses indicated that they make agreements with patients to manage suicide risk and potentially risky situations (e.g. ward leave). Some nurses’ perspectives reflected that making agreements follows a controlling and directing discourse. These nurses indicated that they allow patients to negotiate procedural features in a way that limits the intrusive nature of the procedures and (thus) assures their application and protective value. Furthermore, these nurses use persuasive communication to exercise control both inside and outside the ward. For example, they may express the expectation that patients phone them during weekend leave or move from their room to the ward’s day-room so that they can better be observed. Some nurses indicated that such expectations can be part of a contract in which patients agree not to harm themselves.

We had an agreement that he must call us on Saturday and Sunday morning to let us know what he is doing and how he feels. But he did not call us on Sunday morning! And then we waited for a while, and Sunday afternoon his brother found him dead at home. (female, 35–44y, open ward)

Sometimes patients are able and prefer to come to our nursing station downstairs. And if that is feasible, then I say to them, “Let us agree that you come downstairs every hour to sign the sheet of paper we have for you.” (female, <25y, open ward)

For other nurses, making agreements is a collaborative endeavour of working through suicidal crises with patients. These nurses avoid imposing instant protection and instead engage in dialogue with patients that facilitates understanding of risks and potentially risky situations (e.g. taking a bath), the meaning that patients attach to risks and potentially risky situations, and what can be done to address risks. Nurses reflected that these dialogues are underpinned by mutuality in the form of connectedness, trust, enabling patients’ choice, and including patients’ views. Mutuality also means that nurses can suggest alternatives and express their concerns to patients when they perceive that patients’ proposals (e.g. request for ward leave) might be more harmful than beneficial. Nurses perceive that their way of making agreements enables them to promote and preserve patients’ personal responsibility and self-control. Moreover, they perceive that making agreements enables them to rely less on protective actions without interfering too little or leaving at-risk patients to themselves.

I always consider whether I can make agreements with someone. Of course, agreements do not offer 100% certainty. I cannot read the patient’s mind. But starting from my relationship with the patient, I can try to leave responsibility with them and explore how they can overcome difficult moments and what can help them in this. Then I believe you can rely on agreements just as well as on protective measures. (male, 45–54y, open ward)

I believe that for patients and for me, you achieve far better results when you enter into dialogue instead of immediately saying, “We are going to lock your door!”. Such intervention is so invasive, while they actually ask for help and want to find solutions together. And then I try to appeal to the relationship we have to make agreements and to ask in all honesty whether the agreements are feasible for them. If patients answer, “It will not be possible”, then I have to propose something else. And if they say, “You can trust me!”, then I know it is safe. (female, 35–44y, open ward)

Nurses’ perspectives reflected that several conditions can trigger a pivot to a more controlling and directing approach. Nurses referred to their interactions with patients who they do not yet know very well, isolate themselves, lack engagement in their treatment, do not disclose SI, and who seem to be disconnected from themselves, such as when dealing with psychosis or having concrete suicide plans. Besides these elements, some nurses referred to a lack of time and staffing shortage as conditions under which they cannot or no

longer make agreements with patients, must take control, and rely more on formal observations and protective actions to preserve safety. While nurses perceived that diverse conditions such as lack of time and patients' social isolation can trigger a pivot to a more controlling and directing approach, some nurses framed these conditions as an impetus to make a greater effort to establish caring contact and connection.

I think it is important that we make agreements with patients. But when they are very psychotic... we have already seen that people can do dangerous things and then you cannot just watch and let it happen. In their psychosis they can feel threatened or in their own world, making it difficult to make contact with them and make agreements. (female, 25–34y, open ward)

When I notice that patients isolate themselves, then for me this is an extra trigger to make contact and to try to establish a connection. In this way I can address their loneliness and focus on the healthy elements, instead of being merely fixated on suicide and everything about prevention. I honestly believe that this only induces more suicidality. (female, 25–34y, open ward)

Guiding patients away from SI

Nurses emphasized their actions and aims to guide patients away from SI. These actions and aims reflect a perceived need of nurses to foster patients' sense of hopefulness and prevent hopelessness. This perceived need is underpinned by nurses' perception that patients experiencing SI often seek social isolation, are passive and introverted, share repeated expressions of hopelessness, and have little or no perspective on life. Some indicated that patients can be stuck in 'tunnel vision', reflecting the challenges of guiding patients away from SI.

I believe I am responsible for the well-being of patients. To enable them to see a bit of light at the end of the tunnel or that something can be established that they can hold onto and that gives some new courage to continue with life. (male, <25y, open ward)

People have a whole history, carry a backpack with them, and very often they have got the door slammed in their face several times. I hope for them that one day it will turn out positive or that I can help to bring about a turnaround of their suicidality, but that is one of the most difficult things. (female, ≥55y, open ward)

Nurses find it important to create conditions for patients to (re)gain hope and be distracted from SI. Some nurses are primarily concerned with explicit

actions. They encourage physical activity by persuading patients to plan their day, follow therapies, or just do something (e.g. sports) to distract them. Furthermore, these nurses operationalize assessment information (e.g. protective factors) by using it to refer patients to therapists or therapies. They perceive that the extent to which they can foster hope in patients largely depends on environmental conditions such as routines regarding ward leave and the presence of various therapists.

I explain to patients that we know from experience that if you are preoccupied with suicidal thoughts you get stuck in tunnel vision. And then I ask patients to try something else, to put the death wish aside for a while and to focus on life. Then we discuss actions with them such as walking, listening to music, writing in a diary, calling a friend. We expect those actions from them and try to make them experience that, independent of their bad mood, those actions can prevent them from staying stuck in those negative thoughts. (female, 35–44y, open ward)

I try to support patients in finding distraction, for instance by saying to creative people "go paint in your room" or to people who are sporty "go to the gym". If they come more into the ward's dayroom, do sports, or follow therapy, their thoughts might still be present but will be less intense. (male, 25–34y, open ward)

Other nurses expressed that their commitment to establishing caring contact, connection, and collaboration with patients might instil a sense of hope in patients, even when the nurse is not present. These nurses try to create opportunities for patients to express hopeful experiences and perspectives and to gain a sense of meaningful activity. They stressed their commitment to doing things with patients, listening attentively to the patients' stories, showing genuine interest, and expressing their belief in patients. Furthermore, these nurses emphasized the significance of being attentive to 'little things' such as a daily greeting, drinking coffee together, using humour, and acknowledging positive signs and accomplishments.

Listening and saying, "You are at an end", "I see that you are tired of fighting". But look, "I still see it for you!", or "Tomorrow I will be back, tomorrow we will see each other again". Saying such things really helps! I believe such little things mean a lot. Use their first name, say "good morning", or acknowledge it when someone is laughing, wears make-up, ... (female, 45–54y, open ward)

I find it important to listen to their life story in order to foster their hope. Do they have children who give

them perspective? Did they have a better period in their life? [...] I believe it means a lot to just be together, to make human and warm contact, for instance, when having a coffee together. It must not always be the planned and expected moments, but rather spontaneously and ask what interests them. I believe all those little things can ensure that people have more trust in me and feel a connection. When they feel suicidal, that is something they can hold on to. (female, 25–34y, open ward)

Nurses also try to support patients in acquiring awareness and understanding their SI. They emphasized the meaning of demonstrating concern for patients to raise the patients' awareness of their SI. In addition, some nurses engage in repeated conversations to support patients in identifying and organizing their thoughts and feelings and making sense of their SI. Nurses revealed that this is challenging when patients lack insight into their SI or verbalize chaotic messages. In addition, several nurses indicated that they use conversations with patients to explore warning signs and coping strategies, sometimes in consultation with family. Only a few of them operationalize this information in written safety plans. Some nurses use safety planning as part of a controlling and directing approach, in particular by imposing input for the safety plan based on professional assessments. Other nurses present themselves as a coach who coproduces the safety plan with the patient. In this way, they believe that safety planning enables shared and early recognition of emerging SI and enhances the patients' understanding of their SI.

When a patient is home and calls me in the evening with the message that it is not going well, then I take that safety plan out of my ring binder and look at it with them to see in what stage of crisis they are and what they can do. "I see that you can take a bath because this gives you a relaxed feeling." Then I encourage them to do this again, because they often say, "I have done everything on that list and it does not work". (female, 35–44y, open ward)

In one-to-one conversations, I try to support the patient's insight into triggers and ways to address their suicidal thoughts. "How do you experience that?", "How do you deal with this?", "What are possible actions?". So I coach them in this process. And personally, I start with a safety plan, because I notice that people can communicate very chaotically and mix up the meaning of their thoughts with their feelings. So I help them to get their thoughts and feelings a bit ordered. (male, 35–44y, open ward)

Nurses try to avoid encouraging SI. They indicated that they do not talk too frequently about SI and do not 'dig too deep' into the patients' SI history. They are cautious not to elicit emotionally loaded issues (e.g. trauma) to a point that patients' SI is encouraged and they as nurses cannot offer a solution for the issues raised. Several nurses indicated that talking about traumatic experiences is neither a task nor a competency of them, or that they conform to team agreements that nurses must not engage in such conversations. Some nurses interrupt conversations when patients share repeated expressions of hopelessness or trauma and then offer quick solutions. Offering quick solutions involves directing patients to do something to distract themselves or referring them to a psychologist or psychiatrist for a therapeutic conversation or an evaluation of their medication. Other nurses instead make the autonomous and deliberate decision to engage in conversations in the patients' best interests. They indicated that they as nurses should create time and space to listen to, acknowledge, and understand what patients want to share with them, including trauma and hopelessness.

If people talk about past traumas, then I believe that is better to refer them to the psychologist because they have learned how to respond to that. As a nurse, I feel less competent to do that and it might be that I make things worse by saying something inappropriate. Patients must know that they can go to the psychologist with their story. (female, 25–34y, closed ward)

I believe it is more important for patients to be able to come up with a story than to whom they say it. I deliberately do not say, "I am just a nurse!", because I think we have a very important role. I notice that nurses are often the ones to whom patients tell the most stories and the quickest, even about traumas, because we spend more time with them. So I always tell them that they can tell me everything that lives in them. (female, 45–54y, open ward)

Searching for balance in the minefield

Nurses' interactions with patients experiencing SI can be viewed as a minefield in which nurses act with extreme caution, experience intense emotions, and struggle with conflicting actions and aims. Nurses' accounts revealed a conflict between providing sufficient safety and avoiding overprotection. Nurses perceived that protective actions such as seclusion are sometimes the only safe option. Moreover, some nurses indicated that a lack of protective measures on the ward limits their ability to prevent suicide and is

sometimes the reason they refer high-risk patients to a ward that is more secure. However, nurses also perceive that protective measures do not guarantee that patients will not attempt or die by suicide. Furthermore, they perceive that protective measures can exacerbate patients' feelings of hopelessness, failure, and loss of dignity and can provoke agitation and counter-reactions. Nurses experienced that patients sometimes conceal or lie about their SI to avoid protective measures. Some nurses reflected that they should avoid overprotection by regularly evaluating whether the application and intensity of protective measures are (still) needed.

She must have acted immediately after our supervision. Because precisely after 15 minutes we went back to her room... You know, we watch over them, but patients also watch over us, so if they want to do it [suicide], they always find a way [...]. It will always be searching for a balance. If you want to be certain then you have to put patients naked in a seclusion room under constant camera surveillance. But is that human dignity? Then you take even more freedom and hope away from them. (female, 45–54y, open ward)

I sometimes hear people saying, "I did not dare to open up about those suicidal thoughts because I was afraid of being locked up or being not allowed to leave on the weekend". (male, 25–34y, open ward)

Nurses' actions and aims to protect patients can be reinforced by intense emotions when interacting with patients experiencing SI, including feelings of guilt about a previous suicide and fear of future suicides. Nurses also indicated that they can feel highly responsible for patients' behaviour, feel distrust towards high-risk patients, and feel insecure and powerless regarding their ability to maintain safety. These feelings can trigger nurses to preserve or increase patients' assigned risk level, conduct formal observations (beyond the protocol), and restrain and seclude patients for their own comfort. Some nurses acknowledged a need for emotional debriefing to avoid becoming paralysed by intense emotions and preserve open and caring contact with patients. Furthermore, nurses referred to the pressure they feel to meet legal responsibilities, knowing that they can be held accountable if a patient dies by suicide. Nurses described strategies to protect themselves from blame, including conforming to and upholding protocols, documenting about their actions, and shifting the responsibility for decisions involving risk (e.g. ward leave) to colleagues (e.g. psychiatrist).

If there are no safe alternatives, if that person really cannot function on the ward, then I do feel better with that person being in seclusion. That is maybe bad to say but it just makes me feel more secure that the person is safe from harm. (female, <25y, open ward)

I try to follow the protocol as well as possible. So I go regularly to the patient, ask them questions, and complete my records. Because in case of a suicide, the police will look into these records and the protocol and then query nurses about their involvement. So I find it very important that they do not get the impression that I have been negligent. And also to hear, "You have done everything!". That feels good because if that happens you feel responsible. (female, 25–34y, open ward)

In addition, nurses' perspectives reflected a conflict between upholding protection as a predominant aim and promoting and preserving patients' autonomy and self-determination. A number of nurses emphasized that their foremost responsibility is to protect patients, especially when they are at heightened risk of suicide. They believed that they are justified in taking control of patients and minimizing suicide risk by putting patients under observation, administering psychotropic medication, taking suicide means into custody, and restraining and secluding patients. These actions are guided primarily by a controlling and directing approach in which nurses cautiously conform to and uphold ward protocols, sometimes regardless of the patients' perspective.

If we evaluate that the suicide risk is too high, we look for seclusion and communicate, "We feel that you can no longer guarantee your own safety, we must take over from you, that is to protect you". I really try to persuade patients that they come with us voluntarily to the seclusion room, that they feel, "I am in a protected environment, protected from myself, that is necessary. (female, <25y, open ward)

If we indicate to patients that we are going to the seclusion room, then few patients say they'd "rather not". But even when they say they'd "rather not", we do it anyway, and then we emphasise, "Look, we want to protect you against your thoughts". (male, ≥55y, closed ward)

Other nurses indicated that they avoid a 'protection mode', which they described as a position from which they exert constant vigilance and control over patients to prevent suicide. These nurses instead reason and act beyond protocols to create opportunities to attune themselves to the patients' perspective and preserve their autonomy, self-control, and personal responsibility. They criticized legal responsibilities and

organizational expectations, claiming that these only underpin, value, and legitimize formal practices to prevent suicide rather than the meaningfulness of interactions such as being genuinely present with patients, addressing their needs, and inspiring hope.

If someone says to me, “I want to go to my husband”, then I will not say, “No, you have to stay here and sign the sheet of paper every hour!”. I will listen carefully and negotiate with them, “What would you like to do with your husband?”, “Are you going to feel satisfied afterwards?”. (female, 45–54y, open ward)

Sometimes I spend more time reporting than being present with the person. That is a shame! I sometimes wonder what is most important, “What I write down or what I really do with that person?”. Of course, I believe it is important that you write down things in case something happens, but I also believe that there are too many administrative tasks. (female, 35–44y, open ward)

Nurses also expressed uncertainty regarding the appropriateness of their attempts to foster patients’ hope. They perceived that patients’ suffering can be so intense that it makes no sense to try to inspire hope, which might even induce adverse effects. This conflict was central in the accounts of nurses focusing on explicit actions to foster patients’ hope and prevent their hopelessness. Some of them reflected that their actions (e.g. encouraging physical activity) can evoke agitation or disappointment in patients when they do not match the patients’ preferences or lack realism in terms of future prospects.

Stimulating knitting, crochet and tinkering with someone who is totally not creative or competent in that will lead to frustration. So, I try to look at what interests they have and what those were in the past. (female, 35–44y, open ward)

We try to find out what that person needs? If that person cannot think of anything but suicide, then I think there is no point in fostering hope. If I were in such a negative spiral, it would not have much meaning to me if someone said, ‘Come on, life is beautiful!’. (female, 25–34y, open ward)

DISCUSSION

Nurses’ actions and aims in their interactions with patients experiencing SI are captured within the core element ‘promoting and preserving safety and a life-oriented perspective’. This core element represents the three interconnected elements ‘managing the risk of

suicide’, ‘guiding patients away from SI’, and ‘searching for balance in the minefield’.

The findings reflect that nurse–patient interactions are importantly underpinned by protocols that are focused on safety and suicide prevention. All nurses were involved in actions such as assigning risk levels, using observation procedures, and applying protective measures. These findings resonate with the literature emphasizing the widespread and continuing use by nurses of formal observations, restraint, door-locking, and seclusion. Nurses perform these procedural actions despite evidence questioning their effectiveness in terms of suicide prevention and highlighting their predominant negative emotional and relational outcomes, including increased distress and social isolation, reduced autonomy, and (re)traumatization (Bowers *et al.* 2011; Cox *et al.* 2010; Cusack *et al.* 2018; Huber *et al.* 2016; Kontio *et al.* 2012). The findings confirm some of these outcomes including the nurses’ perception that protective measures can exacerbate patients’ feelings of hopelessness and provoke counter-reactions (e.g. conceal SI) (Cardell & Pitula 1999; Frueh *et al.* 2005).

Alongside uncovering ‘what’ actions nurses perform, the grounded theory approach was most appropriate to uncover the dynamics and meanings underlying these actions. While some nurses adhere more to a controlling and directing approach when performing actions (e.g. observations), others manage to underpin and reconcile their actions with caring contact, connection, and collaboration. This insight was also illustrated in the way nurses involve in making agreements and safety planning. The literature describes that safety planning is an evidence-based intervention for therapeutic risk management in (nursing) practice and that making safety agreements is central to nurse–patient interactions (Higgins *et al.* 2016; Kontio *et al.* 2012; Stanley & Brown 2012). The present study highlights that safety planning can be misapplied and is not a standard in nursing practice and that nurses emphasize other aspects when making agreements. While a connecting and collaborating approach reflects efforts to make shared agreements and to co-construct the patients’ safety plan in order to preserve autonomy and develop a shared responsibility for safety, the controlling and directing approach reflects that agreements and safety planning are underpinned by paternalistic and instrumental actions in order to protect patients from harm and to correct their hopelessness (Higgins *et al.* 2016; Slemon *et al.* 2017).

The findings offer indications that a connecting and collaborating approach has an inherent potential with

regard to achieving safety and therapeutic goals. This insight was highlighted in the nurses' perceptions that efforts to connect and collaborate with patients experiencing SI provide a foundation that serves as a secure base during suicidal crises and as a vehicle that fosters patients' hope and prevents their hopelessness. The literature confirms that nurses' efforts to connect and collaborate with patients can support patients in developing a sense of hope (Cutcliffe *et al.* 2006; Sun *et al.* 2006), efforts that are crucial given the theoretical association of hopelessness with SI (Klonsky & May 2015). Furthermore, the literature suggests that a connection with professionals is crucial for patients' sense of safety and their recovery from suicidal crises, and is a factor that protects against suicide (Berg *et al.* 2017; Lakeman & FitzGerald 2008). Nurses should engage with patients experiencing SI in a way that enables patients to communicate their suffering, gain insight and understanding about their SI, and develop coping strategies (Cutcliffe *et al.* 2006; Lees *et al.* 2014; McLaughlin 1999; Talseth *et al.* 1999).

The findings demonstrate that nurses can experience tension in balancing their role in managing suicide risk to ensure safety, meeting requirements for procedural practice, and their efforts to promote and preserve patients' life-oriented perspective. This tension was particularly present in the nurses' perception that using restraint and seclusion is sometimes the only safe option and their concern that applying these measures might induce adverse outcomes for patients (e.g. exacerbating hopelessness) and for patients' involvement in interaction (e.g. concealing or lying about SI). These findings can be associated with the study of Gerace and Muir-Cochrane (2019), indicating that nurses view restraint and seclusion as 'measures of last resort' to maintain safety. The present study confirms that a large number of nurses conform to these protocol-based measures in order to meet organizational expectations and to protect themselves in the event of an adverse outcome (Cutcliffe & Stevenson 2008, Hagen *et al.* 2017a, Manuel & Crow 2014). As with other studies, nurses urge to conform to protocol-based practice was also associated with experiencing strong emotions when interacting with patients experiencing SI, including uncertainty, fear, and a strong sense of responsibility and accountability (Hagen *et al.* 2017b; Morrissey & Higgins 2019).

Methodological considerations

This qualitative study lacks an integration of nurses' perspectives with patients' perspectives to obtain a

fuller answer to the research question (Lees *et al.* 2014). In addition, the study design is limited in determining variables that influence the crystallization of nurses' interactions with patients experiencing SI. Quantitative studies could examine the influence of variables (e.g. hospital and ward culture) that influence nurses' actions and aims in their interactions with patient experiencing SI.

Furthermore, it is important to acknowledge that the study was conducted in Belgium, a country where both the number of psychiatric beds per 100 000 inhabitants and the number of suicide per 100 000 inhabitants are among the highest in Western Europe (Allison *et al.* 2017; WHO 2018). The recent strong focus in this context on developing national suicide prevention policies and conforming to accreditation norms may partly explain the centrality of some findings, such as nurses' efforts to (indiscriminately) conform to suicide prevention protocols.

Relevance for clinical practice

The findings highlight the crucial importance of supporting nurses' ability and capacity to establish caring contact, connection, and collaboration with patients experiencing SI as an 'intervention' in itself and as a necessary foundation for interventions such as safety planning and observations (Berg *et al.* 2017; Higgins *et al.* 2016). The enhanced conceptual understanding of nurses' actions and aims offers valuable insights to support nurses in providing emotional and relational care to patients experiencing SI and to integrate this care with key aims, such as promoting safety and fostering hopefulness. These insights resonate with the literature indicating that nurses must ground their practice, including risk management, into a foundation of therapeutic engagement and a therapeutic relationship (Lees *et al.* 2014; McAllister *et al.* 2019; Slemmon *et al.* 2017).

At the same time, the findings show that a large number of nurses adopt an overemphasis on procedural, controlling, and directing approaches. This overemphasis seems to preclude nurses from connecting and collaborating with patients experiencing SI, and thereby from more fully realizing their potential to achieve safety and therapeutic goals. For instance, the accounts of these nurses reflected minimal emphasis on relational and emotional elements of safety and on efforts to reason and act beyond protocols. However, these elements and efforts are crucial to creating opportunities to attune to the patients' perspective,

promote their self-control and personal responsibility, and to best serve patients' recovery from mental health problems and SI (Berg *et al.* 2017; Leamy *et al.* 2011).

The findings imply that revising policy documents (e.g. protocols) and strategies is warranted so that these do not (unintentionally) contribute to an overemphasis in nursing practice on directing and controlling approaches, and to an understatement of connecting and collaborating approaches (Hagen *et al.* 2017a; Higgins *et al.* 2016). In this respect, the present study can inform policies that aim to reduce the use of restraint and seclusion in psychiatric hospitals and to replace formal observations with approaches that foster meaningful engagement (Cox *et al.* 2010). The findings highlight the potential of nursing actions such as making agreements and safety planning, actions that can only be considered as 'therapeutic risk management strategies' when being shaped in collaborative interaction (Kontio *et al.* 2012; Stanley & Brown 2012). Furthermore, evidence suggests the potential of empathetic interactions, communication skills, and de-escalation techniques as means to prevent or minimize the need for restraint and seclusion (Cusack *et al.* 2018; Gerace & Muir-Cochrane 2019; Kontio *et al.* 2012). These insights reflect the importance of incorporating the rudiments of trauma-informed and recovery-oriented care in psychiatric hospitals, including attention for patients' self-determination and choice, emotional and physical safety, connection and hope, and mindful and collaborative interactions (Farkas 2007; Muskett 2014).

Special attention should be paid to leadership as a critical component of fostering cultures that promote trauma-informed and recovery-oriented care, patient participation, and seclusion and restraint reduction initiatives (Isobel & Edwards 2017; Kontio *et al.* 2012; Vandewalle *et al.* 2018). Hospital leaders should create an environment in which there is less emphasis on defensive and self-protective interventions and more on recovery-oriented interventions, such as providing time and space for patients to really express themselves and creating opportunities for therapeutic risk management (Higgins *et al.* 2016; Sellin *et al.* 2017). Furthermore, the findings reflect the need to provide opportunities for debriefing and inter- and supervision as venues for nurses to express intense emotions and to reflect upon their interactions with patients experiencing SI (Hagen *et al.* 2017b).

CONCLUSION

The study in the context of psychiatric hospitals enhances the conceptual understanding of nurses'

actions and aims in their interactions with patients experiencing SI. These actions and aims are captured in the core element 'promoting and preserving patients' safety and a life-oriented perspective'. The enhanced understanding of nurses' actions and aims can inform concrete strategies for nursing practice and education. These strategies should aim to challenge overly controlling and directing nursing approaches and support nurses' capacity and ability to connect and collaborate with patients experiencing suicidal ideation.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTION

All authors made substantial contributions to the conception and design of the study; Joeri Vandewalle collected the data; and Dimitri Beeckman, Bart Debyser, Eddy Deproost, and Sofie Verhaeghe contributed to the analysis and interpretation of data. Joeri Vandewalle and Sofie Verhaeghe wrote the draft of the article. All authors critically revised the article, gave final approval for the submission of the article, and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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