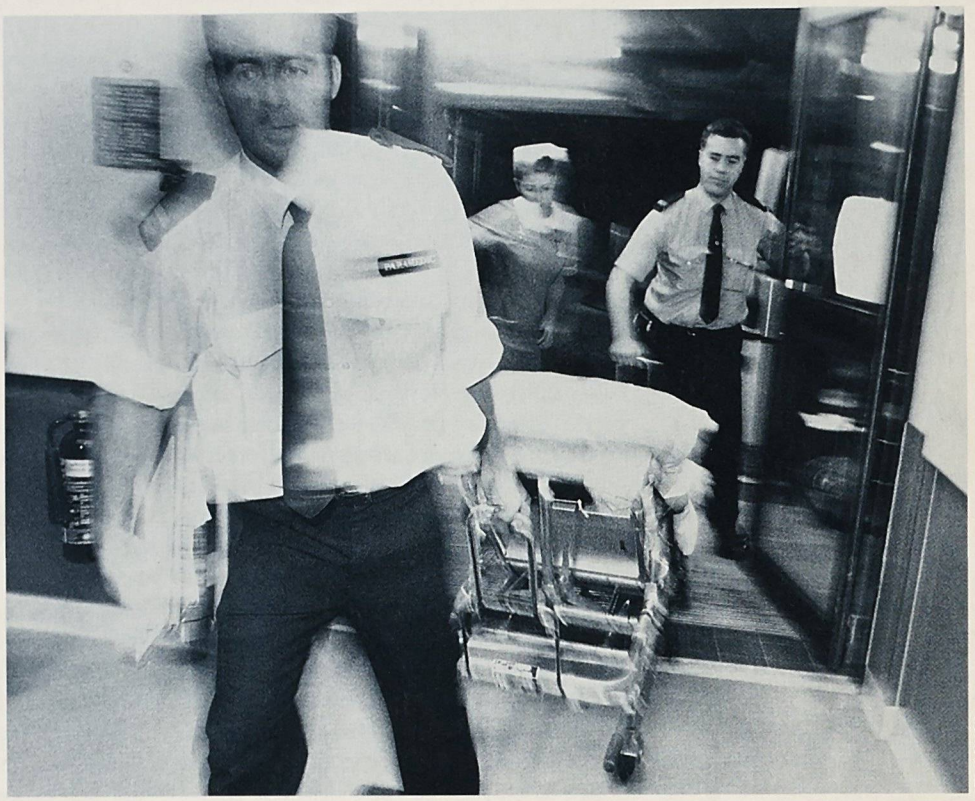
Suicide prevention by general nurses

The underlying reason for suicide attempts can be missed in the urgency to treat physical symptoms



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Dave Roberts RMN, RGN, is Clinical Nurse Specialist in Mental Health, Department of Psychological Medicine, John Radcliffe Hospital, Oxford, and Secretary of the RCN Special Interest Group in Liaison Mental Health Nursing.

This article has been subject to double-blind review.

This article aims to review what is known about the nature of suicide and attempted suicide, and examine the ways in which the general nurse can make the most effective contribution to the management and prevention of these problems.

Suicide and attempted suicide pose a particular challenge to nurses. How can healthcare professionals, who aim to preserve life, help those who try to destroy their own? The health targets on suicide set out in The Health of the Nation have thrown this problem into sharper focus (1). The government proposes to reduce suicide by 15 per cent by the end of the century. The mental health services are primarily charged with this task. However, as general nurses are in regular contact with people at risk of suicide, they too may have a role in its prevention.

General nurses are already familiar with the problem of suicide and attempted suicide (2-6). Nurses in A&E departments, on general wards and in the community frequently have to care for patients after suicidal acts. However, the act often leaves the nurse feeling frustrated and inadequate, and unsure of how best to help.

Suicide rates There is some controversy about whether it is possible for health services to reduce suicide rates. The suicide statistics are of questionable accuracy and it is not clear to what extent suicide is a health problem or a social problem (7, 8). There is also no clear and compelling evidence that the incidence of suicide can be reduced by health service interventions (8).

Suicide accounts for about 4,000 deaths in England and Wales every year. There has been a striking rise in the rate of suicide among young men, approximately 80 per cent in the age range 15-34 years in England and Wales from 1970-1990. Suicide was the second most common cause of death in men aged 15-34, after road traffic accidents, during this period (9).

For a verdict of suicide to be returned, the coroner must be persuaded that the deceased intended to die, and died by their own hand. In cases where this is not clear, he may return a verdict of accidental death or an open verdict, recorded statistically as 'undetermined'. Suicide is, therefore, under-reported, and retrospective analyses of the characteristics of undetermined deaths show similarities with proven suicides (10). There are a number of social factors which are associated with suicide rates and it is not solely the responsibility of the health services to deal with them. These include unemployment, family breakdown, and the availability of fatal means of self-harm (8).

KEY WORDS

- MENTAL HEALTH
- SUICIDE AND SELF-HARM

These key words correspond with entries in the RCN Nursing Bibliography.

The relationship between attempted suicide and suicide Attempted suicide is a significant health problem, accounting for more than 100,000 hospital admissions a year in the UK. In many areas it is the most common reason for the emergency medical admission of women, and the second most common one for men. Most attempts are by drug overdose. Though the majority of suicides are male, most overdoses are taken by women, by a ratio of approximately 2:1 (11).

The rate of suicide attempts is currently rising, and there is an increase in the use of paracetamol, which is extremely dangerous in overdose (12, 13). Various terms have been used to describe non-fatal acts of self-harm. Parasuicide is often used to describe an act which is similar to, but not the same as, suicide. Deliberate self-harm is a general term which describes acts involving harm to the individual. Attempted suicide is a commonly used term, though it can be misleading if suicidal intent cannot be shown (8).

Not all those who harm themselves or commit suicide mean to die. People harm themselves for a variety of reasons which are particular to individuals and their circumstances. Many attempts are committed with a degree of ambivalence. In a recent study of patients admitted to hospital after self-poisoning, over a third wanted to die at the time of the attempt, a quarter did not want to die, and an additional third of the group did not mind either way (13).

Impulsive or planned

All acts of self-harm carry some degree of risk. However, impulsive acts of self-poisoning usually allow time for the individual to change his/her mind and seek help. If a method is high risk, such as shooting, or jumping from a high place, then there is less opportunity to reverse the decision. Most completed suicides are planned, and carried out in an isolated place at a time when the person does not expect to be found (11).

The motivation for acts of suicide is hard to establish, as analysis can only be done retrospectively. Suicide may be viewed as an essentially irrational act and, therefore, only committed when someone is mentally ill. In some cases, however, suicide may be a rational decision. The presence of an all-pervading mood of hopelessness has been identified as a major factor in suicidal behaviour (11). Despair and anger may be prominent emotions (14). In those who survive attempts, it is possible to review motivation in more detail. Hawton *et al* (13) found that the most common reasons given for taking overdoses were to escape from an intolerable situation or unbearable state of mind, to communicate distress or seek help.

It is unhelpful to view attempted suicide as 'failed suicide', as this does not take account of the complexity of the phenomenon. The following description (15) may be useful: 'The attempt is more an enactment of dying which carries with it the discharge of some of the emotion appropriate to the actual event.'

One self-harming phenomenon which is particularly challenging is that of self-cutting. This often involves superficial lacerations of the hands, wrists or forearms, and may be of a different nature from deep self-cutting or mutilation with suicidal intent, or from overdosing. It is usually associated with intense feelings of tension, self-loathing, or depersonalisation, and may become a repeated behaviour. It is particularly hard for hospital staff to understand or identify with, and it is a difficult condition to help (16).

There are differences in the characteristics of suicide attempters, and those who die by completed suicide. Suicide is more common among men and the mentally ill, more likely with increasing age (though this may be changing), more likely to be premeditated and involve violent methods. Non-fatal suicide attempts are more common among women, decrease with age, are usually impulsive and involve self-poisoning (though approximately 10 per cent cut themselves), and only a minority are mentally ill. The national rates of suicide and attempted suicide also show independent variations (11).

Having established that there are significant differences between the suicide and the suicide attempter, it is important to note that 1 per cent of attempters go on to commit suicide within a year, and 2.8 per cent die by suicide within the next eight years (17). Someone who has attempted suicide is 100 times more likely to commit suicide than the general population within the following year (11). Young people are at particular risk of progression to fatal acts if they abuse alcohol and drugs (18).

The nurse's role in the management of attempted suicide The general nurse is primarily trained in the care of physical illness, and in purely physical terms, attempted suicide may be viewed as a self-inflicted injury which does not justify the use of scarce health resources. It is also likely that a lack of confidence and training may make the nurse reluctant to try and form a relationship (19). These factors may lead to negative labelling, rejection and the phenomenon of 'the unpopular patient' (20). However, observers have noted a need for general nurses to take a broader view of self-harming behaviour and to understand it within a holistic model of care (2, 4).

Attempted suicides are often viewed as 'attention seeking' or 'manipulative'. According to the reports of the patients themselves, they are more likely to be seeking a way out of a situation or state of mind which they cannot bear (11, 13). Gibbs (21) has emphasised the importance of effective communication between the nurse and the patient who has attempted suicide. The nurse should be aware of his/her own reactions to the patient, which may be conveyed verbally, or through non-verbal behaviour. Without a con-

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'Nurses have the potential to take a leading role in suicide prevention if adequately prepared.'

scious effort to communicate on the part of the nurse, the patient may be left feeling isolated (3).

Assessment All patients who have attempted suicide should be assessed by mental health service personnel (22). In several centres, assessments are made of suicidal intent, mental state, and a full psychosocial history is taken. These may be conducted by mental health nurses, psychiatrists, or social workers based in the general hospital (11). When specifically trained for this work, mental health nurses are able to do as adequate an assessment as a psychiatrist, and may perform better in the examination of mental state and identification of personal problems (23).

Assessments of this sort will enable severe mental health problems to be identified, so that psychiatric care can be arranged where necessary, whether as an inpatient, outpatient, or with a community psychiatric nurse (24). Where community follow-up is arranged, it is of particular importance that all relevant agencies, including the GP, are involved (11, 25). In the absence of a fully integrated psychiatric service, nurses and doctors in A&E departments need to develop systems for raising their awareness of risk factors associated with acts of self-harm, so that high risk suicidal behaviour can be recognised and psychiatric referral arranged promptly (26).

A tool which can be of use in identifying risk factors is the Beck Suicide Intent Scale, which measures intent based on factors including the degree of premeditation and planning, isolation, timing, the stated purpose of the attempt, expectations of outcome, and any attempt to get help (11). However, the Intent Scale should not be used without a thorough review of all the factors surrounding the attempt, including the patient's mental state.

Attempted suicide and other acts of self-harm can be difficult for the nurse to manage within a general hospital setting. The majority of general nurses lack the time and training to undertake comprehensive psychosocial assessment. It is important for the nurse to have access to specialist staff when necessary. In a growing number of settings, this will be a specialist liaison mental health nurse (27).

Suicide and mental health A high proportion of suicide cases may be mentally ill. A study from 1974 by Barraclough *et al* (28) indicated that as many as 95 per cent of the cases reviewed may have been mentally ill. The majority were depressed (70 per cent), but those suffering from alcoholism (15 per cent), and schizophrenia (3 per cent) formed significant minorities. Many also had personality problems and there was some overlap between these conditions. Depression is recognised as having a high level of morbidity by suicide. Alcoholism often induces despair, and intoxication depresses mood and increases impulsiveness, making suicide attempts more likely.

The above study has been very influential and many view suicide as primarily a problem of mental illness. Others would argue that the 'medicalisation' of despair is too simple a solution to a complex problem (4). However, the evidence from this study is strong, particularly as the retrospective diagnoses of mental illness were confirmed in 50 per cent of cases by a history of treated mental illness, in 25 per cent who were currently in treatment with a psychiatrist, and 80 per cent who were taking psychotropic medication at the time of the act. A disturbing finding of the same study was that two thirds of the suicides had seen their GP within the previous month, and 40 per cent had seen their GP within the previous week. There was evidence that some depressive states were not diagnosed by GPs, and that in other cases the treatment with antidepressants was not adequate (28).

Primary healthcare teams

There is, therefore, an argument that a proportion of suicides could be prevented if the detection and treatment of mental illness, depression in particular, could be improved. This may have particular relevance to the work of primary healthcare teams. A study from Sweden showed a significant reduction in the suicide rate on the island of Gotland in the year after a systematic education programme for GPs (29). The study is controversial, as the population under study was small, so longer term trends on the island need to be followed (8).

The Royal College of Psychiatrists and the Royal College of General Practitioners have undertaken a campaign to 'defeat depression'. This, like the Gotland study, is aimed at GPs and the use of antidepressant drugs. It would be desirable to extend the campaign to all primary healthcare staff, including district nurses and health visitors. These staff have extended exposure to patients at risk, and with adequate training could perform well in the identification of depression and other risk factors. It is significant that the Royal College of Nursing issued an Update package on depression in 1993 (30). More recently, initiatives have been set up to help practice nurses detect mental illness (31).

Suicide and physical health Those who commit suicide are often suffering from physical illness at the time of the act, and this may be in part because the physically ill tend to be older. With increasing age, suicide becomes more common. Suicide may be associated with unrelieved pain, disfigurement, disability and social alienation due to chronic medical conditions. This may explain the higher than expected suicide rates in renal disease, spinal cord injury and systemic lupus erythematosus. Central nervous system involvement in illness carries an increased incidence of depression, and suicides are more common in epilepsy, Huntington's chorea and multiple sclerosis. Patients who abuse alcohol may present in the general hospital with a range

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of gastrointestinal disorders, but they may conceal their habit, and are at high risk of suicide. This may be a factor in increased levels of suicide in peptic ulcer (32).

People with cancer are prone to depression, often very understandably, given the uncertainty of the course of their illness and the complications of treatment. Suicide may occur if they despair of improvement in their condition, or if pain is inadequately controlled (6). The increased suicide risk in HIV/AIDS may be due to stigma, complications of the illness and poor prognosis (32). Nurses tend to be sensitive to the emotional needs of their patients. However, they can also discourage patients from expressing their concerns, sometimes without being aware of it. This is a complex phenomenon, associated with the nurse's personality, training, and the culture of the ward they work in (33).

Suicide prevention in practice There are several factors which have been identified as relevant to suicide prevention in a clinical setting. Depression is commonly present in those who complete suicide, and there is a campaign under way to improve its recognition and treatment. The potential role of nurses in this effort has yet to be realised.

Two studies in particular have indicated that nurses, when specifically trained to do so, can detect and manage clinical depression. One study showed how nurse counsellors intervening post-mastectomy could identify the majority of depressed patients and refer them for treatment (34). As a result the counselled group showed significantly less psychiatric morbidity than the control group at 12-18 months post-operatively.

Health visitors may have a particular role in the detection and management of post-natal depression. A study from Edinburgh showed that health visitors offering counselling to depressed mothers six weeks after delivery led to a significant reduction in depression, without the use of antidepressant drugs (35).

Direct questions

When dealing with patients following a suicide attempt, it is important to ensure that the patient is adequately assessed and referred on if necessary (26). Open questions should be asked about how the patient has been feeling and time given to listen to replies. Questions may then turn to the act itself. Many nursing and medical staff are reluctant to ask direct questions about suicidal intent, fearing that it may introduce the idea to the patient. However, many patients are relieved when a direct enquiry is made. An understanding of the patient's motivation and effective communication with the patient may not prevent further attempts in itself, but is likely to lead to a more thorough assessment and the patient is less likely to be alienated (21).

Some factors have been identified which make an individual more at risk of suicide following an attempt. These include older age, unemployment, living alone, a history of mental illness (especially if previously treated as an inpatient), and two or more previous attempts (36). People with alcohol and drug misuse problems are at increased risk and this is a very important factor in young people (18). Though nurses should be aware of these factors, their significance can only be assessed in the context of a thorough review of the patient's history and mental state, undertaken by trained personnel (11, 26).

Psychiatric assessment

There are particular problems when a patient's physical condition necessitates treatment in a general hospital and they are potentially suicidal. This may occur after a suicide attempt which requires medical treatment, or in a person who is both mentally and physically ill. In such cases, the nurse should ensure that a psychiatric or mental health nurse assessment is carried out. Liaison mental health nurses (formerly known as psychiatric liaison nurses) may have a special role in supporting and advising general nurses. They will have an appreciation of the mental and physical nursing needs of the patient and aid in the formulation of an integrated care plan (37). Care should be taken to ensure that the patient is not labelled as a 'psychiatric case', but an assessment is made of the patient's needs as an individual (20).

Agreement must be reached between the psychiatric and general teams on whether the patient should be nursed in a general or psychiatric setting. This will depend on the severity of the patient's physical condition. If he/she remains in the general hospital, the necessary level of observation of the patient should be specified, as should the minimum number of (appropriately qualified) nursing staff. This should not be altered without reassessment by the psychiatric team. Consideration must also be given to locating the patient in a ward and a room where good observation is possible. Particular attention should be paid to providing a safe environment, by restricting the patient's access to dangerous equipment and materials, which are readily available in hospitals. It may also be advisable to nurse the patient on the ground floor (38).

Conclusion The general nurse will frequently find her/himself in situations caring for potentially suicidal patients. A lack of preparation may result in anxiety and underconfidence, and poor communication with the patient. It is important for the nurse to have an understanding of the complex nature of suicide and attempted suicide, and what is known about its potential for prevention. The detection and treatment of depression may be a major factor in this. Nurses have the potential to take a leading role in suicide prevention if adequately prepared ●

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