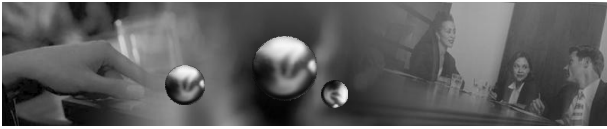


Collaboration, Connection and A Strengths-based Approach to Suicide Prevention



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Collaborating for Suicide Prevention

- Goal 3 of the The New Zealand Suicide Prevention Strategy (Associate Minister of Health, 2006) focuses on improving the care of people who make non-fatal suicide attempts.
- It suggests developing policies, strategies and services that lead to better treatment, management and after-care support for those making non-fatal suicide attempts.
- It outlines areas of action including:
 - Improving methods of treatment, management, after-care and support
 - Improving quality, continuity and accessibility of care
 - Supporting families/whānau to care for someone who has made a suicide attempt
 - Developing better after-care and support systems for Māori who have made a suicide attempt.

The Need to Improve Services, Connect With and Engage Youth

- Buston (2002) echoes these goals in her study of adolescent users of mental health services.
- She claims that further attention needs to be given to the development of empathic communication skills by health professionals working with young people who are experiencing mental health problems.

“The importance of support, empathy and accessibility were repeatedly stressed by respondents” (Buston, 2002, p.240).
- She also highlights the need for health professionals to work on connecting with young people in a way that encourages them to remain engaged with services:

“Further development by clinicians of a manner which encourages the patient to open-up and which gives the impression of caring, empathy and being listened to, should not be underestimated (Ong et al., 1995; Meryn, 1998).” (Buston, 2002, p.241).

Improving Services

- Hickie, Fogarty, Davenport, Luscomb & Burns (2007) identify some of the **key challenges involved in developing new youth-appropriate primary care services:**
 - Increasing young people’s access to such services.
 - Providing the style of services that young people most seek.
 - Focusing workforce training and development largely on early-intervention models.
 - Providing evidence-based psychological and medical services.
- Hickie et al (2007) recognise the importance of developing integrated collaborative care models among some of the solutions.

Different and Diverse

- McGorry (2007) reflecting on the public mental health system in Australia states:

“A new ‘youth mental health’ approach is required that builds on, but is qualitatively different from, existing child and adolescent and adult approaches, which have both struggled to address the mental health needs of teenagers and young adults” (McGorry, 2007, p.S54).
- Youth mental health services need to provide an intensive, comprehensive and integrated service response to young people and their families, focused on symptom remission, social and vocational recovery, and relapse prevention (McGorry, 2007).

Listening to Youth & Collaborating Across Disciplines

- “Our health system needs to take the next step forward in removing the barriers between health professionals and young people. It needs to start listening to what we are saying and what we are asking for. To know what works best for us, the system has to become youth-friendly and youth-oriented. (*Victoria Tonin, Platform youth participation programme, ORYGEN Youth Health, 2007*)” (McGorry, 2007, p.S53).
- In order to understand what supports the healthy development of young people and the best approaches for promoting wellbeing we need to **synthesise and integrate knowledge, not just from a wide range of research fields, or even disciplines,** but from across the natural and social sciences and humanities (Eckersley 2004, p.41).

- Much can be learnt from the study of human development, youth development and youth work, nursing and therapy.
- These disciplines contain concepts, research and knowledge that can inform the development of a strengths-based approach to suicide prevention.
- Much of the work in these disciplines is strengths-based.
- Some key themes within these disciplines are:
 - Starting with the individual's strengths.
 - Participative – providing youth with opportunities to take part, influence decisions that affect them.
 - Empowering – providing youth with competence and confidence.
 - Educative – teaching youth 21st Century skills and knowledge but acknowledging the flow of teaching and learning between youth and those who support them.

Interdisciplinary Approach

Strengths-Based Suicide Prevention

Improving care, protection and treatment
 Collaborating with youth to build competence and confidence
 Fostering development and wellbeing and addressing risk
 Reconnecting youth with their social world and life

Nursing Youth Work Human Development Therapy

Relationships

What Can be Learned from Youth Development?

- Focusing on young people's strengths rather than their failings is the underlying principle of youth development (MYD, 2002).
- Reducing and preventing developmental deficits and promoting developmental strengths are parallel, unique and complimentary tracks.
- Figure 1 illustrates the relationship between deficit- and strengths-based policy orientations.

Approaches to Successful Development

Policy Orientation	Pathways (Means)	Outcomes (Ends)
Deficit-based	A Reduce / Prevent Threats or Risks to Development	C Reduce / Prevent Health-Compromising Behaviour
Strength-based	B Promote Developmental Nutrients/Assets/ Supports and Opportunities	D Promote Developmental Well-being (e.g., caring, competence, and thriving)

(Benson, Mannes, Pittman & Ferber, 2004, p.785)

Suicide and Self-harm as Symptoms of Collapsed Social Worlds

"Traditionally young people have been labelled as 'at risk' on the basis of the symptoms, rather than the causes of their situation" (Martin, 2002, p.20).

We need to look at worlds behaviour occurs in.

Interventions based on symptoms are usually only going to address a single factor (not getting the bigger interconnected picture).

Interventions based on symptoms lead us to look at what is wrong with the individual – deficits-based approach (Martin, 2002).

(Martin, 2002, p.21)

Connecting with Life Histories

- Denov and Maclure (2007) state: "Life histories can provide listeners and readers with insights into the course of human development and 'the workings of the human mind' (McAdams 2001, p.307)"
- The use of a life-histories approach with young people who have engaged in non-fatal suicidal behaviour may shed light on the individual's experiences, choices made, actions taken, and consequences felt as well as reveal important information about local contexts, social structures and cultural mores that influence young people's behaviour.
- Life-histories may also be used to illuminate *turnings* (fundamental shifts in roles and identity) and *adaptations* (alterations of behaviour and identity over time) (Denov & Maclure, 2007) that may help suicidal youth understand their behaviour, lives and find new ways of coping and adapting.
- Health professionals might use a life-histories approach to both connect with youth, provide young people with a voice and find it a useful tool for beginning to collaborate with suicidal youth to find meaning and ways forward for their recovery.

Life Trajectories and Human Development

- The study of suicidal profiles across the life trajectory can help us map distinctive pathways and better understand the cumulative effects of risk and protective factors, including childhood adversity and more recent events (Séguin, Lesage, Turecki, Bouchard, Chawky, Tremblay, Daigle & Guy, 2007).
- The use of Life charts can help in the examination of the duration, development and characteristics of the suicidal process in young people, particularly when based on psychological autopsy information (Fortune, Stewart, Yadav & Hawton, 2006).
- Examining the developmental influences and the unique trajectories of young people is also a key area within the study of Human Development and the area of education for Human Service Professionals (Harms, 2005).

Getting to Know Youth

- As Etherington (2007) states:
"Life story research can help us co-construct complex, multilayered 'narrative knowledge' that we can hold alongside the 'paradigmatic knowledge' gained by using traditional research methods (Bruner, 1986; Mishler, 1999; Polkinghorne, 1988)" (p.456).
- It is not about finding *the* causal explanation – but about how young people make connections between life experiences, health issues, their sense of self and identity.

"If you want to know me, then you must know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I, too, must come to know my own story (McAdams, 1993, p.11)" (quoted in Etherington, 2007, p.456).

Reconnecting with Humanity to Aid Recovery

- Recent notions of 'recovery' seem to encompass a process whereby the individual can reclaim his/her self-esteem, pride, choice, dignity, and meaning (Wright, Haigh & McKeown, 2007).
- Health professionals need to embrace people's humanity to facilitate this process.

"Recovery is about the whole person, identifying their strengths, instilling hope, and helping to function at an optimal level by allowing them to take responsibility for their life" (Townsend & Glasser, 2003, p.83, quoted in Wright, Haigh & McKeown, 2007, p.243)

Defining a Therapeutic Alliance

- The therapeutic relationship, whether it exists within the context of therapy, treatment, care or support calls for a perspective of **collaboration** that enables the individual to define their own needs, use a language that makes sense to them and their significant other and empowers them to take control of their life.
- The therapeutic alliance is important for **alleviating a suicidal individual's sense of powerlessness** to change himself or herself or the environment, and facilitate the experience of success and mastery in dealing with his/her situation.
- **It allows the person to take a new perspective or standpoint** (Söderberg, 2004).
- It requires the **presence of significant others** who can reinforce the individual's new approach to the world.
- These relationships carry the potential for a development of **self-esteem and self-worth** and build on an active decision and personal commitment for change (Söderberg, 2004).

What Can Be Learned from Therapy?

- Summer & Barber (2003) note that the strength of the collaborative relationship between patient and therapist has been recognised as crucial by therapists from different theoretical backgrounds.
- Establishing this relationship is often seen as the first step in treatment.
- Referred to variously as therapeutic, working or helping alliance.
- Bordin (1979) defined it has having three components:
 1. Goals - Shared goals.
 2. Task - Accepted recognition of the tasks each person is to perform in the relationship.
 3. Bond – an attachment.

Connecting with the Experts - Young People

- Suicidal young people are **valuable sources of expertise and knowledge** and that if practitioners have well developed communication skills, and are **willing to see past the suicidal behaviour to meet the "expert" within** the individual they are more likely to find the answers to what the person needs to stop their suicidal behaviour and recover and thrive (Crockwell & Burford, 1995).
- The importance of establishing a therapeutic alliance with the suicidal person is also something recognised within New Zealand guidelines (NZGG, 2003) as something that can facilitate the disclosure of information and a sense of hopefulness and connectedness.

Collaborating with Youth to find Strengths

- Health professionals providing after-care support, treatment and care also need to see beyond the suicidal behaviour and help young people discover or rediscover their strengths and potential.
- Warelow and Edward (2007, p.134) state:

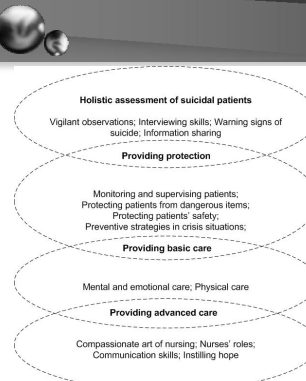
"Recovery or improvement in mental health was often achieved when people with mental health issues discover or rediscover strengths and abilities for pursuing their own personal goals and developing a sense of self that allows them to grow or move beyond the symptomatology that deems them to have a mental illness in the first place (Edward & Warelow 2005; p.101)"
- Warelow and Edward argue that 'caring' as a practice may assist people to become more resilient.
- Psychiatric nurses have opportunities to interrupt an ongoing suicidal process by intervening in suicide attempts and providing care to reduce the incidence of suicide (Samuelsson et al. 1997 cited in Sun, Long, Boore & Tsao, 2005, p.275).

What Can Be Learned from Nursing?

- Samuelsson, Wiklander, Asberg & Saveman (2000) identified the following aspects of care in their study of psychiatric inpatients who had made suicide attempts:
 - Receiving understanding, confirmation (sympathy), allowing action, those who mediated hope and orientation towards the future).
 - Understanding the patient's world from their point of view in order to be able to rehabilitate hope.
 - Warmth and support during initial treatment stage.
 - Being 'in a nurses care' giving a sense of security.
 - Confidence and trust.
 - Accessibility – knowing they were welcome to contact the ward at any time.
 - Sensitivity to needs – the need to talk or the need to be left alone.
 - Verbal contacts with staff (essential for healing and for desire to go on living).
- What wasn't helpful:
 - Nurses who were more interested in research than in the 'person'.
 - Nurses who took role of the 'neutral spectator' – rather than the close involved fellow creature.
 - Lack of understanding of the patient's perspective and not accepting the patient's suicidality.
 - Being treated like children, being guarded and controlled.
 - Not being confirmed – led to feelings of being burdensome, desire to go home, and further suicide attempts.

Nursing Care Theory

- **Nursing care theory** can guide the nursing care for patients at high risk of suicide.
- Sun et al's (2005) study highlighted the need for nurses to have the following skills:
 - Advanced communication qualities and skills to:
 - Effectively and continually assess suicidal patients;
 - Protect their safety;
 - 'Be there' for patients to provide basic care;
 - Use the compassionate art of nursing to provide advanced care;
 - Facilitate patients to heal and regain their desire to live.



Nurses in the study indicated they use dedicated nurses to initiate and maintain a trusting relationship with suicidal patients.

Dedicated nurses assessed patients suicidal thoughts, used suicide index scales to assess thoughts and feelings.

Basic care included being there for patients in their humanity, physically and emotionally, in presence and time.

Compassionate art of nursing included six concepts:

Empathy, being non-judgemental, acceptance of patient as person first, sincerity, kindness and respect for dignity.

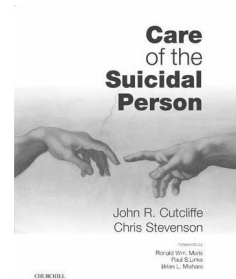
Figure 2 Action/interaction strategies in the nursing care of patients who are suicidal (Sun et al. 2005, p.278)


Key Findings: Roles, Communication Skills & Instilling Hope

- Key Findings from Sun et al's (2005) study:
- Nurses' take on **many roles** when taking care of suicidal people:
 - Person-centred care
 - Educator
 - Counsellor
 - Nurturer
 - Consultant
 - Advocate
 - Crisis management
- Effective use of **seven communication skills** helped nurses acknowledge patients' thoughts and feelings:
 - Listening and hearing
 - Engaging
 - Perceptive of moods
 - Open communication
 - Facilitating disclosure
 - Touch
 - Use of silence
- **Instilling hope** was related to four concepts:
 - Encouraging or teaching positive thinking
 - Promoting self-confidence
 - Valuing patients as people
 - Teaching problem-solving
- **In order to achieve all these nursing care strategies, nurses needed to initiate and maintain therapeutic relationships with patients.**

Caring for Suicidal People


- Cutcliffe & Stevenson's (2007) book argues that nurses need to move beyond observational care because this may only defer and not prevent, suicide.
- A key concept in the book is 'reconnecting the suicidal person/patient with humanity and argues that nurses need to provide suicidal people with:
 - Intense, warm human contact because suicidal people are often 'disconnected' from family and friends and lack support. This stage is about '**being with**' the person.
 - They need to move beyond this to also challenging the patient's ideas and thoughts about suicide and guide the person back to life affirmation. This stage is about '**doing**' and **reconnecting** the person with pre-suicidal ideas, feelings and hope.
 - A third stage involves the suicidal person embracing the hard work of **re-investing** in life.






Ronald Maris, in the foreword to Cutcliffe and Stevenson's (2007) book, notes the following practice implications of the authors' research:

1. Nurses need to be comfortable with death and death-talk.
2. Nurses need to talk in order to listen.
3. Nurses training needs to be more care-focused and less-assessment focused.
4. Nurses need to engage their patients and not merely observe them.
5. There is a need to move away from medication-based treatment.
6. There is a need to move beyond suicide risk assessment to suicidal patient care (Maris notes that risk assessment never saved anyone's life).
7. A recovery not a cure model needs to be adopted (p.ix).




Issues: Microfacism and the Evidence Discourse

- Smith (2007) notes that there is a need to break down "microfacism" which is at play in the contemporary scientific arena.
- Microfacism occurs when a dominant ideology excludes other forms of knowledge. It seeks to protect a privileged status by promoting a "regime of truth".
- He claims that the evidence-based movement in health sciences is "outrageously exclusionary and dangerously normative".
- He also notes that scholars not only have a scientific duty but an ethical obligation to deconstruct regimes of power.
- **Collaboration across disciplines that can contribute to suicide prevention will be difficult if some disciplines continue to act as facist structures and exclude other forms of knowledge including that which comes from young people.**
- Communities of practice: where knowledge emerges, is exchanged and is co-constructed through mutual discussion and where young people can have a voice should be encouraged.
- Communities of practice are where social and intellectual capital are built through research and practice communities working together. They are characterised by processes of mutual negotiation, reciprocity, trust and cohesion exist (Smith, 2007).




Implications

- Those working together to prevent suicide and in particular in those young people who have already engaged in suicidal behaviour need to look at areas of commonality across their services and disciplines and focus on aspects of care, protection and treatment that seek to reduce risk and promote wellbeing and development.
- **Inclusive rather than exclusive communities of learning and practice** should be encouraged that draw upon a wide range of knowledge and expertise to advance 'best practice', and 'research-informed practice' and 'evidence-based practice'.
- There needs to be a move away from the **unhelpful debate** about prevention OR promotion.
- Research needs to be conducted on the best ways to develop and deliver integrated community and after-care services (particularly for those young people with serious mental health problems) by multidisciplinary teams that include nurses, GP's, psychiatrists, counsellors, youth workers, social workers and educators.
- There needs to be a greater recognition that young people occupy many social worlds and contexts that influence their development, wellbeing and behaviour.




- It is important for health care professionals to be more than just knowledgeable doers - prevention activities need to be carried out within an **ethical framework of care with compassion** and sensitivity otherwise young people will feel they are there to be controlled rather than cared for.
- There is a **need to go beyond offering 'basic care'** which is important, to also offering **'advanced and compassionate care'** which could draw on the learning from the compassionate art of nursing.
- Health and human services professionals (and in particular tertiary students) may need specific education in suicide prevention. This is something that has been noted in social work education (Feldman & Freedenthal, 2006).
- Human services and health professionals may also benefit from some education focusing on adolescent and youth development so they better understand the needs and worlds of young people and **training in "basic relationship" skills** (Binder, Bongar & Messer, 1993 cited in Summers & Barber, 2003) and how to build therapeutic or working alliances with young people.



Some Conclusions

- **Strengths-based suicide prevention in relation to youth should:**
 - Focus on promoting healthy youth development and youth engagement in their communities and societies.
 - Still acknowledge the need to address health-compromising behaviours, risk factors, and improve crisis intervention, care and treatment.
 - Focus on health and human service professionals working *with* youth not *on* youth.
 - Provide youth with greater opportunities to develop alliances, connections and to collaborate with those who can support them.
 - Break down barriers between services and youth, foster the development of 'youth friendly' and 'youth-focused' services and models of treatment, care and protection and encourage integrated service delivery within communities.
 - Encourage collaboration between research disciplines so that people can develop partnerships, communities of learning and communities of practice.



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