Beyond the medical model: Future directions for suicide intervention services

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Abstract The medical model continues to dominate research and shape policy and service responses to suicide. In this work we challenge the assumption that the medical model always provides the most effective and appropriate care for persons who are suicidal. In particular, we point to service user perspectives of health services which show that interventions are often experienced as discriminatory, culturally inappropriate, and incongruent with the needs and values of persons who are suicidal. We then examine 'humanistic' approaches to care that have been proposed as a corrective to an overly medical model. We argue that the focus on improving interpersonal relations set out in humanistic approaches does not mitigate the prevailing risk management culture in contemporary suicide prevention and may impede the provision of more effective care. Finally, we draw attention to the tradition of non-medical approaches to supporting persons who are suicidal. Using Maytree (a U.K. crisis support service) as a case study, we outline some of the key features of alternative service models that we consider central to the design of more culturally appropriate and effective interventions.

We conclude by making three key recommendations for improving services to persons who are suicidal.

Keywords Suicide, medicalisation, crisis intervention, humanism, social values, social support

Introduction

In 2006, Don Richie, the so-called 'angel of the gap', was awarded a medal of the Order of Australia (OAM) for his self-appointed role of talking people down from a notorious suicide spot in Sydney known as 'The Gap'. During his lifetime Richie intervened in more than 160 suicidal events. He believed that much of his success was due to forming empathic connections with persons who are suicidal. Richie urged others to do the same. As he put it, "never be afraid to speak to those who you feel are in need. Always remember the power of the simple smile, a helping hand, a listening ear and a kind word."[1] Don Richie's compassionate approach to those experiencing suicidal distress is intuitively appealing. Indeed his work struck a powerful chord with the Australian people. Lauded by the public and media alike, Richie – besides being nationally recognised with an OAM – was named Citizen of the Year for 2010, alongside wife Moya, by Woollahra Council and received the Australian Local Hero Award in 2011. Like humanistic therapeutic techniques, the appeal of Richie's approach perhaps relates to his emphasis on empathy, connection, individual experience, and the assumption of basic 'goodness' about the suicidal person.[2]

The provision of non-medical forms of suicide prevention is hardly new. In 1774, London's Royal Humane Society established a tradition of humane care that provided the foundations

for subsequent organised suicide prevention services over the next two centuries. This included national organisations such as the National Save-A-Life League (U.S.A.), the Samaritans (U.K.), as well as international organisations such as the Salvation Army.[3] Services continue in this vein today, with volunteer organisations such as Sumithrayo (Sri Lanka) and respite centres such as 'Maytree' (U.K.) providing crisis care to persons who are suicidal using a 'befriending' model, which has been described as a non-intrusive, non-judgemental, and trusting approach to care.[4,5] Although on first view the befriending model appears to be fairly straightforward, evidence suggests that, like Don Richie's compassionate approach, the therapeutic model of befriending is a sophisticated approach that has had considerable success in providing relief from stressful and life-threatening situations for those experiencing suicidal distress.[4,6]

Yet, while befriender models are recognised as an organised, legitimate, and useful social intervention,[7] the medical framework continues to dominate research literature and shape service and program responses to suicide in Australia and worldwide. This is not to say that the medical approach has not driven some important changes in community attitudes and treatment options. It is credited for mitigating – to some extent at least – condemnatory views and responses to suicidal behaviour.[8] It has also helped to generate functionally useful concepts for reformulating human distress and suffering, thus rendering it manageable and providing therapies and programs to prevent its occurrence and assist those at risk.[9] However, the considerable body of research that shows how suicide is socially distributed, and that underscores the sociocultural, political and economic conditions that foster poor mental health and distress, is yet to be incorporated into current medical understandings.[10] Accordingly, the medical approach is increasingly seen by many academics, service providers and service users as culturally and socially impoverished.[11-13]

Health care professionals have also questioned the value of the medical framework for clinical practice. Michel and others argue that the persistent focus on psychiatric diagnosis "often leaves the needs of suicidal patients unmet."[14] This view is supported by a growing body of international literature on service user attitudes to clinical services following an episode of nonfatal suicide. For example, a systematic review by Taylor and others found that the majority of service users viewed their experience with health services (specifically medical management, in-hospital psychiatric management and post-discharge management) as unsatisfactory.[15] While many studies are less concerned with the type of management than with the experiences of service users, this research suggests that overall, service users found services that adopted a narrow medical framework as inappropriate and unhelpful.[16-18] In many instances, contact with medical services actually discouraged future help seeking.[17-19]

It is not the case that all suicide prevention, intervention and postvention services are the same. We acknowledge that there is considerable diversity and that current approaches incorporate both population-based and individual level strategies. Nevertheless, we would argue that a large majority of current population-based and community-led approaches such as gatekeeper training and suicide prevention awareness programs continue to operate within a medical framework. That is to say, one in which the primary goal is the identification and referral of persons who are suicidal to mental health services. Our view is that this continues to support an expert-illness approach to suicidal behaviour that overstates the efficacy of clinical treatment models in preventing suicide, while at the same time minimising important critiques of this model of care by service users and clinicians alike.

There is a recognised need to improve suicide intervention services. Preference has been expressed for services that are informal, broader in focus, and sensitive to the needs and values of persons who are suicidal.[15,19,20] However, the power of medicine to structure services continues to be a major barrier to implementing such approaches. Thus, in what follows, we make a case for rethinking how suicide intervention services might be conceived. We use evidence to challenge two key presuppositions underpinning current suicide prevention policy and service design. First, that treatment and service models currently provided for persons who are suicidal are inherently beneficent rather than posing as potential harms to health and wellbeing.[21] Second, that clinical health care services necessarily provide the most appropriate setting for the care of suicidal or recently suicidal individuals.[17] In making our arguments, we draw on a growing body of international research to highlight the limitations of current health service and treatment models and discuss the need to improve care for persons who are suicidal. We then examine alternative 'humanistic' approaches to care put forward by researchers in psychiatry and psychiatric and mental health nursing and discuss the challenges and possibilities that such approaches present. Finally, to illustrate our point further, we draw on the example of *Maytree* (a U.K. crisis support service) to suggest ways that particular understandings and approaches toward suicide and persons who are suicidal might be effectively incorporated into suicide intervention programs.

The problem of current clinically-based treatment and service models

Clinical practice is a key component of suicide prevention.[22] The push to more actively involve health practitioners in suicide prevention, together with the prevalence and increased risk of suicide and self-harm within inpatient psychiatric settings, means that clinicians need to be highly adept at addressing suicidal feelings and behaviour in the clinical encounter [23].

To this end, clinical guidelines such as the National Institute for Health and Care Excellence guidelines for self-harm, which highlight the importance of appropriate and continuing care for those who engage in suicidal behaviour, have been developed to inform and improve practice.[24] Despite these guidelines, a number of systemic, institutional, and attitudinal barriers can affect the quality of care provided.

Research indicates that service users continue to experience stigma and discrimination in services. For those who have engaged in a recent episode of nonfatal suicide, the emergency department often serves as the first point of contact with the health care system. Yet many service users report negative perceptions of their interactions with emergency department staff. Inappropriate staff behaviour including lack of empathy, humiliation, and perceived threats were cited as common reasons for service users' negative experiences.[15] A systematic review of the international literature on staff attitudes toward people who engage in self-harm or nonfatal suicide found that health professionals commonly held negative views of service users, with many reporting feelings of irritation and anger.[24] For example, studies reported that 55% of health professionals in the US and 49.3% in the UK had 'hostile attitudes' toward service users who engaged in self-harm or nonfatal suicide.[24] Differences in attitudes were noticeable based on the location of the service (emergency department or psychiatric setting) and discipline (nurse or doctor), but overall, there was a sense that people who were hospitalised for nonfatal suicide or self-harm were less legitimate than other patient groups (for example, those hospitalised for cardiac or respiratory issues) and were, therefore, less entitled to care.[24]

This is not to say that health professionals are uniformly unsympathetic. Research also indicates that psychiatric and general staff report feeling sympathy towards people who self-

harm or engage in nonfatal suicide.[24] Rather, discriminatory treatment of those who have

engaged in nonfatal suicide is widely attributed to a lack of knowledge, competency, and skill

in dealing with persons who engage in suicidal behaviour. It has been suggested that this

reflects the professional culture of emergency medicine and the prioritising of physiological

over psychological treatment.[15,25,26] Such attitudes may be further impacted by a shortage or

high turnover of staff, as well as the increasing demand for public hospital emergency

department services and increasing hospitalisations for nonfatal suicide and self-harm.[15,27]

Indeed, the negative attitudes and response of staff to the management of patients who have

engaged in nonfatal suicide has been associated with higher levels of burnout and low

personal accomplishment in staff.[28]

The consequence of health care professionals' negative attitudes and knowledge about fatal

and nonfatal suicide has serious implications for the effectiveness of clinical practice.[24,26] For

example, many of those presenting to emergency departments following an episode of

nonfatal suicide received no psychosocial assessment despite this being recommended

practice.[15] Among those who did receive assessments, experiences varied. Some described

the assessment as routine, superficial, rushed, and disengaging.[29,30] This is not to say that all

interactions are negative. Positive experiences have been described where service users were

allowed to share their distress and were involved in treatment decision-making and planning.

It is notable that these kinds of interactions led to change, or the possibility of change, for

persons who were suicidal.[15,30] Yet it must be stressed that these positive kinds of interaction

were the exception and not the norm.

Discharge from emergency care was also reported as a common source of concern for service

users. Discharge has been described as a disorienting and isolating experience with many

service users still struggling with the physical and psychological effects of their injuries.[29] Those who remained distressed, or felt they required further in-patient care, were left to persuade staff that things were sufficiently serious for them not to be discharged. Convincing staff was often difficult given prevailing negative attitudes and the pressure for in-patient psychiatric beds.[30] The process of discharge planning, together with the delivery, duration, and level of aftercare provided has also been cited as a source of dissatisfaction for service users. While many individuals welcomed referrals to outpatient care and the opportunity to discuss their problems, referral processes were sometimes unclear, left to service-users to initiate, or involved considerable waiting times between discharge and the therapeutic intervention.[31] These were not the only reasons that postvention care was problematic. Other reasons given included accessibility, the stigma associated with seeing a therapist, previous negative experiences of services, and the belief that therapy was not beneficial.[30,31]

Taken together, the problems in health services laid out above can be viewed more broadly in consideration of the norms of care that govern the management of persons who are suicidal. Although suicide is acknowledged as a complex, multidimensional problem that requires sophisticated, integrated approaches, in most cases a reductionist, observation-led, and short-term approach to management is adopted.[11,32] To put it another way, short-term medical management and risk containment is privileged over personal relationships.[33] Many of those who have engaged in suicidal behaviour or deliberate self-harm have therefore questioned whether the medical model is best suited to addressing their complex needs.[18,30] It is also of concern that, as noted previously, some service users report that they did not seek medical treatment for subsequent suicidal behaviour.[16,34] It is important to note, however, that if service users were given the opportunity to talk to someone about their problems in a caring, respectful, and nonjudgmental manner this was a significant indicator of quality of care and

increased the likelihood of further help-seeking.[15,16,26,30] However, such beneficial interactions were infrequent.

For those committed to supporting persons who are suicidal, the evidence suggests a clear need to improve health professionals' knowledge, attitudes, communication and clinical skills in this area. Research indicates that an increase in knowledge results in more positive attitudes, which, in turn, influences health professionals' sense of effectiveness.[26,35] However, we should not overlook the institutional and professional issues that challenge staff in this endeavour. Ever-increasing workloads, growing demands for monitoring and accountability, together with a lack of resources, make new learning difficult.[26] Even if institutional barriers can be overcome, it may be the case that busy biomedically oriented hospital settings are ill-suited to delivering the kind of compassionate, empathic, and complex care and support required by those who engage in nonfatal suicide. Currently, efforts to redress the quality of care for persons who are suicidal for the most part focus on changing the caring practices of health practitioners. In the following section, we examine alternative models of in-patient care proposed by psychiatric and psychiatric and mental health nurse researchers and practitioners.

Humanistic medicine and the support and care of persons who are suicidal

Given that "no 'singular' treatment or intervention" appears to successfully address the problem of suicidal behaviour,[32] and in light of the limitations of current service and treatment models, researchers in the field of psychiatric and mental health nursing have advocated strongly for a 'humanistic model' of nursing engagement. The proposed model is characterised by interactions in which nurturing and caring flourish.[32,36,37] Such humanistic

approaches are not intended to replace evidence-based approaches to the management of complex symptoms.[38] Rather, they provide a framework for nurses to respond to and connect with patients in order to ease suffering, promote wellbeing, and encourage hope and personal growth.[32,38,39] Humanistic models emphasise the importance of establishing meaningful social relationships, experiences, and participation in life – a process that entails significantly more than simply 'treating' the 'condition' of suicidality.[20]

A similar shift has also occurred in the field of psychiatry where there is growing recognition that the traditional medical model does not always meet the needs of persons who are suicidal.[14,40] To this end, recent work has begun to acknowledge the importance of understanding subjective experiences of suicidal distress and of fostering a deep empathic appreciation of the patient.[14] Rather than thinking in terms of the causes of suicidal behaviour, clinicians are called on to attend to patients' stories in order to build a therapeutic relationship, develop a shared understanding of suicidality in the context of the patients' life, and to assist the patient to re-establish a sense of meaning and purpose through dialogical exchange.[14,40]

Although these approaches have created the possibility for change in nursing and psychiatric practice, there is a serious drawback in confining change to the realm of interpersonal relations. This is not to say that it is not useful to highlight the importance of nurse-patient or psychiatrist-patient communication. Rather, the focus on interpersonal relations conceals a series of larger questions about the embeddedness of psychiatric and psychiatric nursing practice within predominant technocratic and biopolitical approaches to suicide prevention.[41,42] For practitioners, especially those working within state institutions, the prevailing culture of suicide prevention may actually conflict with notions of humanistic

practice.[42,43] With its emphasis on risk management – of patients as well as practitioners and the institutions they represent – the prevention discourse can appear paternalistic and self-serving, and may impede the capacity of practitioners to openly and fully engage persons who are suicidal, leaving their needs unmet.[41-43] The view of suicide as something to be prevented – at all costs – makes honest listening, including discussions about the uncertainties of life and death and the individual's urge to die, difficult.[12,43] From a health service perspective, it is feared that such approaches open a Pandora's box of ethically problematic and potentially irresponsible approaches to care that may prove dangerous.[12]

Efforts to humanise psychiatric and nursing practice may fall short for other reasons. Medical anthropological studies of psychiatric practice paint a more complex picture of the therapeutic encounter and the ways in which meanings are negotiated and produced. For example, works by Robert Barrett and Junko Kitanaka show how subtle iterative processes of talking and questioning contribute to the co-construction of patient narratives through which psychiatrists are able to translate patients' experiences into clearly defined areas of thought and behaviour that enable the management and control of conduct.[44,45,46] In other words, the therapeutic encounter is more accurately conceived of as a dialogue in which meanings are negotiated and produced. In co-constructing patient narratives, clinicians help to give shape to the complex, unformed, and often contradictory and unresolved aspects of patient's lives and experiences. While the common-sense view is to see the narratives produced during the therapeutic encounter as an accurate reflection of the interaction between clinician and patient, Kitanaka's research illustrates how processes of selective and repetitive questioning suppress alternative interpretations of patient's suicidal behaviour.[45] To put it another way, health professionals actively contribute to the way persons who are, or who have recently been suicidal, construct and narrate stories about their actions, thoughts, and feelings in a

manner that supports certain kinds of understandings, relationships, and responsibilities over others.

Further, drawing on the work of Rossiter and others,[42] we contend that the norms, structures, and practices of mental health service systems may actually impede the efforts of practitioners to work on the patient's behalf; whether this takes the form of affirming a patient's personhood in the face of psychiatric labelling or asserting that a patient's suicidal distress is the result of structural or systemic injustice, oppression or violence – both of which could undermine the clinicians professional legitimacy. For Rossiter and others, the focus on interpersonal relations of power in psychiatric practice is not sufficient to neutralise the institutional contexts in which the therapeutic relationship is embedded. Despite attempts to introduce 'humanistic' practices, the psychotherapeutic frame remains omnipresent. Attending to the patient's story becomes a "mechanism of increased effectiveness…. [that] promises intimacy but is really about control."[47] Being open and listening to the patient is a way of gaining the trust of the suicidal patient so that they are compliant to the therapeutic intervention, as noted by Michel and others.[14]

While we recognise that humanism in medicine can enrich the provision of care for persons who are suicidal,[32] we argue that continuing to view it as a primarily medical or scientific problem and making clinicians more effective at building rapport and trust in order to engage patients in a therapeutic intervention is inadequate. Rather, what is required is a more serious endeavour of calling clinicians out of their objectifying and categorising gaze in order to recognise that suffering, despair, pain, and death are human conditions that affect us all.[41,47] Through an awareness and openness to these fundamental human concerns that are – for many – an intrinsic part of suicidality, we might bring something radically different to suicide

prevention. It would be both a profound and radical move towards a reflexive practice that was more attentive to the needs of persons who are suicidal that steered clear of covert efforts to gain compliance.[41] Nevertheless, our ongoing concern is whether a mental health service system that is under-resourced, governed by rule-based practice and a language that distorts the existential and socio-political contexts of suicide, and one in which social interactions are limited to those with professionals in a medical context, is truly compatible with humanistic approaches.

Moving the discussion forward: non-medical models of care

The considerable body of international research on service user attitudes to health services following an episode of nonfatal suicide is particularly useful for critiquing current health service responses to nonfatal suicide. However, there is a distinct lack of evidence regarding service users' preferences for care. Indeed, recent World Mental Health Survey data indicates that many individuals prefer to manage their suicidal crisis outside of health care settings.[48] In high income countries, attitudinal barriers were cited as the primary reason for not seeking care. These findings are troubling, especially when low perceived need arises from experiences of ineffective treatment, dissatisfaction with mainstream services, or previous contact with uncaring practitioners.[17] Pitman and Osborn argue that this apparent rejection of mainstream services poses a clear challenge for policymakers who "must decide whether to use marketing principles (and scarce resources) to attract people who are suicidal into existing services, or invest in culturally appropriate interventions in more acceptable settings."[17]

Beyond the medical model

A small body of research has, however, examined the preferences for care of people who are suicidal. Notable examples include studies published by Cutcliffe, McKenna, Keeney and others and Jordan and others who examined the service preferences of young suicidal men in Northern Ireland,[19,20] These authors highlighted the need for community-based, informal suicide-support centres that are sensitive, pragmatic, and congruent with the needs and values of young men. They argue that a mental health framework constrains service providers, who focus on mental health issues as opposed to considering the actual needs of young suicidal men. Rather than just tinkering with existing formal mental health services, these authors support a broader approach. To this end, they cite the value of services that offer peer-support to assist young men in managing the challenges of day-to-day living, that help them to understand that having thoughts of suicide is not necessarily pathological, and that recovery is entirely possible. Such an approach does not exclude the possibility that counselling may be necessary or helpful for individuals to deal with past unresolved issues, but acknowledges that care includes being supported to pursue a meaningful, self-determined, and contributing life.[49]

The development of innovative and effective interventions that provide persons with opportunities to reconnect and engage in meaningful activities, we believe, is an important endeavour. It is therefore worth considering the modest, yet important evidence that is already available in order to develop such effective non-medical approaches to care. To illustrate this point, we would like to give a brief sketch of the Maytree service in London which has had considerable success in supporting persons who are suicidal. In doing so, we are less concerned with promoting the Maytree model as *the* approach of choice, as we are in using evidence from existing services to foster dialogue on alternative suicide intervention program and service models.

Beyond the medical model

The Maytree Suicide Respite Centre in London is a charitable organisation that was established in 2002. Founding members Paddy Bazely and Michael Knight's simple aim was to provide support to persons who are suicidal in a peaceful environment that is conducive to open and relaxed conversations.[4,5] The co-founders explicitly moved away from a medicalised approach to care, and adopted what they call a 'befriending' model towards service users, or as they prefer to call them, 'guests'. Guests are able to stay at Maytree for up to four nights. The concept of befriending – borrowed from the Samaritans – distinguishes a kind of approach that involves, as the Director of Maytree explains it, "not putting up any barrier about what can be spoken of. No limits to this naming of people's worst fears."[4] In other words, Maytree founders dared to move away from medical and risk-averse models of care in favour of creating trusting and necessary spaces for guests to openly discuss their reasons for suicide should they wish to do so. As such, Maytree took the radical step of providing an authentic service where 'being with' the person who is suicidal was the main aim, rather than having covert agendas to manage or reduce suicidality.[41]

The model of befriending arguably made such a radical step possible through its central precept that "everyone has the right to make fundamental decisions about their own life including the decision to die by suicide."[4] This does not mean that Maytree is averse to discussions of risk. On the contrary, they have a clearly articulated policy on risks that extends to assessment criteria and house-rules for guests. However, trust and the importance of differentiating between the responsibilities of staff and those of guests is seen as a more suitable approach, and one that in the end holds fewer risks.[4] Evaluations of Maytree are promising. Evidence indicates that Maytree offers its guests short and long-term relief from suicidal distress and that, for some guests, a visit to Maytree was described as

'transformational' since it marked a turning point in their recovery from suicidal thoughts and feelings.[4,50]

Of course, evidence for the efficacy of models such as Maytree is in its early stages. Also, while Maytree provides a striking example of a service which has successfully turned away from conventional medical frameworks, there are some persons for whom the talking-focussed approach appeared ill-suited.[50] We would therefore question whether this model continues to hold to the notion of the psychologised, self-determining, and self-governing individual who is solely responsible for their own recovery.[51] Just as this paper has sought to bring into question the institutional structures and norms that govern the management of suicidality, we would not wish to lose sight of the social, political and cultural circumstances in which individuals live their lives and the ways they are both enabled and constrained by relations of gender, class, and so forth. In other words, although our purpose is to examine alternative approaches to suicide prevention, and we illustrate this with the Maytree example, we support a broader approach to the care of persons who are suicidal that includes advocacy, peer support, critical awareness of the socio-political conditions of suicide, and the linking of crisis support to educational, social, community, and health services.

The design and implementation of alternative services or programs that adequately meet the needs of people who are suicidal challenges many of our tacit assumptions about suicide and how it should best be responded to. It is only by challenging the dominant normative contexts that shape current practices, however, that change can occur. The capacity of service users to make significant contributions to service design is often promoted by researchers and community and health services. Yet too often this is tokenistic with involvement being confined to a consultative role rather than being collaborative or user-led.[52] The research and

argument presented above suggests that the views of service-users need to be heard, and that they have an important role to play in the design and delivery of alternative service models that meet the needs of those who are suicidal.

It is a stated aim of various organisations in Australia and worldwide to improve services to persons who are suicidal. In light of our discussion we make three key recommendations for achieving this. First, we need to engage in frank and honest discussions about current health services to persons who are suicidal. This is not to say that mental health services do not have their place in the care of nonfatal suicidal injuries or serious mental illness, but rather we need to gain a clearer understanding of what medical services can, and cannot, currently offer to persons who are suicidal. Second, we must be prepared to enter into new territories and sincerely consider alternative models of care. Such discussions are necessarily challenging since they require candid discussions of issues such as the limits of the medical model, the social and economic factors that contribute to ill health, distress, and suicide, and how fear and risk-aversion in medical settings limits authentic interactions. Third, the views of service users must be genuinely elicited through processes of research, consultation and collaboration. We need to move away from paternalistic approaches and begin to work *with* persons who are, or have been, suicidal to acknowledge them as experts in the development of comprehensive, acceptable and useful services.

Conclusion

In this paper we have outlined criticisms of current approaches to the care of persons who are suicidal. We have also offered examples of alternative models of care that challenge the current framework, and made recommendations regarding service design. For those

committed to improving services to persons who are suicidal, there is an urgent need to engage in authentic and transparent discussions about the limitations and problems of current services. We can no longer shrink away from difficult conversations or maintain a paternalistic approach to service design. The stakes are simply too high. This means that we must examine the critiques put forward by service users, clinicians, and academics, as well as alternative models of care. We need to become aware of how current services deter help seeking or sincere engagement. Most importantly, to create services that adequately meet the needs of persons who are suicidal, we must begin to genuinely collaborate with those who have lived experience of suicidality.

Conflict of interests

The authors declare that there is no conflict of interest

References

1. Champness L. Vale Don Ritchie: The angel of the gap. 2012; http://www.abc.net.au/local/stories/2012/05/14/3502567.htm. Accessed April 27 2016.

2. Hecker J, Thorpe G. *Introduction to clinical psychology.* Oxford and New York: Routledge; 2015.

3. Colt GH. *November of the soul: The enigma of suicide.* New York: Scribner; 2006.

4. Briggs S, Webb L, Buhagiar J, Braun G. Maytree: A respite center for the suicidal. *Crisis.* 2007;28(3):140-147.

5. Mohammadi D. Under the maytree. *The Lancet Psychiatry.* 2015;2(6):494-495.

6. Marecek J, Ratnayeke L. Suicidal behavior in rural Sri Lanka: Assessing a prevention program. In: Grad O, ed. *Suicide risk and protective factors in the new millenium.* Ljubljana: Cankarjev Dom; 2001:215-220.

7. Balaam M-C. A concept analysis of befriending. *Journal of Advanced Nursing.* 2015;71(1):24-34.

8. Fitzpatrick SJ. Stories worth telling: Moral experiences of suicidal behavior. *Narrative Inquiry in Bioethics.* 2014;4(2):147-160.

9. Fitzpatrick SJ, Hooker C, Kerridge I. 'Suicidology as a social practice': A Reply to Tom Widger. *Social Epistemology Review and Reply Collective,.* 2015;4(4):44-81. Retrieved 1 April from http://wp.me/p1Bfg0-1ZM. Accessed April 27 2016.

10. Mills C. *Decolonizing global mental health.* New York: Routledge; 2014.

11. Cutcliffe JR, Stevenson C. *Care of the suicidal person.* Edinburgh: Churchill Livingstone Elsevier; 2007.

12. Delano L. On the urge to take my life, and my decision to take it back from the 'mental health' system instead. Mad in America Website 2013. http://www.madinamerica.com/2013/09/suicide-prevention-on-the-urge-take-life-decision-take-back-mental-health-system-instead. Accessed April 27 2016.

13. White J, Marsh I, Kral MJ, Morris J, eds. *Critical suicidology: Transforming suicide research and prevention for the 21st century.* Vancouver: UBC Press; 2015.

14. Michel K, Maltsberger JT, Jobes DA, et al. Discovering the truth in attempted suicide. *American Journal of Psychotherapy.* 2002;56(3):424-437.

15. Taylor TL, Hawton K, Fortune S, Kapur N. Attitudes towards clinical services among people who self-harm: Systematic review. *The British Journal of Psychiatry.* 2009;194(2):104-110.

16. Bolger S, O'Connor P, Malone K, Fitzpatrick C. Adolescents with suicidal behaviour: attendance at A&E and six month follow-up. *Irish Journal of Psychological Medicine.* 2004;21(03):78-84.

17. Pitman A, Osborn DPJ. Cross-cultural attitudes to help-seeking among individuals who are suicidal: New perspective for policy-makers. *The British Journal of Psychiatry.* 2011-07-01 00:00:00 2011;199(1):8-10.

18. River J. Suicide and hegemonic masculinity in Australian men. In: Lester D, Gunn JF, Quinnett P, eds. *Suicide in men: How men differ from women in expressing their distress*. Springfield IL: Charles C. Thomas; 2014:248-261.

19. Jordan J, McKenna H, Keeney S, et al. Providing meaningful care: Learning from the experiences of suicidal young men. *Qualitative Health Research.* September 1, 2012 2012;22(9):1207-1219.

20. Cutcliffe JR, McKenna H, Keeney S, Stevenson C, Jordan J. 'Straight from the horse's mouth': Rethinking and reconfiguring services in Northern Ireland in response to suicidal young men. *Journal of Psychiatric and Mental Health Nursing.* 2013;20(5):466-472.

21. Pilgrim D, Rogers A. The troubled relationship between psychiatry and sociology. *International Journal of Social Psychiatry.* September 1, 2005 2005;51(3):228-241.

22. Cutcliffe JR, Santos JC. *Suicide and self-harm: An evidence-informed approach.* London: Quay Books; 2012.

23. James K, Stewart D, Bowers L. Self-harm and attempted suicide within inpatient psychiatric services: A review of the Literature. *International Journal of Mental Health Nursing.* 2012;21(4):301-309.

24. Saunders KEA, Hawton K, Fortune S, Farrell S. Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders.* 2012;139(3):205-216.

25. Cleaver K. Attitudes of emergency care staff towards young people who self-harm: A scoping review. *International Emergency Nursing.* 2013;22(1):52-61.

26. Timson D, Priest H, Clark-Carter D. Adolescents who self-harm: Professional staff knowledge, attitudes and training needs. *Journal of Adolescence.* 2012;35(5):1307-1314.

27. FitzGerald G, Toloo S, Rego J, Ting J, Aitken P, Tippett V. Demand for public hospital emergency department services in Australia: 2000–2001 to 2009–2010. *Emergency Medicine Australasia.* 2012;24(1):72-78.

28. Gibb SJ, Beautrais AL, Surgenor LJ. Health-care staff attitudes towards self-harm patients. *Australian and New Zealand Journal of Psychiatry.* 2010/08/01 2010;44(8):713-720.

29. Horrocks J, Hughes J, Martin C, House A, Owens D. *Patient experiences of hospital care following self-harm: A qualitative study.* http://www.researchgate.net/profile/Allan_House/publication/228359199_Patient_Experiences_of_Hospital_Care_Following_Self-HarmA_Qualitative_Study/links/551a7dbf0cf244e9a4587b04.pdf2005. Accessed April 27 2016.

30. Hunter C, Chantler K, Kapur N, Cooper J. Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking: A qualitative study. *Journal of Affective Disorders.* 2013;145(3):315-323.

31. Hume M, Platt S. Appropriate interventions for the prevention and management of self-harm: A qualitative exploration of service-users' views. *BMC Public Health.* 2007;7(1):9.

32. Cutcliffe JR, Barker PB. Considering the care of the suicidal client and the case for 'engagement and inspiring hope' or 'observations'. *Journal of Psychiatric and Mental Health Nursing.* 2002;9(5):611-621.

33. Pilgrim D, Rogers A, Bentall R. The centrality of personal relationships in the creation and amelioration of mental health problems: The current interdisciplinary case. *Health.* 2009;13(2):235-254.

34. NHMRC Centre of Research Excellence in Suicide Prevention. *Care after a suicide attempt.* Sydney: Black Dog Institute. http://www.blackdoginstitute.org.au/docs/CareAfteraSuicideAttempt02-09-15.pdf;2014. Accessed April 27 2016.

35. Draper BM, Krysinska K, De Leo D, Snowdon J. Health care professional attitudes toward interventions to prevent suicide. *Suicidology Online.* 2014;5(1):24-32.

36. Hewitt JL, Edwards SD. Moral perspectives on the prevention of suicide in mental health settings. *Journal of Psychiatric and Mental Health Nursing.* 2006;13(6):665-672.

37. Talseth A-G, Gilje F, Norberg A. Struggling to become ready for consolation: Experiences of suicidal patients. *Nursing Ethics.* 2003;10(6):614-623.

38. Wu H-L, Volker DL. Humanistic nursing theory: Application to hospice and palliative care. *Journal of Advanced Nursing.* 2012;68(2):471-479.

39. Silva TN. Paterson and Zderad's humanistic theory: Entering the between through being when called upon. *Nursing Science Quarterly.* 2013;26(2):132-135.

40. Frei M, Grimmer B, Michel K, Valach L, Boothe B. First encounters with patients after attempted suicide: A conversation and interaction analytical approach. *Forum: Qualitative Social Research.* 2012;13(1).

41. Petrov K. The art of dying as an art of living: Historical contemplations on the paradoxes of suicide and the possibilities of reflexive suicide prevention. *Journal of Medical Humanities.* 2013;34(3):347-368.

42. Rossiter A, de Boer C, Narayan J, Razack N, Scollay V, Willette C. Toward an alternative account of feminist practice ethics in mental health. *Affilia.*1998;13(1):9-30.

43. Nicholl E, Loewenthal D, Gaitanidis A. 'What meaning does somebody's death have, what meaning does somebody's life have?' Psychotherapists' stories of their work with suicidal clients. *British Journal of Guidance & Counselling.* 2015:1-14.

44. Barrett RJ. *The psychiatric team and the social definition of schizophrenia: An anthropological study of person and illness.* Cambridge: Cambridge University Press; 1996.

45. Kitanaka J. Diagnosing suicides of resolve: Psychiatric practice in contemporary Japan. *Culture, Medicine and Psychiatry.* 2008;32(2):152-176.

46. Kitanaka J. *Depression in Japan.* Princeton, NJ: Princeton University Press; 2012.

47. Bishop J. Rejecting medical humanism: Medical humanities and the metaphysics of medicine. *Journal of Medical Humanities.* 2008;29(1):15-25.

48. Bruffaerts R, Demyttenaere K, Hwang I, et al. Treatment of suicidal people around the world. *The British Journal of Psychiatry.* 2011;199:64-70.

49. Davidson L. Living recovery. *Epidemiology and Psychiatric Services.* 2012;21(4):365-366.

50. Briggs S, Linford H, Harvey A. *Guests experience of Maytree during and after their stay.* London: University of East London and Tavistock Clinic, UK. http://www.maytree.org.uk/download/CSWR-2012.pdf;2012. Accessed April 27 2016.

51. Rose N. *The politics of life itself.* Princeton: Princeton University Press; 2007.

52. Horsfall J, Cleary M, Walter G, Malins G. Challenging conventional practice: Placing consumers at the centre of the research enterprise. *Issues in Mental Health Nursing.* 2007;28(11):1201-1213.