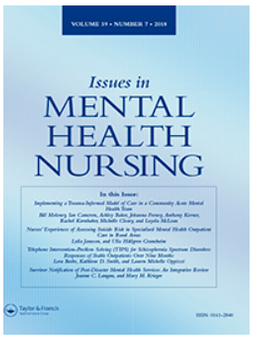

Issues in Mental Health Nursing

ISSN: 0161-2840 (Print) 1096-4673 (Online) Journal homepage: informahealthcare.com/journals/imhn20

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To cite this article: Leila Jansson (Clinical Specialist) & Ulla Hällgren Graneheim (Senior Professor) (2018) Nurses' Experiences of Assessing Suicide Risk in Specialised Mental Health Outpatient Care in Rural Areas, Issues in Mental Health Nursing, 39:7, 554-560, DOI: 10.1080/01612840.2018.1431823

To link to this article: https://doi.org/10.1080/01612840.2018.1431823

Published online: 13 Mar 2018.

ISSUES IN MENTAL HEALTH NURSING
2018, VOL. 39, NO. 7, 554–560
https://doi.org/10.1080/01612840.2018.1431823

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Nurses' Experiences of Assessing Suicide Risk in Specialised Mental Health Outpatient Care in Rural Areas

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ABSTRACT

This study describes nurses' experiences of assessing suicide risk in specialised mental health outpatient care in rural areas in Sweden. We used a qualitative, descriptive design based on twelve interviews that were subjected to qualitative content analysis. The results showed that the nurses felt anguish due to a lack of control. They expressed uncertainty and loneliness, and they struggled with ethical issues and organisational challenges. Having the sole responsibility to assess suicide risk can increase a person's emotional vulnerability and moral stress. Consequently, in order to prevent ill health among these nurses, there is a need for a tolerant work climate and an organisation that provides support to its employees.

Assessing suicide risk is a demanding task within mental health outpatient care. Further, nurses operating in rural areas have to initiate and conduct assessments on their own, and they are, together with the physician in charge, also held individually responsible for their assessments. Consequently, it is important to describe nurses' experiences of how they deal with questions concerning suicide risk. Their experiences can foster awareness of the responsibility and the ethical standpoints related to assessing suicide risk, can help outline the need for further education and supervision, and can improve support from co-workers and management.

Background

Assessing suicide risk is always an inexact science and can only be done on a short-term basis (Social Board of Health and Welfare, 2010). Graig and Rudd (2006) claim that society has unrealistic expectations that professionals should be able to predict suicide, and they argue that the health care system instead should focus on assessing and identifying when a patient transfers to an increased level of risk. As pointed out by Barker (2001), this requires courage, experience, and awareness of the stigma that surrounds suicide and how these can influence the assessment.

Assessing suicide risk is even more demanding in rural areas. There are few studies focusing on nurses' experiences of suicide assessments in outpatient care taking place in rural areas. According to Hawton (2009), suicide is most common among middle-aged/older men living in male-dominated, depopulated areas, and American nurses have reported that women living in rural areas are often depressed and in significant need of treatment (Groh, 2012). Despite the need for such treatment, Growther and Ragusa (2011) reported that in Australia it was difficult to recruit mental health nurses to rural areas because these positions were not considered attractive but rather as carrying a low status. To our knowledge, there are no Swedish studies that include nurses' experiences within mental health outpatient care in rural areas. Therefore, this study aimed to describe nurses' experiences of assessing suicide risk in specialised mental health outpatient care in rural areas.

Method

This is a qualitative, descriptive study based on semi-structured individual interviews that were subjected to qualitative content analysis (Graneheim & Lundman, 2004) using an inductive approach (Elo & Kyngäs, 2008)

Context

The study was carried out in northern Sweden in an outpatient unit. This unit is part of a psychiatric clinic and is divided over three open-care facilities situated in three rural municipalities. In the study area, the distance between medical health care centres and the closest psychiatric outpatient clinic varied from 80 to 230 kilometres. Similarly, the distance to the closest inpatient clinic varied from 140 to 380 kilometres. Due to these large distances, the nurses visited the medical health centres and even private homes once a week. The outpatient unit offered care for adult, voluntary patients with all kinds of mental ill health and was open eight hours a day five days a week.

The unit offered different forms of treatment such as supportive contact, therapy, psychological assessment, pharmaceutical treatment, and health education. There was also a possibility to meet a nurse through videoconferencing if the patient could not visit the outpatient unit. A patient in need of inpatient care was moved to the main clinic, which was far away from their families and ordinary caregivers. The unit was staffed by enrolled nurses in mental health, registered nurses,

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psychologists, social workers, occupational therapists, a physiotherapist, psychiatrists, and unit managers.

In 2006, the management at the outpatient clinic decided that all experienced staff members would assess suicide risk and that the physician in charge would then verify each assessment. Since 2008 the nurses were trained to use a structured suicide assessment instrument, a procedure recommended by Sweden's Social Board of Health and Welfare (2003, 2010). The instrument included issues about age and gender, anamnesis, diagnosis, symptoms, treatment and adherence, risk, and protective factors. The Social Board of Health and Welfare considered this as a planning tool, providing structure and content in terms of how to think, resolve, and make conclusions about the suicide risk.

Participants

All nurses in the three rural municipalities working in specialised mental health care were invited to participate if they had a minimum of one year of experience with assessing suicide risk.

Initially, eight registered nurses accepted the invitation to the study, a number deemed too low to give valid results. Therefore, we extended the invitation to include four enrolled nurses in mental health care as long as they fulfilled the criteria originally decided upon. Totally, four enrolled nurses and eight registered nurses were recruited. In this context registered nurses and enrolled nurses had similar responsibility for assessing suicide risk. The participants' characteristics are given in Table 1.

Data collection

Twelve semi-structured individual interviews were conducted using a similar set of questions. The initial query was "Can you describe your experiences of assessing suicide risk in mental health outpatient care, focusing on a specific situation that has left a strong memory". During the interview, follow-up and clarifying questions were asked, for example, "What did you feel/think/do in this situation?"

The interviews were performed by the first author (L J) in an undisturbed room at the unit. The interviews ranged in time from 45 to 75 minutes (median = 55 minutes). All interviews were audio-recorded and transcribed verbatim, including non-verbal expressions such as laughter, crying, sighs, and pauses.

Table 1. Presentation of participants' characteristics ($n = 12$).

	n	Median
Gender		
Women	8	
Men	4	
Age	39–62	56
Profession		
Registered nurse	8	
Enrolled nurse	4	
Education		
Specialist training in mental health nursing	7	
Basic training in psychotherapy	8	
Registered psychotherapist	1	
Motivated intervention/Social psychiatry	4/1	
Years employed in mental health out-patient care	1.5–14	14

Before the analysis, the transcribed versions were compared to the recordings two times.

Analysis

The transcribed data were analysed using qualitative content analysis. Qualitative content analysis focuses on describing variations, and it identifies similarities and differences in the text by analysing the manifest as well as latent content of the text, where the manifest components constitute categories and the latent components constitute the themes (Graneheim & Lundman, 2004).

Initially, the text was read several times to get a sense of the whole. Next, the text was divided into meaning units answering the aim. Each meaning unit was condensed and eventually given a code. During this process, the authors continuously returned to the original text to ensure that the core meaning of the sentences was maintained. This process of continuously cross-referencing with the original text was maintained throughout the entire analysis. Similar codes were grouped into subcategories that later were sorted and abstracted into categories. Finally, the latent meanings in the categories were connected and used to describe the underlying theme on a higher level of interpretation and abstraction (cf. Graneheim & Lundman, 2004). During this entire procedure, the authors reflected on codes, preliminary categories, and themes and reached consensus in four categories and one theme that corresponded to the aim of the study.

Ethical considerations

This study was undertaken according to the ethical guideline described in the Helsinki Declaration (World Medical Association, 2008). Furthermore, the authors applied for approval from the boards of directors at the clinics to conduct the interviews. In the application, the aim of the study was clearly stated, as well as its design and how the findings might improve daily work routines. This was in concordance with the guidelines provided by The Swedish Research Council (2016) where all empirical studies require information, consent, confidentiality, and knowledge of usage. In order to ensure that these requirements were fulfilled, the information component was delivered twice in person during staff meetings as well as in writing. In the written information, it was stated that participation was voluntary and that the participants could terminate their involvement at any time without giving a reason. In order to guarantee confidentiality, work titles, names, and gender were not used to describe any of the participants. All personal information was stored together with the collected data in a secure location only accessible by the authors.

Results

Feeling anguish due to lack of control

The study resulted in one theme showing that the nurses experienced anguish due to lack of control when assessing suicide risk in outpatient care in a rural area. The theme is based on four categories describing how the nurses felt uncertain and lonely

and struggled with ethical issues and organisational challenges. Table 2 present an overview of the results of the study.

Uncertainty

The nurses described how they found it difficult to interpret patients who expressed themselves in an ambivalent manner. Furthermore, they realized that the assessments were only applicable in the short term and that old beliefs and myths contributed to the sense of feeling uncertain. Tools, including agreements and local routines, could both help and hamper the assessment. The nurses all relied on their experience and intuition in assessing suicide risk.

Ambivalent messages

During the suicide risk assessment, the nurses did not know if they could trust the information from the patient. One nurse said: "Well, there is always the question about whether or not you can really trust what the patients say" (I:1). They described feelings of security when assessing a well-known patient, rather than a new patient, and they felt safer if the patient had upheld previous agreements regarding suicidal thoughts. Reserved patients and patients who expressed themselves cryptically were considered difficult to assess because their responses were difficult to interpret. Sometimes the nurses got a sense that certain patients replied in a way that they thought would please the nurse. In the case of repeated suicide threats, there was a risk of making an incorrect assessment, but there was also the possibility that the patient was trying to trick the nurses.

Short-term assessments

Suicide assessments were only considered viable for a limited time. In order to make a well-grounded assessment, the nurses had to ask numerous questions, some of them repeatedly, phrase the same question in different ways, and constantly ask themselves whether they had asked the right questions and made the right assessment.

Table 2. Presentation of the subcategories, categories, and theme revealed during the analysis.

Subcategory	Category	Theme
• Ambivalent messages	Uncertainty	Feeling anguish due to lack of control
• Short-term assessments		
• Old beliefs contributing to uncertainty		
• Agreements and routines for better or for worse		
• Experience and intuition as resources		
• Constantly looking for signs	Loneliness	
• Having sole responsibility		
• Patient integrity versus professional obligations	Ethical issues	
• Private experiences about life and death versus maintaining professionalism		
• Bridging geographical distance	Organisational challenges	
• Improving teamwork		

> *Once I have done a suicide risk assessment, I feel that I have done everything in my power. And if something still happens, it is not because I have failed but rather that some things are impossible to foresee, affect, or prevent.* (I:2)

The suicide risk assessment questions were clear, accurate, and straightforward. When assessing risk over a longer time, as in severe depression, the nurses had to perform repeated assessments that were combined into a summarised assessment.

Old beliefs and myths

The nurses confirmed that the risk of suicide was perceived as frightening when they entered the field of mental health care, and they were afraid of triggering suicidal thoughts in patients if they spoke about the issue. Also, they initially struggled with thoughts like, "What gives me the right to ask this" (I:3). These thoughts evolved over many years of experience, and one nurse reflected: "I think that we sometimes are a little too cautious, too scared, to ask these types of personal questions" (I:4). Another issue was the belief that patients who were vocal about their lack of will to live were considered low risk. because one does not usually commit suicide if one is willing to talk about it. One nurse said: "My experience is that those who have decided to end their lives, they don't talk about it" (I:4).

The nurses also described preconceptions among patients that suicidal thoughts were uncommon, dangerous, unhealthy, and a taboo topic. They emphasised the need to address these thoughts by showing the patient how to talk about suicide, making sure that the severity of the topic stayed in focus. As the nurses' experiences increased, they found a sense of security in their own capabilities and learned to speak openly about suicide.

Paradoxically, some nurses still claimed that the main danger in mental health care was to try to ignore suicidal thoughts, especially because the subject triggered feelings of shame and guilt among patients.

Agreements and routines for better or for worse

The nurses had experiences of making agreements with the patients. In these situations, the patients' stories helped the nurses to understand the complexity of the suicide processes, and they experienced mutual trust and confidence. These agreements reduced their uncertainty as well as served to make the patient less anxious until their next visit. One nurse said: "There are no guarantees … but as much as I can, I will try to make an agreement, we will see each other tomorrow" (I:5). These short-term agreements were simple but powerful and often included a plan, guiding the patient towards immediate help, especially during evenings, nights, and weekends. Sometimes the nurses were an active part of the agreement "Won't hurt yourself for my sake" (I:4) in order to emphasise that the patient's life mattered. There were also thoughts that the agreements should only specify a time for the next contact and not include promises about not hurting oneself.

The nurses described the clinic's suicide prevention programme. Although they were all aware of the programme, it was only sporadically used because they perceived the programme routines as vague. However, all of the nurses highlighted one specific routine of importance – " …there is one routine that we

constantly keep in mind, you always have to ask if the patient is having suicidal thoughts …" (I:7).

Experience and intuition as a resource

Using intuition and following a hunch was something that all the nurses described. Intuition was described as a vague feeling of discomfort that made them proceed further and assess the risk of suicide. Intuition could also manifest as a worrying feeling of a patient wanting to say something but instead keeping secrets and changing their behaviour.

> *…there was a feeling that he was hiding something because he shut down and would not …*
> *I got the feeling that he had changed his behaviour.* (I:8)

The nurses described that it was draining to listen to and to trust their intuition, partly because they worried about putting too much emphasis on the importance of their intuition, but also because they wanted to protect themselves against the threat of suicide. Sharing intuition with others was described as impossible because intuition is subjective. Also, there were different views on the subject of trusting intuition – while some nurses questioned its relevance, others described it as the tool they felt most secure in using.

Loneliness

Working with suicidal patients in rural areas was experienced as lonely. The nurses described how they were constantly looking for signs indicating an increased risk of suicide, and they felt alone with this responsibility.

Constantly looking for signs

In hard-to-assess cases, the nurses found it challenging to decide whether to send a patient home or to continue with further assessment. In these cases, they tried to assess the patient's ability to withstand unexpected and sudden shortcomings in life or to make the decision based on how the patient had reacted to similar situations in the past, knowing that it would be a while until the next contact was a source of concern. However, assessing suicide risk more or less on a daily basis could result in mechanical and meaningless assessments. Even though nurses were accustomed to meeting suicidal patients, they experienced that the loneliness increased when several patients were dealing with suicidal thoughts. The nurses could perceive numerous patients as suicidal, but only after one patient had been deemed to have a higher risk. Also, if they had experienced a committed suicide, they could be reminded of that experience during other assessments and this triggered them to be particularly thorough.

> *"In some way, I had worked some years and so … maybe I missed all the clear signs … I believe however, due to this event … I have become more aware and focused more on suicide risk assessments. After what happened it has become like a reflex" (I:9)*

The nurses described how the patients' thoughts about ending their lives had different meanings, which had to be assessed in order to determine how to proceed. They experienced that suicidal thoughts could act as an emergency exit when a patient felt trapped and felt that all odds were stacked against them. The nurses knew that suicidal thoughts could provide a sense of comfort and relief when the patient felt mentally drained, and thinking about suicide could be soothing, liberating, or a wake-up call and not actually increase the risk of committing suicide ending one's life. However, this meant that the nurses had to ensure that the suicidal thoughts remained a thought and were not realised during emotional episodes or on an impulse.

Exposed with sole responsibility

The nurses felt exposed due to their responsibility to save lives, and they experienced how their workload in rural areas had increased as periods spent in inpatient care had become shorter and easier cases were dealt with through primary care. This meant that more complex cases had to be treated in outpatient care. For example, assessing suicide risk over the phone was common in rural areas, but this was considered most unpredictable and difficult. A nurse described such individual responsibility as "hanging like a ghost above you" (I:5).

Sole responsibility meant that the nurses would question themselves to a greater extent, and they experienced the assessment accountability as personal because the patient had entrusted them with this responsibility. Regarding this responsibility, there was no consensus among the nurses as to what the individual responsibility encompassed or how far it reached during assessments.

> *… perhaps it's mostly about this, the sole responsibility of the contact person has increased, and you feel like you need more material to feel secure in these types of risk assessments* (I:9).

Ethical issues

The nurses described how it was a dilemma to protect the patient's integrity and at the same time to do one's duty. Further, they reflected on the dilemma of allowing private thoughts regarding life and death and at the same time maintaining their professionalism.

Patient integrity versus professional obligations

The nurses described how the suicide risk assessment constituted a dilemma because on the one hand they had to protect the patient's integrity, and on the other hand they had to fulfil their duties and remedy the threat of suicide. They also described it as difficult to encourage the patient to talk about current suicidal thoughts while at the same time making decisions conflicting with the patient's autonomy. As a nurse said: "I have no choice but to act when suicide risk is assessed" (I:4). This itself constituted a danger because some patients might then prefer to hide their thoughts about ending their lives. As professionals, the nurses had to accept the conflict emerging when a patient's right to decision-making was overruled by the need to use force to prevent suicide. It was also discussed whether it was ethical to make agreements with suicidal patients by asking them to promise to not end their lives commit suicide. The nurses questioned if it was right to burden the patient with this extra responsibility or if such agreements supported the patient to keep fighting.

Private experiences regarding life and death versus maintaining professionalism

The nurses described how suicide risk assessments could trigger their own emotions, thoughts, and memories about life and the fact that death is inevitable. They called for an outlet allowing them to talk about their private thoughts regarding life and death, as well as to discuss their professional approach with colleagues. One nurse said: " … then it's also, it's about how I experience this with desire and death thoughts, because it has sometimes been very close to me." (I:10). Furthermore, they mentioned that it was necessary to address grief after a suicide in order to be able to meet the anguish in both relatives and colleagues.

There were also different views on the extent that one's personal life would be affected if a nurse found out that there was a risk of suicide during their spare time. On the one hand, it was considered an ethical obligation to always react, but on the other hand some nurses had negative experiences from interfering when someone close to them was not feeling well and ultimately ended one's life committed suicide. Suicide affecting the nurses on a personal level was described as living with "a tormented consciousness" with strong feelings of self-reproach for not being able to prevent the outcome despite being a professional. Overall, it was a complicated matter to separate private and professional thoughts regarding suicide. Therefore, it was more functional to keep such thoughts separate and not to talk about them.

Organisational challenges

The nurses described several organisational challenges when assessing the risk of suicide in rural areas. These concerned bridging the geographical distances and improving teamwork.

Bridging geographical distances

Assessing suicide risk in rural areas was perceived as a challenging task, especially in personal homes, but also at the mental health outpatient unit, and that this led to strong feelings of personal responsibility and loneliness. Distance had a large impact on the level of mental health care it was possible to offer in rural areas. Patients living in the same community as the care unit had more treatment options available than patients living farther away. A common solution to this problem was a mobile mental health team consisting of two nurses who would travel to see rural patients once per week. Mostly, these trips offered supportive dialogues taking place in a local health care centre or at the patient's home. In between the visits, the nurses remained in contact with the patients by phone or through telehealth systems.

The nurses reported that they had experienced difficult scenarios in private homes. As one nurse said: " I didn't know the building, what was happening in other rooms, or who else was there … and what could I do if something unexpected happened." (I:7). In addition, it was more difficult to deal with increased suicide risk, to complete the assessments, and to provide remedies in the patients' homes. The nurses acknowledged that they had experienced difficult situations in the "rural countryside" and that these experiences could not be compared to their everyday work in the clinic.

Improving teamwork

It was mentioned that there was no opportunity for the nurses to get daily support and that it was up to the individual nurse to find the support they felt they needed from colleagues and/or management. Several nurses felt that it was difficult to find a colleague who could assist during situations of greatly increased suicide risk. A common request among the nurses was to organise the work using teams with a joint team responsibility. The nurses wanted to share their experiences, hear others' thoughts, and see their colleagues in action during risk assessments. There was also a desire for support and relief when questioning the outcome of a risk assessment. They wanted an accepting work environment that allowed them to freely talk about insecurities without facing criticism. In some cases, the nurses mentioned specific comments that had the opposite effect, offering no support and causing silence and increased pressure:

> *Just continue the way you have, because this is an old behaviour, it has been like this for a long time, the patient won't do anything [end her/his life commit suicide].* (I:9)

However, there were also examples of supportive colleagues who made others feel understood and secure. These cases involved nurses devoting time to unconditionally listening to thoughts and feelings and promoting self-reflection regarding "how come that I took this decision" as well as "was it right or wrong". It was also mentioned that newly employed staff members needed to be treated well in order to feel secure in their assessments. Teamwork was perceived as a way to utilise both colleagues and management to the fullest.

Discussion

This study aimed to describe mental health nurses' experiences of suicide assessments within specialised outpatient care in rural areas. The results showed that nurses felt anguish due to a lack of control during the assessments and felt insecure because the risk of suicide can only be a short-term assessment. They worried about unexpected events that could trigger the patients to end their lives commit suicide. This is in line with Overholster et al. (2012) who reported that common personal events, for example, family conflicts, losses, and alcohol/drug abuse increase the risk of suicide, especially when the patient is depressed. Negative personal events, in combination with impulsiveness, can also cause an unexpected suicide. Robertson, Paterson, Lauder, Fenton, and Gavin (2010) highlight the issues related to dealing with the discrepancy between expected/unexpected behaviours, such as a suicide during ongoing treatment. Regardless of how in-depth the suicide assessment is, it cannot cover all potential events that might occur after the assessment. However, in the case of suicide, it might appear as if the assessment was incomplete or flawed.

Old beliefs and myths also contributed to the nurses' uncertainty. In our study, the nurses acknowledged that it was easier to identify prejudices about triggering suicidal behaviour as a new employee and that prejudices and myths circulated among experienced staff members. This could be interpreted as suicide still being a taboo subject and there is a need for further critical thinking and self-evaluation. Barker (2001) stressed that taboos,

myths, and prejudices affect suicide risk assessments and that it is crucial to be aware of their significance.

The nurses felt lonely when performing the suicide risk assessments, and constantly looking for signs and assessing suicide risk was experienced as a heavy responsibility. Several studies have described the demanding work that is involved in suicide risk assessments and being responsible for someone else's life. Gilje, Talseth, and Norberg (2005) describe how nurses were able to deal with the burden of suicidal patients but not with being responsible for the patients' lives. The nurses in that study argued that the patients also had their own responsibility. However, Robertson et al. (2010) showed that nurses in mental health care have a strong sense of responsibility and that they feel that there is no room for mistakes in suicide assessments. They also highlighted how the law as well as professional organisations emphasise patient autonomy but fail to provide instructions of what the responsibility entails, especially in cases that go wrong.

Suicide causes strong emotions of dismay and a wish that someone could have prevented it from happening. The nurses stated that they had expectations to predict suicides, a topic discussed in Graig and Rudd (2006) and Robertson et al. (2010). Robertson et al. (2010) claim that if suicide is perceived as avoidable and predictable, this promotes the development of a guilt culture where the blame is directed towards the person working closest to the patient. These expectations can also cause unrealistic societal expectations in combination with the nurses blaming themselves. The nurses described how they sometimes disconnected themselves from the situation in order to protect themselves emotionally, an observation also supported by Hellzen, Asplund, Sandman, and Norberg (2004).

The nurses reported that it was an ethical dilemma to protect the patient's integrity and at the same time to do one's duty. In Sweden, patients with an increased suicide risk can be forcibly admitted into care without their consent, which in itself constitutes an ethical dilemma and is further complicated by the fact that there is not always a sharp definition between voluntary and involuntary admission (Robertson et al., 2010. During periods of increased suicide risk, nurses can no longer protect the patient's ethical and existential integrity. Instead they have to consider prioritising the patient's physical health and thus overriding the patient's right to personal choice. In these situations, the nurses reported that they experienced sorrow and guilt, which could be interpreted as moral stress. Lützen, Cronqvist, Magnusson, and Andersson (2003) suggested that moral stress could also arise when nurses are sensitive to a patient's vulnerability but are prohibited from doing what is best for the patient and feel that they have no control over the situation.

Questions regarding accountability for no-harm agreements between the nurse and the patient have an ethical aspect. In the current study, it was discussed whether or not one can hold a suicidal patient accountable and can make agreements with them. There is no evidence in the literature for making such no-harm agreements (Stanley & Brown, 2012) and the purpose and intention of this making such agreements can be questioned. Mitchell (2011) discussed the purpose of professional relationships between nurses and patients and emphasised that the purpose of such relationships must be to reach a solution that respects the capabilities of the other and can be mutually agreed upon. Therefore, we argue that no-harm agreements should be replaced by safety plans (Stanley & Brown, 2012) which is more in line with the ethics of the nurse–patient relationship.

The nurses acknowledged that death and suicide was something that concerned them as fellow humans outside the professional realm. In some cases, it was easier to talk about death and suicide and to show vulnerability as a civilian. Talseth, Gilje, and Norberg (2003) showed that nurses in mental health care had a hard time defining the boundaries between their private and professional take on existential questions such as the meaning of life and death, issues that the current study also confirms. Further, Talseth and Gilje (2011) reported that nurses had a difficult time expressing the burden, the sense of helplessness, and the anger they felt in connection with caring for suicidal patients.

As the distance between the patient and mental health care facilities in a hospital setting grew, the nurses in this study required an increasing amount of collaboration and support from colleagues in order to conduct the suicide risk assessments. Growther and Ragusa (2011) and Robertson et al. (2010) emphasised the importance of having colleagues in order to reduce the sense of loneliness and of being left with the sole responsibility for someone else's life. On an organisational level, it was always possible to access support through an on-call function, a solution that the nurses were satisfied with as long as the response was quick.

Colleagues that took time to listen to one's concerns and self-doubt were considered an invaluable support. A colleague could give comfort, hope, and courage to continue working, and the nurses asked for a more open work climate that would allow them to openly discuss issues without fear of criticism. In a study conducted by Mitchell, Garand, Dean, Panzak, and Taylor (2005) focusing on how nurses deal with conflicting responsibilities during times of increased suicide risk, it was shown that the nurses might stop carrying for co-workers. The nurses in our study wanted the work at the outpatient unit to be organised from a team perspective. Further, they wanted the opportunity to get alleviation by scheduled daily feedback rather than having to turn to a colleague. The collegial support was reported to be important for the individual, but was also reported to be important in terms of passing down experience and knowledge to new staff members. According to Barker and Barker-Buchanan (2010), this support, in conjunction with proper education, was crucial in order to build up the confidence to talk about suicide and to help the patients tell their stories.

Methodological discussion

It might be considered a limitation of this study that the selection of participants was made among colleagues. Several researchers (e.g., McDermid, Peters, Jacksom, & Daly, 2014; McEvoy, 2002) have addressed the methodological and ethical issues concerning the insider and outsider perspective among interviewees. They emphasise that shared experiences might help to generate new insights by opening up and extending the depth of a discussion. However, the participants were informed about the interviewer's dual roles, and the participants were free to quit the study if they found the arrangement uncomfortable. Our experience was that the participants were able to relax and that they provided open and elaborate answers even though they knew the interviewer.

Qualitative content analysis focuses on variation in content, and the homogenous group participating in this study constitutes a potential weakness. A more diverse group in terms of gender, age, education, and experiences might have resulted in a greater variation of experiences. However, the data were rich and offered a wide range of experiences.

Krippendorf (2013) argues that a text gets its meaning through the reader, meaning that data will be interpreted individually and that a text does not have one single meaning, just the most accurate meaning from a particular perspective. Thus, the findings presented here is one possible interpretation of the nurses' experiences of assessing suicide risk in outpatient care in rural areas.

Conclusions with clinical implications

The demands of a suicide risk assessment need to be realistic and clear in order to reduce the expectations that one can accurately predict the risk of suicide. Regardless of how carefully a risk assessment is conducted, it can never cover all of the possible risk factors.

Assessing suicide risk is an extensive task for the nurses, and having the sole responsibility to assess suicide risk contributes to a sense of uncertainty and loneliness that can increase the nurse's emotional vulnerability and moral stress. Consequently, in order to prevent ill health among these nurses, there is a need for a tolerant work climate and an organisation that provides support for its employees.

Having the confidence to discuss suicidal thoughts with patients is crucial in a risk assessment. However, it is equally important to talk about suicide with colleagues in mental health care in order to change attitudes and reduce societal prejudices and myths about suicide. Joint efforts in regard to research, education, and in-house training are required to maintain an appropriate knowledge base. These efforts include offering training on an advanced theoretical and practical level as well as clinical experience where it is possible to practice suicide risk assessments.

Acknowledgment

We thank the participants who generously shared their experiences.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content of the manuscript.

References

Barker, P. (2001). The Tidal Model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, *8*, 233–240.

Barker, P., & Buchanan-Barker, P. (2010). The Tidal Model of mental health recovery and reclamation: Application in acute care settings. *Issues in Mental Health Nursing*, *31*, 172–180.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*, 107–115.

Gilje, F. L., Talseth, A. G., & Norberg, A. (2005). Psychiatric nurses' response to suicidal psychiatric inpatients: Struggling with self and sufferer. *Journal of Psychiatric and Mental Health Nursing*, *12*, 519–526.

Graig, J., & Rudd, D. M. (2006). Advance in the assessment of suicide risk. *Journal of Clinical Psychology*, *62*, 185–200.

Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*, 105–112.

Groh, C. J. (2012). Depression in rural woman: Implications for nurse practitioners in primary care setting. *American Association Nurse Practice*, *25*, 84–90.

Growther, A. J., & Ragusa, A. T. (2011). Realities of mental health nursing practice in rural Australia. *Issues in Mental Health Nursing*, *32*, 512–518.

Hawton, K., & van Heeringen, K. (2009). Suicide. *The Lancet*, *373*, 1372–1381.

Hellzen, O., Asplund, K., Sandman, P.-O., & Norberg, A. (2004). The meaning of caring as described by nurses caring for a person who acts provokingly: An interview study. *Scandinavian Journal of Caring Sciences*, *18*, 3–11.

Krippendorff, K. (2013). *Content analysis: An introduction to its methodology*. (3rd ed.). Thousand Oaks: Sage.

Lützen, K., Cronqvist, A., Magnusson, A., & Andersson, L. (2003). Moral stress: Synthesis of a concept. *Nursing Ethics*, *10*, 312–322.

McDermid, F., Peters, K., Jacksom, D., & Daly, J. (2014). Conducting qualitative research in the context of pre-existing peer and collegial relationships. *Nurse Researcher*, *21*, 28–33.

McEvoy, P. (2002). Interviewing colleagues: Addressing the issues of perspective, inquiry and representation. *Nurse Researcher*, *9*, 49–59.

Mitchell, A. M., Garand, L., Dean, D., Panzak, G. L., & Taylor, M. V. (2005). Suicide assessment in hospital emergency departments. Implications for patient satisfaction and compliance. *Topics in Emergency Medicin*, *27*, 302–312.

Mitchell, V. (2011). Professional relationships. In P. Barker (Ed.), *Mental health ethics*. London, New York: Routledge.

Overholster, J., Braden, A., & Dieter, L. (2012). Understanding suicide risk: Identification of high-risk groups during high-risk times. *Journal of Clinical Psychology*, *68*, 334–348.

Robertson, M., Paterson, B., Lauder, B., Fenton, R., & Gavin, J. (2010). Accounting for accountability: A discourse analysis of psychiatric nurses´ experience of a patient suicide. *The Open Nursing Journal*, *4*, 1–8.

Social Board of Health and Welfare (2003). Vård av självmordsnära patienter – en kunskapsöversikt. [Care of patients close to suicide – a literature review.]. Article number: 2003-110-8.

Social Board of Health and Welfare. (2010). Nationella riktlinjer för vård vid depression och ångestsyndrom. [National guidelines for care of depression and anxiety syndrome.]. Article number: 2010-3-4.

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, *19*, 256–264.

Talseth, A. G., & Gilje, F. L. (2011). Nurses´ responses to suicide and suicidal patients: A critical interpretive synthesis. *Journal of Clinical Nursing*, *20*, 1651–1667.

Talseth, A. G., Gilje, F. L., & Norberg, A. (2003). Struggling to become ready for consolation: Experiences of suicidal patients. *Nursing Ethics*, *10*, 613–623.

The Swedish Research Council. (2016). *Etikriktlinjer. [Ethical guidelines]*. Available at: http://www.vr.se/forskningsfinansiering/sokabidrag/forutsattningarforansokningarochbidrag/etikriktlinjer.4.29b9c5ae1268d01cd5c8000955.html (accessed 2016-05-15)

World Medical Association. (2008). *Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects*. Available at: http://www.wma.net/en/30publications/10policies/b3 (accessed 2016-05-15).