
Better care, fewer suicides?

PERSPECTIVES

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Current efforts in the mental health service to prevent suicide appear to be more concerned with implementing formal and instrumental procedures than ensuring best possible care for patients. Many people take their own lives or attempt suicide while they are hospitalised in psychiatric wards. Do we pay too little attention to how to provide good care to patients at risk of suicide?

In November 2017, the Norwegian Directorate of Health published an instructional memo from its reporting scheme indicating that in 2015 and 2016, the Directorate received 283 notifications of suicide from the specialist health service. Of these, 58 occurred during hospitalisation in a psychiatric ward [\(1\)](#).

The instructional memo points to *failure of safety measures* (e.g. that the patient had access to drugs and dangerous objects), deficiencies in *assessment of suicide risk* (e.g. incomplete and undocumented assessment of suicide risk or failure to follow up such assessments) as well as *resource problems* (e.g. lack of a doctor/psychologist and trained healthcare professionals who know the patient) [\(1\)](#).

We call for greater attention to be focused on the quality of care provided to patients at risk of suicide.

Prevention of suicide in mental health care

In mental health care, suicide prevention largely appears to concern identifying and treating a presumed underlying mental disorder [\(2, 3\)](#). A well-established 'truth' is that at least 90 % of those who take their own lives have one or more mental disorders [\(4\)](#). Even though it has been documented that the evidence base for this 'truth' is weak [\(5\)](#), constant reference is made to it [\(6, 7\)](#). This helps to maintain the assumption that suicide is primarily linked to an underlying mental disorder. However, suicide is a complex relational phenomenon that cannot be understood independently of contextual factors [\(8\)](#).

We do not deny that a number of those who take their own lives may have one or several mental disorders. Nevertheless, suicide probably always involves something more than or something other than a mental disorder [\(9\)](#). Only a very small proportion of those with serious mental disorders take their own lives [\(10\)](#). A recent study shows that many of those who take their own lives have been in contact with the mental health service and/or interdisciplinary

addiction treatment teams during the previous year (46.2 %) or in the course of their lives (66.6 %) [\(7\)](#). However, this gives an incomplete picture of what suicide entails.

But what underlies mental difficulties and/or addiction problems? What problems or living conditions contribute to the pain, despair, hopelessness and desperation that cause someone to see death as the best and perhaps the only solution? Moreover, clinical practice and research devote little attention to whether the treatment the person in question received – or did not receive – may have played a role in the suicide [\(11\)](#).

In keeping with the *National guidelines for suicide prevention in mental health care* [\(12\)](#), considerable focus has also been put on assessments of suicide risk and various safety measures, for example, intermittent observation or continuous observation of the patient.

Care for patients at risk of suicide

When a person is hospitalised in a psychiatric ward as a result of suicidal behaviour, it is crucial that he/she meets empathetic healthcare personnel who have the ability to establish good contact with people experiencing severe mental pain: healthcare personnel who are able to establish a relationship of trust and who listen to the person's history without judgment, and who try to understand, acknowledge the person's thoughts and feelings, and involve the patient in the course of treatment [\(13–17\)](#).

A good relationship is essential in ensuring that the person at risk of suicide feels safe and well looked after [\(18\)](#). Good care can assist patients to share their pain and their problems [\(19\)](#), and thereby gain hope that someone can help [\(20\)](#). A lack of care may entail that patients do not contact healthcare personnel when their desperation grows [\(21\)](#). At worst, a lack of care can lead to a greater feeling of hopelessness and an increase in suicidal behaviour [\(17, 18, 21\)](#).

Do we overrate the value of risk assessments?

Even though good care and a good relationship between the healthcare personnel and the patient are essential in mental healthcare, this does not seem to be sufficiently prioritised in efforts to prevent suicide. Neither the guidelines [\(12\)](#) nor the instructional memo [\(1\)](#) reflect such a priority.

The guidelines primarily highlight healthcare personnel (psychiatrists and psychologists in particular) and their screening, assessment and management of suicide risk. The word 'risk' is in fact mentioned a total of 147 times. Little attention is devoted to the care that healthcare personnel should provide to patients at risk of suicide.

There is still reason to ask whether professionals and others have an exaggerated belief in assessments of suicide risk [\(22\)](#). This impression is reinforced by Ekeberg & Hem [\(23\)](#), who assert that clinicians must stress risk

assessments, but only in a short-term perspective. They presume that it is possible to predict who will take their own life in a short-term perspective of up to a few days.

Other researchers have demonstrated that it is impossible to predict suicide – either in the long term or the short term – based on risk assessments [\(24\)](#). Putting emphasis on risk-factor assessments with ensuing categorisation of patients as at low, medium or high risk of suicide is advised against [\(25\)](#). Instead clinicians should attempt to achieve good dialogues with patients and give them the best possible treatment based on their needs, including aspects linked to suicidal behaviour [\(26\)](#).

Underrating experiential knowledge

We do not oppose the assessment of suicide risk in patients – it is *the way* this is carried out that is of key importance. It is also vital to emphasise the help and care professionals should provide *after* the assessment of suicide risk. The role and expertise of nurses and others in psychiatric wards is of great significance.

Studies have shown that experienced nurses find that they can detect (warning) signals of self-harm/suicidality communicated by patients, and that they have thus helped to avert serious self-harm and perhaps suicide [\(27, 28\)](#). They have sensed that patients have been in danger of harming themselves and have acted on this assumption. It appears that such vigilance and experience-based skills among nurses and other health personnel are underrated.

The instructional memo notes that patient safety can undoubtedly be increased when the patient is cared for by skilled personnel who know the person in question, but the key message is that suicide can be prevented by better implementation of the guidelines and stronger provision and follow-up of preventive measures and assessments of suicide risk [\(1\)](#). Either the importance of good care and good relations between the healthcare professional and the patient is underrated, or it is taken for granted that staff in mental health care have sufficient relational and communication skills to offer the kind of care that persons at risk of suicide need.

A key question, nevertheless, is whether healthcare workers *in practice* prioritise or have an opportunity to prioritise relational care if this is not stressed in national and policy guidelines for suicide prevention in mental health care. We think that the guidelines should be revised, also in view of the wide-ranging criticism they have received [\(22, 29, 30\)](#).

New priorities

It is understandable that attempts are being made to deal with such a complex phenomenon as suicidality (suicidal thoughts, suicidal actions and suicide) by considering aspects of the phenomenon (e.g. concentrating on diagnosing and treating mental disorders, charting risk factors, implementing suicide risk assessments and safety measures). However, it is about time to emphasise the

complexity of the individual's suicidality and think more about *how* healthcare professionals can create good encounters with patients at risk of suicide and provide good care.

This should now be prioritized by politicians, health authorities, managers and health workers in mental health care. Moreover, we must also be willing to use resources to ensure that personnel are given the necessary education, training, supervision and support to enable them to provide the kind of care patients at risk of suicide need.

LITERATURE

1. Selvmord og selvmordsforsøk under innleggelse. Læringsnotatet fra Meldeordningen. IS-2675. Oslo: Helsedirektoratet, 2017.
<https://helsedirektoratet.no/publikasjoner/selv-mord-og-selv-mords-forsok-under-innleggelse> (14.12.2017).
2. Hagen J, Hjelmeland H, Knizek BL. Connecting with suicidal patients in psychiatric wards: Therapist challenges. *Death Stud* 2017; 41: 360 - 7. [PubMed][CrossRef]
3. Hagen J, Hjelmeland H, Knizek BL. Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses. *Issues Ment Health Nurs* 2017; 38: 99 - 106. [PubMed][CrossRef]
4. Cavanagh JTO, Carson AJ, Sharpe M et al. Psychological autopsy studies of suicide: a systematic review. *Psychol Med* 2003; 33: 395 - 405. [PubMed][CrossRef]
5. Hjelmeland H, Dieserud G, Dyregrov K et al. Psychological autopsy studies as diagnostic tools: are they methodologically flawed? *Death Stud* 2012; 36: 605 - 26. [PubMed][CrossRef]
6. Ekeberg Ø. Selvmord under pågående behandling. *Tidsskr Nor Legeforen* 2017; 137: 1390.
7. Haaland VØ, Bjørkholt M, Freuchen A et al. 2017; 137: 1420 – 5. Selvmord, psykisk helsevern og tverrfaglig rusbehandling i Agder 2004-13. *Tidsskr Nor Legeforen* 2017; 137: 1420 - 5. [CrossRef]
8. Hjelmeland H, Knizek BL. Qualitative evidence in suicide: findings from qualitative psychological autopsy studies. I: Olson K, Young RA, Schultz IZ, red. *Handbook of qualitative health research for evidence-based practice*. New York: Springer Science + Business Media, 2016.
9. Hjelmeland H, Knizek BL. Hva er meningen? Selvmordsatferd som kommunikasjon. *Sosiologi i dag* 2013; 43: 7-30.
10. Franklin JC, Ribeiro JD, Fox KR et al. Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychol Bull* 2017; 143: 187 - 232. [PubMed][CrossRef]

11. Large M, Ryan C, Walsh G et al. Nosocomial suicide. *Australas Psychiatry* 2014; 22: 118 - 21. [PubMed][CrossRef]
12. Nasjonale retningslinjer for forebygging av selvmord i psykisk helsevern. IS-1511. Oslo: Sosial- og helsedirektoratet, 2008.
<https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/3/Nasjonal-faglig-retningslinje-for-forebygging-av-selvmord-i-psykisk-helsevern-IS-1511.pdf> (14.12.2017).
13. Cutcliffe JR, Stevenson C. The care of the suicidal person. Philadelphia, PA: Churchill Livingstone Elsevier, 2007.
14. Jobes DA. Managing suicidal risk. A collaborative approach. New York: The Guilford Press, 2006.
15. Michel K, Valach L. The narrative interview with the suicidal patient. I: Jobes, DA, Michel K, red. Building a therapeutic alliance with the suicidal patient. Washington D.C.: American Psychological Association, 2011.
16. Talseth AG, Jacobsson L, Norberg A. The meaning of suicidal psychiatric inpatients' experiences of being treated by physicians. *J Adv Nurs* 2001; 34: 96 - 106. [PubMed][CrossRef]
17. Talseth AG, Lindseth A, Jacobsson L et al. The meaning of suicidal psychiatric in-patients' experiences of being cared for by mental health nurses. *J Adv Nurs* 1999; 29: 1034 - 41. [PubMed][CrossRef]
18. Berg SH, Rørtveit K, Aase K. Suicidal patients' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. *BMC Health Serv Res* 2017; 17: 73. [PubMed][CrossRef]
19. Talseth AG, Gilje F, Norberg A. Struggling to become ready for consolation: experiences of suicidal patients. *Nurs Ethics* 2003; 10: 614 - 23. [PubMed][CrossRef]
20. Vatne M, Nåden D. Experiences that inspire hope: Perspectives of suicidal patients. *Nurs Ethics* 2016; 1 - 14. [PubMed]
21. Samuelsson M, Wiklander M, Åsberg M et al. Psychiatric care as seen by the attempted suicide patient. *J Adv Nurs* 2000; 32: 635 - 43. [PubMed][CrossRef]
22. Hagen J, Hjelmeland H, Knizek BL. Overdreven tro på selvmordsrisikovurderinger? *Tidsskr Nor Laegeforen* 2014; 134: 394. [PubMed][CrossRef]
23. Ekeberg Ø, Hem E. Kan vi forutsi selvmord? *Tidsskr Nor Legeforen* 2017; 137: 1680 - 1.
24. Large MM, Ryan CJ, Nielssen O. Suicide risk assessment: Reply to Draper. *Aust N Z J Psychiatry* 2012; 46: 387. [CrossRef]

25. Large MM, Ryan CJ. Suicide risk categorisation of psychiatric inpatients: what it might mean and why it is of no use. *Australas Psychiatry* 2014; 22: 390 - 2. [PubMed][CrossRef]
 26. Large MM, Ryan CJ, Carter G et al. Can we usefully stratify patients according to suicide risk? *BMJ* 2017; 359: j4627. [PubMed][CrossRef]
 27. Hagen J, Knizek BL, Hjelmeland H. Mental health nurses' experiences of caring for suicidal patients in psychiatric wards: An emotional endeavor. *Arch Psychiatr Nurs* 2017; 31: 31 - 7. [PubMed][CrossRef]
 28. Tofthagen R, Talseth AG, Fagerström L. Mental health nurses' experiences of caring for patients suffering from self-harm. *Nurs Res Pract* 2014. E-publisert 13.11.2014.
 29. Aarre TF, Hammer J, Stangeland T. Ingen kan føresjå sjølv mord. *Aftenposten* 22.5.2017.
 30. Straume S. Selvmordforebyggingens pris. *Tidsskr Nor Psykol foren* 2014; 51: 242 - 51.
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