Tidsskriftet Tidsskrift for Den norske legeforening

A suicide

PERSONAL EXPERIENCES

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The author has completed the ICMJE form and declares no conflicts of interest.

Every year, mental health care patients take their own lives. These are some of my thoughts as a family member of one such patient.

In 2020, nearly 700 people took their own lives in Norway, half of whom were receiving psychiatric treatment (1). One of them was our daughter. She had survived several suicide attempts, including one while in hospital. This is often referred to among professionals as 'chronic suicidality'.

Night and fog

Norway's suicide prevention plan for 2021 is entitled 'No One to Lose' (2). I assume that the path to 'no one' passes through an 'individual'. Psychiatric patients who take their own life live under conditions that should be particularly reassuring. My question is: Why don't we save them? And when the patients are dead, how do the supervisory authorities investigate the death? What do these investigations say about Norwegian authorities' view of the deceased and the bereaved?

Our story speaks to a lack of thoroughness, responsibility, respect and consideration for the deceased and for death. In my view, psychiatrists and the authorities in Norway seem to be in a great hurry to obscure suicide through silence, obfuscation and outright lying. Moreover, they seem to disregard sensible guidelines for accountability and compassion. We see this perhaps most clearly in the complaints process: individual assessments disappear, the

medical history is simplified, the suicide becomes indistinct and insignificant. The deceased disappear into night and fog, hidden in faceless statistics, forgotten in hospital archives and by supervisory authorities.

In my experience, complaining about the treatment usually results in the bereaved not only having to live with one loss, but with two, when the complaint is summarily dismissed.

Procedures

How should the system be structured to ensure the safety of patients at risk of suicide? In the Journal of the Norwegian Psychology Association, Berg and Walby write that procedures and guidelines for treatment standards are not enough (3). Yet it is precisely these procedures and guidelines that constitute the standard for treating those at risk.

The main guiding principles that the field of psychiatry in Norway adheres to are the National Guidelines for the Prevention of Suicide from 2008 (4). One of the core principles is to avoid admissions to inpatient units, and if admission is necessary in an emergency situation, the duration should be limited to the acute suicide crisis.

This means that patients at risk of suicide should not be treated in institutions where safety is relatively good, but locally in primary care facilities, where safety is poorer. With this approach, the conclusion is not that 'we have no one to lose' but rather that we have few to save.

Berg and Walby emphasise that 'safety is created through relationships and individualised adaptation for each patient'. A system that 'ignores the need to connect' is not what we need – but it is precisely what we have.

A revolving door

Effective treatment is about building trust between the therapist and patient. However, this is not the reality. Those at risk of suicide are, in the time before their death, what they and their family call 'revolving door patients'.

After a suicide attempt, the patient is admitted to an inpatient facility – a hospital – and discharged the next day or a few days later. The 'revolving door' is not a construction flaw, but a deliberate design. It is the visible consequence of the rule that inpatient admissions should be avoided. The system is designed to cultivate distance and rules, not closeness and relationships. Everything is based on the assumption that the patient will be discharged again.

We will decide your narrative

The medical history of suicidal psychiatric patients can easily become their life story. The narrative of the illness becomes the patient's story. This is despite the fact that healthcare documents are largely composed of contextless, momentary observations of limited value. The observations describe and interpret behaviour with considerable uncertainty, little precision and far-reaching consequences. Psychiatrists and psychologists presumably have the key that can give meaning to the material. However, the life stories are also read by others.

We find the momentary observations in the discharge reports repeated in the health authority's reports, as a clueless amplification of meaning and relevance in the authorities' assessment of what constitutes proper treatment.

At some point in the supervisory authority's investigations into suicide in psychiatric patients, the treatment, as recommended in regulations and procedures, will match the description of the actual events as documented in records and discharge reports. Is it possible to get an accurate picture of what happened when the inspectorate assesses risk understanding and treatment? Or does the health data allow for selective use that renders the investigation irrelevant and irresponsible? And perhaps worse: the discharge reports, and how they are written, can cause serious health problems for the patients who read them.

When a key part of the description involves observations such as 'nicely dressed', 'lacks facial expression' and 'speaks in coherent sentences', it is easy to question the point of this, but we can also observe the negative consequences. We ask: Have the documents contributed to the patient's improvement? And: Is the story being told true?

I believe the answer to both of these questions is no. Suicidal patients have a fragile self-image. The hospital's descriptions are interpreted and understood from this perspective. The vast majority of people who take their own life did not want to die. They wanted to live. They were fighting a battle where the enemy was themselves and the voices telling them they were ugly, worthless and should die. They die alone, lonely, desperate and afraid. And when they are gone, it is as if they never lived. The voices, the illness and the loneliness merge with the narrative of the system leading them to their inevitable conclusion – that suicide is the only option.

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Publisert: 12 December 2023. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.23.0546