



Guidelines do not prevent suicide

DEBATT

HEIDI HJELMELAND

E-mail: heidi.hjelmeland@ntnu.no

Heidi Hjelmeland (born 1960), professor at the Department of Mental Health, Norwegian University of Science and Technology.

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

JULIA HAGEN

Julia Hagen (born 1975), postdoctoral fellow at the Department of Mental Health, Norwegian University of Science and Technology.

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

KRISTIN ESPELAND

Kristin Espeland (born 1982), PhD candidate at the Department of Mental Health, Norwegian University of Science and Technology.

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

TOVE UELAND NYGAARD

Tove Ueland Nygaard (born 1971), master's degree in mental health and a psychiatric nurse at Tiller DPS, St. Olavs Hospital.

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

BIRTHE LOA KNIZEK

Birthe Loa Knizek (born 1957), professor at the Department of Mental Health, Norwegian University of Science and Technology, and specialist in clinical psychology (child and adolescent).

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

We must rethink our approach to preventing suicide in mental health care.

Ten years after the launch of the *National guidelines for suicide prevention in mental health care* (1), it transpires that every year approximately 250 people in the specialist health services take their own lives (2). This constitutes 43 % of the total number of suicides in Norway. The high number prompts us to query the impact of the guidelines.

The guidelines, in particular the recommendation of frequent assessments of suicide risk, have been widely criticised (3, 4). Nevertheless, the Norwegian Directorate of Health recently published an instructional memo that stressed that patient safety can be increased by better implementation and follow-up of protective measures and suicide risk assessment, and that implementing national guidelines in local procedures is part of the enterprise's obligation to maintain internal control (5).

Deficient evidence base and a narrow concept of knowledge

The guidelines are said to be based on two knowledge reviews (1). However, these provided very little relevant knowledge. This is also made explicit in the guidelines, where the measures are ranked in relation to the underlying knowledge base. The ranking shows that 31 out of 34 recommendations (91 %) are based on 'deficient documentation'. Consequently, the guidelines are not knowledge based (in respect of the definition adopted).

Moreover, the guidelines rely unilaterally on a biomedical focus (6) whereby suicidal behaviour is explained as a consequence of risk factors, based on linear cause and effect thinking (7). Mental disorders, particularly depression, are singled out as one of the key risk/causal factors for suicide (7). Diagnosing and treating mental disorders is indeed included as a key measure. However, it is far from certain that the *suicidality* is related to mental disorders in all cases (7). A meta-analysis of 50 years' research on risk factors for suicide states emphatically that there is no evidence that any known risk factors – broad or specific – approach what many might define as clinical significance (8, p. 215).

The guidelines shall help to ensure the provision of a standardised, quality-assured treatment (1, p. 8). Suicidality, however, is a complex phenomenon that cannot be understood independently of the life course and the context in which it develops and is maintained (7). A 'one-size fits all' approach focusing strongly on mental disorders and suicide risk assessments can be perceived as dehumanising and may contribute to the distancing and marginalisation of patients (9). This may contribute to increasing rather than diminishing the risk of suicide.

Urgent need for innovative thinking

It is high time we move away from a unilateral biomedical understanding of suicidality. However, both the Norwegian Directorate of Health (5) and the National Centre for Suicide Research and Prevention (NSSF) seem to want more of the same. The Centre's spokesperson, Fredrik Walby, said on the Norwegian radio programme *Dagsnytt 18* (18 April 2018) that there must be a focus on diagnosing and treating mental disorders, and that safety measures must be established at group level in line with the same principles as for traffic safety efforts.

Perhaps we should rather listen to professionals who declare, based on comprehensive research, that clinicians should stop categorising patients in relation to the level of suicide risk, and that health authorities should withdraw guidelines that require this (10). We call upon the Norwegian Directorate of Health to invite researchers and clinicians to an open discussion based on the experiences we now have.

People want to be seen, heard and understood, not necessarily assessed and protected based on standardised procedures. Professionals must be given space, time and trust to apply their medical skills when treating the individual patient (4). They should also be provided with suicidological competence that far exceeds a biomedical understanding of suicidality.

REFERENCES:

1. Sosial- og helsedirektoratet. Nasjonale retningslinjer for forebygging av selvmord i psykisk helsevern. 2008.
<https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/3/Nasjonal-faglig-retningslinje-for-forebygging-av-selvmord-i-psykiskhelsevern-IS-1511.pdf> (2.5.2018).
2. Nasjonalt senter for selvmordsforskning og -forebygging. Nasjonalt kartleggingssystem for selvmord i psykisk helsevern og tverrfaglig spesialisert rusbehandling.
www.uio.no/kartleggingssystemet (2.5.2018).
3. Hagen J, Hjelmeland H, Knizek BL. Overdreven tro på selvmordsrisikovurderinger? Tidsskr Nor Legeforen 2014; 134: 394. [PubMed][CrossRef]

4. Straume S. Selvmordsforebyggingens pris. *Tidsskr Nor Psykol foren* 2014; 51: 242 - 51.
5. Helsedirektoratet. Selvmord og selvmordsforsøk under innleggelse. Læringsnotatet fra Meldeordningen. 2017.
<https://helsedirektoratet.no/publikasjoner/selv-mord-og-selv-mordsforsok-under-innleggelse> (2.5.2018).
6. Nygaard TU. Selvmordsforebygging i psykisk helsevern: Er vi på riktig spor? Masteroppgave i psykisk helsevern. sTrondheim: Norges teknisk-naturvitenskapelige universitet, 2017.
7. Hjelmeland H, Knizek BL. Time to change direction in suicide research. I: O'Connor R, Pirkis J, red. *The international handbook of suicide prevention*. 2. utg. Chichester: Wiley Blackwell, 2016: 696-709.
8. 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]
9. Rogers JR, Soyka KM. "One size fits all": An existential-constructivist perspective on the crisis intervention approach with suicidal individuals. *J Contemp Psychother* 2004; 34: 7 - 22. [CrossRef]
10. 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]

Published: 12 June 2018. *Tidsskr Nor Legeforen*. DOI: 10.4045/tidsskr.18.0349

Received 23.4.2018, first revision submitted 1.5.2018, accepted 2.5.2018.

© The Journal of the Norwegian Medical Association 2020. Downloaded from tidsskriftet.no