Summary of a two-year study of suicides in the mental health service

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Statens helsetilsyn / Norwegian Board of Health Supervision
P.O. Box 8128 Dep, NO-0032 OSLO, Norway
Telephone: 21 52 99 00
Fax: 21 52 99 99
E-mail: postmottak@helsetilsynet.no

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One of the central tasks of the Norwegian Board of Health Supervision is the supervision and mapping of areas of the health service with a high risk of failure and to communicate our experiences in this field to the administration and the health services. The purpose of this report is to communicate our experiences of a review of reported cases in which patients undergoing treatment in the mental health service committed suicide. We wish to focus on the health services' procedures and systems for suicide prevention by showing where we have registered failure, and thereby hope to promote greater awareness of the importance of good follow-up of and treatment procedures for suicidal patients.

Target groups:

- Health trusts:
  Under section 2-2 of the Act relating to Specialized Health Services (1), health services provided or offered must be in accordance with sound professional standards. This requirement means that the trust's management must establish systems that will to the greatest possible extent prevent human error. Any errors must be detected by the trust and measures taken to prevent such errors from re-occurring. This requirement to sound professional standards is supported by two sections of the Specialized Health Services Act: the health trusts must ensure that medical records and information systems are sound (section 3-2) and that any health personnel appointed are provided with necessary training, supplementary education and further schooling to ensure that each employee will be able to perform his/her work properly (section 3-10).

  In recent years, the health authorities have focused their attention on ensuring that the trusts establish integrated and effective systems to ensure that the services are of good quality. One example of this is the Internal Control Regulations, according to which the trusts' activities must be planned, organised, performed and maintained in conformity with requirements laid down in or pursuant to social and health legislation (2). According to the Internal Control Regulations, the health trusts must not only have established a quality assurance system, but they must also ensure that quality improvement is constantly taking place. This can be achieved by following up and evaluating the services and the effect of miscellaneous measures and by implementing new measures when needed to improve the services. In this improvement work, arrangements must be made for learning through the reporting of errors and non-conformities (3).

- Health personnel:
  The requirement to sound professional standards that applies to the health trusts must be seen in the context of the requirement to

1. Act relating to Specialized Health Services etc. of 2 July 1999 no. 61 (the Specialized Health Services Act).

2. Regulations relating to Internal Control in the Social and Health Care Service of 20 December 2002 no. 1731, section 1.

3. National Strategy for Quality Improvement in Health and Social Services (2005-2015). For leaders and providers. (6.1.2009)

responsible conduct and diligent care on the part of the individual, laid down in section 4 of the Health Personnel Act [4].

- Representatives of society engaged in suicide prevention work. This may be user associations, special interest or next-of-kin organisations, the media, etc.

- The supervisory authorities: Our aim is an integrated form of supervision in the 18 Norwegian Board of Health in the Counties.

Chapter 2 and some of the sections in Chapter 4 of this report coincide largely with an article which Unni Rønneberg, Senior Adviser of the Norwegian Board of Health Supervision, wrote in cooperation with Fredrik Walby, specialist in clinical psychology and researcher at the National Centre for Suicide Research and Prevention at the University of Oslo. This article was published in the Journal of the Norwegian Medical Association no. 2, 2008 [5].

Chapter 2 takes up the number of suicides, how the Board of Health Supervision was informed of and processed the cases, and the patient's status in the mental health service (compulsory/voluntary treatment, inpatient/outpatient, etc.)

After this article was published, the Norwegian Board of Health Supervision continued its processing of the data material and systematised variables such as sex, age, suicide method, etc. The finds made are presented in Chapter 3. The Norwegian Board of Health Supervision hopes with this to extend the store of knowledge of suicide prevention work performed by other public agencies, academic communities, user and special interest organisations and others.

Chapter 4 and 5 sum up the results and discuss the finds in light of the questions raised and on which this suicide study was based.

Chapter 6 is addressed to the target groups and contain recommendations on what results should be borne in mind.

The attachment is meant to support the supervisory authorities' handling of suicides and attempted suicides. The checklist has been updated in accordance with the guidelines for suicide prevention of the Norwegian Directorate of Health and is the final version of the preliminary checklist that was sent to the Norwegian Board of Health in the Counties in March 2006.

4. Act relating to Health Personnel, etc. of 2 July 1999 no. 64 (the Health Personnel Act).

5. Rønneberg U, Walby FA. Suicides in patient undergoing mental health care. Journal of the Norwegian Medical Association 2008; 128: 2: 180-3.

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1 Introduction

Brief history of suicide prevention in Norway

At the end of the 1980s, the suicide rate in Norway had doubled compared to the situation around 20 years before. In 1988, 708 suicides were registered in the Causes of Death Statistics of Statistics Norway. This constituted a rate of 16.8 per 100,000 population.

In 1993, the then Directorate of Public Health prepared a national programme for suicide prevention work. The action plan was adopted by the Storting *[Norwegian Parliament]* in 1994 and was originally to apply from 1994 to 1998. On 1 January 1994, the Directorate of Health was reorganised into the Norwegian Board of Health Supervision, with responsibility for miscellaneous directorate tasks and with greater emphasis on supervisory duties and due process protection in the health services. This reorganisation delayed the start-up of the planning period, which was extended until the end of 1999. In 2000, the Norwegian Board of Health Supervision published a final report, describing measures implemented during the planning period and recommending continued work within specific areas of commitment (6).

In Proposition no. 1 (2000-2001) to the Storting, it was decided to set up a new three-year project, which was also to be under the auspices of the Norwegian Board of Health Supervision (7). In 2002, a comprehensive reorganisation of the central health authorities was undertaken once more, and the Directorate of Health and Social Affairs was established. The Directorate was made responsible for national action plans and publication of professional guides and guidelines, while the Board of Health Supervision was given a clearer supervisory role. One of the core responsibilities of the new Board of Health Supervision was defined as monitoring and mapping health service areas with a high risk of failure, and also communicating experiences of this supervision work to the public administration and the health services.

New national guidelines for suicide prevention in 2008

In recent years, the Directorate of Health and Social Affairs (which changed its name to the Directorate of Health on 1 April 2008) has therefore been responsible for developing national suicide prevention work in Norway. In 2004, a task group was appointed to assist the Directorate in preparing national guidelines, and in January 2008, the "National Guidelines for Prevention of Suicide in Mental Health Care" was published (8). The target group for these guidelines is in principle the specialized health service, but the recommendations may be useful to anyone who needs knowledge about suicide prevention.

Role of the Board of Health Supervision after the 2002 reorganisation

The Board of Health Supervision is made up of the Norwegian Board of

6. Action plan against suicide –fi nal report. IK-2720. In the series of leafletsoftheNorwegian Board of Health Supervision 2000:3. Oslo: Norwegian Board of Health Supervision, 2000.

7. Follow-up project – initiatives against suicide. Project plan prepared by the Norwegian Board of Health Supervision in the autumn of 2000.

8. National guidelines for the prevention of suicide in the mental health service. IS-1511. Oslo: Norwegian Directorate of Health, 2008.

Health Supervision and the Norwegian Board of Health in the Counties. The Norwegian Board of Health Supervision is the superior body for the Norwegian Board of Health in the Counties (previously the Chief County Medical Officer) and for the County Governor's supervision of social welfare services. The Norwegian Board of Health Supervision's responsibilities include individual cases concerning serious failure in the health services, where reactions against health personnel may be considered. The Norwegian Board of Health Supervision can give orders to remedy the situation when a health service is run in contravention of rules or regulations and when the situation may be harmful to the patients. In this connection, the Norwegian Board of Health Supervision is also authorised to impose a coercive fine until the situation has been rectified.

The Norwegian Board of Health in the Counties carry out planned supervision of the trusts, process cases concerning service or health personnel failures and deal with complaints relating to non-compliance with the legislation in the health service. In addition, they receive reports under section 3-3 of the Specialized Health Services Act [9] of serious personal injury or circumstances that could have led to serious injury.

The duty to report suicides under section 3-3 of the Specialized Health Service Act

In circular letter I-54/2000 [10] of the Ministry of Health and Care Services, the Ministry underlines that the specialized health service must as soon as possible give written notice to the Norwegian Board of Health in the Counties of any serious injury inflicted on a patient as a result of the provision of a health service or because one patient has injured another. Events that could have led to serious injury must also be reported. In case of suicide or suspected suicide, the box *unnatural death* must be ticked on reporting form IK-2448, [11], and the Police must be notified (see section 36 of the Health Personnel Act) [4]. Part 1 of the form must be filled in by the person who reports the event, part 2 by the department management (causal relations, prevention), part 3 by the trust's quality assurance committee and part 4 by the Norwegian Board of Health in the Counties. All such reports are gathered in a national database (Meldesentralen) administered by the Norwegian Board of Health Supervision.

Supervisory follow-up

Should any data in the report furnish grounds for suspecting a breach of health legislation, the Norwegian Board of Health in the Counties will open a supervision case and obtain any information necessary for the proper elucidation of the case. Such supervision cases will normally be initiated also if the Norwegian Board of Health in the Counties should receive a complaint from the next-of-kin or an inquiry from the Police, the Institute of Forensic Medicine or others.

The supervision case will be assessed against section 2-2 of the Specialized Health Services Act on the duty to provide sound professional care [1] and section 4 of the Health Personnel Act relating to professional responsibility and diligent care [4]. Other regulations (for example the Medical Records Regulations) [12] may also be included in the basis of assessment. If the supervision case should conclude that the trust is guilty of a breach of duty, the Norwegian Board of Health in the Counties will normally close the case by drawing the trust's attention to this and requesting a review of and a change to procedures. If an individual employee has committed a breach of duty pursuant to the requirement of sound professional care of section 4 of the Health Personnel Act, in addition to the presence of a system error, if applicable, the case may be forwarded to the Norwegian Board of Health Supervision, which will consider an administrative reaction against the person concerned. Such a reaction may be a warning, the revocation of authorisation, licence, certificate of completion of specialist training or requisition rights, the institution of public prosecution, etc.

9. Act relating to the Specialized Health Services, etc. of 2 July 1999 no. 61, section 3 (the Specialized Health Services Act).

10. Obligation to report serious personal injury to the Chief County Medical Officer – section 3-3 of the Specialized Health Services Act – adjustments of the reporting regime. Circular letter I-54/2000. Oslo: Ministry of Health and Care Services, 2000.

11. Report to the Norwegian Board of Health in the Counties [form]. IK-2448. Oslo: Norwegian Board of Health Supervision, 2007. (6.1.2009)

4. Act relating to Health Personnel, etc. of 2 July 1999 no. 64 (the Health Personnel Act).

1. Act relating to Specialized Health Services etc. of 2 July 1999 no. 61 (the Specialized Health Services Act).

12 Medical Records Regulations of 21 December 2000 no. 1385.

2 The suicide study 2005-2006

2.1 Background for the suicide study

2.1.1 How many suicides are committed during treatment in the mental health service? Have the events been reported pursuant to current legislation?

International studies show that adverse events may occur in up to 10% of all inpatient stays and entail a death rate of approximately 5%. Translated to Norwegian conditions, this would mean around 80,000 adverse events and 4,000 unnatural deaths per year [13]. The 2005 annual report of Meldesentralen* showed a total of 1,902 reports of adverse events, hereunder 191 deaths. It also appeared from Meldesentralen's annual report that as per 1 December 2006, 261 events had been registered (14%) in the mental health service for 2005. Of these, 165 (63%) concerned self-inflicted injuries, i.e. self-injury (n = 50), attempted suicides (N- 51) and suicides (n = 42), besides overdoses (n = 8) and other circumstances (n = 14) [14].

A comparison of the figures from the international studies and Meldesentralen thus gave reason to suspect general under-reporting of both adverse events and deaths. It would be natural to suspect such under-reporting also with respect to suicides reported by the mental health services (the specialized health service). Nor did other registration systems and public statistics provide any clear indication of the number of suicides committed while the patient was undergoing treatment in the mental health services. The Norwegian Board of Health Supervision therefore wished to register data we receive as supervisory authority in order to increase our knowledge of the scope of such events.

2.1.2 Could the suicides be connected with treatment failure?

Relatives and other persons close to the patient expect the patient to be well taken care of and protected against serious acts of self-injury when the patient is admitted for treatment in the mental health service. This applies in particular to inpatients. In our processing of supervisory cases relating to suicides, we had seen that many patients committed suicide in spite of the psychiatric treatment received and we found criticisable conditions in many health trusts. The Norwegian Board of Health Supervision wished to obtain a more detailed overview of the scope of such non-compliance at individual or system level and to see if any common features could be found in case of such failures.

2.1.3 Are such events used for quality development in the trusts?

One of the circumstances which the supervisory authorities had observed in the treatment of suicide cases prior to this study, was that many trusts did not have adequate procedures for a review of causal relations and did not use the event in their further suicide prevention work. We wished to obtain more information on whether the health trusts

13. Hjort PE. Adverse Events in the Health Service. Oslo: Gyldendal, 2007.

* The Reporting System for Adverse Events in the Specialized Health Services

14. Annual Report 2005 for MedEvent (Meldesentralen – the Reporting System for Adverse Events in Specialized Health Services). Report from the Norwegian Board of Health Supervision 1/2007

initiated specific quality-improving measures in the events that came to the notice of the supervisory authorities.

2.1.4 Are suicides treated consistently by the Norwegian Board of Health in the Counties?

The Norwegian Board of Health Supervision is to ensure that the 18 Norwegian Board of Health in the Counties perform their supervisory work in the most consistent way possible. We expected that such a study would disclose any regional differences, so that we could use this in the supervisory authorities' own quality development work.

2.2 Method and material

In 2005, the Norwegian Board of Health Supervision prepared a new form in which the Norwegian Board of Health in the Counties were to register all suicides that came to their notice and that had been committed while the patient was undergoing treatment in the mental health services. We also asked for copies of the closing letter in each suicide case concluded by the Norwegian Board of Health in the Counties in 2005 and 2006. The material therefore comprises cases *completed* by the supervisory authorities in the course of these two years, regardless of when the suicide occurred or when it was reported to the supervisory authorities.

The registration form contained four main items: how the suicide was reported, the patient's status within the mental health service, the supervisory authority's processing of the case (hereunder whether the institution had taken quality improvement measures after the event) and the supervisory authority's decision in the case. We defined "suicide under treatment in the mental health service" as suicide committed in the course of treatment in an institution (voluntary, compulsory, while on leave), during outpatient treatment at a district psychiatric centre (DPS), up to two weeks from being discharged from inpatient or outpatient treatment, as well as patients waiting for treatment. No distinction was made been adult and child/youth psychiatry on the registration form.

In the course of the registration, some great differences were disclosed in the Norwegian Board of Health in the Counties procedures. In 2006, the Board of Health Supervision therefore forwarded a preliminary checklist of what the supervisory authorities should take into account in such cases. The checklist was prepared in cooperation with the National Centre for Suicide Research and Prevention at the University of Oslo. The preliminary checklist indicated how the health trusts should arrange for proper suicide risk assessments, establish requirements for the qualification of those making the assessments and systems and procedures for record-keeping, scaled monitoring and protection/security, training requirements, procedures for taking care of the bereaved, notification requirements, quality development work, etc.

2.3 Results

2.3.1 Number and reporting method

The Norwegian Board of Health in the Counties closed 176 events in 2005 and 2006 relating to suicide, reported or subject of complaints (table 1). More than one source of reporting was found in 22 of the events (12.5%). In 33 cases (nearly 20 %) that came to the notice of the supervisory authorities, the trusts had not reported the event pursuant to section 3-3 of the Specialized Health Services Act ("section 3-3 reports"). The category "other" largely contains information given by the health service to the Norwegian Board of Health in the Counties, but where no report was filed pursuant to section 3-3. This could for example be letters from the trust concerning the event, often a long time after the suicide.

Table 1

How the event was brought to the notice of the Norwegian Board of Health in the Counties

	N	*%*
Report pursuant to section 3-3	143	81.3
The Police	7	4.0
Complaint from the next of kin	23	13.1
Institute of Forensic Medicine	17	9.7
Other	8	4.5
Total	**198**	**112.6**

2.3.2 Status of the patient in the mental health service

76 suicides (43.2 %) were committed by patients admitted to inpatient treatment. Of these, 23 were on leave from the institution. A further 15 persons committed suicide in the course of the two first weeks after being discharged from mental health care, and all of them had been discharged from inpatient treatment. A total of 51.7% of the suicides occurred during or immediately after treatment at an inpatient clinic. 12 of the patients admitted to inpatient centres were under compulsory care, while the majority of the suicides were related to outpatient treatment, committed by patients undergoing voluntary treatment.

Table 2

Status of the patient undergoing mental health treatment

	n	*%*	*Total %*
Inpatient; compulsory care	12	6.8	51.7
Inpatient; voluntary	41	23.3	
Leave from inpatient clinic	23	13.1	
Within two weeks from discharge from inpatient clinic	15	8.5	
Outpatient; coercive care	3	1.7	39.8
Outpatient; voluntary	67	38.1	
On waiting list	7	4.0	4.0
Unknown/other	8	4.5	4.5
Total	**176**	**100**	

2.3.3 The Norwegian Board of Health Supervision in the Counties´ processing of the cases

The Norwegian Board of Health Supervision in the Counties found reason to initiate supervision cases in 61 of the suicides that had been reported or made the subject of a complaint. In around half of these cases, they requested information about the health trust's routines and procedures. In four of the cases, external experts were used to examine whether the patient had been offered adequate follow-up before committing suicide.

The supervisory authority's decisions appear in table 3. Health personnel were given advice or counselling in four cases, and a breach of the requirement to sound professional care under the Health Personnel Act [4] was established in a further four cases.

With respect to the health trusts (so-called system cases), advice or guidance was given in four cases, while breaches of section 2-2 of the Specialized Health Services Act [1] were found in 19 cases. Data were available for 18 of these 19 cases. Most of the cases were closed by the Norwegian Board of Health in the Counties, while six cases were transferred to the Norwegian Board of Health Supervision for assessment of administrative reactions against health personnel. Two of these cases concerned breaches of duty in the primary health service in connection with suicides, and were not directly related to treatment received in the mental health service.

4. Act relating to Health Personnel, etc. of 2 July 1999 no. 64 (the Health Personnel Act).

1. Act relating to Specialized Health Services etc. of 2 July 1999 no. 61 (the Specialized Health Services Act).

Also in the 61 supervision cases, most of the cases were suicides committed during inpatient care or in the course of the two first weeks after discharge. Only four cases concerned breaches of duty in connection with suicide during outpatient treatment. Approximately one third of the suicides were committed while the patient was on leave from an inpatient clinic.

Table 3
The Norwegian Board of Health in the Counties' decisions in 61 supervision cases

Board decisions, health trusts	*n*	*%*
No observations made to health personnel or trust	24	39.3
Advice/guidance, health personnel	4	6.6
Advice/guidance, trust	4	6.6
Breach of duty disclosed, health personnel	4	6.6
Breach of duty disclosed, trust	19	31.1
Forwarded to the Norwegian Board of Health Supervision	6	9.8
Total	**61**	**100.0**

2.3.4 Regional differences in the supervisory work

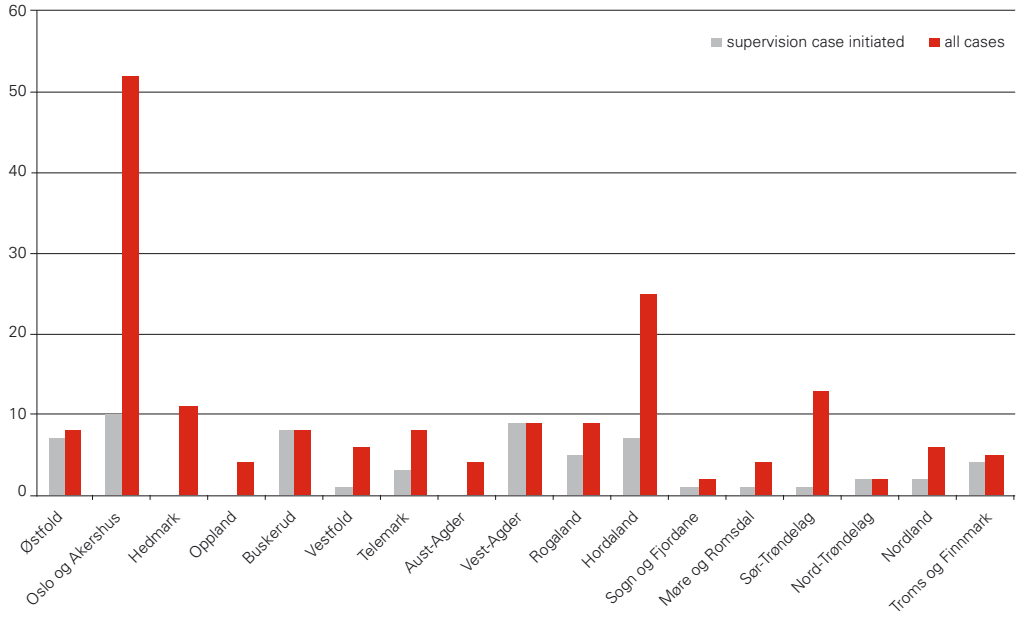
There were great variations between counties as regards the percentage of cases reported that led to a supervision case. In some counties, no supervision cases were opened at all, while other counties did this as a matter of routine for all reports of or complaints relating to suicide within the mental health service.

Table 4
Supervision cases/events by county

County	*Cases*		*Supervision cases/events*
	n	*%*	
Østfold	8	4.5	7/8
Oslo og Akershus	52	29.5	10/52
Hedmark	11	6.3	0/11
Oppland	4	2.3	0/4
Buskerud	8	4.5	8/8
Vestfold	6	3.4	1/6
Telemark	8	4.5	3/8
Aust-Agder	4	2.3	0/4
Vest-Agder	9	5.1	9/9
Rogaland	9	5.1	5/9
Hordaland	25	14.2	7/25
Sogn og Fjordane	2	1.1	½
Møre og Romsdal	4	2.3	¼
Sør-Trøndelag	13	7.4	1/13
Nord-Trøndelag	2	1.1	2/2
Nordland	6	3.4	2/6
Troms	5	2.8	4/5
Finnmark	0	0	-
Sum	**176**	**99.8**	**61/176**

Figure 1 is a graphic presentation of all suicides, cases reported and complaints, by county, in relation to the number of supervision cases initiated.

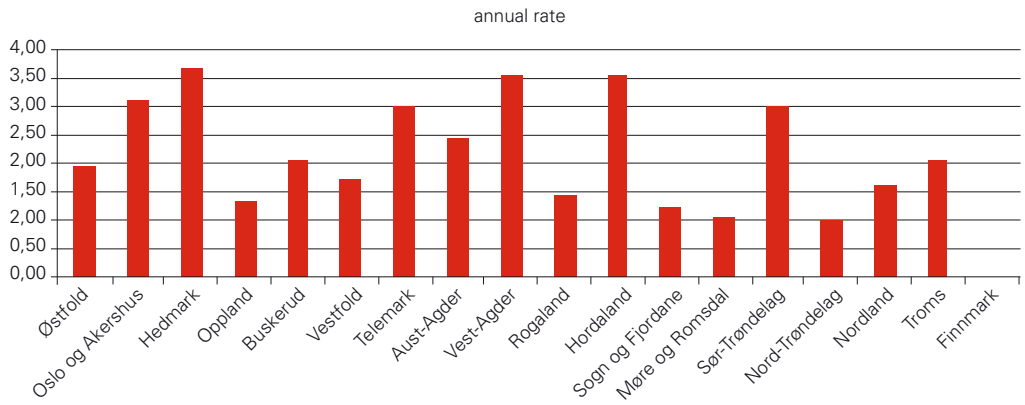
Figure 1
Distribution by county of supervision cases/events



2.3.5 Regional differences in the suicide rate

Based on population figures >18 years in each county, we get the following average annual suicide rate (per 100,000 population in each county) for 2005 and 2006 among patients treated in the mental health service:

Figure 2
Annual suicide rate by county



It is important to bear in mind that this rate does not necessarily reflect the real number of suicides in the county in question. Very many factors may affect the result: differing reporting cultures in the various health trusts, the geographic location of outpatient and inpatient institutions, consent to compulsory care, etc. One example is Finnmark, which has to transfer patients who need compulsory care to Troms county.

We also refer to the summary and the discussion of results in Chapter 5, where we examine both established and assumed under-reporting.

3 The patients

3.1 What was characteristic of the patients? How did they die?

After the first results were published in the Journal of the Norwegian Medical Association [5], we were informed that two of the cases were not suicides, but death by natural causes. These two cases were deleted from the data material. In the following, the total number of suicides is 174 (for 2005 and 2006).

The Board of Health Supervision has reviewed each report and any additional information available. Unfortunately, it was not possible to obtain all the parameters we wished to map, and the figures in the categories "not given", "unknown" or the like are therefore relatively high for some of the variables. The figures may nevertheless give an impression of what characterises patients that have committed suicide and the suicide methods used.

3.2 Distribution by sex

In the Causes of Death statistics for 2006, Statistics Norway registered that 391 men and 141 women had committed suicide, totalling 532 [15]. The men constituted 73.5% and the women 26.5% of the total number. In our material, we see that the percentage of women is considerably higher. Of the total of 174 suicides, 91 are men (52.3%) and 68 (39.1%) women. Gender is not given in 15 of the cases (8.6%).

Table 5
Distribution by sex

	N	*%*
Male	91	52.3
Female	68	39.1
Not stated	15	8.6
Total	**174**	**100.0**

3.3 Age

The table includes one person in the age group 28-37 with sex "not stated", as it does not appear from the name or the text whether this person was male or female. Other data for this person are known. In 14 suicides by persons whose sex was unknown, the age group was also unknown.

Table 6
Age groups – men and women

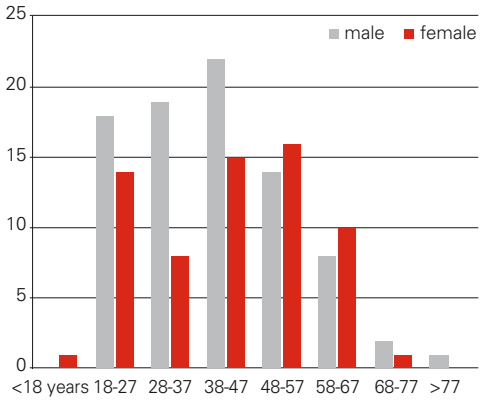
	< 18	*18-27*	*28-37*	*38-47*	*48-57*	*58-67*	*68-77*	*>77*	*unknown*	*total*
Male	0	18	19	22	14	8	2	1	7	91
Female	1	14	8	15	16	10	1	0	3	68
Unknown	-	-	1	-	-	-	-	-	14	15
Total	**1**	**32**	**28**	**37**	**30**	**18**	**3**	**1**	**24**	**174**

5. Rønneberg U, Walby FA. Suicides in patient undergoing mental health care. Journal of the Norwegian Medical Association 2008; 128: 2: 180-3.

15. Statistics Norway. Suicide by method. 1976-2006 [Table].

Figure 3 shows 10-year age groups by sex. The categories unknown/not stated were removed from the variables of sex and age to simplify the table. It appears from the table that in this study there are far fewer women in the age group 28-37 that committed suicide than in the groups of younger and older women.

Figure 3
Age groups – men and women



3.4 Suicide method of men and women

The suicide method was not stated or unknown in more than one third of the cases. The health trusts had often stated "found dead", "has committed suicide", etc. on the forms without specifying the suicide method.

Hanging is the most common suicide method in the study. Materials used comprise bed-linen, belts, pieces of clothing or cables; tied to shower fittings, handles, bedrails, curtain rods, etc. Suffocation refers to a few cases in which the patient had covered his/her head with plastic bags, tape or the like.

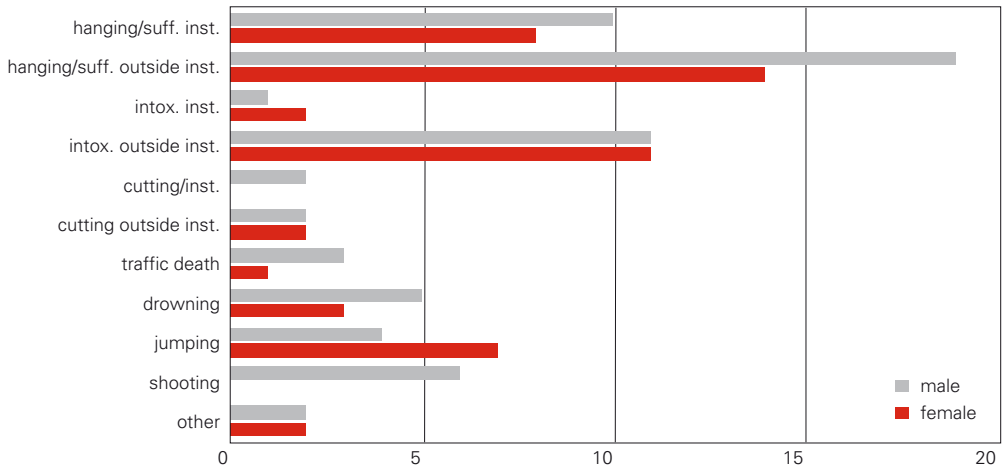
The category "other" comprises death by poisonous exhaust gases and the use of explosives.

Table 7
Suicide method, both sexes

Method	*Number*	*%*	*Total %*
Hanging or suffocation in institution	18	10.3	29.3
Hanging or suffocation outside institution	33	19.0	
Intoxication in institution	3	1.7	14.3
Intoxication outside institution	22	12.6	
Cut injuries in institution	2	1.1	3.4
Cut injuries outside institution	4	2.3	
Traffic death	4	2.3	2.3
Drowning	8	4.6	4.6
Jumping	11	6.3	6.3
Shooting	6	3.4	3.4
Other	4	2.3	2.3
Not stated/not known	59	33.9	33.9

In figure 4, unknown sex and unknown method have been removed to arrive at a cross-table with only known variables. The table includes 91 men and 68 women. Like table 7, the figure distinguishes between hanging/ suffocation committed inside and outside an inpatient centre. Only one of the cases of jumping occurred from an institution. No women used shooting as suicide method. Nor did any women die from cutting injuries as inpatients or while undergoing outpatient treatment.

Figure 4
Sex (number) by suicide method



3.5 Age groups by method and sex

Tables 8 and 9 show suicide methods by age group and sex. No men under the age of 18 were reported to have committed suicide in this period. A man over the age of 78 committed suicide by drowning. The category hanging in or outside an institution also includes some cases of suffocation. Traffic death means the patient had been talking in advance of driving into a mountain face or a heavy-goods vehicle, jumping in front of a tram/train, or the like, and where the cause of death coincided with such statements.

Table 8
Method by age groups (male)

	Men – age groups								
Method	*18-27*	*28-37*	*38-47*	*48-57*	*58-67*	*68-77*	*>78*	*Unknown*	*Total*
Hanging in institution	2	3	1	0	2	1	0	1	10
Hanging outside institution	3	2	8	4	2	0	0	0	19
Intoxication institution	0	1	0	0	0	0	0	0	1
Intoxicaton outside institution	4	4	0	0	1	0	0	2	11
Cutting in inst.	0	0	1	1	0	0	0	0	2
Cutting outside institution	0	0	1	0	0	0	0	1	2
Traffic death	0	0	3	0	0	0	0	0	3
Drowning	2	0	0	0	1	1	1	0	5
Jumping	0	1	2	0	1	0	0	0	4
Shooting	0	2	1	2	1	0	0	0	6
Other	1	0	0	1	0	0	0	0	2
Unknown	6	6	5	6	0	0	0	3	26
Total	**18**	**19**	**22**	**14**	**8**	**2**	**1**	**7**	**91**

Table 9
Method by age group (women)

	Women – age groups								
Method	*<18*	*18-27*	*28-37*	*38-47*	*48-57*	*58-67*	*68-77*	*unknown*	*Total*
Hanging in institution	1	3	0	1	2	1	0	0	8
Hanging outside institution	0	4	3	1	3	3	0	0	14
Intoxication institution	0	0	0	1	1	0	0	0	2
Intoxication outside institution	0	3	2	1	4	1	0	0	11
Cutting outside institution	0	0	1	1	0	0	0	0	2
Traffic death	0	1	0	0	0	0	0	0	1
Drowning	0	0	0	0	1	1	0	1	3
Jumping	0	1	1	2	2	1	0	0	7
Other	0	1	0	0	0	1	0	0	2
Unknown	0	1	1	8	3	2	1	2	18
Total	**1**	**14**	**8**	**15**	**16**	**10**	**1**	**3**	**68**

3.6 Diagnoses

The Norwegian Board of Health Supervision has used the categories of the diagnosis system ICD-10 to classify the diagnoses appearing in the material. The categories F00-F09 (organic diseases) and F70-F79 (mental impairment) were omitted, as none of the patients had these diagnoses.

The diagnosis categories are as follows:

F10-F19 Mental and behavioural disorders due to psychoactive substance abuse

F20-F29 Schizophrenia, schizotypal and delusional disorders

F30-F39 Mood (affective) disorders

F40-F48 Neurotic, stress-related and somatoform disorders

F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors (e.g. an eating disorder)

F60-F69 Disorders of adult personality and behaviour

F80-F89 Disorders of psychological development (e.g. autism, Asperger's syndrome)

In 37.9% of the cases, the diagnosis had not been made or did not appear in the data material. Where depression symptoms are present as part of another, more comprehensive disorder, for example schizophrenia and personality disorders, the latter disorders are registered in the table.

As shown in table 10, the most frequently diagnosed category is mood disorders. Depression diagnoses were in the majority. Nine of the cases registered in the category of mood disorders were diagnosed as bipolar (manic-depressive) disorders.

Table 10
Diagnosis groups by number and per cent

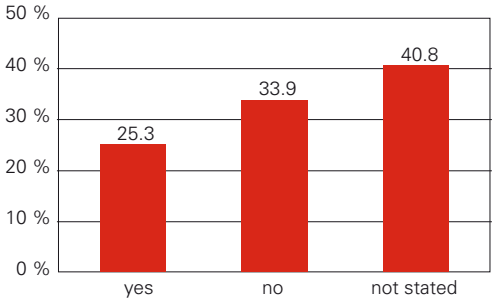
Diagnosis group	*N*	*%*
F10- F19	9	5.2
F20-F29	23	13.2
F30-F39	59	33.9
F40-F49	3	1.7
F50-F59	1	0.6
F60-F69	11	6.3
F80-F89	2	1.1
Not stated	66	37.9
Total	**174**	**100.0**

3.7 Substance abuse

Mental and behavioural disorders due to use of psycho-active substances were included as a separate diagnosis category F10-F19 in the previous item. In this item, all cases of substance abuse are included, whether this was registered as a main diagnosis or is mentioned in forms or in medical records. The category "not stated" was used where no special information was furnished about substance abuse. The category "no" was only used where it was possible to infer from the data that the patient did not use alcohol, drugs or narcotics.

In 44 cases, substance abuse was stated to be a problem, while no use/abuse was recorded in 59 cases. In the remaining 71 cases there was no basis for determining whether substances had been abused or not.

Figure 5
Substance abuse (percentage)

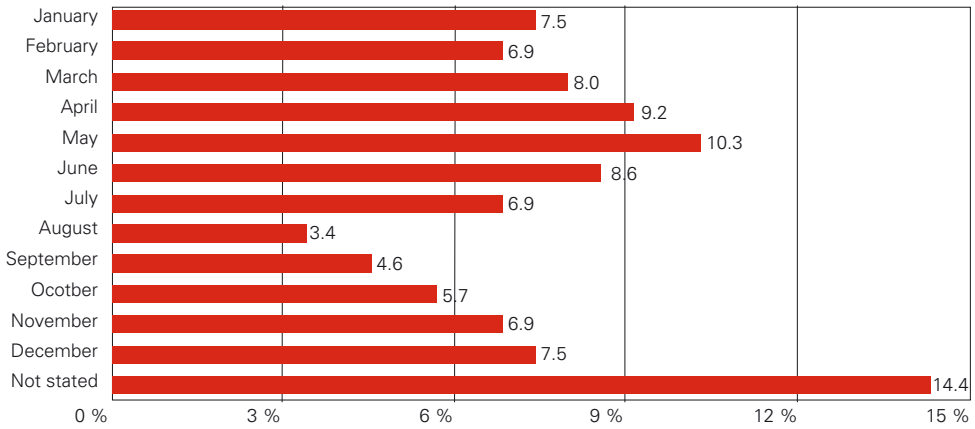


3.8 Seasonal variations

In the registration of seasonal variations, we have used the date of the event given in the reporting form or information from the supervision case. In figure 6, August and September are the months with the lowest suicide rate, while it was somewhat higher in the spring months. It has often been claimed that the use of summer temps and generally poorer manning during the summer holidays could affect the quality of the treatment offered, and that this would lead to a higher number of suicides. Our findings do not support this assumption. However, several factors may affect the figures. We cannot exclude the possibility that poorer manning and the use of substitutes not familiar with the system may have contributed to a reduced number of suicides being reported.

Of suicides with a known date, 21.9% were committed during the winter months December, January and February, 27.5% in the spring months March, April and May, 18.9% in the summer months June, July and August and 17.2% in the autumn months September, October and November.

Figure 6
Suicides by month (per cent)



4 Where did we identify failure to comply with the legislation?

4.1 Assessment of the health trust

No proper suicide assessments were made at the onset of treatment in eight of the 18 supervision cases that resulted in the criticism of the health trusts. Eight cases lacked a reassessment of suicide risk in vulnerable transitional phases (transfer from compulsory to voluntary health care, before leave, upon transfer, discharge, etc.). Attention was called to inadequate record-keeping in six of the 18 cases. We also found a lack of protection or security measures (for example during transportation, transfer between departments or securing dangerous objects) in four cases. The follow-up of relatives was very good in two cases; in four cases failure to comply with the legislation was found, and in the remaining 12 cases, the follow-up of relatives was not specifically mentioned. In two cases, the assessment of suicide risk was made by personnel with clearly inadequate qualifications (a medical student, personnel with college education) who did not contact more qualified health personnel. We found a general lack of systems for training health personnel and insufficient information was given to new employees about procedures/ guidelines.

In only three of the cases that led to criticism did the health trust tick the box on the registration form to confirm that the trust had improved its control systems after the event. Two of the cases concerned an improvement of the routines for transportation of patients and more rapid forwarding of discharge summaries. In one case, the trust carried out a comprehensive audit and improvement of their suicide prevention procedures and guidelines.

4.2 Assessment of health personnel

In four cases concerning specialized health service personnel, we found breaches of section 4 (the requirement to sound professional practice) of the Health Personnel Act, and these cases were forwarded to the Norwegian Board of Health Supervision for an evaluation of administrative reactions. The outcome of these cases was that the Board did not find any basis for administrative reactions against the health personnel concerned, as the trusts had not ensured that adequate procedures and systems were in place in their suicide preventive work. Two other cases forwarded to the Norwegian Board of Health Supervision concerned therapists in the primary health service and were thus not directly related to treatment received in the mental health service.

5 Summary and discussion of the results

5.1 Under-reporting and dark figures

In the course of the relevant two-year period, the supervisory authorities closed a few cases in which the event occurred in 2003, but most of the complaints/reports concerned events that occurred in 2004, 2005 and 2006. The processing of cases received by the Norwegian Board of Health in the Counties towards the end of 2006 had not been completed when the period of the survey finished, and they have therefore not been included in the data material. However, the figures from Meldesentralen have shown a relatively stable number of reports from the mental health service during the last years, and we therefore assume that the backlog from 2004 will offset the cases that had not been completely processed when the study was concluded in December 2006. Thus, the Board of Health Supervision was informed of 85-90 suicides a year by patients undergoing treatment in the mental health service.

Around one in five of the suicides brought to the attention of the supervisory authorities in this period was not reported pursuant to section 3-3 of the Specialized Health Services Act. The supervisory authorities came to know of these cases through complaints from relatives, notifications from the public authorities, the media, etc. According to Statistics Norway, around 500 persons commit suicide in Norway every year [15]. Some researchers maintain that more than 90% of those who commit suicide have a diagnosable mental disorder [16]. Translated to Norwegian conditions, this would mean around 450 persons with a mental disorder. If we deduct the 85 to 90 persons we know for certain committed suicide while undergoing psychiatric treatment, we are left with 350 cases of which we know nothing. In a study of all suicides in Oslo by inpatients and during the three first years after their discharge, Walby and his collaborators found that 20% of the suicides occurred while the patient was formally hospitalised, and the remaining 80% in the course of the ensuing years, with a clear majority during the first year after discharge [17]. Even if not all of these patients were necessarily undergoing active treatment, a great majority of theses suicides were committed *outside* the institutions.
In our study, 76 of the reports, corresponding to 43.2%, came from inpatient institutions. This may suggest that the reporting culture is better at inpatient that at outpatient centres, even if both are defined as a specialized health service and thereby have a statutory obligation to report suicides. This also gives us reason to believe that the total number of suicides while under mental health care is substantially higher than our material suggests.

We have in this study *established* under-reporting, in that around 20% of the suicides were not reported in the way required, but came to our notice through other channels than the reporting system. But we also have an *assumed*

15. Statistics Norway. Suicide by method. 1976-2006 [Table].

16. Cavanagh J-TO, Carson A, Sharpe M et al. Psychological autopsy studies of suicide: a systematic review. Psychol Med 2003; 33: 395-405.

17. Walby FA, Odegaard E, Mehlum L. Psychiatric comorbidity may not predict suicide during and after hospitalization. A nested case-control study with blinded raters. J Affect Dis 2006; 92:

253-60.

under-reporting, which appears when we make comparisons with other suicide studies and which may probably be related to the lack of reports from outpatient clinics/DPS's. If 90% of the around 500 patients who commit suicide in Norway every year have a mental disorder, we may have reason to question whether all of them were offered the treatment and follow-up they were entitled to.

With respect to the regional differences shown in figure 2, we must be very cautious in interpreting the results. The differences may suggest that reporting cultures vary in different parts of the country, and we know that some institutions are "good" at reporting. The county in question will then appear to have a higher suicide rate. Many other factors, such as the geographic location of large treatment centres, authorization to provide compulsory care, socio-economic conditions, etc. may affect the results.

5.2 Responsibilities of the health trust

The supervisory authorities have in their assessment of suicide cases chosen to emphasise the health trusts' responsibility for providing appropriate training in identifying and treating suicidal patients, as well as adequate routines for protection, interaction and record-keeping.

The two-year study showed that very few health trusts used each event to take measures to improve quality, and great deficiencies were found in some cases in their suicide prevention work. The trusts must be aware that many patients in the mental health service have a high suicide risk. They have an obligation to establish good procedures and to detect the signals of suicide risk and adapt the treatment situation to this risk. Extensive information is available on how such preventive work should be organised, most recently the summary in the national guidelines published by the Directorate of Health in 2008 [8].

After our study was concluded, some of the health trusts have communicated that they have changed their procedures or established the necessary procedures and systems in their suicide prevention work. Unfortunately, the Board of Health Supervision frequently receives new supervision cases that show there are still significant non-conformities in the trusts' procedures in this area in many places in Norway.

5.3 Differences in board of health supervision practice

The Norwegian Board of Health in the Counties do not have a joint understanding of how suicide reports should be followed up by the supervisory authority. The decisions on opening a supervision case and the supervisory assessments made in such cases are based on discretionary assessments in each county and with each case officer. After having summed up the first year's data material, the Norwegian Board of Health Supervision prepared a preliminary checklist of factors that should be included in the supervisory authorities' basis of assessment. A final checklist has now been prepared and is published together with this report.

8. National guidelines for the prevention of suicide in the mental health service. IS-1511. Oslo: Norwegian Directorate of Health, 2008.

6 Worth noting

6.1 What aspects of this study should the health trusts take note of?

The requirement to sound, professional practice of section 2-2 of the Specialized Health Services Act
We refer to our findings in the assessment of health trusts (item 4.1). We found failures in the suicide risk assessment, inadequate record-keeping, deficient security/protection of the patient, poor follow-up of surviving relatives, etc. Many trusts lacked procedures or had failed to implement their procedures by providing appropriate information and training.

Central issues the supervisory authorities should heed are suicide risk assessments (who is in charge, when?), protective measures (who removes dangerous objects?), who is to take and revoke decisions on interval-based or constant care, who is responsible for the institution's physical conditions (cf. that hanging is the main method). Procedures for keeping records and for interaction, etc, must have been established. The bereaved must be properly taken care and be informed of their right of access to the records of the deceased and their right to file a complaint with various public agencies.

The reporting obligation under section 3-3 of the Specialized Health Services Act
The objective of the reporting obligation is not to blame individual health workers involved in the case, but to ensure that the health trusts make use of adverse events and unnatural deaths in their internal quality development work. If a case is reported to the Norwegian Board of Health in the Counties by letter, by a copy of medical record memos or the like, the reporting duty will indeed have been complied with, but it will not be possible to register the case in Meldesentralen. The report must therefore be sent to the Norwegian Board of Health in the Counties on the right form, IK – 2448 [11]. Record memos and other information necessary for the further clarification of the case can be attached to the form.

Quality assurance work
The Board of Health Supervision expects mental health care trusts to use these tragic and adverse events in their suicide preventive work. The objective is not to apportion blame, but to evaluate current procedures and if necessary update and improve them. The health trusts must do their utmost to prevent such events in the future. The Internal Control Regulations for the Social Affairs and Health Service [2] and guide IS-1183 "Keeping your own house in order" [18] of the Directorate of Health clearly underline the trust's obligation to make use of their employees' experiences, to identify areas with a risk of failure and to engage in constant improvement work.

Chapter 2 showed that the suicide method was not stated or known in 33.9% of the events. If the cause of death has not been established at the

11. Report to the Norwegian Board of Health in the Counties [form]. IK-2448. Oslo: Norwegian Board of Health Supervision, 2007. (6.1.2009)

2. Regulations relating to Internal Control in the Social and Health Care Service of 20 December 2002 no. 1731, section 1.

18. "Keeping your own house in order" IS-1183. Oslo: Norwegian Directorate of Health and Social Affairs, 2004.

time or filing the report, this should be stated in the form, otherwise the method should be given. Some of the learning potential of such events lies precisely in this. One example may be that a patient takes his life by shooting himself at home. The health care institution treating him and the institution's quality committee should then examine whether they had adequate routines/procedures for asking the patient whether he had arms at home, whether the Police should have been notified, etc. In case of poisoning from dangerous medicinal drugs, the event should be reviewed and an assessment made of routines for handling medicine: should the medicine have been kept by the health institution, administered differently, etc.

6.2 What should health personnel take note of?

Above we have underlined the responsibility resting on the management to ensure that all procedures are in place and that health personnel are given sufficient suicide prevention training. However, health personnel should not forget that they have an independent liability for responsible and professional conduct, see section 4 of the Health Personnel Act [4]. They are to provide sound and diligent care and act in accordance with their qualifications. If they lack the required competence, they should have a low threshold for seeking advice from colleagues, the person on call or others. Health personnel must, for example, know the regulations relating to medical records and make sure that good documentation is provided of any assessments made, treatment commenced, information given to cooperating or succeeding therapists, etc. If a suicide risk assessment is not recorded, the Board of Health Supervision will assume that such an assessment has not been made.

Health personnel are obliged to familiarise themselves with and observe the procedures and guidelines established for their department. They must make sure that they keep professionally updated. With respect to suicide prevention, they should be familiar with the Health Directorate's new guidelines and comply with them. One of the Directorate's new recommendations is that *all* patients admitted for mental health care should be asked whether they are thinking of or planning suicide.

6.3 What should relatives, organisations, the media and others take note of?

In several of our supervision cases, we have seen that relatives have taken steps to have a patient admitted to inpatient care and have expressed serious concern about his/her risk of suicide. Subsequently, however, their concerns have not been sufficiently taken into consideration, such vital information has not been recorded, the patient is allowed home-leave without relatives being notified, etc.

After a suicide, we also found failures in the department's follow-up of the patient's next-of-kin. In four of the 18 supervision cases referred to, the Norwegian Board of Health in the Counties pointed out that the bereaved had not been properly taken care of. True, this is not a high number, only around 2% of the total number of cases. However, our general experience of supervision work gives us reason to believe that many relatives are not properly taken care of after a suicide, and that the number could be substantially higher. We know that many are reluctant or do not have the strength to complain to the health service, the Board of Health Supervision or other public bodies. Handling the relatives' reactions may be a challenge to the health personnel involved, who may need to process the event themselves. However, as professional service providers, health personnel are responsible for offering the best possible dialogue and follow-up. If the next-of-kin would like access to the medical records, they are entitled to this with a few exceptions, and they have a right to receive information about appellate bodies, support organisations and the like. In October 2008, the Directorate of

4. Act relating to Health Personnel, etc. of 2 July 1999 no. 64 (the Health Personnel Act).

Health published the guide "Next-of-kin – a resource". This guide is intended to stimulate health trusts to establish good procedures to ensure that the rights, wishes and needs of the next-of-kin are safeguarded [19].

In some cases, suicides were brought to the Board of Health Supervision's attention through media reports, and supervision cases were opened on this basis. The media have an important role and a great responsibility in such cases. The Code of Ethics of the Norwegian Press recommends sober coverage of suicide, and the media generally seem to respect this. But at times we find dramatic headlines on deficiencies in the mental health service, where the press has not taken the time for a proper elucidation of the matter. Neither patients nor employees or relatives are served by this. In our 174 cases over two years, we only found breach of duty on the part of the trust in 19 cases and at the individual level in four cases. These low figures illustrate that even if routines and procedures are in place and the health personnel have not acted in a censurable way, some of these events may be difficult to prevent.

6.4 What should the Norwegian Board of Health in the Counties take note of?

The Norwegian Board of Health Supervision has registered great differences between counties, both with respect to how they assess the grounds for opening a supervision case based on a section 3-3 report and to how they process the cases after initiating a supervision case. The Norwegian Board of Health Supervision has overall responsibility for ensuring that the Norwegian Board of Health in the Counties' practice is as homogenous as possible. We therefore recommend Norwegian Board of Health in the Counties to make a very careful assessment of data in any section 3-3 report. The report must be forwarded on form IK-2448 so that it may be correctly registered in Meldesentralen. In many cases, information in the reporting form will not be sufficient to examine whether the patient has been offered sound, professional treatment and that any non-conformance was properly managed. In such cases, further information must be obtained about the health trust's suicide prevention work. The attachment to this report may be used to show the quality committee the routines and procedures we expect them to have in place. The attachment is also intended to promote a systematic and homogenous practice in the review of supervision cases dealing with suicides and serious suicide attempts.

19. Next-of-kin – a resource. IS-1512. Oslo: Norwegian Directorate of Health, 2008.

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16. Cavanagh J-TO, Carson A, Sharpe M et al. Psychological autopsy studies of suicide: a systematic review. Psychol Med 2003; 33: 395-405.

17. Walby FA, Odegaard E, Mehlum L. Psychiatric comorbidity may not predict suicide during and after hospitalization. A nested case-control study with blinded raters. J Affect Dis 2006; 92: 253-60.

18. "Keeping your own house in order" IS-1183. Oslo: Norwegian Directorate of Health and Social Affairs, 2004.

19. Next-of-kin – a resource. IS-1512. Oslo: Norwegian Directorate of Health, 2008.

Attachment

Checklist for the supervisory authorities' review of suicides and attempted suicides among patients undergoing treatment in the mental health care service*

1. Mapping and assessment of suicide risk

Mapping: The Directorate of Health recommends [1] that **all** patients admitted to mental health care should be asked if they have suicidal ideation or plans and about any previous attempted suicide. If the patient gives a positive answer to any of these questions, the trust must have procedures to ensure that he/she will be followed up with an **assessment** of suicide risk, see below.

Assessment: The suicide risk assessment should be thorough and systematic. Current mental status should be assessed in relation to risk factors and suicidal ideation/plans. The suicide risk assessment should be a reliable professional assessment concluding with the assumed suicide risk (high, medium, low)

1.1 Qualifications needed: ***all*** occupational categories should ask questions about suicidal ideation, suicidal plans and previous attempted suicide (*mapping*) when they meet a new patient in the mental health service. The actual suicide risk *assessment* should preferably be made by a physician or a psychologist, but may also be made by other health personnel with adequate professional qualifications for making such an assessment and adopting appropriate measures. The trust must have a procedure indicating the person to be contacted if the health personnel looking after the patient are not sufficiently qualified.

1.2 Circumstances to be included in the suicide risk assessment: The health trust must have procedures, which may well be in the form of checklists, to ensure:

1.2.1 That all vulnerability and risk factors are clarified (serious mental disorder, previous attempted suicides, substance abuse, history of abuse, recent loss of a person close to the patient, breakdown of important relationship, social problems, previous suicides in the family, loss of functions, loss of skills or hope, etc.)

1.2.2 That relevant information from persons with knowledge of the patient or relatives is obtained, if possible

1.2.3 That the patient is asked if he has access to weapons or dangerous medications

1.2.4 That the degree of suicide risk has been established.

1.3 When the risk assessment must be repeated: The trust must have procedures for how often a risk assessment should be repeated if a patient is suicidal, and for repeating the assessment in case of any change to his/her condition, during vulnerable transitional phases in the treatment (leave from institution, transfer to another department/ward, change of therapist, upon being discharged, etc.).

1.4 Recording suicide risk assessments: The trust must have routines to ensure that other therapists or public agencies receive appropriate and accurate information.

1.5 Training measures: The trust must have procedures for training in suicide risk assessment and suicide prevention measures, and to ensure that new employees receive sufficient information.

* Replaces the provisional checklist of 28 March 2006

1. Act relating to Specialized Health Services etc. of 2 July 1999 no. 61 (the Specialized Health Services Act).

Attachment (cont.)

2. Treatment

A correct diagnosis should be made as soon as possible and treatment commenced based on the knowledge status of each disorder (psychotherapy, medicines, ECT, etc.). The trust should make sure that the patient is hospitalised long enough for a sound assessment of his/her status to be made.

3. Prevention in inpatient units

The health trust must have procedures to ensure:

1.1 An unambiguous system for scaled monitoring/protection of suicidal patents: This entails a definition of the most common concepts: close monitoring *["fotfølge"]*, constant observation, interval observation (how often day/night), and must be known to all. This must be consistent with the degree of suicide risk. The Directorate of Health recommends that the person who is to decide/implement and revoke such security measures should have specialist competence.

1.2 Physical protection measures: Does the trust carry out regular (at least annual) inspections of the physical conditions at the wards to identify physical risks and implement any necessary protective measures (security against hanging, jumping and the like (suspension points, lockable windows, doors, etc.)). Does the inpatient unit have procedures for the removal of dangerous objects that may be used for hanging, suffocation, cutting, etc.

1.3 Assessment of status as regards outdoor stays, leave, transfer (documented in the medical records).

4. Prevention after discharge from inpatient units

4.1 The suicide risk must be assessed and documented on discharge

4.2 Due care upon discharge: entails an individual plan/treatment plan, preferably an appointment with the institution that is to follow up the patient, rapid issue of a discharge summary, accompanying the patient to the next therapist or ambulant team if applicable, information about whom the patient is to contact if in need of immediate help, etc. The Directorate of Health recommends follow-up within one week from discharge.

5. Chronic suicidality

The Directorate of Health recommends a long-term plan of treatment and efforts to achieve a good treatment alliance and good cooperation with other players. The basic disorder and any comorbid conditions must be diagnosed and factors that may trigger suicidal conduct should be mapped.

6. Relatives and the bereaved

6.1 Collaboration: it is important that they are heard, that they receive the information they are entitled to, etc. in accordance with the statutory framework.

6.2 Looking after the bereaved: procedures for grief support; information about: relevant user organisations, right of access to medical records, the possibility for claiming compensation through NPE** in case of error or omissions of treatment, the possibility for requesting the supervisory authorities to assess the health care provided.

7. Reporting and follow-up after suicides and serious attempted suicides

7.1 Reporting obligation: procedures for reporting in case of suicide and events that could have led to significant bodily injury

** NPE = Norsk Pasientskadeerstatning, the Norwegian System of Compensation to Patients

Attachment (cont.)

7.2 Review and learning from the incident (quality development work). Does the health trust have procedures for suicide analyses for the purpose of learning and prevention? The national guidelines (page 28) states: *"Each health trust should keep an overview of the number of reported suicides and serious attempted suicides, and whether the trust was criticised by the Board of Health Supervision or not. Feedback from the Board of Health Supervision should be communicated to all therapists for purposes of learning".*

Report from the Norwegian Board of Health Supervision

Publications 2008

1/2008 Annual Report for MedEvent (Meldesentralen) 2006 – the Reporting System for Adverse Events in Specialized Health Services

2/2008 "While we are waiting…." – do patients receive adequate treatment in accident and emergency units?

3/2008 Summary of countrywide supervision in 2007 of municipal health and social services for adults with mental disorders

4/2008 Respite care and support contact – services that improve the quality of life. Summary of countrywide supervision in 2007 of respite care and support contact services

5/2008 Report 2001-2007 for MedEvent (Meldesentralen) – the Reporting System for Adverse Events in Specialized Health Services

6/2008 Summary of supervision of isolation of infection for ten health trusts in 2006

7/2008 Necessary coercion? A summary of data registered by the Offices of the County Governors about use of coercion and restraint for people with mental disabilities for the period 2000-2007

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3/2009 Summary of a two-year study of suicides in the mental health service

4/2009 District psychiatric centres: Countrywide services, but variable quality? Summary of the first phase of countrywide supervision 2008-2009 with specialized health services provided in district psychiatric centres

5/2009 Vulnerable children and adolescents – need for better cooperation. Summary of countrywide supervision in 2008 of municipal health, social and child welfare services for vulnerable children

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HELSETILSYNET
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SUMMARY

Report from the Norwegian Board of Health Supervision 3/2009

Summary of a two-year study of suicides in the mental health service

During 2005 and 2006, the Norwegian Board of Health Supervision conducted a systematic registration of suicides committed by patients registered in the mental health care service and that were brought to the notice of the Norwegian Board of Health in the Counties.

We found that the health trusts did not comply with their statutory obligation to report to the supervisory authorities in nearly one of five cases, and that the events were only to a small extent used for quality improvement work. The health trusts failed in preparing routines/procedures for suicide prevention work, in training their employees, in keeping records and in taking care of the bereaved, etc. We also found great differences in how the Norwegian Board of Health in the Counties handled suicide cases.