ANNUAL SUPERVISION REPORT 2004

HELSETILSYNET
tilsyn med sosial og helse

Norwegian Board of Health
Supervision of health and social services

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Our Product is Trust!

I used the same title in last year's Annual Supervision Report, but it is still relevant to consider.

The main challenge for a public health service is that it is run in such a way that people wish to finance it from public funds, writes the editor of the Journal of the Norwegian Medical Association (1). The essence of this challenge lies in the concept "trust". This is something that seems to be lacking between the parties. In the editorial, it is pointed out that control procedures are developed in order to compensate for this, but they serve to undermine trust even more. The editor is talking about health services, but the same could just as well be said about social services.

I believe that this important issue is still relevant to consider. Mistrust that results from people feeling that they have been let down, and that their expectations are not met, is an evil. This is true even if the reason is understandable and often reflects a gap between what services can offer and what people expect.

However, mistrust can be seen in a more constructive light. In order to prevent mistrust coming as a reaction to deficiencies in provision of services, someone needs to take a sidelong glance at service provision, in a systematic, open and reviewable way. Professor Harald Grimen uses the concept "institutionalized mistrust" to describe this. This is not unique for health and social services. The banks' credit ratings are actually about the same thing (2).

If the population is to have trust in health and social services, they need to know that there is someone who looks at the services with a critical eye. This is the core task of the Norwegian Board of Health. We shall act as watchdog.

Trust in the Norwegian Board of Health as administrator of "institutionalized mistrust", is not gained through legislation. It must be earned through what we do in practice. Without openness, our prioritization and tasks cannot be publicly reviewed. Without predictability we will not gain credibility.

Our findings are published in the open. During the last few years, we have also worked on developing more systematic and open methods for deciding which tasks to give priority to, based on risk assessment. Correct prioritization presupposes a correct assessment of the situation, based on reliable information. We shall be independent and professional. Reliable information is not just about professional knowledge, but also how this is expressed in terms of gender, age, region, and ethnic and cultural affiliation. Some of the articles in this report reflect this.

If "institutionalized mistrust" is to be turned into credibility, then people must see that deficiencies that are exposed are made good. This is the responsibility of both the service providers and the service owners. We cannot hide the fact that things are moving slowly in some areas. Mental health care is an area in which the Norwegian Board of Health, both through countrywide supervision, supervision of institutions and complaints against health care personnel, have detected widespread deficiencies in service provision that must be dealt with. Thus it is important to continue for a long while to direct both managerial and professional focus on this area of service provision.

In other areas, significant efforts have been made to improve service provision when deficiencies have been detected. Examples of such areas are municipal health and social emergency planning and control of communicable diseases. The Norwegian Board of Health has had to warn some municipalities that we are considering issuing them with an order. This seems to have had an effect. After the events in Asia between Christmas and New Year, and threats of a world-wide influenza epidemic, there has been no need to argue strongly for the need for such plans.

However, in the middle of the tragedy in South-East Asia, it was encouraging to see that municipalities and health trusts met the challenges in a way that inspired confidence. Such challenges do not only demand that service systems are in place, but also that one is able to live with the despair and emptiness one meets when service systems are tested to the limit.

Institutionalized mistrust shall not only impart that which is difficult, even though it is this that is expressed by these words. Institutionalized mistrust shall impart thoughts of change and growth. I choose to end with a poem written by one of our employees at the Norwegian Board of Health. It illustrates how words full of loss and pain can blend with spaces full of hope for the future.

February 2005

Lars E. Hanssen
Director General of Health

After the flood

All of my words are blue

While my poem is looking for its words about you
Who are searching for the ones you need to find
Who are searching for the ones you need to hold
Who are searching for the ones you need to cry for
No-one has anyone to lose

The river in the ocean hit the beaches
Hit the hillsides, the harbours and the houses
Hit the people and a child who was playing in the sand

So many people are searching on the beaches
On the hillsides, in the harbours and the houses
The fathers and the mothers, their daughters and their sons
All the people and their memories, their sounds and their smells
Of everyone who came and of everyone who disappeared
While the sun is reflected on the waves and in their eyes

Violent forces that no one can defeat
The tale told by numbers is hard to comprehend
Lord almighty, where is your wisdom
People seek their destiny while so many ceased to exist

Man alone, infinite and small
Living with you who vanished in the waves
The words can comfort, they struggle and they strive

In a life continued in blue

John Agnar Johansen

References

1. Haug C. Mistillitens pris. Tidsskr Nor Lægeforening 2005; 125: 273.

2. Nortvedt P, Grimen H. Sensibilitet og refleksjon. Oslo: Gyldendal Akademisk, 2004.

Deficiencies in Allocation of

Social Services to Alcohol and Drug Abusers

In many municipalities, alcohol and drug abusers are not offered the social services they need and are entitled to. The municipalites have not come far in organizing their social services so that they are suitable for alcohol and drug abusers, and legal safeguards for these people are not adequately ensured when allocating services. Follow-up of alcohol and drug users who are undergoing treatment is also unsatisfactory in several municipalities.

In 2003 the Norwegian Board of Health were given responsibility for general supervision of social services. In the first countrywide supervision, the Norwegian Board of Health wished to investigate whether the municipalities give advice and counselling to alcohol and drug abusers and how they do this, how they allocate support measures and temporary accommodation, and whether the municipalities follow up people who are undergoing treatment. The Offices of the County Governors carried out supervision in 58 municipalities.

Information, Advice and Counselling

Social services have responsibility for giving information, advice and counselling, that can help to solve or prevent social problems. Alcohol and drug abusers often have complex problems and different needs, and a well-functioning advisory and counselling service is of great value.

The Offices of the County Governors found deficiencies in one-quarter of the municipalities they investigated. The following are examples of deficiencies that were found. Incomplete or wrong information about services was given, allocation of responsibility and tasks was unclear, and opening times were limited so that access to services was reduced.

The reports from supervision indicate that alcohol and drug abusers who apply to social security offices for social security benefits, usually also receive advice and counselling. Alcohol and drug abusers who need practical help or a support person, run the risk that advice and counselling about these types of services is not appropriate for them.

In the opinion of the Norwegian Board of Health, it is serious that municipalities do not adequately ensure that alcohol and drug users, irrespective of their needs for services, receive appropriate information, advice and counselling.

Support Measures

It is not always enough for alcohol and drug abusers to be given advice and counselling. Many also need concrete social measures such as practical assistance and training, a support person and a place in an institution. According to the Social Services Act, municipalities have a duty to provide services to those who cannot take care of themselves,

Reference

1. *Summary of Countrywide Supervision of Municipal Social Services for Alcohol and Drug Abusers in 2004. Report from the Norwegian Board of Health 4/2005. The Norwegian Board of Health, 2005*

or who need practical or personal help.

Supervision revealed that the municipalities have not come very far in organizing social measures in such a way that they are appropriate for alcohol and drug abusers. Deficiencies in this area were found in nearly all the municipalities. One example of such a deficiency is that in written information to the people in the municipality, practical assistance and training were described as "home help services for elderly and physically handicapped people". Support person services were described in the same way, and these services were also not organized specially for alcohol and drug abusers. Support persons shall help alcohol and drug users to have meaningful leisure time and social contact, according to the individual's wishes and needs. Supervision also revealed that there were alcohol and drug users with great needs for assistance and care, who did not receive the services they needed, even though they wished to receive help. Examples of deficiencies in legal safeguards are as follows. Verbal applications for services were not recorded and dealt with, but rejected verbally. Services that were allocated, were not supplied. Provision of support persons is particularly difficult.

In one-quarter of the municipalities that were investigated, milieu therapists or accommodation counsellors were used to provide a service for alcohol and drug abusers. These services were allocated without making a formal decision. The municipalities presented these services as something other than the social services that alcohol and drug abusers have a right to receive. Thus, it was not clear that people who received these services have the right to complain about the content and extent of such services.

Most alcohol and drug abusers have complex and long-lasting needs for services. Even if services are developed and adapted to clients' needs, these people will require municipal social services over a long period of time. In the opinion of the Norwegian Board of Health, it is very serious that so many municipalities seem to organize their services in such a way that access to them is poor for alcohol and drug abusers. It is a serious deficiency when measures such as practical assistance and training, support person services and places in institutions are often not organized so as to be appropriate for alcohol and drug abusers. It is unacceptable that alcohol and drug abusers are not offered the social services that they need and that they have a right to receive.

The Norwegian Board of Health is also concerned that some appropriate services are not allocated in the form of an individual decision, but allocated in such a way that clients have no possibility to complain. The right to complain about decisions made by the municipality is one of societies most important measures for ensuring equality and an acceptable standard of services. If services for vulnerable groups are organized in such a way that the right to complain is limited or non-existent, then legal safeguards for individuals can be seriously jeopardized.

Temporary Accommodation

Social services have responsibility for providing temporary accommodation for people who do not manage to find accommodation themselves. Alcohol and drug abusers often lead turbulent lives with split relationships and broken homes. Therefore, it was investigated whether the municipalities ensure that these people are provided with temporary accommodation of an adequate standard.

The Offices of the County Governors found deficiencies in this area in just under half of the municipalities. Examples of deficiencies are as follows. Some small municipalities do not have routines to ensure that temporary accommodation is allocated when the need arises. In large municipalities, that regularly allocate temporary accommodation, there is a lack of temporary accommodation and the standard is inadequate. There are several examples of municipalities that are dependent on the use of camping grounds, guest houses and hotels. These places do not always have vacancies, and alcohol and drug abusers may be denied access. A few municipalities have inadequate plans for dealing with emergency situations, and must find ad hoc arrangements when acute need for temporary accommodation arises. Thus the accommodation offered is often unplanned and of inadequate standard. In some cases, alcohol and drug abusers must find accommodation themselves, because the social services do not manage to provide temporary accommodation. The Norwegian Board of Health is concerned that there are several municipalities that do not manage to provide temporary accommodation of an adequate standard when alcohol and drug abusers need it.

Follow-up after Discharge from an Institution

Whilst the services that are described above are for all alcohol and drug abusers, follow-up after discharge from an institution is relevant for people who are undergoing treatment. These people can require different types of support measures. A stable social situation is often a prerequisite for successful treatment. Therefore the social services have responsibility for following up alcohol and drug abusers who are undergoing treatment, through counselling, and, if necessary, a home visit. Some people who are resident in an institution do not have accommodation and a social network to return to. Therefore, the social services have special responsibility to organize measures for people who are discharged from an institution, as appropriate.

Deficiencies were found in 18 of the 58 municipalities. The findings indicate that follow-up of alcohol and drug abusers who are undergoing treatment is a weak spot, and dependent on individuals. Examples of deficiencies are as follows. Responsibility for follow-up was left up to individual employees. There were no routines for follow-up, and things went wrong during holiday periods, when employees were sick, or when turn-over of staff occurred. There were also examples of municipalities who left follow-up up to the treatment services and that no measures were organized after discharge from an institution. This applied particularly to people in private institutions that are part of the specialist health services. Several municipalities did not have an overview of people under treatment, who they have a responsibility to follow up. There is then a risk that adequate follow-up is not initiated. Supervision detected examples of unplanned and unsystematic recording of needs and measures.

According to the evaluation of the Norwegian Board of Health, it is unacceptable that the municipalities do not provide adequate services for alcohol and drug users undergoing the difficult transition between a stay in an institution and residency in a municipality.

Health Services for Newly-arrived Asylum Seekers, Refugees and People Reunited with their Families

There is a risk that newly-arrived asylum seekers, refugees and people reunited with their families do not receive essential health care because the municipalities do not ensure that these people are informed about health services. Many municipalities do not have a complete overview of newly-arrived people in order to ensure adequate control of tuberculosis. The municipalities do not pay enough attention to other communicable diseases. There are also deficiencies in mental health services for newly-arrived people who have mental disorders.

In 2004, the Norwegian Board of Health in the counties carried out countrywide supervision of health services for newly-arrived asylum seekers, refugees and people reunited with their families. Supervision was carried out in 55 municipalities. The most important areas for supervision were:

- whether municipalities meet the regulations on control of tuberculosis
- whether information is provided about health services and essential health care in connection with communicable diseases, pregnancy and mental disorders
- whether municipalities meet their responsibilities for supervision of environmental health in reception centres for asylum seekers.

Control of Tuberculosis

Everyone who comes to Norway from countries where the prevalence of tuberculosis is high have a duty to allow themselves to be examined for tuberculosis, so that people who are infected can receive correct treatment and avoid infecting others. The municipalities have responsibility for finding out whether asylum seekers, refugees and people reunited with their families have been examined. People who have not been examined shall be given an examination within fourteen days after arrival. People reunited with their families shall be examined as soon as possible.

At any given time, the municipalities should have an overview of those who have moved into the municipality and those who have moved on to other places, in order to ensure that these people are examined for tuberculosis.

The results of supervision clearly show that people who have signs of being infected are followed up satisfactorily. Patients are speedily referred to specialist health services for examination and treatment.

The results of supervision have also shown that one-third of municipalities that had asylum seekers and refugees, and one-quarter of municipalities that had persons reunited with their families from countries with a high prevalence of tuberculosis, did not meet the deadline for examination, laid down in the regulations relating to tuberculosis. Many municipalities do not have the necessary overview of newly arrived immigrants.

In the opinion of the Norwegian Board of Health, lack of an overview of people who live in the municipality, and breach of the regulations relating to tuberculosis, are unacceptable. But we point out that there are complex reasons for this situation. In order to have an overview, cooperation with different actors is necessary. Reasons why municipalities encounter difficulties in meeting the deadlines can be the following: delayed notification about people who become resident in the municipality and people who move from the municipality, health data sent to the wrong place, creating misunderstandings and delays, and lack of communication within the municipality or between municipal health services.

Information

In order for asylum seekers, refugees and people reunited with their families to receive the health care they are entitled to, the municipalities must ensure that they

Reference

1. *Summary of Countrywide Supervision in 2004 of Municipal Health Services for Newly-arrived Asylum Seekers, Refugees and People Reunited with their Family. Report from the Norwegian Board of Health 3/2005. Oslo; The Norwegian Board of Health, 2005*

receive information. Information must be adapted in such a way that it is understood by the recipients. The service providers have responsibility for this. The municipalities must organize a system for providing essential health care before a regular medical practitioner is allocated. Professional interpreter services shall be provided as needed.

The results of supervision have shown that one-quarter of municipalities did not ensure that everyone received information about health services. Another finding was that some municipalities were not aware that they had a duty to provide information, or that it was not clear who in the health services had responsibility for this. As a rule, interpreter services were used when people were given information.

In the view of the Norwegian Board of Health, it is a very serious situation that many municipalities have not organized things to ensure that newly-arrived asylum seekers, refugees and persons reunited with their families receive information about health services a short time after they have become resident in the municipality. It is thus not possible for them to ask for the health services they have a statutory right to receive. Norwegian society is unfamiliar to most of these people. They have no knowledge of how health services are organized, what types of services are available, or how health services can be contacted. Deficiencies can have serious consequences for individuals. In the opinion of the Norwegian Board of Health, it is unacceptable that many municipalities do not meet their responsibility to provide information in a satisfactory way.

Essential Health Care in the Case of Communicable Diseases

Tuberculosis is the only disease that asylum seekers, refugees and people reunited with their families have a duty to allow themselves to be examined for. The municipalities shall offer examination for other communicable diseases as an individual and appropriate service. The aim of the Communicable Diseases Control Act is to protect the population against communicable diseases by preventing the spread of infection, to prevent others being infected, and to prevent the spread of diseases into or out of the country. The legislation shall ensure the legal safeguards of individuals for whom statutory measures to control communicable diseases apply.

In 10 of the 55 municipalities that were investigated, the Norwegian Board of Health in the counties found deficiencies in preventive measures and examination for communicable diseases. In some municipalities, no special attention is given to people who come from countries where the prevalence of communicable diseases is high. There is no mention of asylum seekers or refugees in the municipal plans for control of communicable diseases, and there are no set routines for offering examination for communicable diseases to people who are reunited with their families.

The Norwegian Board of Health is concerned that many municipalities do not pay adequate attention to communicable diseases other than tuberculosis, and that they do not follow up newly-arrived persons. Control of communicable diseases is considered to be a right to essential help care, and in the opinion of the Norwegian Board of Health, deficiencies in this area are unacceptable.

Essential Health Care for Pregnant Women

Supervision showed that the municipalities systematically offer care to pregnant asylum seekers, refugees and people reunited with their families, when the health services receive information about the pregnancy.

Essential Health Care for People with Mental Disorders

Many asylum seekers, refugees and people reunited with their families have experienced things that can make them disposed to mental disorders. Language problems and cultural barriers can make it difficult for them to make contact with others or to seek help for problems related to mental disorders. If serious mental disorders are detected, the municipality has a duty to provide essential health care. The municipality must therefore pay particular attention to mental disorders, and must organize health services in such a way as to ensure that asylum seekers, refugees and people reunited with their families receive health services before they have got a regular medical practitioner, and that they receive more that just emergency care.

Supervision included investigating whether the municipalities referred people to specialist health services as required. Whether specialist health services fulfil their obligations was not investigated. Thus, the results of supervision tell us little about how cooperation between different levels in the health services functions.

The results of supervision show that detection of people with mental disorders and provision of adequate care for such people varies in different municipalities. The Norwegian Board of Health in the counties have pointed out that breach of the duty to supply essential health care for this group seldom occurs, but several municipalities have been informed about areas where improvements must be made, and deficiencies that must be dealt with. Examples of deficiencies are as follows: It could be difficult to get a physician to go to a reception centre for asylum seekers in an emergency situation. Mental disorders were detected, but not followed up. Interpreters were not used. The municipality did not have adequate follow-up of patients who were sent back from specialist health services.

Earlier experience from supervision, particularly from specialist health services, has shown that there are serious deficiencies in mental health services. Even though general deficiencies have not been detected in this supervision, in the way municipalities deal with newly arrived immigrants who have mental disorders, information was obtained that indicates that the health services as a whole fail to provide adequate services for this group. There are examples of patients who, according to the assessment of the municipality, have been discharged too early from specialist health services, without the municipality being informed, and without the municipality being prepared to follow up the person adequately. There are examples of physicians who have not referred asylum seekers to specialist health services because the patient would not be offered treatment in any case. Concerns have been raised that personnel in reception centres have too much responsibility for people with serious mental disorders. In the opinion of the Norwegian Board of Health, the results of this supervision confirm that there are deficiencies in mental health services. The results do not provide evidence that deficiencies affect asylum seekers more than other people with mental disorders, but the Norwegian Board of Health believes that the consequences of deficiencies can be more serious for this group, taken into account the special situation that many of them are in when they come from a foreign country.

Environmental Health in Reception Centres for Asylum Seekers

The regulations relating to environmental health lay down requirements to institutions regarding conditions that can directly or indirectly influence health, such as hygiene, noise, indoor climate and the risk of accidents. The municipality has responsibility for supervising that the person responsible for running the institution ensures that the reception centre adequately takes care of environmental health.

In over one-half of the municipalities with a reception centre for asylum seekers, supervision of environmental health was not adequately organized. The results of supervision indicate that municipalities are not aware of their supervision responsibility in this area.

Maternity Units

do not Have a Good Enough Overview of their own Results

The leadership in the country's maternity units must take much more responsibility. Allocation of responsibility in the units is often unclear. Many units do not have a good enough overview of results and complications. This provides a poor basis for evaluation of maternity care in Norway.

This was the conclusion after countrywide supervision of maternity units that was carried out by the Norwegian Board of Health in the counties in 2004 (1). Despite many serious findings, the Norwegian Board of Health stresses that it is still safe to give birth in a Norwegian maternity unit. This area was chosen for supervision because maternity care is given much attention, and because deficiencies in maternity units can have serious consequences for mothers and children. The timing was also right, because the health authorities were considering the organization of maternity care.

Supervision included 26 of the approximately 60 maternity units in the country. All five health regions and all three levels of maternity care were represented: that is maternity clinics, maternity wards and obstetrics and gynaecology departments. The Norwegian Board of Health wished to investigate whether the standard of maternity services was acceptable, in particular whether maternity care was in accordance with sound professional standards. When supervision was carried out, a specialist physician and a midwife were present as professional experts.

Supervision included four main areas:

- selection of women to different types of maternity unit
- monitoring and follow-up of a selection of conditions
- dealing with acute emergencies
- learning and improvement

Selection Most Often to the Correct Level

Of all the maternity units, maternity clinics have the lowest level of preparedness for dealing with complications. On the basis of information collected before the birth, it is generally possible to predict the probability for complications occurring. Thus the most appropriate place for the woman to give birth can be selected, according to the skills that are needed, and the facilities that are needed for dealing with complications that may occur with the mother or child.

With a few exceptions, the maternity clinics had drawn up selection criteria. However, some maternity clinics admitted women who, according to their condition and risk, should have been admitted to or transferred to a maternity unit with a higher level of preparedness for dealing with complications. In some maternity wards, the threshold for transferring women to an obstetrics and gynaecology department was rather too high.

In order to ensure that selection criteria are followed and that they are in accordance with the skills and facilities for dealing with complications that the maternity unit has, the units were advised to assess their routines regularly.

Better Communication and Clearer Responsibility

Adequate and safe monitoring of women who are giving birth is a comprehensive task that demands good cooperation between physicians and midwives. Monitoring must be carried out in such a way that any complications that may arise are detected as soon as possible, so that appropriate measures can be taken.

A physician shall be consulted or called when a midwife has ascertained that the birth is complicated. If there is risk associated with the birth, or if unexpected events occur, it is particularly important that allocation of responsibility is clear, and that there is good communication between the health care personnel who are attending the birth.

The results of supervision have shown that not all maternity units had clear guidelines for when a physician should be called during monitoring of the birth. In several units, it was not clear what was the responsibility of the midwife, and what was the responsibility of the physician when monitoring the birth. In order for monitoring to be adequate and safe, the health care personnel attending the birth must have the necessary skills and must cooperate well. This means that midwives and physicians must have the opportunity to develop and maintain their skills. Many units lacked formal meeting places where health care personnel could discuss professional issues and cooperation, and where they could come to agreement about routines. This has an influence on the service that is provided to women giving birth. The Norwegian Board of Health has therefore given advice about establishing an appropriate arena for development of cooperation.

The patient record shall be a tool for ensuring that the treatment provided is of a sound professional standard. During a birth, the midwife shall record everything in the patient record for the birth (partogram), in which the most important information is recorded consecutively and systematically. If a physician monitors the woman who is giving birth, this shall be recorded. In this way, all relevant information is collected together, is easily available, and health personnel have a good overview so that complications can be detected at once and appropriate measures instigated. It was found that recording of information in patient records was inadequate in most of the maternity units. A description of important assessments that were made, measures taken and information given, was not always to be found in the patient record. In the opinion of the Norwegian Board of Health, what is actually done for the woman who is giving birth is the most important thing. However, recording of information in patient records should be improved, so that documentation functions as an important tool in ensuring that the treatment provided is of a sound professional standard.

Improved Registration and Overview are Essential

In order to assess the monitoring of births, an overview of the incidence of different types of events is necessary. Approximately 56 000 births take place in Norway each year.

Some of the data that is registered in the Medical Birth Registry of Norway is

unreliable. In most cases, these data cannot be used to compare maternity units. There is therefore great uncertainty concerning the registration of complications and results by most of the maternity units. At the national level, we do not have reliable data to indicate what is an acceptable incidence of complications such as post-partum haemorrhage and serious perineal rupture. The Norwegian Board of Health have recommended that the health authorities and health professionals reach a consensus about this.

This was the background for carrying out countrywide supervision in order to evaluate whether monitoring of four selected risk situations was such that complications are detected and essential measures instigated early enough.

Slow Progress

If a birth progresses slowly, the reasons for this must be found and appropriate measures must be taken. In several maternity units it was unclear when progress was slow, and in some maternity units there was disagreement between physicians and midwives about which measures were appropriate. The results of supervision show that in some cases measures should have been instigated earlier, and that routines had not been followed.

Hypoxia

Hypoxia is present when the foetus shows signs of lack of oxygen. This condition indicates that the foetus is not managing to tolerate the stress of being born. Independent of the degree of hypoxia, measures must be instigated and it can be necessary to bring the birth to completion quickly. The results of supervision have shown that, in some maternity units, this situation is regarded differently by physicians and midwives. There were examples of situations where this had led to misunderstandings, when the physician had been called too late, and when essential measures had not been taken when they should have been.

Rupture of the Perineum Grades III and IV

During a birth, perineal rupture can often occur. Small ruptures (grades I and II) do not normally cause problems. Large ruptures that involve the anal sphincter and mucous membrane (grades III and IV) are more serious. About one-third of women who have large ruptures suffer from long-lasting symptoms and functional problems. There is great variation between the maternity units in the incidence of large perineal ruptures. Because registration practice varies, the figures cannot be used to compare maternity units. However, there is agreement that large perineal ruptures (grades III and IV) occur too often. The results of supervision indicate that, in some cases, treatment was not in accordance with sound professional standards. In the opinion of the Norwegian Board of Health, this is not acceptable. In addition, work must be done to find out the causes of large perineal ruptures, so that they occur less often. This is an important task, that involves the individual maternity units, professional people, researchers and central health authorities.

Serious Post-Partum Haemorrhage

Few women die in Norway during childbirth today, but wrong treatment in the case of serious haemorrhage (more than 500 ml) is an important cause of maternal mortality. Such haemorrhages must therefore be prevented and treated rapidly and correctly. Blood loss during childbirth is difficult to measure, and is often under-estimated. The results of supervision have shown that the maternity units, to varying degrees, had good routines for preventing serious post-partum haemorrhage, and that some of the maternity units did not pay much attention to this complication.

Dealing with Acute Situations Needs Training

To a large extent, complications during childbirth can be predicted. However, in some situations, acute and unforeseen situations can occur. Most maternity units had good routines for dealing with such situations. No deficiencies regarding equipment or personnel were detected. In order to reduce the number of serious incidents, all health care personnel who attend births must know what to do when acute and unexpected situations occur. In large maternity units, there will be several health care personnel who have experience with dealing with such situations. In small maternity units, there will be fewer people with such experience, since acute situations occur less frequently. Health care personnel at all levels must therefore have regular training in dealing with acute situations, and they must be given the opportunity to visit and work in departments where acute situations occur more often. The results of supervision have shown that there is a need in several maternity units for more systematic training.

Greater Emphasis on Management and Leadership

Leadership has responsibility for all aspects of the maternity unit. The leaders must ensure that responsibility is clearly defined, that shift arrangements are adequate, and that the maternity unit is organized in such a way that health care personnel can provide health services that are in accordance with sound professional standards. They must ensure that necessary procedures have been drawn up, that these procedures are known and followed, and that essential equipment is available. Employees must have the necessary skills and they must receive training and further education. It is also a requirement that the maternity unit is managed and led in such a way that accidents and injuries are prevented. This means that leadership must follow developments and have control of the professional content of the service, such as registration and monitoring of results and complications, and that they must follow up adverse events and regularly assess the management of the maternity unit.

The results of countrywide supervision of maternity units have shown that leadership must take much more responsibility. The way in which responsibility is shared between physicians and midwives must be clarified. The maternity unit must be organized in such a way that communication and cooperation are improved. Selection criteria should be revised. It should be ensured that health care personnel have the necessary skills and that they receive appropriate training. The results of supervision have also shown that maternity units, to a far too limited degree, register data on the results of their own activities and use these data for systematic evaluation, improvement and management of the maternity unit. It was difficult to obtain an overview of the occurrence of various conditions and complications of childbirth. The Norwegian Board of Health recommends that a minimum standard data set is decided on, that all maternity units can register in the same way. These data can be used internally by each maternity unit to monitor trends, and can also be used to compare maternity units. Up until now, unreliable and incomplete national data about several important conditions related to childbirth have made it difficult for the health service to have adequate knowledge about the occurrence of different conditions and about variation between maternity units. The lack of an overview in each maternity unit limits the possibilities for health trusts to follow up the maternity unit and to identify conditions at an early stage that should be analysed more closely.

Reference

1. *Summary of Supervision of Maternity Units in 2004. Report from the Norwegian Board of Health 11/2004. Oslo: The Norwegian Board of Health, 2004.*

The Question of Double Penalty

Decided by the Supreme Court

Withdrawal of authorization after being imposed a penalty is not double penalty. This has been established by the Supreme Court in a recent judgement.

Health care personnel who have lost their authorization because of a criminal offence for which they have received a penalty, have claimed that their loss of authorization is contrary to the injunction against being punished twice for the same offence. This situation can occur in cases of sexual exploitation of a patient, and in cases of "behaviour considered to be incompatible with professional conduct", according to the Health Personnel Act, section 57.

The case in question was that of a physician who demanded compensation after the health authorities had suspended his licence to practice as a physician. The Supreme Court stated unanimously that: "It (is) clear that withdrawal and suspension of a given authorization to practice as a physician, because the statutory and necessary conditions for continued practice no longer are present, is not a penalty in the sense of the European Court of Human Rights" (8 September 2004)". The justification of the decision made by the Supreme Court was that neither withdrawal nor suspension of authorization to practice as a physician is a penalty according to Norwegian law. Further, the Supreme Court stated that the purpose of withdrawal of authorization is to protect future patients and the relationship of trust between patient and health care personnel. With regard to the content and seriousness of the sanction, the basis of the Supreme Court's statement was that the case must concern very serious reactions, in practice imprisonment.

The injunction against double penalty is in accordance with article 4 number 1 in Protocol 7 of the European Convention on Human Rights. Penalties, according to the Convention on Human Rights, are not only penalties according to penal provision, but can also include sanctions. In the judgement of 8 June 1976 in the case Engel and others against the Netherlands, the European Court of Human Rights based its decision on the following: that the question should be decided upon on the basis of how the offence is classified according to national legislation. In addition, the content and seriousness of the sanction in question shall be taken into account. The factual basis for the cases must be the same.

The Social Ombudsman

– Between Services and Clients

Krishna Chudasama,
Social Ombudsman in the Municipality of Fredrikstad

Krishna Chudasama

The social ombudsman service is the result of discussions over the last few years about user participation and organization of services. After the publication of two important reports to the Storting – the Equalization Report (Utjamningsmeldinga) and the Welfare Report (Velferdsmeldingen) (1,2), a pilot project with social ombudsman services was initiated in several municipalities in 1998.

Evaluation of the project concluded that the services were useful and that the state should partly finance the costs to support municipalities that wish to establish or extend social ombudsman services (3). In the two previous Supervision Reports of the Norwegian Board of Health, the social ombudsman service is mentioned as a means of securing legal safeguards for social service clients (4, 5).

The Municipal Council in Fredrikstad established a social ombudsman service three years ago. The background for this was, among other things, feedback from many people that they found it difficult to know what kind of help they were entitled to. The social ombudsman was given the task of ensuring that clients receive the services they have the right to receive, and strengthening user participation. Since the service was established, the social ombudsman has received more than 1500 enquiries. The ombudsman gives support to clients and relatives so that they can receive the help they are entitled to as quickly as possible from municipal, county municipal and state authorities.

Who Contacts the Social Ombudsman?

The people who use the social ombudsman service are primarily people who receive social services, or who are potential users of the services. The Social Services Act is extensive and includes many clients who have complex needs. Clients have often contacted several different services and feel that they do not manage to find their way in the ordinary system before they contact the ombudsman. Clients or relatives are often referred to the social ombudsman by the municipality, the Office of the County Governor, the media, social services or the national insurance service. The service receives many enquiries whenever the social ombudsman service is mentioned in the media. Clients from neighbouring municipalities also ring to ask for help, but they can only receive advice and counselling.

Method of Working

Most enquiries are made by telephone, but email and personal visits to the office are also common. Most of the work of the ombudsman involves meeting clients and talking to them, listening to them and clarifying their need for support, guidance and information about complaints procedures. In most cases, the service that is being complained about is contacted by telephone. Many cases can be dealt with by the social ombudsman discussing the matter with the person who has dealt with the case. The result is often that the client communicates with this person, and together they can clarify the matter and quickly come up with an appropriate solution. The ombudsman also helps with making complaints or writing to the service. The social ombudsman is given access to cases, registers them in a data program and records weaknesses in the system in a systematic way. On this basis, the ombudsman is able to give feedback to the responsible leaders in monthly meetings. Cases which lead to changes in practice are often discussed.

The social ombudsman service is a separate body under the municipal council. The ombudsman reports directly to the municipal council and publishes an annual report. The post is independent of the municipal administration. This strengthens the ombudsman's legitimacy.

There are few municipalities that have a social ombudsman service. A network of municipal ombudsmen was established in 2004. Fredrikstad has a social ombudsman

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for clients of social services and a client ombudsman for elderly people, handicapped people and people who are sick. The ombudsmen share experience and seek advice from each other about difficult cases. There is large variation in the time it takes to deal with cases. The social ombudsman in Oslo takes the longest time. Generally, the ombudsmen have the same job description, but the definition of user groups and titles varies. The annual reports of most of the ombudsmen show that most of the cases concern social services and few cases concern other services. Most of the ombudsmen miss having a local forum where they can discuss cases.

Examples of Cases and the Work of an Ombudsman

There are many complex reasons why clients contact social welfare offices. The problems encountered often require much more than standard solutions. When clients contact the services, they often find that their situation does not fit in with the regulations. For example, set routines and standard rates for social services are often referred to. Clients wish to be dealt with on their own terms, as complete people who find themselves in a difficult situation, or who are going through a difficult phase in their life. They want their description of their situation to be just as valid as the description made by the person who is dealing with their case. This demands more individual treatment, and more use of judgement on the part of the services. Clients often experience that the services cannot give them help with their problems, and they are left with the feeling that their difficulties and problems are theirs alone. Such negative experiences are reinforced when communication between the two parties is poor. The result is that many clients complain about the way their case has been dealt with and the treatment they have received, and they request a new person to deal with their case. The Office of the County Governor has limited possibilities to look into such cases, but the social ombudsman can often investigate them outside the normal complaints procedure, to clarify misunderstandings quickly and to re-establish communication between the client and the professional.

Experience has shown that many new clients have a high threshold for contacting public services. Many clients find it difficult to complain when their application is rejected. There can be several reasons for this. We have reason to believe that more people should formally complain when they receive a rejection that they mean is unfounded. The number of complaints can give an indication about the quality of the service, but many people give up, because the complaints procedure takes such a long time. Some clients experience that they are misunderstood, or else that they are not able to understand the text and references to the legislation in the letter they receive informing them of the decision. One client expressed this in the following way: "This is a letter from one lawyer to another lawyer". People who receive social security benefits are among the most vulnerable in society, and predictability and prompt dealing with their case are important for them. The ombudsman at the municipal level works to ensure that clients' cases are dealt with as quickly as possible and that unnecessary bureaucracy is avoided.

Some Reflections

To a large extent, allocation of economic support is delegated to professional people who take decisions and make judgements on behalf of the public administration. The Office of the County Governor has limited possibilities to carry out supervision of what happens between the client and the professional. This presents a serious challenge. There is a great risk of imbalance when only the interpretation of the organization or the service provider shall apply when recommendations and assessments are made in the process of taking decisions and dealing with complaints. The risk is even greater when a complaint is made, since the case may have been initially discussed with the Office of the County Governor, and the same office acts as appeals body. Thus the Office of the County Governor has an unfortunate double-role, as adviser to the social services and as appeals body. This is not the case for patients who complain about health services. According to the Patients' Rights Act, patients are entitled to a second opinion with another doctor. This illustrates how great the risk is for a client not to receive adequate help, when in practice professional judgement regarding both the case and the complaint is made by the same person. Clients of social services have limited possibility to complain to the Office of the County Governor, and they are in a weak position with regard to legal safeguards. Within this system, many clients feel that they are powerless. Routines and length of time taken to deal with complaints should be reviewed, in order to ensure that legal safeguards operate as intended.

Experience

The way in which clients, services and the social ombudsman interact has revealed certain weaknesses in routines, and this has led to changes in such routines. One-third of enquiries to the ombudsman come from relatives or public employees, who either advise clients to seek help from the ombudsman, or else refer clients to the ombudsman. The social ombudsman has gained the trust of the services that it co-operates with, such as social services, the national insurance office, Aetat (the employment office) and the Office of the County Governor. Experience with taking up matters with these services, either by telephone, or in meetings, has generally been positive. The Annual Report from Østfoldforskning (Østfold Research) (6) shows that clients value the social ombudsman service, and that the number of enquiries is increasing. Politicians and special interest organizations in neighbouring municipalities often ask for a presentation of the ombudsman service, with a view to initiating a similar service in their own municipality.

The social ombudsman service is not meant to be an easy alternative to normal administrative procedures, nor is it meant to compensate for existing services or complaints procedures. The social ombudsman shall facilitate integration and place the focus on clients' experiences with service providers, appeals bodies and supervision authorities, and strengthen the legal safeguards of users of social services. The social ombudsman service is a genuine supplement to existing services and appeal bodies with a common goal – to improve the quality of the services (6). Today, we experience that the doorway to welfare arrangements such as unemployment benefit and rehabilitation is getting narrower. This has serious consequences for those who are the weakest in society, who become dependent on minimum public income support. This makes supervision of social security offices even more important. The social ombudsman service is not legally compulsory, but is a corrective to compulsory social services and shall help to improve them. The result is that the services become more open and thorough in the way they deal with cases and clients. Clients are often dissatisfied with the way they are dealt with and the length of time it takes to deal with cases. Only 13 of 846 complaints in 2003 had to do with payment of economic support. This confirms the fact that clients are most concerned with the quality of administrative procedures and the organization of services. In this context, the social ombudsman can play an important role in the welfare state, strengthen legal safeguards and supplement the roles of the Office of the County Governor and the supervision authorities.

Alcohol and Drug Abuse

– the most Important Causes of Loss of Authorization

In 2004, the Norwegian Board of Health dealt with 237 cases of serious incidents in the health services. That was 65 more cases than in 2003. The Norwegian Board of Health gave an administrative reaction in 148 cases, compared to in 125 cases in the previous year. One hundred and one cases were decided without any administrative reaction.

The most common reason for initiating a supervision case is a complaint from a patient or a relative. In cases where the result was loss of authorization, most cases came from the employer (30 cases) and a few cases came from the prosecuting authority (8 cases). In 2004, only seven cases were initiated by the patient ombudsman. Information from the media and from different types of reports can also form the basis for a supervision case. If the Norwegian Board of Health in the county believes that there is reason to consider giving an administrative reaction against health care personnel, the case is sent to the Norwegian Board of Health, that has the authority to give formal administrative reactions, such as a warning or withdrawal of authorization.

The number of administrative reactions given by the Norwegian Board of Health has increased from 125 in 2003 to 148 in 2004. Sixty health care personnel lost their authorization in 2004, compared with 56 in the previous year. In most cases, the reason for withdrawal of authorization is abuse of alcohol or drugs, or other personal circumstances.

The Norwegian Board of Health dealt with 237 cases in 2004. An administrative reaction was given in 148 cases, and 21 decisions were appealed against to the Norwegian Appeals Board for Health Personnel. More than half of the supervision cases that ended up with an administrative reaction against an individual, were cases against physicians. Thirty-eight physicians were given a warning, nineteen lost their authorization, and 9 lost their right to requisition drugs in groups A and B. Among those who lost their authorization, four physicians had previously lost their authorization in another Nordic country. Their Norwegian authorization was withdrawn as a result of this.

Twenty-six health care personnel lost their authorization as a result of alcohol or drug abuse. Fifteen of these were nurses. Ten persons lost their authorization because of unacceptable behaviour, including criminal acts that were regarded as incompatible with their position as a health care worker, six of them because of sexual exploitation of a patient, four of them because of sickness and five of them because they had previously lost their authorization in one of the other Nordic countries, and this authorization had formed the basis for their Norwegian authorization. The others lost their authorization because of a serious breach of the Health Care Personnel Act.

Seventeen institutions were given criticism by the Norwegian Board of Health for inadequate organization, including inadequate internal control system. In most cases it is the Norwegian Board of Health in the county that gives criticism to the leadership for deficiencies in organization or management of health service provision. Thus the number of such cases is relatively small in relation to the total number of completed cases.

Despite the increased number of cases, the time taken to deal with supervision cases remained generally unchanged. The mean length of time for dealing with cases was 8.2 months (8.9 months in 2003). The median length of time was 6.3 months. Per 31 December 2004, 142 supervision cases were being dealt with by the Norwegian Board of Health.

Table 1 Number of supervision cases 2002–2004

	Administrative reaction	No administrative reaction
2002	103	71
2003	125	55
2004	148	101

Table 2 Administrative Reactions against Health Care Personnel 2004 (Figures for 2003 in brackets)

	Warning	Loss of authorization	Loss of the right to requisition medicinal prod.	Limited authorization
Physician	38 (37)	19 (16)	9 (2)	1 (3)
Dentist	5 (2)	2 (2)	0 (0)	
Psychologist	2 (6)	1 (3)		1 (0)
State reg. nurse	4 (6)	25 (28)		3 (0)
State enrolled nurse	1 (2)	7 (3)		0 (1)
Social educator	0 (0)	2 (1)		0 (0)
Midwife	0 (1)	0 (0)		0 (0)
Physiotherapist	2 (2)	1 (2)		0 (0)
Other groups	2 (1)	3 (1)		0 (0)
Unauthorized person.	3 (2)			
Total	57 (59)	60 (56)	9 (2)	5 (4)

Table 3 Reason for Withdrawal of Authorization, according to Health Care Personnel Group

	State reg. nurse	State enrolled nurse	Physician	Other	Total
Alcohol or drugs	15	4	5	2	26
Illness	0	0	3	1	4
Sexual exploitation of patient	2	1	2	1	6
Behaviour	3	1	4	2	10
Unsound profes. standards	2	1	0	2	5
Warning not taken into account	0	0	1	1	2
Authorization lost abroad	1	0	4	0	5
Other	2	0	0	0	2
Total	25	7	19	9	60

Pål Kristian Molin

Marius Råkil

Men's Violence

in Close Relationships – a Health Problem?

Men's violence in close relationships has existed for all time. This has only become an official problem during the last few decades, both in Norway and in the rest of the world. An important dimension of violence is that it is an extensive health problem: for women, children and the men themselves.

Psychologist / deputy leader Pål Kristian Molin
Psychologist / leader Marius Råkil
Alternative to Violence

Violence represents a health problem, both because mental problems can be the cause of the person's use of violence, and because violence creates serious health problems for the victims. Violence as a health problem has significant health costs for society (1). Nordic studies have shown that the extent of violence in the home in our part of the world is alarming (2, 3).

Men's violence against women represents a significant health problem, because violence significantly damages the health of women, children and men. In addition, there are ripple effects that affect people's social network and society in general. The knowledge that was gained during the 1970s and 1980s, as a result of the work of the Women's Movement, has resulted in men's violence in close relationships being recognised and taken seriously as a problem.

Men's violence is a problem on many levels, from a problem for society to a problem for men. All levels are important in understanding the problem and in providing the best possible help. But the health aspects of the problem can easily disappear in the analysis. What does violence do to the health of the people involved? Which health services focus on helping the victims, the witnesses and the perpetrators? Do we have enough knowledge about the problem? The report Women's Health in Norway pointed out that "it seems, only to a very small degree, that the ordinary health services manage to take up the issue of the problem of violence in the home (4). In Norway, it has mainly been crisis centres, individuals in treatment services and the police that have worked with people who are victims of violence.

An important reason why violence is not detected and why nothing is done about it, is that health care personnel and therapists do not relate to or do not take up the issue of violence with the person they are talking to. Our experience is that the victims, the perpetrators and the witnesses of violence, seldom talk about what has happened, or if the issue is raised, they make it out to be unimportant. An important lesson for health care employees who meet members of families where violence takes place, is that one seldom gets to know about violence if one does not as about it. Health care personnel have very little training in talking with people they meet about

violence. It is only in exceptional cases that teaching about the subject is part of their basic education. This can be interpreted as a signal from the education authorities that basic knowledge about violence and the people who are affected is not necessary. Generally, health care personnel have little knowledge about what help is available. Few people have experience of security work with women and assessment of how dangerous the man is. In the Norwegian Government's new plan of action "Violence in Close Relationships", one of the measures that is proposed is a pilot scheme with pregnancy check-ups, in which routine questions about violence are asked (5). Such measures in the health services are simple, but very effective.

One of the consequences of the fact that we have just recently begun to see violence as a psychological problem, is that our professional understanding of violence is no longer an integrated part of our understanding of health and illness. Children's and adolescents' mental problems can illustrate this. The public health services in this area are divided into child and adolescent psychiatry services and children's welfare services. If a child has a mental problem, the problem is dealt with by the child and adolescent psychiatry service. If a child has a behavioural problem, the problem is dealt with by the children's welfare service. Usually, children's and adolescents' violence has been regarded as a behavioural problem. If these children are to receive help from the child and adolescent psychiatry service, they must have a diagnosed psychiatric problem in addition. Such a two-part treatment system does not exist for adults. The services provided for adults are the mental health care services. What happens with behavioural problems when one is no longer an adolescent? It seems as though the probation service comes closest to a kind of continuation of the children's welfare service.

This organization can be seen as a reflection of our lack of understanding of violence as a psychological problem – and as a health problem. For a long time we have been concerned about children who have parents with mental illness or alcohol or drug problems. During the last few years we have also become concerned about children who live in homes where there is

continues on page 16

violence. The term "double diagnosis" is often used in the health services, about the relationship between alcohol and drugs and mental illness. A similar relationship between violence and mental illness has only been recognised to a small degree.

When we talk about children and adolescents who are violent, we mainly talk about boys. When we talk about adults who are violent, we mainly talk about men. We talk about women mainly as the victims. Thus violence as a problem is primarily associated with men. If it is reasonable to assert that the health and social sectors are characterized by a lack of knowledge and understanding about violence as a health problem, this also includes lack of knowledge about the gender perspective of violence. This demands the development and use of methodology suitable for this dimension of violence.

It is important for people who work in the Norwegian health services to have knowledge about the damage to health caused by violence, how this occurs and how this can be prevented. Historically, many women who have been the victims of violence have been regarded by helpers as "hysterical and nervous". General medical practitioners often know little about post-traumatic stress disorder (PTSD), a disorder that many women and children who are the victims of violence suffer from. Very many of the symptoms that people develop when they are exposed to violence are normal reactions to abnormal conditions. But health workers often do not understand these reactions, and do not understand the cause.

Men's violence in close relationships also affects children. Violence affects children both directly as the victims of violence, and as witnesses to violence. Some studies have shown that up to 50 % of men who are violent to their partners are also violent to their own children. Treatment of men who are violent and women who are the victims of violence should therefore also include an assessment of the children. Children can suffer from the same sort of damage to their health as women can, as a result of violence. But there are some specific disorders that only children suffer from. For example, recent research has shown that there is a relationship between the development of attachment disorders and experienced violence among babies. These developmental abnormalities also show a relationship with the development of dissociative disorders when the children become adults. Children with PTSD after experiencing violence have symptoms which are very similar to attention deficit/hyperactivity disorder (ADHD). Is there a danger of diagnosing these children incorrectly? Just as for women, there are few concrete help measures available for these children, particularly within the health services. Every year, nearly 2 000 children and 4 000 women use the country's crisis centres, amounting to about 80 000 days.

Men who are violent also damage themselves. There has been very little research in this area, but it is reasonable to assume that violence gives specific experiences that lead to reduced health. For example, shame and guilt after episodes of violence can lead to depression and alcohol and drug problems. If the violence leads to the loss of a partner and children, this can also lead to health problems. Some health surveys have shown that men's health is best when they have a partner. There are very few specific help measures for violent men (6). Mental health care services have offered treatment to people with problems with violence to a very limited extent.

There is a lack of treatment services in Norway for women who have a violent partner. The services lack people with the necessary skills, and there is little capacity. Another problem is that there are only a few centres for women who have been raped, in contrast to the large number of rape victims. Apart from the rape centres, the only specialized treatment service for women who have been raped is the Partner Service (Partnertjenesten) at Alternative to Violence (ATV), and this is a privately-financed service.

In other words, the health services have several challenges. In our view, there are two main challenges. There is too little competence in this field, and specific help measures and specialised services are in very short supply. We believe that the root of the problem is a lack of basic understanding of the psychological and health-related aspects of violence, the causes of violence and the factors that perpetuate violence. In the government's latest plan of action, the authorities have taken a big step forward in meeting the great need for knowledge and help services. It remains to be seen whether concerted efforts in this area will contribute to changing the basic understanding of violence. Such a change is needed if society is to manage to meet children's, women's and men's needs for help.

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Ingrid Lycke Ellingsen

Uncompromising Against Torture

Per Halvorsen

Do not be fooled by the slender grandmother figure of Lycke Ellingsen. Even stocky Ukrainian military policemen have been seen to nod in agreement with her on the issue of human rights. The retired psychiatrist was presented with the Karl Evang Award for 2004.

As the delegate for the Council of Europe's Torture Committee, Lycke Ellingsen had searched a police station, which was far from being a good example when it came to humane treatment of prisoners. Now she sat there, in front of twenty-five hefty fellows in uniform, and should give her recommendations.

I didn't feel too confident, but when standing up for human rights, one cannot compromise. And at least the policemen listened to what I had to say – the former chief county psychiatrist for the Norwegian Board of Health in the county of Buskerud tells us.

For almost 12 years, she has travelled round visiting Europe's prisons and asylums as a member of the expert panel of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The mandate is to prevent torture and abuse of human dignity. Apart from Belarus, all the European nations have ratified the convention.

A Gradual Transition

The 71-year-old has visited 25 countries and countless institutions since Grete Knudsen, who was then minister for social affairs, proposed her in 1993. She stresses that CPT shall primarily strengthen legal safeguards for people who have lost their freedom.

Our task is not to denounce countries that break the convention. Therefore, confidentiality and cooperation are leading principles, she explains. However, if a country refuses to cooperate, then the committee reserves the right to publicize its findings.

Lycke Ellingsen has experienced a genuine will to humanize the asylums.

No-one wants to be the worst pupil in the class, she says.

However, she does not conceal the fact that torture occurs, even in Europe. This has been documented by Amnesty International. She has personally taken part in discovering clubs and other items that have obviously had the purpose of punishing people or forcing people to give information or to confess.

But pure torture, as it is described in the media, or as it appears in our worst nightmares, is not part of her routine work for human rights. Her work is about ensuring that there are clear standards to ensure that people who have lost their freedom are treated humanely. Lycke Ellingsen believes that the transition between torture and inhumane treatment can be gradual.

For some people, being one of 45 prisoners who have to share 28 beds and sleep in shifts four hours at a time, can cause such suffering, that it can be experienced as torture, she says.

Burst into Tears

Or it can be as simple as lack of human contact. During one of her assignments, the prison guard warned her about contacting a special prisoner who was regarded as being particularly dangerous. Lycke Ellingsen disregarded the warning, and was locked into the cell, where everything was upside-down. On the edge of the bed sat a sick prisoner, who burst into tears when she held out her hand to him and asked him how he was. "You are the first person who has touched me for a very long time", he said.

Despite the fact that he had not been tested, the prison guards assumed that he was HIV-positive. The task that needed to be done here was to ensure that the prison guards were given instruction about how to deal with people who are HIV-positive, says Lycke Ellingsen.

Scarred Souls

She is also concerned about the situation of women:

I have seen women prisoners who have been denied the possibility to take care of basic hygiene with regard to menstruation. To walk around among male prison guards with streaks of blood on your legs, can be experienced as deeply humiliating. Body searches, often carried out in asylums, can also be particularly difficult for women to deal with when they are carried out by men, she says.

But the deepest scars to her soul have got after she visited some of Europe's orphanages.

There are no people who are more vulnerable to breaches of human rights than children, says Lycke Ellingsen.

Her commitment in this area goes way beyond her contribution for CPT. Some of the prize money will therefore be allocated to selected orphanages.

– It helps to make the world a little better, she says, and quotes the words of Elie Wiesel: "The opposite of love is not hate, but indifference".

The Karl Evang Award is presented each year to a person or organization that has made a particularly important contribution in the following fields: promotion of public health, improvement of social conditions of importance to public health, improvement of legal safeguards and safety within health and social services, health education and contribution to social debate about important health and social policy issues.

– Language is the Doorway to Culture

Per Halvorsen

– Language, says Edel Hætta Eriksen, almost before we have asked. – The Sami language is the doorway to culture. If the health service has no knowledge of the Sami language, then it is difficult to imagine that Sami people can feel safe and understood.

Edel Hætta Eriksen

She has had plenty of time to think about the characteristics of an effective Sami health service since she was born in Kautokeino in the early 1920s, and six months later received a female reindeer as a christening present. The eighty-three year-old believes that trust can only be earned through respect for tradition.

– To a large extent, the health service is about communication. Therefore, we need a Sami health service from a language perspective. This means that one must have the opportunity to meet health care personnel who speak Sami. Those who understand the language will also understand the cultural codes, she says.

Assimilation Policy

Throughout her adult life, Edel Hætta Eriksen has fought for the interests of the Sami people. She has been a member of the Nordic Sami Council (Nordisk Sameråd) a committee member of the Norwegian Sami People's Association (Norske Samers Riksforbund), active in the Values Commission (Verdikommisjonen) and director of the Sami Education Council (Samisk utdanningsråd). She is presently leader of the Council for the Elderly (Eldreråd) in Kautokeino. But her work as a teacher has also provided her with a sounding board for her reflections about health services for Sami people. She remembers her first temporary job. She was 19 years old and the first lesson was natural science for pupils in the fourth class.

– The pupils had been given homework about wild mustard. One boy raised his hand. He stood up and recited the whole passage from the book by heart. I asked the class questions in Sami. No-one could answer, not even the boy who had learnt the passage by heart. The textbook was in Norwegian, but none of the pupils understood this language. They understood Sami. It was a hopeless situation. Thirty years were to pass before Sami was allowed to be used in schools, she tells.

She uses this story as an example of assimilation policy. She says that this policy created the conditions for deep mistrust in the relationship between Sami people and Norwegians.

– Sami people were to be like other people. That we should have a special health service, with our own language, was unthought of.

Thus Sami patients did not manage to make themselves understood. Health care workers had great problems giving information and providing the right treatment.

– The attitude was that Norwegians were always right. This made it difficult for us to be open. This is still a problem for the older generation, she says.

Lower Life Expectancy

Health status in Finnmark has always been the worst in Norway. Lack of doctors is still a problem. Both prevention and treatment have been less advanced. In 1980, the district medical officer Per Fugelli studied the health status of the population of Skogan-varre. He found that nine out of ten cases of illness were hidden or neglected. Thirty-six per cent of Sami people had not visited

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the doctor during the previous five years. Many reindeer have wandered across the plains of Finnmark since that time, and many conditions have improved. But there are still many challenges. One of the most obvious is the lower life expectancy among Sami people than among the rest of the population.

Hætta Eriksen does not wish to exaggerate the differences between Sami people and Norwegians, but there is little doubt that differences do exist. The Sami people's concept of the extended family, in which godparents play a much greater role than in the ethnic Norwegian culture, is an important difference.

– The whole network of relatives and family is an important resource in Sami society. It is important for those who wish to have legitimacy in Sami society to understand this. An understanding of the strong folk medicine traditions is also important, she says.

Lack of knowledge about Sami language, culture and traditions has meant that Sami people have searched for help outside the official health services. They have used their own healers and readers: "buorideaddji". The local folk doctors use herbs and wild mushrooms (krøsk), organs from reindeer and other remedies to treat disease.

– These people are accepted by the Sami people because they are indigenous people and can speak Sami and understand Sami culture. Doctors must show respect for folk medicine and work together with these forces if they wish to gain the trust of their Sami patients, says Hætta Eriksen.

And maybe one must extend the normal consultation time of twenty minutes, when much of the time is spent by the doctor and the patient trying to understand each other.

– A bit more flexibility and generosity when meeting Sami patients would not be out of place, says Hætta Eriksen.

"Ean hal moai gal gulahallan"

– We Don't Seem to Understand Each Other

Ole Mathis Hetta, Chief County Medical Officer

Since I was a child, I have heard the sentence "ean hal moai gal gulahallan", which means "We don't seem to understand each other". It could be someone who had rung from the telephone exchange and who met someone who spoke Norwegian at the other end, or it could be an elderly man who came out of the doctor's surgery.

Until about 1985 the use of interpreters in consultations with a doctor or in health centres in Norway was almost unheard of. The limited need for interpreters for Pakistani and Turkish immigrants was taken care of by relatives. The same has been the case for Sami people in inner Finnmark. The use of interpreters in the Norwegian health services first became an issue when people from many different ethnic groups came to our country in the middle of the 1980s. Without meaningful direct communication or the use of an interpreter, a doctor's practice will in many respects resemble a veterinary practice. That is what the title of this article is about. This is not an unknown situation in 2004. In addition to verbal communication, interpretation of non-verbal signals and decoding of cultural characteristics will present challenges for health care personnel and patients.

Culture reflects lifestyle, philosophy of life, seasonal rhythm, values and habits. Views about what is health, what is healthy and what is sickness, are dependent on the individual's or the group's view of the world and philosophy of life. In Sami society, certain individuals are recognised as healers, and are called "readers" (reflecting the fact that they read or pray for a cure) or "buorideaddji", which means "the one who cures". The function that these people have is old, and, before any doctors or other health care personnel were to be found, everyone was dependent on them. Some of them used herbs or other remedies. There are two things that distinguish this practice from other alternative therapeutic practices in the rest of Norway. First, it is based on folk medicine tradition, and uses means, methods and media that are culturally rooted in Sami culture, and which are therefore "effective" in the local context. Second, to a large degree it has not been, and to a certain degree it is still not, orientated towards profit. It reflects the opposite of the title: "Moai gal gulahalaime" – we understand each other.

Language is perhaps the strongest and most widespread cultural element in the central Sami areas of inner Finnmark. For very many families, reindeer husbandry is also a very important cultural element. In today's situation, many of these Sami people have to stop working with reindeer husbandry. This represents a much greater threat to these people than the reindeer administration, the Ministry of Agriculture and Food, or for that matter the Storting (the Norwegian parliament) have been aware of. When I was district medical officer in Karasjok in the middle of the 1970s, the first signals came that it was necessary to limit the number of reindeer husbandry units. At the time I suggested that the trade organization, the reindeer husbandry authorities and the health service should initiate a research project to investigate the health and social consequences of such a change in lifestyle. Now, thirty years later, very little has been done in this area. Why? How can a health and social plan for the Sami population help, if the basis of their existence and culture are despised and disappear. Fine words and promises do not help, nor do programmes for creating the right attitudes to minority groups, if action or lack of action from people in the majority culture signalise assimilation. "Ean hal moai gal gulahallan".

Confusion about Sedation and Pain Relief for Terminally ill Patients

The Norwegian Board of Health is concerned that hospitals still have different views about principles and practice for sedation and pain relief for terminally ill patients, four years after the so-called Bærum Case.

In connection with the Bærum Case, in July 2000, the Norwegian Board of Health informed all the hospitals in the country about the principles of sedation and pain relief for terminally ill patients with cancer. Sedation and pain relief is defined as reduction of a patient's level of consciousness by the use of medicinal products in order to relieve severe, persistent pain or other severe, troublesome symptoms. The letter from the Norwegian Board of Health contained the conditions for such treatment, the necessary requirements in the decision process, and the necessary requirements when carrying out the treatment.

In the autumn of 2004, the Norwegian Board of Health carried out a survey of the use of sedation and pain relief for terminally ill patients in hospitals. Thirty-four health trusts received a questionnaire, which they distributed to 110 departments. All the departments answered (1). The results must be interpreted with caution, since misunderstandings can easily occur in this type of questionnaire survey.

- 77 departments answered that they had not given sedation and pain relief in 2003. 25 departments had given such treatment less than 10 times and 3 departments more than ten times.
- 33 departments answered that patients' consent is not necessary for sedation and pain relief.
- 28 departments answered that the physician responsible for the patient, or the senior consultant in the department where the patient is admitted, is responsible for sedation and pain relief. 13 departments answered that responsibility is shared between the anaesthetist and the physician in the department, and 14 departments answered that the anaesthetist is responsible.
- 9 departments answered that the physician responsible for the patient, or the senior consultant in the department where the patient is admitted, record the treatment in the patient record. 6 departments answered that this is done by the anaesthetist, and 37 departments answered that both the anaesthetist and the physician in the department do this.

The Norwegian Board of Health asserts that a clear, informed consent shall be obtained from the patient before sedation and pain relief are given. If the patient is unable to give consent, the physician providing the treatment can make the decision, if the treatment is in the best interests of the patient, and if it is probable that the patient would have given consent to such treatment. The opinions of the relatives shall be taken into account, but shall not be decisive.

The Norwegian Board of Health also asserts that the physician who provides the sedation and pain relief, for example an anaesthetist, also has responsibility for ensuring that the treatment is in accordance with sound practice. The medically responsible physician in the department where the patient is admitted has responsibility for all other treatment the patient receives. Close contact between these two physicians is important.

According to the provisions in the Health Personnel Act relating to patient records, and the regulations relating to patient records, consent, assessment and treatment shall be recorded in the patient record. The physician should write notes in the journal every time the patient is attended to.

The survey has shown that different hospitals have different practice for sedation and pain relief:

- sedation and pain relief for terminally ill patients, and pain relief that can have a sedative effect, are not clearly distinguished
- too much attention is given to the medical indications for giving sedation and pain relief
- little attention is given to the fact that patient consent is required
- there is confusion about who is responsible for sedation and pain relief
- there is confusion about who shall record the treatment in the patient record, and how often this shall be done.

Reference

1 *Survey of use of sedation for terminally ill patients. www.helsetilsynet.no*

The Bærum Case

In 1999, a senior consultant at Bærum Hospital was reported for several cases of active euthanasia. The criminal proceedings were dismissed by the Director General of Public Prosecution on the grounds of no punishable offence for some of the patients, and on the grounds of lack of evidence for one patient. The Norwegian Board of Health dealt with this as a supervision case, which resulted in the senior consultant being given a warning. The senior consultant appealed to the Norwegian Appeals Board for Health Personnel. The Appeals Board upheld the Norwegian Board of Health's decision to give the senior consultant a warning.

Hidden Differences

in Decisions Taken by the Norwegian Abortion Boards

Although the Abortion Boards follow the legislation, their discretionary judgements can be different. This can threaten the legal safeguards of women who apply for an abortion. The legislation does not take this variation in discretionary judgements into account.

This is the conclusion of the Norwegian Board of Health after countrywide supervision in 2004 of the way in which the Abortion Boards dealt with applications for abortions in 2003 (1).

The background for the supervision was that regional variation in decisions taken by the boards had been detected in earlier studies (2, 3, 4). Statistics on abortions provide no clear answer to the question of whether hospitals' Abortion Boards fulfil the requirements laid down in the legislation when they deal with applications for abortions.

Supervision encompassed cases from a representative sample of Abortion Boards. All the cases at the university hospitals with Regional Appeals Boards were included in the sample. Supervision concentrated on applications for abortions on the basis of the woman's mental or physical health and/or social reasons (5). Supervision did not detect departure from the regulations.

Examination of documents revealed that the boards, particularly when dealing with applications based on social indications, have to relate to very complex situations. The exercise of judgement is central in the process of dealing with cases. Evaluation when the case is first dealt with by the board, according to current regulations, is assigned to physicians who are central members of the Abortion Board. Decisions shall be made by weighing up the two sides: on the one side the woman's evaluation of her own conditions and life situation, and on the other side the rigorous requirements laid down in the Abortion Act about the length of the pregnancy. Importance shall be given to the woman's own evaluation.

The grounds for the Board's decision are formulated according to the requirements laid down in the legislation: for example, "not important enough grounds", "the pregnancy is too advanced in relation to the requirements laid down in the Act", and formulated in the opposite way when an abortion is granted (4).

The Norwegian Board of Health did not identify any deviations from the current regulations. However, some decisions showed that the boards exercise their discretionary assessments differently. Comparable situations resulted in refusal of an abortion by one board and consent to an abortion by another. The results of supervision confirmed that subjective factors, that cannot be checked later, and the relationship between different factors, can contribute to unpredictable decisions, with the way in which the boards are presently organized. This can weaken legal safeguards for women who apply for an abortion.

References

1. *Summary of Supervision of the Composition and Activities of the Norwegian Abortion Boards. Report from the Norwegian Board of Health 1/2005. Oslo: Norwegian Board of Health, 2005.*
2. *St.meld. nr. 16 (1995-96). Om erfaringer med lov om svangerskapsavbrudd.*
3. *Eskild A, Nesheim BI, Berglund T, Totlandsdal JK, Andresen JF. Svangerskapsavbrudd på grunn av fosterskade i Norge. 1996-97. Tidsskr Nor Lægeforen 2000; 120: 1000-3.*
4. *Eskild A, Nesheim BI, Berglund T, Totlandsdal JK, Andresen JF. Geografisk variasjon i forekomsten av induserte senaborter i Norge 1996-97. Tidsskr Nor Lægeforen 2000; 121: 24-7.*
5. *Act of 13 June 1975 No. 50 relating to the termination of pregnancy*

Cases of Complaint Relating to the Social Services Act

The length of time taken to deal with cases of complaint relating to the Social Services Act has become shorter, but many administrative decisions relating to the Act are returned to the municipalities to be dealt with again.

At the end of 2004, the Offices of the County Governors had 704 cases of complaint relating to the Social Services Act waiting to be dealt with. The number of cases waiting to be dealt with at the end of 2003 was 1 592. The number of cases waiting to be dealt with in 2004 is less than half the number in 2003. In particular, the situations at the Office of the County Governor in Oslo and Akershus, and at the Office of the County Governor in Rogaland have contributed to this reduction. Two out of three cases were dealt with within three months. At the beginning of 2005, according to the Offices of the County Governors, the time taken to deal with new cases was less than three months.

In 2004, the number of cases relating to Chapter 4 of the Social Services Act dealt with by the Offices of the County Governors was 1 288 (1 399 in 2003). Chapter 4 relates to practical assistance and training (including client-managed personal assistance), relief for carers, support person services, placement in an institution or in accommodation with full-time care services, economic assistance for carers, and temporary accommodation. Cases relating to economic assistance for carers made up the largest proportion of cases, with 417 cases. The next largest group was practical assistance and training, with 361 cases (including 96 cases relating to client-managed personal assistance). Two hundred and fifty-six cases related to support person services, and 191 related to relief for carers.

54% (49%) of cases were affirmed, 21% (28%) of cases were revoked and returned to be dealt with again by the municipality, and 22% (21%) were reversed. 3% (2%) of cases were rejected. The figures in brackets are for 2003.

In total, 5 464 cases relating to financial support according to Chapter 5 of the Social Services Act were dealt with by the Offices of the County Governors (4 471 cases in 2003). Of these, 80% were affirmed, 9% were revoked and returned to be dealt with again, and 10% were reversed. 1% were rejected. The figures for 2004 are about the same as for 2003.

In 851 cases relating to Chapter 4 and Chapter 5 of the Social Services Act, the decision of the municipality was reversed by the Office of the County Governor. The reason given in 10% of cases was incorrect administrative procedure, in 34% of cases obviously unreasonable practice of judgement, and in 19% of cases incorrect application of the legislation. Of the 769 cases that were sent back to the municipality to be dealt with again, the reason given by the Office of the County Governor in 60% of cases was incorrect administrative procedure.

In 2004, 6 394 cases were sent in. The number in 2003 was 6 712. The Offices of the County Governors dealt with 7 333 cases in 2004, compared with 6 340 cases in 2003. The number of cases sent in reflects the level of activity in the municipalities, whilst the number of cases dealt with reflects the level of activity in the Offices of the County Governors.

The Norwegian Board of Health has initiated the project: "Consistent treatment of supervision cases and complaints concerning clients' rights". Among other things, this project will investigate the reporting of cases of complaint according to the Social Services Act, with a view to changing the system of reporting from 2006.

Facts and Figures

The facts and figures presented on these pages give an overview of the most important tasks of the supervision authorities (the Norwegian Board of Health, the Offices of the County Governors, the Norwegian Board of Health in the counties). More detailed statistics are to be found on the web site of the Norwegian Board of Health: www.helsetilsynet.no.

COMPLAINTS REGARDING PEOPLES' RIGHTS FOR SOCIAL SERVICES

The Office of the County Governor is the appeals body for decisions taken by the social services, according to the Social Services Act section 8–6. According to section 8–7, the Office of the County Governor can assess all aspects of the decision, but when assessing discretionary judgement, the decision can only be altered if the judgement was obviously unreasonable.

Table 1 gives an overview of complaints regarding the Social Services Act in 2004.

Chapter 4 of the Social Services Act deals with advice and guidance, practical assistance and training (including client-managed personal assistance), relief for carers, support person services, placement in an institution or accommodation with full-time care services, economic assistance for carers, individual plan and temporary accommodation. Chapter 5 of the Act deals with financial support (for subsistence etc.).

The number of complaints received by the Offices of the County Governors per 100 000 inhabitants varies from 85 in the county of Sogn og Fjordane to 219 in the county of Finnmark. The mean for the country is 139 complaints per 100 000 inhabitants. More statistics about complaints can be found in the article: Cases of Complaint Relating to the Social Services Act.

The figures for the counties of Oslo and Akershus also include cases relating to the Regulation regarding compensation and the Social Services Act Chapter 4A.

COMPLAINTS REGARDING PEOPLES' RIGHTS FOR HEALTH SERVICES

The Norwegian Board of Health in the counties is the appeals body when a person does not receive the services that they have the right to receive according to the Patients' Rights Act and certain other regulations. Those who have responsibility for services (the municipality etc.) shall have reassessed the case before a complaint is sent to the Norwegian Board of Health in the county. The Norwegian Board of Health in the county can assess all aspects of the decision. Their decision is final.

Tabell 1 Complaints regarding the Social Services Act. New and completed cases, 2004

County	New cases	Completed cases Chapter 4	Of which decision reversed	Completed cases Chapter 5	Of which decision reversed	Total completed cases
Østfold	530	116	81	420	54	536
Oslo og Akershus	1 477	380	98	1 713	212	2 093
Hedmark	227	60	9	163	11	223
Oppland	207	48	13	147	12	195
Buskerud	387	95	17	258	19	353
Vestfold	356	71	3	267	16	338
Telemark	282	70	32	195	36	265
Aust-Agder	121	24	2	84	4	108
Vest-Agder	243	41	1	212	7	253
Rogaland	544	92	5	510	49	602
Hordaland	584	99	18	444	41	543
Sogn og Fjordane	91	50	6	55	3	105
Møre og Romsdal	269	79	11	155	7	234
Sør-Trøndelag	246	48	2	224	5	272
Nord-Trøndelag	141	31	4	88	6	119
Nordland	315	63	8	234	21	297
Troms	214	40	5	191	26	231
Finnmark	160	14	2	104	5	118
The whole country	6 394	1 421	317	5 464	534	6 885

Table 2 Complaints regarding peoples' rights for health services. Cases completed by the Norwegian Board of Health in the counties – assessed according to specific provisions in the legislation, 2003 and 2004

Provision	Provision regarding:	Number of cases 2004	Of which in favour of the complainant	Number of cases 2003
Patients' Rights Act				
Section 2–1 firts paragraph	the right to required health care from the municipal health serv.	34	15	30
Section 2–1 second paragraph	the right to required health care from the specialist health serv.	72	20	29
Section 2–2	the right to an evaluation within 30 workdays	5	4	4
Section 2–3	the right to a re-evaluation	4	1	1
Section 2–4	the right to choose hospitals	9	4	4
Section 2–5	the right to an individual plan	11	5	16
Section 2–6	the right to ambulance transportation	42	6	a new right from 2004
Chapter 3	the right to participation and information	11	6	11
Chapter 4	consent to health care	1	1	4
Chapter 5	the right of access, correction and deletion of medical records	20	14	30
	Patients' Rights Act, unspecified	47	9	13
Municipal Health Services Act				
Section 2–1	the right to required health care	143	49	89
Dental Health Services Act				
Section 2–1	the right to required dental care	1	1	4
Total no. of assessments of specific provisions		**400**	**135**	**235**

Table 2 shows complaints regarding peoples' rights for health services – the number of cases completed by the Norwegian Board of Health in the counties. Several provisions can be assessed in each case.

The number of completed cases in 2004 was 361 (199 in 2003). Of the 361 cases, the decision in 135 of the cases was wholly or partly in favour of the complainant. The right to ambulance transportation was included in the Patients' Rights Act from 1 January 2004 (42 cases were completed in 2004). From the same date, the right to choose hospitals, the right to receive treatment abroad, and alcohol and drug abusers' rights for health services, were extended. Figures specifically for the right to receive treatment abroad, and alcohol and drug abusers' rights for health services, are not available.

SUPERVISION OF SOCIAL SERVICES

System Audits

Table 3 shows the number of system audits carried out by the Offices of the County Governors in 2004.

In 19 of the 109 system audits, no breaches of laws or regulations were found.

In 2004, twenty-five of system audits of social services and health services carried out by the Offices of the County Governors and the Norwegian Board of Health in the counties, were carried out together.

Of the 109 system audits, 58 of these were countrywide supervision of the municipalities' services for alcohol and drug abusers (see article: Deficiencies in Allocation of Social Services to Alcohol and Drug Abusers, and Report from the Norwegian Board of Health 4/2005. The report is in Norwegian, with an English summary).

Table 3 Supervision of social services. No. of system audits carried out by the Offices of the County Governors, 2004

County	Number of system audits
Østfold	7
Oslo og Akershus	6
Hedmark	4
Oppland	4
Buskerud	8
Vestfold	3
Telemark	3
Aust-Agder	8
Vest-Agder	5
Rogaland	3
Hordaland	5
Sogn og Fjordane	9
Møre og Romsdal	6
Sør-Trøndelag	8
Nord-Trøndelag	10
Nordland	10
Troms	6
Finnmark	4
The whole country	109

Altogether, 51 system audits were not part of the countrywide supervision. The institutions and themes for supervision for these were chosen on the basis of information the Office of the County Governor had on risk and vulnerability. The themes for the 51 system audits were, among other things, Social Services Act Chapter 4A (see also the description below), home help services, relief for carers and support person services according to the Social Services Act Chapter 4 (approximately 20 system audits), management system and administrative procedures in general (approximately 10 system audits) and services specifically for alcohol and drug abusers (6 system audits).

Of the 86 system audits of social services that were carried out in 2003, there are 7 places where the audits were carried out, where there were open breaches at the end of 2004 (breaches of laws or regulations detected during supervision, for which the deficiencies have not been corrected).

Supervision of Institutions for Alcohol and Drug Abusers

In addition to the 109 system audits, 25 supervisions of institutions for alcohol and drug abusers, according to the Regulations relating to the Social Services Act.

The Use of Restraint and Compulsion for People with Mental Disabilities, According to the Social Services Act Chapter 4A

Table 4 shows the number of decisions and number of people for whom the decisions apply, relating to the Social Services Act Chapter 4A.

Table 4 Supervision Cases – the Offices of the County Governors.
Number of decisions and number of people for whom the decisions apply, relating to the Social Services Act Chapter 4A, 2004. (Figures for Oslo and Akershus, Buskerud, Finnmark and total corrected april 2005)

County	Decisions sections 4A–5 a	Per 100 000 inhabitants	No. of people: decisions sections 4A–5 a	Decisions approved sections 4A–5 b and c	Decisions not approved	No. of people: decisions sections 4A–5 b and c	Dispensation from the requirement to undergo training section 4A–9	Local supervision
Østfold	633	245	70	12	5	8	7	6
Oslo og Akershus	3 311	325	153	37	2	30	21	7
Hedmark	390	207	29	43	1	25	16	2
Oppland	286	156	28	40	0	37	36	17
Buskerud	332	137	21	23	2	11	9	2
Vestfold	434	197	35	15	5	12	8	7
Telemark	1 585	955	39	13	4	10	6	7
Aust-Agder	192	186	19	8	0	6	4	0
Vest-Agder	344	215	44	30	1	21	3	7
Rogaland	2 233	570	91	53	6	39	29	20
Hordaland	5 796	1 297	129	81	4	47	50	12
Sogn og Fjordane	355	332	25	16	0	12	7	8
Møre og Romsdal	431	177	45	114	5	46	36	10
Sør-Trøndelag	5 591	2 063	25	30	5	28	13	5
Nord-Trøndelag	177	138	13	21	5	15	9	12
Nordland	185	78	18	87	0	25	20	8
Troms	195	128	17	22	2	11	14	9
Finnmark	230	315	14	10	2	5	31	9
Total	22 700	494	815	655	49	388	319	148

Table 5 Supervision of health services. Number of system audits carried out by the Norwegian Board of Health in the counties, 2004

County	Number of system audits in total	Number of system audits of municipal health services	Number of system audits of specialist health services
Østfold	12	10	2
Oslo og Akershus	8	6	2
Hedmark	10	7	3
Oppland	12	11	1
Buskerud	15	11	3
Vestfold	10	8	2
Telemark	11	8	3
Aust-Agder	11	9	2
Vest-Agder	11	8	3
Rogaland	7	3	4
Hordaland	15	13	2
Sogn og Fjordane	11	10	1
Møre og Romsdal	11	9	2
Sør-Trøndelag	11	8	3
Nord-Trøndelag	10	4	5
Nordland	17	15	2
Troms	10	8	2
Finnmark	10	8	2
Total	202	156	44

The Social Services Act Chapter 4A, regarding legal safeguards for the use of restraint and compulsion for individuals with mental disabilities, came into force on 1 January 2004, and replaced the provisional Chapter 6A.

The municipalities report decisions regarding measures to prevent injury in emergency situations (single episodes) to the Office of the County Governor, according to the Social Services Act section 4A–5, third paragraph, a. There were 22 700 decisions in 2004, concerning 815 persons.

The Office of the County Governor has to authorize planned measures to prevent injury in repeated emergency situations and measures of restraint to meet the client's basic needs for food, drink, dressing, rest, sleep, hygiene and personal safety, including teaching and training, according to the Social Services Act section 4A–5, third paragraph, b and c.

Of 655 authorized decisions in 2004: 272 decisions were related to planned measures to prevent injury in repeated emergency situations. 242 decisions were related to restraint to meet the clients' basic needs. 47 decisions were related to use of mechanical means of restraint (24 decisions according to b, 23 to c). 87 decisions were related to comprehensive warning systems (27 according to b, 60 according to c). 7 decisions were related to teaching and training. The decisions applied to 388 persons.

The Offices of the County Governors gave dispensation from the requirement to undergo training in 319 cases, which in the Social Services Act section 4A-9 applies to personnel who shall implement measures according to the Social Services Act section 4A–5, third paragraph b and c.

The Offices of the County Governors received very few complaints regarding measures relating to the Social Services Act section 4A–5, third paragraph. The Offices of the County Governors carried out 147 local supervisions of measures according to the Social Services Act section 4A–5 third paragraph, relating to the duty of supervision in relation to measures according to b and c, and in section 2–6 first paragraph, second point. The number also includes local supervision of measures according to a.

Issuing instructions

In 2004, the Offices of the County Governors have not issued instructions according to the Social Services Act.

SUPERVISION OF HEALTH SERVICES

Table 5 shows the number of system audits carried out by the Norwegian Board of Health in the counties in 2004. Two system audits were carried out in private institutions.

Of the 156 system audits of municipal health services carried out by the Offices of the County Governors and the Norwegian Board of Health in the counties, twenty-five of them were carried out together.

In 30 of the 202 system audits, no breaches of laws or regulations were found.

In 2004, the Norwegian Board of Health in the counties carried out countrywide supervision of two areas, according to instructions laid down by the Norwegian Board of Health:

- municipal health services for newly-arrived asylum seekers, refugees and people reunited with their families – 57 system audits
- maternity units – 28 system audits.

Summaries in English of the reports of supervision are to be found on the English pages of the web site of the Norwegian Board of Health.

The areas for supervision that are not part of countrywide supervision, are chosen on the basis of information from, for example, risk and vulnerability analyses, that the Norwegian Board of Health in the counties have.

Among ninety-nine areas of this type of supervision of the municipalities, some of the areas were:

nursing and care services (63), control of infection in institutions (13), public health tasks (4), rehabilitation (3), emergency planning (2), teamwork between schools and social services.

Table 6 Supervision cases – the Norwegian Board of Health in the counties. Number of completed cases, and percentage of cases that took more than 5 months to deal with, 2003 and 2004

County	Number of completed cases 2004	Percentage of cases that took more than 5 months	Number of completed cases 2003
Østfold	89	55	47
Oslo og Akershus	457	65	258
Hedmark	77	69	81
Oppland	65	32	35
Buskerud	110	49	88
Vestfold	67	37	66
Telemark	70	70	72
Aust-Agder	34	53	62
Vest-Agder	50	64	93
Rogaland	100	52	104
Hordaland	115	30	144
Sogn og Fjordane	44	14	39
Møre og Romsdal	63	73	51
Sør-Trøndelag	94	49	80
Nord-Trøndelag	56	41	61
Nordland	82	46	107
Troms	65	42	42
Finnmark	37	54	16
Total	1 675	53	1 446

The theme for 16 system audits of specialized health services that were not part of countrywide supervision were: the work of the quality improvement committees, management systems, client participation, continuity of care, admissions and discharges. free choice of hospitals.

The Norwegian Board of Health in Rogaland carried out 23 system audits of the petroleum industry. These are not included in the above figures.

Breaches of laws or regulations, that are more than one year old

Per 31 December 2004, there were still open breaches in 40 places where supervision was carried out in 2003 or earlier (breaches of laws or regulations detected during supervision, for which the deficiencies have not been corrected). Twenty-one open breaches were from supervision carried out in 2003, 13 from 2002 and 6 from 2001, 2000 and 1999.

There were 71 open breaches per 31 December 2003, and 39 open breaches per 31 December 2002.

The 40 open breaches per 31 December 2004 were from the following areas:

- municipal health services (29), including: nursing and care services, such as meeting the basis needs of people with dementia, and providing services for them (12) school health services (8)
- specialized health services (10): themes such as continuity of care, waiting time for an assessment, individual plan, child and adolescent psychiatry, and capacity
- general medical practitioner services (1)

The Norwegian Board of Health in the counties will follow up breaches of laws or regulations with the owners and the people responsible for running the services, until the breaches are closed.

Issuing instructions

In 2004, the Norwegian Board of Health issued instructions to the municipalities of Torsken and Gratangen, regarding lack of plans for control of communicable diseases, in accordance with the Municipal Health Services Act section 6–3. The Norwegian Board of Health gave warning about issuing instructions to:

- Helse Vest RHF (the health authority for region west), regarding overcrowding in the short-stay department in Sandviken Hospital (Specialized Health Services Act section 7–1)
- Helse Sør RHF (the health authority for region south), regarding lack of a plan for control of communicable diseases (Communicable Diseases Control Act section 7–10a)
- 46 municipalities, regarding lack of plans for health and social emergency preparedness (Municipal Health Services Act section 6–3).

SUPERVISION CASES (INDIVIDUAL CASES) IN THE HEALTH SERVICES

Supervision cases are cases dealt with by the Norwegian Board of Health in the counties on the basis of complaints from patients, relatives and other sources, concerning possible deficiencies in provision of services. Table 6 shows the number of cases dealt with by the Norwegian Board of Health in the counties, and the percentage of cases that took more than 5 months to deal with.

For 2004, the aim was that more than half of the cases should be dealt with within five months. This aim was achieved in nine counties (eleven counties in 2003). Half of the cases were dealt with within five months. The mean time taken to deal with cases was approximately seven months in 2004 and in 2003.

Distribution

Information is given below about the source of supervision cases, what they relate to, and the assessments and results of the cases. Some cases are complex, so that several health services or health care personnel are assessed in the same case. Some cases are assessed according to several provisions in the legislation, so that the number of cases in the different categories is greater than the total number of cases.

Distribution of supervision cases according to source

Of the 1 675 supervision cases completed in 2004, patients, their relatives and their representatives were the source of 1 284 of the cases (62 %). Other common sources were the Patient Ombudsman (140 cases) and employers (111 cases).

Distribution of supervision cases according to type of service

Of the 1 675 supervision cases completed in 2004, 1 980 assessments were made of health services.

Table 7 shows the distribution of supervision cases according to type of service.

In 68 % of cases, no breach of laws or regulations were found (detected breach of duty of health care personnel, or criticism of the system to the institution by the Norwegian Board of Health in the counties, or case referred to the Norwegian Board of Health). The emergency services had the highest proportion (77%) and home-based health services had the lowest proportion (53 %) of cases referred to the Norwegian Board of Health.

Table 7 Distribution of cases according to type of service, 2003 and 2004

Service	Number of cases 2004	Percentage of cases	Number of cases 2003
Public specialised health services	720	43	604
Reg. med. practitioner	680	41	635
– of which: emergency services	199	12	191
Nursing homes	138	8	109
Private specialized health services	119	7	75
Home-based health services	90	5	64
Dental services	49	3	35

Distribution of supervision cases according to type of health care personnel

Table 8 shows the distribution of supervision cases according to type of health care personnel, for the most common types of health care personnel that were assessed. Seventy-seven assessments of the other 19 types of health care personnel were also made. Altogether, 689 assessments were made of organizations (municipality, health trust etc.).

Distribution of supervision cases according to specialty

Table 8 Distribution of supervision cases according to type of health care personnel, 2003 and 2004

Health care personnel	2004	2003
Physicians	952	838
Nurses	111	96
Dentists	50	35
Psychologists	33	39
Physiotherapists	25	15
Auxiliary nurses	22	18
Midwives	11	4
Emergency Med. Technician	10	4

Of the 1 675 supervision cases completed in 2004, 772 cases were related to specialized health services. These cases were categorized according to speciality, as shown in Table 9.

Altogether, 902 assessments were made of the 772 cases regarding specia-

Table 9 Distribution of supervision cases according to specialty, 2003 and 2004

Specialty	2004	Percentage of all cases (%)	2003
Psychiatry	238	31	177
Surgery	133	17	109
Internal medicine	93	12	86
Obstetrics and gynaecology	79	10	62
Anaesthetics	39	5	22
Nevrology	26	3	17
Orthopeaedic surgery	22	3	25
Ophthalmology	19	2	8
Child and adolescent psychiatry	17	2	20
Paediatrics	17	2	17

lized health services. In 66% of these assessments, no breach of laws or regulations was found. This varied from: highest – ophthalmology 79% and orthopaedic surgery 77%, to lowest – obstetrics and gynaecology 56%, and anaesthetics 49%.

Distribution of supervision cases according to legislative basis

Table 10 shows the distribution of supervision cases according to legislative basis, in 2003 and 2004.

The number of "legislative bases" for the 1 675 cases was 3 631. In 65 % of these assessments, no breach of laws or regulations was found.

Table 10 shows that, as expected, most supervision cases are about sound professional practice. A large number of cases relate to information and documentation. Cases about fitness to practice – alcohol and drug abuse and other reasons – are often serious, and in many cases result in administrative reactions from the supervision authorities.

Distribution of supervision cases according to outcome of cases

Table 11 shows the distribution of supervision cases dealt with by the Norwegian Board of Health in the counties in 2003 and 2004, according to outcome of the case.

Supervision cases dealt with by the Norwegian Board of Health

Cases dealt with by the Norwegian Board of Health (the most serious cases, which are referred by the Norwegian Board of Health in the counties to the Norwegian Board of Health centrally) are discussed in a separate article: Alcohol and Drug Abuse are the most Important Causes of Loss of Authorization.

Table 10 Distribution of supervision cases according to legislative basis, 2003 and 2004

Legislative basis	Number of cases 2004	Percentage (%): violation of the provision	Number of cases 2003
Provisions in the Health Personnel Act			
Sound professional standards: behaviour (section 4)	200	72	183
Sound professional standards: examination, diagnosis, treatment (section 4)	1 313	73	1 208
Sound professional standards: medication (section 4)	169	60	159
Sound professional standards: other (section 4)	244	66	240
Emergency treatment (section 7)	43	72	58
Information (section 10)	99	65	74
Organization of the service (section 16)	140	63	119
Duty of confidentiality, right of disclosure, duty of disclosure (chapters 5 and 6)	95	59	83
Patient records (sections 39–44)	269	36	205
Fitness to practice: alcohol and drug abuse (section 57)	45	24	35
Fitness to practice: other reasons (section 57)	74	36	51
Provisions in the Specialized Health Service Act			
Duty of sound professional standard (section 2–2)	298	69	173

MEDEVENT (MELDESENTRALEN – THE REPORTING SYSTEM FOR ADVERSE EVENTS IN SPECIALIST HEALTH SERVICES)

MedEvent is a database of registered events, that are registered according the Specialized Health Services Act section 3–3. Health institutions have a duty to send a written report to the Norwegian Board of Health in the county in the event of serious injury to patients, or events that could have led to serious injury to patients, that occur as the result of provision of health care, or as a result of one patient injuring another.

About 20 % of all events in 2004 were related to medication, 9 % were related to medical devices, and 2.5 % were related to suicide. This is similar to in previous years.

The Annual Reports of MedEvent provide a summary of the experience from the previous year, based on reported events.

Health institutions have a duty to report within two months of the event taking place. One problem is that, in many cases, the deadline is not met. Of the 1 941 reports registered in the database in 2004 by the Norwegian Board of Health in the counties, 43 events had occurred in 2002 or earlier and 442 events had occurred before 31 October 2003. One result of this delay is that MedEvent data have to be corrected long after the report is published.

It is unfortunate that some reports do not contain enough information about the events. This makes it difficult in many cases to understand what happened, how and why it happened, what measures have been initiated to help the patient, and what has been done to prevent similar events occurring later. The Norwegian Board of Health is concerned that there is little information about the measures initiated by the institutions to prevent events occurring and being repeated.

Figure 1 Number of reports relating to the Specialist Health Services Act § 3–3 in 2004 (n = 1405)

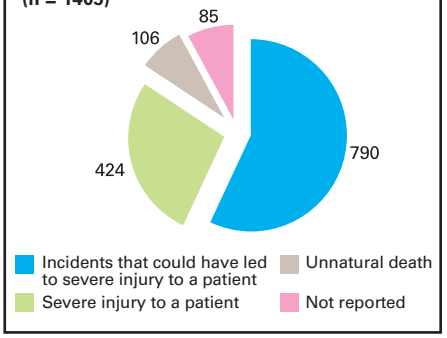

Table 11 Distribution of supervision cases according to outcome of cases, 2003 and 2004

Outcome	2004	2003
Referred to the Norwegian Board of Health	293	195
Criticism of the system, to the director/municipal executive	38	33
Criticism of the system, to the professional leader	14	17
Notification of breach of duty by health care personnel	284	213
Advice or guidance given to health care personnel	511	443
No remarks	832	763

ACCESS TO DOCUMENTS

In 2004, the Norwegian Board of Health received 2 136 requests from the media for access to documents in the Electronic Mail Record. This is an increase of 25 % from 2003 (1 700 requests).

PRESS RELEASES

1/2004 More health care personnel are loosing their authorization, and supervision cases are becoming more serious

2/2004 The final reports are ready: The "Dent-O-Sept" case revealed serious deficiencies and has led to intensified supervision. Joint press release: the Norwegian Institute of Public Health, the Norwegian Directorate for Health and Social Affairs and the Norwegian Board of Health

3/2004 The message to the municipalities is clear: They must have plans for control of communicable diseases, and plans for health and social emergency preparedness!

4/2004 The Director General of Health Lars E. Hanssen invites the media to the presentation of the Annual Supervision Report 2003, Monday 8 March

5/2004 The Annual Supervision Report 2003 shows that much is still to be done

6/2004 Invitation to the Karl Evang Seminar 2004

7/2004 Karl Evang Award 2004 to Ingrid Lycke Ellingsen, psychiatrist – work against torture

8/2004 Invitation to press seminar – countrywide supervision of maternity units.

VISITS TO THE WEB SITE WWW.HELSETILSYNET.NO

The Norwegian Board of Health launched its new web site on 4 May 2004 (see the back cover). There were 1.6 million visits to the web site from May until December, distributed as follows:

- 350 000 supervision reports
- 330 000 publications and hearing statements
- 180 000 pages for the Norwegian Board of Health in the counties
- 175 000 legislation
- 100 000 news
- 75 000 information about the Norwegian Board of Health
- 65 000 rights and complaints procedures
- 65 000 links (sources of information)

Articles and links to legislation relating to social services are vested as often as those relating to health services.

Of the 1 500 supervision reports from the Norwegian Board of Health in the counties and the Offices of the County Governors, the reports about countrywide supervision of maternity units, and the reports of supervision with emergency services in the large towns, are those that are read most often.

Earlier report series from the Norwegian Board of Health have been visited almost 140 000 times.

DIRECTIVES FROM THE NORWEGIAN BOARD OF HEALTH

The Ambulance Service – Guidelines for Dealing with Cases of Complaint. Directive IK1/2004

ACCOUNTS

Table 12 The Norwegian Board of Health. Budget, Chapter 721, 2004

(NOK 1 000)	Budget	Accounts	Differ.
Expenditure: fixed wages	38909	38589	321
Expenditure: variable wages	3855	4445	-590
Operating costs, buildings etc (rent, electricity, cleaning security)	11 947	11 948	-1
Other expenditure	13 475	13 307	168
Total expenditure	68 186	68 289	-103
Income	3960	4232	-272
Net expenditure	64 226	64 057	169

Report series

Report from the Norwegian Board of Health

In the series, the results of supervision of health and social services are presented. The series began in 2002. All the reports are available in full text in Norwegian. All the reports have a summary in English, which can be found on the website: www.helsetilsynet.no

Publications in 2005

1/2005 Summary of Supervision of the Composition and Activities of the Norwegian Abortion Boards

2/2005 Norwegian Alcohol and Drug Abusers – Health Problems and Health Services in Relation to General Supervision. An Evaluation of Central References

3/2005 Summary of Countrywide Supervision in 2004 of Municipal Health Services for Newly-arrived Asylum Seekers, Refugees and People Reunited with their Family

4/2005 Summary of Countrywide Supervision of Municipal Social Services for Alcohol and Drug Abusers in 2004

5/2005 Annual Report 2003 for MedEvent (Meldesentralen – the Reporting System for Adverse Events in Specialist Health Services)

6/2005 Practice Concerning the Use of Compulsion for People with Mental Disabilities, and Practical Services Offered by the Municipalities – Experience Gained from Supervision 2003–2004

Publications in 2004

1/2004 Summary of Supervision of the Municipalities' Emergency Planning for Control of Communicable Diseases at Six Airports with International Traffic

2/2004 Still Overcrowded Capacity in Departments of Internal Medicine. A Survey in 2003 and the Trend from 1999–2003

3/2004 Summary of Supervision of Patients' Rights in Somatic Out-patient Clinics in 2003

4/2004 Summary of Supervision of Specialist Health Services for Adults with Psychological Problems in 2003

5/2004 Dental Services in Norway. Supply of Public Dental Services to the Priority Groups, and the Dental Manpower Situation

6/2004 Medical Reports 1804: a Retrospective Glance at the First Issues of a Long-established Series of Reports

7/2004 Annual Report 2001–2002 for MedEvent (Meldesentralen – the Reporting System for Adverse Events in Specialist Health Services)

8/2004 Cosmetic Surgery in Norway

9/2004 Still Not Enough Places Capacity in Acute Departments of Psychiatry. A Survey in 2003 and the Trend from 2002–2003

10/2004 Supervision of Coding Practice

11/2004 Summary of Supervision of Maternity Units in 2004

12/2004 Summary of Supervision of Testing for Illegal and Legal Drugs in Two Hospital Laboratories and Four Institutions for the Treatment of Drug Users

13/2004 "Primary Physician Services – a Risky Business". A Report about Risk and Vulnerability in Primary Physician Services

14/2004 More Young People and Adults under Supervision of the Public Dental Services

Publications in 2003

1/2003
In the Wrong Place at the Right Time? Capacity in Departments of Internal Medicine. A Survey in 2002 and the Trend from 1999–2002

2/2003 Survey of Availability of Doctors "When Help is not Urgent"

3/2003 Summary of Supervision of Control of Infection in Intensive Care Units, in September 2002

4/2003 Summary of Countrywide Supervision of Health Services for Children and Young People with Mental Problems, in 2002

5/2003 Improved Control of Communicable Diseases in the Municipalities – Final Report from the Project

6/2003 A Survey of Capacity in Acute Departments of Psychiatry in 2002

7/2003 Survey of the Municipalities' Emergency Planning in the Area of Control of Communicable Diseases, per June 2003

8/2003 The Contribution of the Norwegian Board of Health to the Report on the Regular Medical Practitioner Scheme

9/2003 Municipal Health Services in the Nursing and Care Sectors. Experience from Supervision 1998–2003

10/2003 Nursing and Care Services in the Municipalities: Service Users, Service Needs and Service Supply

11/2003 Report to the Ministry of Health on Follow-up of the Dent-O-Sept Incident by the Norwegian Board of Health

Are you familiar with www.helsetilsynet.no?

The web site of the Norwegian Board of Health is primarily for people who have responsibility for social services and health services, and for journalists. Other target groups are the general public, client organizations, trade unions and government administration.

On the web site, you will find the following:

- the requirements laid down by the authorities relating to services: acts, regulations, directives and other sources that present the authorities' interpretation of legislation
- information about people's rights and about complaints procedures: for service providers who shall ensure that people receive the services they are entitled to, and for the general public
- results of the work of the supervision authorities: supervision reports, the report series "Report from the Norwegian Board of Health", "Supervision Info" with decisions made in supervision cases, and other publications and statements
- information about how the supervision authorities work: methodology, sources of information, plans for supervision, administrative routines, tasks, authority and organization.

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