Suicide Notifications to Norwegian Authorities

Unni Rönneberg
Senior adviser
Norwegian Board of Health Supervision

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Norway

HELSETILSYNET
tilsyn med sosial og helse

19 Counties
18 Supervision Offices

1.800 km S-N

Huge distanses

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MedEvent (Meldesentralen)

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Specialised health services have a duty to report to us:

- *Events that **have** lead to*
- *Events that **could have** led to*

Significant damage to patients
(+ unnatural death)

Other sources of information

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- Complaints from family members
- Notifications from the police
- Notifications from The Institute of Forensic Medicine (Oslo)
- TV, newspapers

This type of information will almost always result in the opening of a ”supervision case”

Background for the survey

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- How many suicides occur during psychiatric treatment?
- Why do they occur?
- Are the cases reported correctly? (MedEvent)
- Do the institutions use these occurrences in their suicide - prevention work?
- Do the 18 county offices handle the cases in a similar manner?

Method and material

- **Registration form**
  - How were the County Offices informed about the case?
  - Patient status in the mental health care
  - Supervision procedures and results of the assessment
- **Closing letter**

Results – number of cases, notifications

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- 176 cases (concluded) in 2005 and 2006 (almost **90 / year**)
- 81,3% were reported to MedEvent (143/176)
- 4 % from Police
- 13 % complaints from family members
- 10% Institute Forensic Medicine

(12 % were reported by more than one source)

Results – patient status

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- **43,2 %** on inpatient units (76/176)
  - 6,8 % (12/176) involuntary
  - 23,3 % (41/176) voluntary
- **39,8%** on outpatient units
  - 1,7 % involuntary (3/176)
  - 38,1 & voluntary (67/176)
- **4%** waiting list
- **8,5%** < 2 weeks after discharge

Supervision handling

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- The Board of Health Supervision in the Counties “opened” 61 supervision cases
- 18 cases concluded with breach of law by the health care provider (systemic level)
- 4 cases concluded with breach of law by the health care personnel (individual level)
- 13 system cases and 4 individual cases concluded with advice / counselling

The 18 system cases

- 12 on inpatient units
  - 4 involuntary
  - 8 voluntary
- 4 outpatient treatment (voluntary)
- 2 < 2 weeks after discharge from inpatient units

What went wrong in these 18 cases?

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- **Suicide risk assessment:**
  - Not realized/insufficient at the intake evaluation (almost 50 %)
  - No reassessment in vulnerable stages like transfer to voluntary care, before a leave, changing therapist, discharge… (almost 50 %) Not the same cases
- **Health personnel competence**
  - Risk assessment done by medical students, social workers, summer stand-ins etc.
  - Health care provider did not "see to it" (law text) that health care personnel are given necessary training and further education (*so they can do their work in accordance to sound professional practice*). Newly hired personnel receive no training before they meet suicidal patients. Deficient routines for contacting superior for advice.

What went wrong - continued

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- **Documentation** (6 cases)
  - Failure to document suicide risk assessment and interventions to insure patient safety
- **Patient safety** (4 cases)
  - Failed to remove dangerous objects (also medicines, firearms etc. at the patient's home)
  - Missing routines for transport between wards
  - Missing or unclear routines for control/intensive care (how often should they control patient in day/ night, one-to-one observation etc)
- **Interventions for surviving family and friends**
  - Very good in two cases, very poor in four cases, no information in 12 cases

Use of information in suicide prevention work

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- **Only three institutions had changed their routines**
  - Better routines for transport between wards
  - Final treatment report (to referring agent) should be sent in the course of one week
  - One institution did a very good work in revising and improving their procedures and routines
- **After the survey, we have continued to receive similar supervision cases**.
  - They do not seem to learn from their errors!

Individual level

- 4 cases were sent to the Central Office.
- We considered that the individuals could not be blamed. The institutions had not provided conditions for the personnel to act in a medically appropriate way.

County differences

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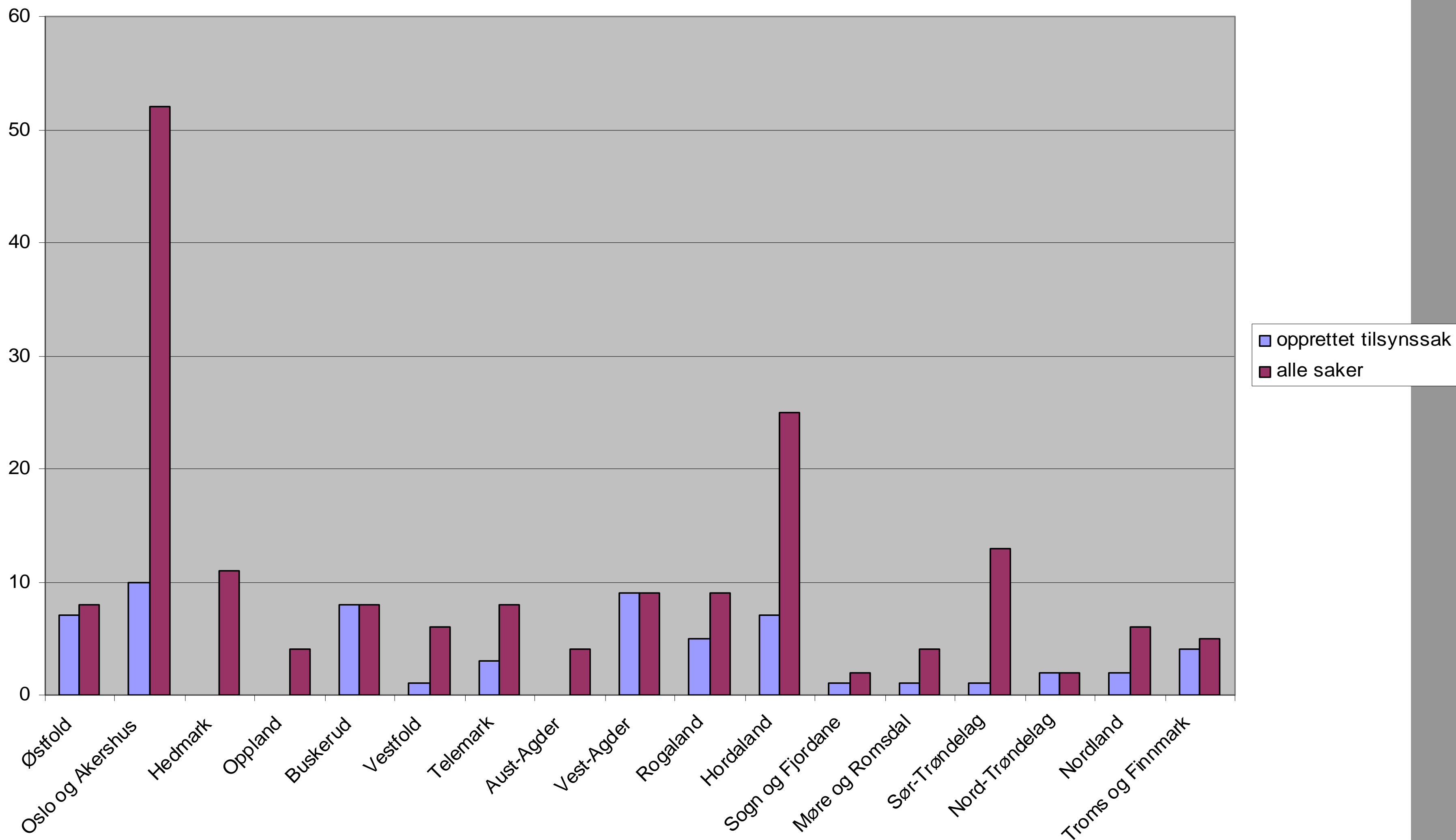

Conclusions, discussion

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1. ***Near 20 % of the cases were not reported***, and came to our knowledge rather unsystematically.
2. In our survey:
   1. 43 % inpatient
   2. 39,8 % outpatient

   International and national research shows that most suicides occur at out-patient units and especially in 1. year after discharge:

   Reason to believe that there are committed far more suicides in mental health care

3. Population-related incidence: 2/100.000 inhabitants. Norway has totally around 500 suicides/year

   Proportion in psychiatric treatment not even 20 %