The Bærum Model
Foreword

One of the objectives of the European strategy for Health for all by the Year 2000 is to reverse the increase in the incidence of suicide in individual countries. In Norway, the National Plan for Suicide Prevention has as its main objective that: during the 1990s, the health service will attempt to arrest the negative development towards an increased incidence of suicide that has occurred during the period from the end of the 1960s.

In order to provide the necessary assistance to those who are troubled by suicidal thoughts or who have survived a suicide attempt, there is a need for specialized skills. The ability to understand the signals before it is too late is dependent on recognizing them. We have currently far too little knowledge concerning suicide problems. There are also considerable shortcomings in the organization of assistance for suicidal persons. Many suicide attempters are discharged from hospital after receiving life-saving somatic treatment, but without any offer of follow-up or aftercare in relation to the problems that lie behind the suicidal behaviour.

Today, systematic procedures are followed to a certain extent in relation to persons who show suicidal behaviour. The Bærum model, which involves cooperation between Bærum Hospital and the municipalities of Asker and Bærum, is the first model for systematic follow-up and cooperation to be adopted in Norway. The model has received a considerable amount of attention, and information about the model has been included by many county medical officers in their training programmes for medical and social work personnel. Some hospitals and some municipalities have developed their own routines on the basis of ideas derived from the Bærum model.

The National Plan for Suicide Prevention recommends that municipalities and county authorities enter into permanent and binding cooperation.

The Norwegian Board of Health hopes that this publication may stimulate cooperation across both academic and administrative boundaries.

Oslo, December 1995

Anne Alvik
Director General of Health
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Bærum Hospital and the municipal health service in Asker and Bærum have cooperated for ten years on a suicide prevention team.

The form of cooperation practised by this team is known as the "Bærum model".

In January 1994, in connection with the tenth anniversary, a working group was appointed to prepare a description of the Bærum model. This work is now complete.

The present report has two purposes. Firstly to provide information to the administrative and political leaders in the county and the municipalities on how we have organized suicide prevention work.

Secondly, we hope that through our experience and expertise we will be able to inspire colleagues to establish similar forms of cooperation on the prevention of suicide and attempted suicide.

The working group has consisted of the following persons:
• Anne Marie Silander Klette, Public Health Nurse (until summer 1994), Asker municipality.
• Lillian Aaserud, Public Health Nurse Asker municipality.
• Brit Burmo, Public Health Nurse Bærum municipality
• Hilde Svellingen Public Health Nurse, Bærum municipality.
• Fredrik Jakhelln, Psychiatrist, Bærum Hospital.
• Wenche Haukø, Head of Department for Social Services, Bærum Hospital.

Chapters 2.2 and 9 of the report were written by clinical psychologist Gudrun Dieserud, Bærum municipality. Chapter 6, "Medical treatment of intoxications", was written by Dr. Are Normann, Bærum Hospital. The remaining chapters were written by the members of the working group.

Bærum Hospital, December 1994

Wenche Haukø
Chairman of the working group
Summary

Part 1 General information

1. Introduction

Each year approximately 200 patients are treated at Bærum Hospital following suicide attempts. Since 1 January 1984, there has been a permanent and binding cooperation between the hospital and the municipal health services in Asker and Bærum municipalities for treatment and aftercare of suicide attempters. This form of cooperation has been designated the Bærum model.

The cooperation involves the following:

Bærum Hospital is a local hospital (County Hospital 2) and is owned by Akershus County. The hospital is designed to cover the hospitalization needs of the population of Asker and Bærum municipalities, a total of 140 000 inhabitants. Asker municipality has approximately 43 000 inhabitants. The municipalities have a relatively young population.

Bærum municipality is a neighbouring municipality of Oslo. The population totals 94 000.

Between 30 and 40 per cent of suicide attempters treated at the hospital are subsequently referred to the public health nurse in the municipality for aftercare. The remaining patients are referred to other forms of first or second line treatment.

2. Theoretical basis

Definitions of suicide and attempted suicide in this report have been taken from “Selvmord” (Suicide) (Retterstøl 1990) and from “Nasjonalt Program for forebygging av selvmord i Norge” (The National Plan for Suicide Prevention). (Helsedirektoratets veiledningsserie, 1 – 93). Parasuicide includes: “All intentional intoxications and selfinflicted physical injuries that are followed by medical treatment”.

We base our understanding on psychiatric, psychological, social work and sociological, theory.

3. Historical background

As early as 1978, the former head of the hospital’s social work service, Kari Halvorsen Holten, pointed out the arbitrary nature of the aftercare given to suicide attempters after discharge from hospital.

In 1979, she prepared, in cooperation with the medical department, internal routines for psychosocial treatment and aftercare of these patients. All hospitalized patients were then referred to a social worker for consultation.
In spring 1981, a group of students from a college of social work carried out a project on the treatment needs of suicide attempters and the facilities available in Asker and Bærum. In spring 1983, a cooperation project was started between Bærum Hospital and Bærum municipality. The municipal public health nurses were to provide the patients concerned with aftercare in their own homes.

From 1 January 1984, this cooperation has involved both municipalities. This way of organizing a suicide prevention team has been designated the Bærum model.

Legal considerations, particularly relating to provisions concerning confidentiality, have provided the greatest challenge to our cooperation.

It has transpired that different professions interpret provisions concerning confidentiality in different ways, and there may be a number of reasons for this. Firstly, legal matters are accorded different degrees of emphasis in the basic training of the different professionals involved. Secondly, the legislation concerning matters subject to confidentiality is complex. It is often necessary to consult travaux préparatoires for more detailed information. Both of these considerations concern the legal duty of confidentiality, i.e. the legislation concerning professional confidentiality (legal statutes applying to the professions) and the provisions concerning administrative confidentiality laid down in the Public Administration Act. If a disagreement arises in the interpretation of provisions concerning confidentiality, this is likely to concern ethical confidentiality, i.e. a duty of confidentiality founded on the different professions’ ethical guidelines or principles. In our cooperation, the duty of confidentiality of the hospital staff is revoked by means of written consent from the patient. A standard information document has been prepared for this purpose.

The Bærum model consists of four stages:
1. Medical treatment and monitoring.
2. Psychosocial/psychiatric intervention.
3. Aftercare by a public health nurse.
4. Continued residential or non-residential treatment.

Written routines have been prepared defining the internal distribution of responsibilities, and regulating the cooperation between the public agencies involved. The routines are reassessed once every two years. The teams consist of a psychiatrist and social workers from the hospital, public health nurses and a psychologist from Bærum municipality and public health nurses and a psychiatrist from Asker municipality.

Systematic professional counselling is a precondition for involvement in this type of work. Work with suicidal patients should only form part of the work done by team members. We advise against anyone working full time with suicide attempters. We recommend that there should be no internship scheme, since long experience is essential to developing the necessary confidence for dealing with this type of work.
Most patients who are brought to Bærum Hospital following a suicide attempt are dealt with first by a medical team. This is because most cases involve overdoses. After an overdose, the patient is usually aspirated, and activated charcoal is introduced into the stomach. When necessary, specific antidotes are used. Further medical treatment primarily involves observation and supportive treatment. In accordance with routine rules, the doctor on duty in the accident and emergency unit is responsible for making a careful assessment of the patient’s need for further treatment. This applies irrespective of whether the patient is to be admitted or allowed to go home.

At Bærum Hospital, social workers have chosen to work with suicide attempters on the basis of a psychosocial model for social work. The theoretical basis of this model is derived from system theory and from psychodynamic theory (Bernler and Johnsson 1988). In contact with the patient, emphasis is placed on direct and clear communication. An interview guide is used in connection with the first interview with the patient.

A valuable source of inspiration for our interview guide has been the schedule prepared by the World Health Organization (European Parasuicide Study Interview Schedule, EPSIS). The purpose of this interview is to make a thorough survey of the circumstances around the suicide attempt to enable the social worker to assess the suicidal risk and the need for further treatment. The social workers cooperate closely with the doctor on duty in the ward. In this approach, consideration is also given to the fact that the patient is in an emotional crisis.

The hospital’s routines for work with suicide attempters define when the patient shall be referred to a psychiatrist, who is present two days a week. The psychiatrist’s approach is based on openness as a means of giving support while encouraging the patient to take responsibility for his/her actions. The purpose of the psychiatrist’s intervention is partly to make a diagnostic assessment, to assess the need for treatment or care or to assess the need for psychopharmacology. A major function of the intervention is the attempt to make the patient understand that there are alternatives to suicide. The psychiatrist has responsibility for counselling in the teams.

The public health nurse has responsibility for following up the care of the patients in their own homes. The target group consists not only of patients treated at the hospital, but also includes patients treated at accident and emergency units and suicidal patients who take direct contact with the municipal team as well as persons who in different ways are affected by the suicidal act, family, friends, etc. The intervention by public health nurses is based on a psychological understanding of suicidal behaviour derived from the work of the suicidologist Dr. Edwin Shneidman (Shneidman, 1985) in addition to general crisis theory.

Emphasis is placed on the suicidal person’s need for a helper, an active intermediary or “ombudsman”, whose role is to ensure that measures are implemented to create an immediate change for the better for the patient. This is the role that the public health nurses attempt to fulfil. The public health nurses also work to activate the patient’s social network, and to continue the motivation for treatment that was initiated at the hospital.
The public health nurses have also participated to some extent in work by the psychologist on primary prevention in the schools, and participate in information and training in cooperation with the members of the team from the hospital. The team's psychologist has professional responsibility for the intervention carried out by the public health nurses.

10. Summing up

The different professional groups in the teams are trained to work in accordance with different approaches, and we believe that this experience of several disciplines strengthens their ability to cooperate. We believe that we must have different types of available resources to deal with the patients' different needs. Not least, this multi-professional cooperation enhances the counselling situation, particularly in relation to complicated cases. We believe that similar cooperation projects could be started by other municipalities and county authorities, and we hope that others will be able to make use of our experience.

THE BÆRUM MODEL 1984–1994

El les som ikke borer frueh
haller syrskibard,
men bærer undersender
jordt
S:va. Brechtl.
Each year approximately 200 patients are treated at Bærum Hospital following suicide attempts. There are considerable variations in the patients’ demographic, socioeconomic, medical and psychological data. In order to provide the best possible resources for treatment and aftercare of each patient, it is important that we are able to offer broad treatment facilities.

Since 1 January 1984, the hospital has had fixed routines for treatment of these patients. The routines also involve a permanent and binding cooperation between the hospital and the municipal health services in Asker and Bærum. This form of cooperation, involving the use of a suicide prevention team, has been designated the Bærum model.

In the course of time, we have increasingly felt a need to cooperate on preparing a description of the Bærum model.

In the winter of 1994, a working group was appointed to plan the commemoration of ten years of cooperation. The group consisted of representatives from both the hospital and the municipal health service. As part of the commemoration, it was decided that the present report should be prepared.

The purpose of the report is to describe the organization, working method and ideology that lies behind our work. It is our wish that others shall be able to make use of our experience.

1.2.1. Bærum Hospital is owned by Akershus County. It is a local hospital with some central hospital functions, and is designed to cover the hospitalization needs of the western region of the county, i.e. for the population of Asker and Bærum municipalities, a total of approximately 140 000 inhabitants. The hospital’s new wing was opened in 1982, and was built to have a capacity of 380 beds. Today (1994), approximately 200 beds are in use. Bærum Hospital is a purely somatic hospital. It has approximately 900 employees, including three social workers and a psychiatrist in a half post.

The social workers and the psychiatrist are the hospital’s members of the suicide prevention teams.

1.2.2. Asker municipality

Asker municipality lies approximately 12 miles from Oslo. The municipality covers an area of 100.7 km², and has a 68 km long coastline.
The municipality has approximately 43,000 inhabitants. A major part of the population consists of persons of fertile age and children and young people. The municipality is characterized by considerable population mobility. There is a high frequency of moving both within the municipality and into and out of the municipality. Asker is a municipality rich in resources. It is the home of many highly educated and occupationally active women. Many of these work outside of the municipality. A disadvantage for many people is that there are not sufficient nursery school places, and this results in frequent changes of babysitters and trainees. The municipality has a high divorce rate, and a large proportion of single-parent households. There are many recreational facilities for children and young people in Asker. Young people whose parents have good economy and the time to drive them to different activities have no lack of opportunities. Those who, for one reason or another, fall outside have very few resources available to them.

1.2.3. Bærum municipality

Bærum municipality has an area of 191.3 km², and is the nearest neighbour to the country's capital. The population is approximately 94,000. The municipality has areas with high population density. Bærum is one of the country's richest municipalities. This is reflected by the large range of facilities available to different groups of the population. In many areas, Bærum has been ahead of the rest of the country, for example in the school sector (school entry for six-year-olds) and in care of the elderly. The population has a high average level of education and income. Those who fall outside the labour market or become social deviants for other reasons can be assumed to experience the class distinctions as being considerable.

Children and young people are subjected to a high pressure of expectations both by their parents and the schools and by the community at large. "Only the best is good enough", is an attitude that many inhabitants of Bærum seem to base their lives on.

Good private economy, coupled with the municipality's liberal alcohol policy, can be assumed to be the reason for the high alcohol consumption among people in Bærum. Senior Consultant Jens Christian Bull Engelstad at the Clinic for Social Medicine in Bærum has calculated that the alcohol consumption in Bærum is 50 per cent higher than the national average (Damerell & Dieserud, 1990). Many heavy drug abusers are also registered in the municipality (Damerell & Dieserud 1990). Asker and Bærum are otherwise municipalities that have much in common with most other areas of Norway.

Other cooperation partners are described in the information on routines for treatment and aftercare in Appendix 1.

1.3 Patient statistics

We assume it to be important to an understanding of how the tasks are distributed to provide an estimate of the number of patients we treat each year. The following account is based on average figures.

As mentioned in the introduction, the hospital receives approximately 200 suicide attempters for treatment each year. The number of patients has varied somewhat, with a peak so far of 246 patients in 1985. The lowest
figure to date is from 1991, when 161 persons were treated following suicide attempts. During the last four years, less than 200 persons have been treated each year. Between 30 and 40 per cent of these patients only receive treatment in the accident and emergency unit, without being admitted. The patients who are hospitalized are put under the care of a social worker or a psychiatrist. One third of the hospitalized patients are examined by a psychiatrist and the remaining two thirds are interviewed by a social worker.

The sex distribution is subject to annual variations, and there are also variations between the municipalities. In 1993, an equal number of men and women from Asker were treated at Bærum Hospital following suicide attempts. However, the average for the last ten years for the two municipalities taken together shows that twice as many women as men were treated following suicide attempts.

The age distribution for this group of patients shows little variation. Approximately 25 per cent are under 25 years of age, 50 per cent are between 26 and 45 years of age, 20 per cent between 46 and 65 years of age, while the age group over 66 years of age constitutes approximately 5 per cent.

Of the approximately 200 suicide attempters treated at the hospital each year, between 30 and 40 per cent are referred to a municipal public health nurse for further care. The remaining patients are referred other forms of treatment. Approximately 15 per cent are admitted to psychiatric hospitals. Between 18 and 20 per cent are transferred by the hospital to psychiatric treatment as outpatients (Annual reports, Social work service Bærum Hospital, 1984–1993).

2. The theoretical basis

We wish here to provide a number of definitions before giving a brief account of our joint theoretical approach.

2.1 Definitions:

By **suicide** is understood a conscious and deliberate act, carried out by an individual in order to harm himself, and where the harm results in the death of the individual (Retterstøl, 1990).

By **suicide attempt** (parasuicide) is understood a conscious and deliberate act, carried out by an individual in order to harm himself, and which the individual could not be certain to survive, but where the harm does not result in the death of the individual (Retterstøl, 1990).

Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution (Shneidman, 1985).

"The strength of suicide attempters’ determination to die varies. Some survive quite by chance, while others may be relatively sure of surviving. The latter may be people who take overdoses of medicine, but who see to it that they receive medical treatment as soon as possible. It is usual to regard all intentional acute intoxications and self-inflicted physical injuries that result in medical treatment as parasuicide" (National program, 1993).
2.2 Approaches

Psychiatric, psychological and sociological theoretical systems have all contributed to an understanding of suicide and of how suicidal behaviour can be prevented and treated. In Norway, research into suicide has primarily been based on psychiatric or sociological models, while the psychological approach has not received the same amount of attention.

In the psychiatric approach, a major role has been played by psychopathology, particularly by the study of depression and personality disorders. In recent years, considerable interest has been shown in special conditions associated with the biochemistry of the brain. Treatment and preventive work has focused to a great extent on early diagnosis and treatment of depression, where an important part has been played by views emanating from the fields of biology, psychodynamics and social psychiatry.

The roots of the sociological approach extend back to the work of the French sociologist Émile Durkheim, whose book “le Suicide” (Suicide) was published in 1897, receiving wide acclaim throughout the world. Durkheim’s theory of social disintegration as a contributory factor in suicide, is still highly regarded as an approach within large parts of sociological research into suicide. Durkheim put forward the view that people do not commit suicide because life’s burdens have become too heavy for them to bear or because of a lack of material goods, but because their integration in society is not as it should be, or because society itself is disintegrated (Norwegian Board of Health, 1994).

A psychological approach to understanding suicidal behaviour involves taking as one’s point of departure common psychological characteristics of individuals who carry out a suicidal act.

The suicidologist Dr. Edwin Shneidman’s definition of suicide takes the cultural perspective into consideration, reflecting the view that suicide must be seen in the light of the cultural framework of the period in which the suicidal person lives. It also takes account of the individual and interpersonal perspective. Suicidal behaviour can be understood in terms of the individual’s being in a complex state of mental crisis where an important part is played by frustration of major emotional needs, and where the individual’s strategies for overcoming his difficulties are inadequate for the task of solving the current life crisis. The individual suffers a sense of helplessness and hopelessness in relation to solving the life crisis in which he finds himself (Norwegian Board of Health, 1994).

3. Historical background

3.1 Organization of work internally at the hospital

The former head of the social work service at Bærum Hospital, Kari Halvorsen Holten, began as early as 1978 to focus on the problems associated with the treatment of suicide attempters. Many of these patients were treated in the accident and emergency unit without hospitalization, and were then sent home immediately. The medical treatment was satisfactory, but no-one discussed with the patient the social and psychological factors that gave rise to the suicide attempt. Nor was any form of systematic aftercare available following discharge from hospital. At that time, the hospital had 1.5 social worker posts. Whether or not suicide attempters were offered an interview with a social worker was purely a matter of chance.
In the summer of 1979, an agreement was made with the doctors in the medical department that all suicide attempters receiving treatment at the hospital were to be referred to the social work service for intervention. The head of the social work service prepared internal routines for treatment and psychosocial aftercare of suicide attempters.

However, it proved problematical to have patients referred to further treatment by the first and second line services (the Family Welfare Centre, Centre for Alcohol and Drug Abuse and Psychiatric Outpatients Clinic). The reason was that these treatment units had little experience with suicide attempters.

In Autumn 1980, Ms Holten took contact with the Social Services School in Bærum, and subsequently acted as supervisor for a group of students who carried out a comprehensive project in the spring of 1981. The purpose of the project was to make a survey of existing facilities both within and outside of the hospital, to attempt to identify patients' wishes, needs and resources, and on this basis to propose ways of providing aftercare for this group of patients (project report, 1981).

The most important conclusion of the project report was: “No patients treated at Bærum Hospital in connection with a suicide attempt, should be discharged from the hospital or sent home after treatment in the accident and emergency unit before someone at the hospital had spoken with the patient about what had happened, and informed him/her of the possibility of being referred to a support facility outside the hospital” (Project report, 1981, page 28). The report also outlines proposals for cooperative routines, both internal and external. This project report played an important part in the hospitals' further work in this area, and can be viewed as a pilot project for the cooperation project that is described in the following (Project report, 1981).

By 1 March 1983, enough progress had been made to start a cooperation project between Bærum Hospital and Bærum municipality. The chief municipal medical officer in Bærum, Ludvig Daæ Holand, took contact with the hospital as a result of the attention aroused by the student project on suicide prevention that had taken place at the hospital since 1979. The municipal health service wished to participate in a treatment process. The core of the cooperation consisted, as is still the case, of the public health nurses in the municipal health service and the social workers at the hospital. The object was to prevent recurrences and to reduce the number of suicide attempts. During the project period, all hospitalized patients were interviewed by a social worker and many were referred to a public health nurse for aftercare. The project continued until 31 December 1983. During the project period, 156 patients from Bærum municipality were treated at the hospital. Of these, 64 were referred to a public health nurse for aftercare.

This cooperation project was so successful that the hospital wished to make a similar arrangement with Asker municipality. During 1983, a total of 52 suicide attempters from Asker municipality had been registered.

Since 1 January 1984, there have been set routines for cooperation between the hospital and both municipalities. The tasks of the suicide prevention
teams in the municipalities involve more than aftercare of patients from Bærum Hospital. The work of the teams is described in greater detail in part 2, chapter 9.

4. Challenges of cooperation between agencies

Most people find cooperation across administrative and professional boundaries a challenge. Those who began the work involving suicide prevention teams were involved in breaking completely new ground, putting a tabooed subject on the agenda and adopting untraditional forms of cooperation.

Decisions concerning what social welfare policy measures the health and social services shall be responsible for are governed by political, economic and legal frameworks.

In the present paper, we will not discuss the political and economic preconditions for suicide prevention work. Political priorities and financial allocations are of course necessary. We will restrict ourselves here to a discussion of the legal conditions, particularly the provisions concerning confidentiality in public administration. It is within this area that we have met the greatest challenges. For a time, the cooperation between the hospital and the municipal health service was somewhat strained owing to disagreement on interpretations of the provisions concerning confidentiality.

4.1 Legal conditions

4.1.1 General statutory provisions

The Act of 19 November 1982 relating to the municipal health services defines the objectives of the service as being the prevention and treatment of illnesses, injuries and physical defects. The Act specifies concrete statutory duties of the municipal health services, among them the public health nursing service.

In section 1-4 of the Act, there is a provision concerning cooperation between agencies, “The municipality shall cooperate with the County and Central Government authorities in ensuring that the health service functions as uniformly as possible throughout the country”.

The Hospitals Act of 19 June 1969 establishes the County’s responsibility for planning, building and running hospitals to meet the needs for examination, treatment and hospitalization for the population of a specific geographical area (section 2 of the Hospitals Act).

The requirements are formulated somewhat vaguely: “Satisfactory medical examination and treatment shall be provided”.

Both Acts give general descriptions of objectives and responsibilities. There are no concrete statutory provisions requiring hospitals and municipalities to organize special teams for suicide prevention, although prevention of health problems are central responsibilities for both organizations.

The Municipal Health Service Act and the Hospitals Act contain no provisions that prevent cooperation between municipal and County health services.
4.1.2 Confidentiality

In the following, we will discuss issues relating to legal confidentiality, and only to a small extent enter into a discussion of ethical confidentiality. What is termed ethical confidentiality is the form of confidentiality that is founded on the ethical guidelines or principles of the various professional groups (Lingås, 1992, Nordeik & Stang, 1987). Some professional groups view legal and ethical confidentiality as being two aspects of the same issue, and therefore regard the distinction as artificial. In assessing the limits of one's own duty of confidentiality, it is necessary to take all aspects into consideration, including the ethical guidelines of one's own profession. If conflicts arise in interpreting the provisions concerning confidentiality, the disagreement is very likely to relate to the ethical aspect of the matter.

Legal confidentiality is founded on two main sets of rules. Firstly, administrative confidentiality prescribed by the Act of 10 February 1967 relating to procedure in cases concerning the public administration (the Public Administration Act) and secondly professional confidentiality prescribed by the various Acts relating to professions, e.g. the Medical Practitioners Act. Where patient-oriented activities are concerned, it is this legislation that applies.

Sections 13 to 13 f of the Public Administration Act contain general provisions concerning confidentiality in the public administration.

Provisions concerning the duty of confidentiality in public administration are also found in other "administration acts" such as the Hospitals Act and the Municipal Health Service Act (Kjønstad, 1992).

The most extensive provisions on confidentiality are laid down in the Acts relating to the various professions. In hospitals, all medical personnel regarded as "doctors' assistants" have the same duty of confidentiality as doctors. This applies to both nurses and social workers.

There are several reasons why different professions have different approaches to the rules of confidentiality. In the basic training of the different groups, there is differing emphasis on legal matters, and the various Acts are complex, so it is sometimes difficult to interpret what it is that shall be kept secret. A precise understanding probably requires consultation of the travaux préparatoires of the Acts concerned (Kjønstad, 1992). In addition to this, the different professions all have their own traditions with varying interpretations of the ethical aspects.

In our cooperation, the disagreement related to whether the municipal health service should receive confidential information on all suicide attempters, including cases referred to other medical personnel. There were also divergent views as to whether oral or written consent should be given by the patients before they were referred to the health service.

The Norwegian Board of Health gave different answers to the hospital and the municipalities in reply to our questions as to how we should handle this question.

We have solved the cooperation problems, and have prepared the following routines for revocation of confidentiality:
1. by written consent
The simplest way of revoking the duty of confidentiality is to obtain the consent of the patient. In the case of children under the age of 16, consent must be obtained from the parent or guardian (section 32 of the Medical Practitioners Act). If the child is between 12 and 16, the opinions of the child shall be heard. Written consent for revocation of the duty of confidentiality must be given voluntarily on the basis of thorough oral and written information. Our choice is based on both legal and ethical considerations. In connection with referral for examination or treatment of suicide attempters, written consent is not required by legal or ethical principles. However, written consent ensures the patient's legal protection, autonomy (power to make his own decisions) and integrity (inviolacy) (Syse, 1993). We have prepared an information document to be used in connection with the written revocation of the duty of confidentiality. By signing this document, the patient revokes the duty of confidentiality of the hospital staff in relation to external collaborators. It is our duty to ensure that the patient understands the consequences of signing the information document (Appendix 3). A copy is inserted in the journal.

2. by presumptive consent
This is relevant in the few cases where the patient discharges himself on his/her own responsibility or disappears from the hospital without making a written revocation of the duty of confidentiality, and without sufficient clarification of the suicidal act. The few patients that this concerns are first sent a letter by the social work service with information about the suicide prevention teams and stating that the public health nurse will be notified and will take contact unless the patient himself contacts the hospital and requests that this is not done. In this way the patient is always given a genuine opportunity to object to the hospital notifying the public health nurse. If the patient does not respond within a week, tacit consent to revocation of the duty of confidentiality is assumed, and the case is referred to the public health nurse for follow-up.

If we take the complete process of treatment as our point of departure, we can regard the Bærum model as consisting of four stages:

1. Medical treatment and monitoring
This stage also includes registration by the accident and emergency unit, the doctor's first assessment of the situation, the acute life-saving treatment and the medical monitoring.

2. Psychosocial and psychiatric treatment
At this stage, crisis intervention and psychosocial monitoring is carried out. The hospital's psychiatrist or social workers assesses whether the patient is still suicidal, and whether he or she needs further treatment. Appropriate measures are implemented in cooperation with the patient and the doctor on duty in the ward, who (of course) has the medical responsibility. Appropriate measures may be admission to a psychiatric ward or referral to a psychiatric outpatients clinic, to a centre for treatment of alcohol and drug problems or to a family care centre.

3. Aftercare by a public health nurse following discharge from the hospital
In cases where the risk of suicide and the mental state of the patient are not serious enough to qualify hospitalization in a psychiatric hospital or direct
referral to an outpatients clinic, referral of the patient to a public health nurse for aftercare shall be considered. Patients with substance abuse problems are not referred to a public health nurse (Appendix 1, Routines).

4. Continued residential or non-residential treatment
The patient can be referred for further treatment, either directly from the hospital (this is done in approximately 60 per cent of cases) or by the public health nurse. The team cooperates with all other relevant health and social services. Many patients need further psychiatric treatment or family therapy. Some wish to receive substance abuse-related care or help from the social services.

5.2 Current routines
Written routines have been prepared defining the internal distribution of work and responsibilities, the target group for suicide prevention work and the form of external cooperation. Written routines formalize the work and commit the employees to follow up. The main challenge involves informing new employees in the different professional groups of the procedures that apply. The head of the social work service provides training for new social workers and for the nurses in the accident and emergency unit. The psychiatric adviser is responsible for providing information to new doctors as part of their general training at the hospital. The routines are assessed and revised every two years (Appendix 1, Routines).

5.3 Counselling
5.3.1. The reason for providing systematic counselling
Work with suicidal patients is both difficult and stressing. Although we make our assessments to the best of our ability, we are bound to assess wrongly sometimes, and this can have tragic consequences. Care workers themselves need a forum where they can receive care. Systematic professional counselling is a prerequisite for working in this area, and helps to prevent burning-out syndrome. In order to ensure the extra vitality that is so important in the work we do, it is important to attempt to create a positive and secure climate in the teams and in the counselling situation. Frequent contact between the staff creates a sense of collective responsibility. We avoid situations where individuals are left to carry the responsibility alone for the solutions that are chosen.

In this work, long experience is needed to build up professionalism and security.

Nevertheless, working with suicide cases over time involves a particularly high degree of strain. There is therefore always the danger of a dilemma where those with most continuity and expertise are at the same time those who run the greatest risk of burning themselves out. We therefore recommend that people do not work full-time with suicidal patients, but rather combine this work with other work. However, we advise against a rota model where many different persons work for periods in suicide prevention teams.

One of the goals of counselling is to prevent staff from burning themselves out. Another goal is to integrate professional and personal growth in individual members of staff.
The counselling also aims to contribute to professional development and to increased expertise within the field in general and for this group of care workers in particular.

5.3.2 Counselling practice

The regular cooperation meetings between the hospital and the municipal health service also have a counselling function. Once a fortnight a meeting is held between the health authorities in Bærum municipality and Bærum Hospital. Corresponding meetings are held between the hospital and Asker municipality once every six weeks. The purpose of the meetings is to improve measures through continual evaluation of work. Part of the time is used to review background information and aftercare measures concerning patients referred since the previous meeting, while part of the time is used to discuss cooperation routines between the hospital and the municipalities. Cooperation counselling also has a theoretical element, concentrating on the professional understanding of suicidal behaviour. Once every two weeks, the public health nurses are given group counselling by the psychologist in the municipal health team in Bærum municipality. The municipal health team in Asker receives this counselling as needed from the team's psychiatrist. The purpose of the counselling is to enable the public health nurses to:

- develop an appropriate helper role adapted to the theoretical understanding that underlies the model for the work
- exercise increasingly greater skill in identifying the patient’s main problem and need for help
- work on death-related issues in a well defined and professional way, so that they improve their ability to distinguish between taking responsibility for the quality of the remedial measure and taking responsibility for the patient’s life.

The public health nurses also receive individual counselling as needed from, respectively, a psychologist in Bærum and a psychiatrist in Asker.

In addition to the counselling in connection with the meetings, the hospitals provide social workers with a weekly hour of group counselling from the hospital's psychiatrist. Information on the objectives and methods of this counselling is given in 5.2.1. The aim of the counselling for social workers differs very little from that of the group counselling provided for the public health nurses. The difference lies in that some of the hospital patients have an extensive history of mental illness.
In the following, we will describe the various professional groups' work with suicide attempters. Medical practitioners, public health nurses, psychiatrists, social workers and psychologists have of course been trained to adopt different approaches in their work. In that patients have very different needs, we consider it an advantage to offer varied facilities across several disciplines. This applies particularly in connection with counselling, especially in complex cases.

The differences between approaches have proved to be both a source of conflict and a stimulus for further development.

Defining common problems and objectives and reaching agreements on joint measures are preconditions for successful team cooperation. In our experience, using time and energy to familiarize oneself with the fields of other team members and showing respect and acceptance for their interpretations have great importance for achieving successful cooperation. On the other hand, this requires that one is able to explain the theoretical background for one's assessments and that one is aware of the limitations of one's own profession.

After a certain amount of trial and error, cooperation in the teams now functions well.

6. Medical treatment of intoxications

Most of the patients who are brought to the hospital following self-inflicted intoxications and/or attempted suicide are taken care of first by the medical team in the accident and emergency unit. This is because most cases involve overdoses, and to a much lesser extent self-inflicted physical injuries.

Sample statistics
During a period of three months in 1993, in the accident and emergency unit at Bærum Hospital, 40 patients were registered following self-inflicted intoxications or suicide attempts.

Of these, 37 were purely medical, two were a combination of medical and physical, and one was purely physical.

After the acute treatment, 31 of the 40 patients were hospitalized. Most were admitted to Bærum Hospital, while some were transferred to other institutions (Blakstad hospital, Akershus Central Hospital and Ullevål Hospital).
Seven patients were sent home after receiving acute treatment in the accident and emergency unit, while two went home on their own responsibility. Of the 40, only three had to be transferred to other hospitals for medical reasons during hospitalization, in all three cases for dialysis.

Out of the 40 cases, one had a fatal outcome. The patients varied considerably in relation to the degree of suicidality. Some had only had too much to drink in connection with a party, whereas others had carried out serious suicide attempts. However, it is our impression that the majority of the intoxications can be characterized as a cry for help rather than a genuine wish to die, though it is important to bear in mind that this applies to the patients who were discovered in time, and who were therefore taken to hospital.

**Acute treatment**

In the accident and emergency unit, almost all victims of overdoses are aspirated and activated charcoal is administered to prevent absorption from the stomach of the substance that has been swallowed. Aspiration is generally appropriate except when a long time has elapsed since the overdose was taken or in cases involving caustic substances.

Blood pressure, pulse, temperature and ECG are taken in all cases. In the accident and emergency unit, an assessment is made as to whether the patient shall be admitted or sent home. As a rule, the patient is admitted for observation. Even when patients are not in need of further observation or treatment, they are often admitted for social or psychological reasons. The awareness of the facilities made available to these patients from the suicide prevention team is also instrumental in justifying hospitalization, even in cases where this is not necessary on purely medical grounds.

All patients who are sent home without receiving an interview with a social worker or a psychiatrist are to be carefully assessed for continued suicidal risk by the doctor in charge of the case. The doctor should also make sure that further treatment will be offered to the patient if this is found to be necessary. All suicide attempters who are sent home from the accident and emergency unit are also to be given information about the suicide prevention teams (Appendix 1, Routines). Some overdoses are accidental intoxications, and not genuine suicide attempts. These patients are generally sent home without hospitalization.

**Further treatment**

Specific antidotes exist for many medicines and other substances, and these are used in the treatment when necessary.

One example is paracetamol intoxications, which are relatively usual (paracetamol and/or lobak: 9 cases in 1993). Another example is heroin preparations.

The more serious the intoxication is, the more likely one is to make use of available antidotes.

However, further treatment consists mainly of observation and support. In practice, this means administering intravenous liquids, and monitoring heart rhythm, blood pressure, convulsions, diuresis, level of consciousness,
etc. The poorer a patient's condition, the more important this monitoring is.

As shown by the above figures, serious intoxications requiring intensive medical monitoring and treatment are relatively rare. This is primarily a reflection of the fact that most people who are brought to the hospital after taking an overdose have themselves reported the overdose. Those who really wish to die, and who intend to succeed, are usually not found in time, and are therefore not treated in hospital.

Most intoxication patients who are admitted to the hospital need no more than 24 hours monitoring and are then assessed by a social worker or a psychiatrist. As regards further treatment, the social worker or psychiatrist cooperates closely with the doctor on duty in the ward. One problem is that the doctor on duty might be given a false feeling of security, and therefore not take much notice of the patient's psychological or social situation. It is important that cooperation with the suicide prevention team does not deprive the doctor on duty of the medical responsibility for the patient, or replace good medical work.

We who work on the medical side are generally very satisfied with the facilities that the suicide prevention team represents for patients in this group.

Social work, like most fields is divided into three parts. It consists of ideology, theory and practice. Many authors of books within the field of social work adopt an eclectic approach to theory (Sverdrup, 1989), and social work derives much of its theory from other fields. However, a good deal of theory has also been developed within the field, not least in relation to family therapy and systems theory. Social workers receive through their training a basic knowledge of the factors involved in relational conflicts and how these can be solved. In work with suicide attempters, this knowledge plays an important role.

We select working methods and models on the basis of an overall theoretical framework. In order to work professionally, we need such a theoretical superstructure to relate our daily tasks to. Otherwise, our approach to these difficult problems might be arbitrary or even meaningless. Not least for the patients, it can be insufferable to be exposed to the subjective pontificating and moralizing of an individual social worker.

The term *psychosocial work* has for nearly 50 years been used to designate the work carried out by social workers in Norwegian hospitals. It is a term that has become part of the everyday language of most people working in the fields of health care and social work.

We tend to take for granted that we all use the term to mean the same, but it is likely that there are as many interpretations as there are professions. In this connection, a psychosocial perspective in relation to suicide attempts involves firstly attempting to understand both social and psychological factors and the interplay between them to be able to carry out a successful social intervention. Secondly, social workers work according to a psychosocial model. We will return to this later. Social workers also derive much of their approach from crisis theories that describe the situation of
the patient and the patient's family, and their way of reacting to it. Crisis theories teach us that therapists must give the patient cautious support in the confrontation with the real world.

For the social worker, suicidal patients are both a personal and a professional challenge. In our experience, it is important that the social worker has taken a stand on ways of solving his or her own existential and social conflicts, and that suicide is not one of the options. In this work, we are also confronted with our own death, with an awareness of our vulnerability and the transitory nature of our own existence. We witness interpersonal conflicts that most of us easily recognize from our own experience, and we may be shocked that some people respond with the degree of aggression that is expressed by a suicide attempt. In this work, professional counselling is absolutely essential (cf. 5.2). In our experience, counselling gives us greater security to meet the patients' hopelessness and despair.

The social workers at our hospital base their work with suicide attempters on two main models. The first of these is the psychosocial model. This model has elements of both systems theory and psychodynamic theory. The essential feature of the model's action plan is work on three levels by means of:
1. own action,
2. direct control and
3. indirect control.

The goal of psychosocial work according to this model is ambitious, and involves attempting to alter the personality, relations and social situation (circumstances) of the patient. In the hospital we are only able to make a start on this process with suicide attempters. The precondition for bringing about a change here, as in other models, is that a good relationship is established between the patient and the social worker (Bemler and Johnsson 1988).

The second model that forms part of the basis of the social workers' approach is the short-term contract model. (Short-term casework) In recent Norwegian social research the model is designated OOT, which stands for "oppgaveorientert tilnærming" (Task-Centred Approach) (Eriksen, 1994).

At the hospital, the social worker usually has either one or two interviews with a suicide attempter. The principles of the short-term contract model are therefore entirely applicable.

The model defines social problems as: lack of material resources and/or lack of social skills.

The main components of the model are: structured approach, clear and concrete definition of problems, prioritizing of achievable goals, distribution of responsibilities and tasks between the patient and the social worker and a time-limited contact.

In this model, the problem defined determines which theory shall be used as a basis in working with the patient.
Here too, it is important to be able to establish a good relationship between the patient and the social worker.

Mastering and integrating both models is dependent on the social worker having a sound knowledge of communication and conversation techniques. Empathy, psychological insight and social understanding are also essential qualities.

The models are tools for thought that can help us to address and explain reality on the basis of various theoretical and value-related frameworks. A model shall also include an action plan, define the target group and describe the role of the therapists (Sverdrup 1989).

In the following, we will give an outline of the factors that are emphasized in the first interview with the patient and of how we assess the suicidal risk.

**ELEMENTS OF THE FIRST INTERVIEW WITH A SUICIDE ATTEMPTER**

A suicide attempt is a powerful and dramatic way of communicating. According to Jarl Jørstad (1986), “these people need to be met with an intensity on the part of the therapists commensurate with the strength of this expression. This implies an active therapist, inspired by great investigative curiosity in piecing the patient's story together, trained in interview and evaluation techniques”.

A valuable source of inspiration for our “interview guide” has been the World Health Organization's European Parasuicide Study Interview Schedule (EPSIS). We believe this approach to be appropriate for all other professional groups working with suicide attempters and suicidal patients.

**1. Establishing contact**

Elementary techniques are used to establish contact, taking into account factors that promote or interfere with communication. After introducing oneself clearly, one explains the reason for the visit. It is of major importance to establish a secure atmosphere for the interview.

First a recollective interview is carried out for the 48 hours prior to the suicide attempt. This is followed by a review of underlying factors and then an assessment of intentions.

**2. The immediate situation**

The social worker focuses on the suicide attempt through active, concrete and direct communication.

2.1 *What happened during the last 48 hours prior to the suicide attempt?*

It is important to obtain as clear and detailed a picture as possible of what has happened and of the patient's interpretation of the events. What triggered the suicidal crisis?

2.2 *The circumstances surrounding the attempt itself are established*

Where did the attempt take place?
What did the patient do, which method?
Who was involved? Was the act directed towards any specific person?
When did it happen?
What consequences did the patient expect?

3. Degree of planning/impulsiveness
Was the attempt the result of lengthy planning?
Suicidal thoughts over time?
Have such thoughts become more predominant recently?
Isolation tendencies recently?
Did the patient talk to anyone about suicide?
Who?
If so, what was the person’s response?
Did the patient write a farewell note?
Was it posted?
Diary notes?

4. Establish the degree of impulsiveness
Was there anything that triggered the attempt at the time?
Does the patient regret making the attempt?

5. How did the patient come to the hospital?
Found by accident?
Patient told someone. Who?
Why was this person told? To ask for help or to say goodbye?

6. Had the patient used alcohol or drugs?

7. Previous attempts are established
Had the patient made previous attempts? When? What happened then?
Suicide or attempted suicide in the family?
Suicide or attempted suicide among friends/colleagues?

8. Survey of previous and current treatment contacts

9. Survey of previous events of life and handling of traumas

10. Current and previous social situation (family, work, accommodation and economic factors)

ASSESSMENT OF SUICIDAL RISK
Assessment of suicidal risk is always difficult. It is necessary to discuss one’s own observations and assessments both with one’s own and with other professional groups.

In our experience, it is necessary to take the following factors into consideration when assessing whether the patient is still suicidal:

The nature of the attempt
We assess the gravity on the basis of the information we have received, both the medical evidence and the patient’s own assessment of his/her intention.

The patient’s reaction to surviving the attempt
Regret?
Relief at still being alive?
Determined to try again?
Determined not to try again?

The mental state of the patient (as far as the social worker is able to judge).
Depression?
Feeling of hopelessness?
Anxiety?
Feelings of guilt?
Feeling of being let down?
Constricted awareness?
Degree of ambivalence?
What was the intention? Has it changed in the process?
Or is the patient emotionally stable and motivated for change?

Has there been any change in the triggering factors?
Does the patient still have access to medicines? The patient’s social situation:

Are there care-givers in the patient’s network who can be mobilized?

All of these factors must be taken into consideration when assessing the degree of continued suicidal risk.

Assessment of measures.
After careful assessment, a decision is made concerning the measures that need to be implemented. The measures depend of course on the suicidal risk and the mental state of the patient, and on what aftercare the patient wishes to receive.

The social worker always discusses appropriate measures with the doctor on duty. The social worker gives both oral and written reports to the doctor on duty and the nursing staff. A note is immediately dictated into the patient’s medical record. If mental illness is suspected, the patient is examined by a psychiatrist.

The activities of the psychiatrist at Bærum Hospital range over many areas. Between 20 and 30 per cent of efforts are directed towards persons admitted as a result of self-inflicted injuries. I examine and assess between 30 and 40 such patients each year, i.e. approximately one third of the suicide attempters who are admitted.

My approach is based on openness as a means of giving support while encouraging the patient to take responsibility for his/her actions. Many patients find it disconcerting at first to talk openly about their suicide attempt.

However, most people soon feel the relief that is given by such openness. The knowledge that there is someone with whom it is possible to share their feelings of despair often gives a sense of relief. The attempt to make the patient aware of the fact that there are alternatives to taking his life is a major element of such intervention. The suicidal patient takes a very narrow view of his situation, and usually sees suicide as being the only way
out. If we succeed in persuading the patient to see the feasibility of other ways of surmounting his difficulties, we will have come a lot closer to starting him/her thinking along more constructive and realistic lines.

The objectives of my intervention:

Diagnostic assessment:
- Obtaining important anamnestic data
- Assessing behaviour/appearances in the interview situation
- Assessing the degree of suicidal risk

Proposals for appropriate treatment/measures for care of the patient:
- Guidance concerning hospitalization in psychiatric hospitals / referral to psychiatric outpatients clinic
- Referral to a private psychiatrist or psychologist
- Referral to an outpatients clinic specializing in social medicine (care of alcohol and drug abusers)
- Referral to a psychiatric team specializing in young people

Informing the patient about services administered by the public health nurses when visiting patients at home:
- Supporting the patient
- Mobilizing the patient's network
- Continuing work on keeping up the patient's motivation to stay in contact with the treatment facility
- Supporting the patient until contact has been established with the next stage in the treatment process

Assessing the need for psychopharmacology – and making any relevant suggestions concerning medicines and doses

Support for the patient

Support for the patient's family

An oral report is given to medical personnel with relevant guidelines for handling and understanding the patient. A report is also given to the referrer, in writing and, if required, also orally. Finally, a report is given to the next stage of the treatment process.

9. The approach of public health nurses in work on parasuicide

Home visits
The municipal health team visits patients in their homes after discharge from hospital or following treatment in accident and emergency units. In the municipal teams it is the public health nurses who are responsible for direct contact with the patients. The professional basis for the Bærum team's interventions is derived from cognitive psychology, primarily from the work of the American suicidologist Dr. Edwin Shneidman. In his book published in 1985, “Definition of Suicide”, Dr. Shneidman describes the common psychological characteristics of suicidal behaviour, and provides guidelines for crisis intervention in relation to suicidal individuals. These characteristics are described in ten points (“ten commonalities”), which are presented below with descriptions of the operations that we carry out in connection with each of the points, adapted to intervention by public health nurses. The ten points relate to both suicide and parasuicide (Shneidman, 1985).

We wish to emphasize that the public health nurse uses no more than approximately five hours on each case, including contact with the
treatment facility and with the patient’s family. This means that the ten points are used as overall guidelines to ensure that the brief intervention is as purposeful as possible. The intervention is a continuation of the work carried out at the hospital by the social worker and the psychiatrist.

Dr. Shneidman says that suicidal individuals need a kind of helper, an intermediary or "ombudsman". By this, he means a person who ensures that measures are implemented to make immediate improvements in the suicidal person's situation.

An "ombudsman" is firstly a benign person, a helper who enters into the acute crisis situation and acts to reduce the risk of suicide. Secondly, the ombudsman ensures that the individual receives more long-term help with his or her existential problems (Shneidman, 1985).

It is this role that the public health nurse attempts to fill in the work that constitutes the core of the activities of the municipal health team in Asker and Bærum municipalities.

In the municipal health service's aftercare team, it is the public health nurse who organizes the work in relation to each patient, in consultation with the psychologist in the Bærum team and with a psychiatrist in Asker. Public health nurses have proved to be well suited to the role of intermediary or "ombudsman" that should, in Dr. Shneidman's view, first be taken by helpers of suicidal persons. However, the complexity of the phenomenon and the emotional stress that can result from work in this field make close professional counselling absolutely necessary (cf. chapter 5). The professional counselling of the public health nurse group is carried out in Bærum by a clinical psychologist in the municipal team and in Asker by a psychiatrist in the municipal team.

The intermediary or "ombudsman" function must be adapted to work on suicide issues. In our system, the public health nurse looks after the referred patients during the period between treatment in hospital and other treatment. Her intervention complies with the advice given by Dr. Shneidman regarding the "psychological first aid" needed by the individual after a suicidal act.

Common psychological characteristics (Shneidman, 1985):

• There is always a purpose behind suicidal behaviour
  Suicide is seen as being the best possible solution to problems that generate intense suffering for the individual, and which seem insoluble. Suicidal behaviour also involves an attempt on the part of the individual to reduce internal tension, while at the same time eliciting reactions from others.

  Intervention: Surveying problems. The public health nurse attempts to initiate communication concerning the problems that seem insoluble, while at the same time sorting the problems according to their significance for the suicidal crisis. Gradually, an attempt is made to arrive at an order of priority of possible help measures, making it possible to reach agreement on something that can be solved here and
now. Usually, this involves the public health nurse undertaking to obtain help through the ordinary treatment channels.

- **The common goal of suicide is cessation of suffering / cessation of consciousness**
  The individual wishes to bring an end to troublesome thoughts, receive a respite, obtain peace of mind. He may at the same time be aiming to achieve a change in his life, and to obtain help and support from other people. The act does not necessarily express a wish to die.

  **Intervention:** Mapping of problems continues, with an increasing focus on interaction with the environment. If desirable and possible, persons close to the patient are included in the dialogue. The public health nurse gives support and help within a clear, limited objective of functioning as an intermediary or "ombudsman" who ensures that further measures are implemented.

  She attempts to mobilize a network where this is possible, and she attempts to adjust individual elements of destructive interaction in existing networks, if these have the effect of blocking further measures.

- **The most important feeling that normally drives a person to suicidal behaviour is unendurable psychological pain.**
  It is the pain of living that the suicidal individual is seeking to escape. It must be emphasized that it is the individual's subjective perception of pain that determines the intensity of his suffering.

  **Intervention:** The public health nurse attempts to reduce the pain by being an ally in finding and implementing adequate help measures. By being genuinely friendly, and helpful within a clearly defined role, she is able to reduce the sufferings of most suicide attempters sufficiently to motivate new attempts at solving problems.

- **The individual's feeling that strong psychological needs are not fulfilled is a major influence in suicidal behaviour**
  Many suicide attempters say that they have long felt that they live with unfulfilled needs for close relationships, security, care, affection, respect, acceptance, etc. These are factors that contribute to the psychological vulnerability that is a major contributing factor of the acute life crisis.

  **Intervention:** For many suicide attempters, it is advisable for the crisis intervention to be followed by a course of psychotherapy. The public health nurse attempts to motivate the patient for this, and refers him to a psychotherapist.

- **The most major painful emotion in suicidal behaviour is hopelessness/ helplessness.**
  Suicide attempters often relate their attempt to the experience of losing or being rejected by a person they love, which may result in a feeling that *everything* is hopeless, and that there is no-one who can help them. Other feelings commonly experienced by suicidal persons are hostility, shame, guilt, depression and loneliness.
Intervention: A subsidiary objective of the public health nurse’s intervention is to kindle hopes in relation to realistic aims. Attention is focused on an activity that the person can carry out himself, or with the help of another, to free himself at once from the sense of hopelessness. We will again emphasize the importance of remaining within the role of intermediary or “ombudsman”, so that hope is kindled in relation to a change that is attainable and realistic.

- **The common cognitive state in suicidal behaviour is ambivalence**
  Suicide attempters may take an overdose and cry for help almost simultaneously, and both acts are seriously intended.

Intervention: The public health nurse attempts to set up an alliance with the part of the individual that wants to live. The fact that the person has made sure of getting help must not be wrongly interpreted as indicating that the suicide attempt was not seriously intended. The public health nurse makes it clear that she understands the internal conflict, and the internal strain that the suicide attempter has been suffering.

- **The individual’s thinking and perceptual state in the suicidal situation is characterized by constriction (tunnel vision)**
  Both the emotions and the intellect become constricted as a result of great internal pressure. Thinking is more or less in black and white. A suicidal person can express a wish for a magical solution to all painful problems as the only acceptable alternative to a suicidal act. If this is not satisfied, death is seen as being the only alternative.

Intervention: Through the problem-solving work mentioned above, the public health nurse attempts to broaden the patient’s field of vision. By being more than normally active in obtaining adequate help, the public health nurse can give an impression of working a little “magic”, at the same time as she is able to help the suicidal individual to acknowledge that most suicide crises are transient (broaden the field of vision). The role of intermediary or “ombudsman” allows for considerable active problem-solving by the public health nurse because the limits are defined as part of the aims of the intervention.

- **The suicidal act is escape (egression)**
  The intention was to escape from the pain of living, to receive a respite, but it was also an attempt to let someone know that one was suffering.

Intervention: Emphasize the potential of alleviating pain through problem-solving as an alternative to obliteration. Make it clear that the suicide attempt could have resulted in death even if this was not the intention. The public health nurse can also help in ensuring that the means of committing suicide are removed, e.g. by controlling access to dangerous drugs or firearms, and ensuring that someone watches out for the suicidal person.

- **Suicidal individuals usually communicate their intention to commit suicide**
  On average, it is believed likely that advance warning is given of approximately 80 per cent of all suicides. This warning is associated
with varying degrees of clarity. The suicidal individual may for example communicate that he is unhappy and needs help, without directly revealing his intention to commit suicide.

**Intervention:** During home visits to suicidal persons, the public health nurse must listen attentively for indications of the presence of a risk of suicide. In this situation, it is important to ask direct questions about the risk of suicide, and to pursue vague answers. Suicidality is not static. The risk of suicide can show rapid variations, and of course this makes it difficult to assess. The family of the patient can also be given support in asking direct questions about the risk of suicide.

- **Suicidal behaviour can be seen in relation to the individual's lifelong coping patterns.**
  People's ways of handling life crises are associated with a certain uniformity. Previous attempts to solve life crises may therefore provide information of relevance to the current situation.

**Intervention:** Obtain information about previous attempts to solve life crises, capacity to tolerate mental pain, any tendency to think in black and white, any tendency to passivity in relation to problem-solving and usual problem-solving strategies. Attempt to help the person to adopt problem-solving strategies that have proved appropriate in similar life crises.

**Working method**

Patients are referred by the social worker or psychiatrist at the hospital. The patient receives written and oral information from the hospital staff about the suicide prevention teams’ way of working, in which the patient is notified that he or she will be contacted by the public health nurse shortly after discharge from hospital. The service is not obligatory. The public health nurse rings the accident and emergency unit twice a week, and is notified of the patients due for transfer.

The public health nurse rings patients to arrange a home visit as soon as possible after discharge from hospital. If she is unable to contact the patient by telephone, she either calls at the patient’s house or writes a letter. If no one is at home when she calls, she leaves a letter suggesting a time for an appointment and requesting that the patient ring her if the suggested time is not convenient.

The process that was begun at the hospital is continued from the first interview with the patient or a new process is initiated, and the patient’s mind is usually put at rest concerning any objections he or she may have to further measures. Experience shows that the public health nurse must take an active, direct role in the interview. This applies to all professional groups in the team, regardless of where we meet patients. Even though the public health nurse takes an active role and does not easily allow herself to be turned away, it must be the patient himself who decides whether he wishes contact with the team. By visiting patients at home, the public health nurse meets them in a situation where they generally feel more secure than in the alien environment of a consulting room.
The public health nurse is flexible concerning the time for the home visit. This is often after normal working hours. It is important that the patient is given the time he needs, and plenty of time is therefore allowed. Visits may last from one hour to several hours.

The public health nurse steers the conversation. A primary purpose of the meetings is to bring to light aspects of the patient’s living situation that have clearly functioned as triggering factors for the suicide attempt, and this is then followed by further investigative activity. To establish what kind of help is most appropriate, it is important to be direct when interviewing both the patient and members of the patient’s family. Both the patient and his/her family must be allowed to express their feelings, and the public health nurse listens attentively to all parties before attempting to structure the conversation in such a way that as much as possible relevant information is disclosed. It is not certain that the first visit will result in an agreement concerning the content of further care. Sometimes several visits are needed before the patient and his/her family are motivated to accept help.

The patient participates in the planning of all measures. Agreement is reached jointly on how the help should be implemented. The public health nurse assesses on a case-by-case basis how quickly other groups of helpers should be involved. Which help measures are appropriate depends at any time on the degree of suicidal risk. One of the responsibilities of the public health nurse is therefore continual assessment of the suicidal risk in close cooperation with the team’s psychologist or psychiatrist. The public health nurse has at least one interview with the patient alone. Other family members are gradually involved when this is seen to be appropriate. If several family members are present, the public health nurse functions as a chairman for the family discussion.

When the patient has decided to accept help, the public health nurse assists in making an appointment with the appropriate institution. First she obtains the patient’s permission to provide the treatment facility with information concerning the patient’s problems, with a primary emphasis on the suicide attempt.

With the patient’s consent, the suicide prevention team can enter into an agreement with the treatment facility that the team is to be notified if the patient fails to attend treatment.

If a patient decides not to abide by the treatment agreement, the public health nurse attempts to remotivate him or her to accept the treatment that was agreed on. When the patient so wishes, the public health nurse accompanies him or her to the first consultation.

Some patients are not interested in having contact with anyone except the public health nurse. They assert for example that they have received the help they needed to get out of the situation they were in. Others do not want any help to change their circumstances of life for the time being. So that these patients shall not be left without any form of help at all, and because they may need time to overcome their reluctance to commit themselves to a more long-term treatment programme, the public health nurse gives them the option of contacting her again if they change their minds.
Experience shows that quite a number of people are taking advantage of this offer. The public health nurse may also make an agreement with the patient to take contact if she hears nothing from him/her before a certain date.

In most cases, once the patient has been transferred to another treatment programme, the public health nurse’s job is done. In cooperation with a therapist, she may however remain in contact with certain patients who have poorly developed social networks as well as considerable problems otherwise. When discontinuing contact with patients, the public health nurse always encourages them to take contact with her in the future should they feel a need to do so. In cases where patients take advantage of this, the contact once again involves functioning as an intermediary or “ombudsman” in relation to other help measures.

**Primary prevention work in the Bærum schools.**
The suicide prevention team is involved in providing information and training, and the Bærum team has cooperated with different schools on measures for pupils. The psychologist has held courses for teachers in the lower and upper secondary schools, and the team has assisted teachers with counselling in specific cases where pupils have been directly affected by matters involving suicidal behaviour. A more detailed account of this is given in the evaluation report submitted by the municipal health team (Dieserud et al., 1990). More thorough suicide prevention work is now being planned for the Bærum schools.

**Relations with cooperation partners.**
It is important to hold discussions with cooperation partners in the ordinary treatment facilities so as to provide professional guidance concerning the structuring of psychological first aid, which differs in certain ways from the working methods traditionally applied in psychiatric treatment.

It is important that the suicide prevention team provides professional explanations for its approach to suicide issues, so that our active, problem-solving approach is not regarded as unprofessional by the remainder of the assistance apparatus.

It is important that patients are not led to expect that they will receive the same kind of concrete help in solving their problems as is provided by the public health nurse if they begin a course of more insight-oriented therapy. This clarification serves an important function in avoiding patients being disappointed over not receiving the same degree of concrete assistance during the therapy process, and in preventing this from making difficulties for the public health nurse’s intervention.

After the first life-saving intervention, most suicidal individuals feel a need to work on both their internal and their interpersonal conflicts in a therapy situation. This may involve individual psychotherapy, couple therapy, family therapy, group therapy or network intervention.

More long-term treatment gives the patient an opportunity to establish more appropriate problem-solving strategies aimed at solving future conflict situations and avoiding further suicide attempts. Psychotherapy may also
make the patient better able to fulfil his or her underlying frustrated psychological needs.

In parallel with the psychotherapeutic work, and in some cases as an alternative to this, attention should be given to the patient’s social network. As mentioned above, we know that adequate social support is a contributing factor in protecting people against the development of serious health problems during stressful periods of life.

Patients in this group need to be transferred personally to the assistance apparatus rather than merely referred. This is because they are often emotionally unstable, show varying degrees of ambivalence, are tormented by feelings of shame and have a tendency to withdraw from help measures. So as not to exacerbate feelings of anxiety and distrust, the helper should in some cases take over the responsibility for obtaining suitable treatment. This does not increase the patient’s feeling of helplessness; on the contrary, it is experienced as a much-needed helping hand.

Emphasis is placed on conveying to the patient that one understands that he or she has a lot of troubles, that one does not regard him/her as “difficult” and that one regards him/her as “deserving” help. Patients in this group seem to be extremely vulnerable in relation to the quality of the help measures they are offered, and are easily offended. It is therefore important to ensure that all measures, including short-term measures, are of a high quality.

10. Summing up

For ten years, Bærum Hospital and the municipal health service in Asker and Bærum have cooperated on treatment and aftercare of suicide attempters. From its inception as a project, via disagreements concerning confidentiality, this cooperation has evolved to give us the extremely well functioning team that we have today.

We believe that the principles of our model can be transferred to other municipalities and county authorities. However, it is important to take existing resources as one’s starting point, and to find local solutions. By principles we mean: written routines, written information to patients, written consent to the revocation of confidentiality, regular cooperation meetings and systematic counselling. When establishing a suicide prevention team, it is important to make use of existing structures for cooperation and local resources, and one should attempt to find local solutions.

Work in a suicide prevention team is never static. It is therefore important to make regular assessments of the form of organization, target group, working methods, forms of cooperation and the patients’ views of the measures.
References


Jørstad, J. (1986). *Selvmordslære.* (Suicide Theory). Organon, Oslo


Skriftserie nr 9.


Appendices

I. Routines for psychosocial and psychiatric treatment and aftercare of patients treated at Bærum Hospital following suicide attempts

II. Project in Asker municipality

III. Information leaflet for patients

IV. Letter to patients who have been discharged from hospital without contact with a psychiatrist or social worker
ROUTINES FOR PSYCHOSOCIAL AND PSYCHIATRIC TREATMENT AND AFTERCARE OF PATIENTS TREATED AT BÆRUM HOSPITAL FOLLOWING SUICIDE ATTEMPTS

THE ROUTINES WERE REVISED AND APPROVED IN JUNE 1993

Wenche Haukø
Head of Department
for Social Services,
Bærum Hospital

Harald Torsvik
Chief Consultant
Medical Department,
Bærum Hospital

Fredrik Jakhelin
Psychiatrist,
Bærum Hospital
Appendix I

ROUTINES FOR PSYCHOSOCIAL AND PSYCHIATRIC TREATMENT AND AFTERCARE OF PATIENTS TREATED AT BÆRUM HOSPITAL FOLLOWING SUICIDE ATTEMPTS

THE BÆRUM MODEL

SUICIDE PREVENTION TEAM

ROUTINES FOR TREATMENT AND AFTERCARE OF PATIENTS TREATED AT BÆRUM HOSPITAL FOLLOWING SUICIDE ATTEMPTS

When a patient is received by the hospital's casualty department, decisions shall be made concerning the following:

CASUALTY DEPARTMENT:

The doctor on duty in the casualty department examines the patient and considers the following options:

1. Hospitalization:
   - Bærum Hospital
   - Other somatic hospital
   - Psychiatric hospital

2. Sending the patient home after treatment in the casualty department

1. ADMITTING THE PATIENT TO BÆRUM HOSPITAL

The Department for Social Services shall be notified of all patients admitted to the hospital following suicide attempts or self-inflicted injuries.

The head of the Department for Social Services has administrative responsibility for the suicide prevention team. This includes the responsibility for registering patients, keeping statistics and preparing an annual report on the work.

It also includes the responsibility for ensuring the functioning of current routines for coordination of work at the hospital and cooperation with external services, and for reviewing and developing these routines.

The Head of Department is also responsible for arranging and chairing the team's meetings with representatives from the municipal health authorities.

The head of the Department for Social Services has overall responsibility for all work carried out at the hospital by social workers, including work carried out in relation to this group of patients.

The overall medical responsibility for patients admitted following intoxications is held by the Chief Consultant of the Medical Department. In the case of other self-inflicted injuries resulting in surgical treatment, the overall responsibility is held by the Chief Consultant of the Surgical...
Department. The practical treatment of individual patients involves cooperation between doctors on duty in the ward, social workers and psychiatrists.

Cooperation with the casualty department

Nurses in the casualty department keep a separate list of all patients diagnosed as suffering from intoxication or other self-inflicted injuries. The patients who are admitted, those who are transferred to other hospitals and those who are sent straight home from the casualty department are all registered in this list. The list also contains some information concerning the patients, including personal details, method adopted, social situation, background for the attempt and whether or not the patient wishes to have contact with the suicide prevention teams. The ward sister in the casualty department is responsible for ensuring that these lists are kept up to date every day and are properly looked after, and for supplying information to the Department for Social Services. The head of the Department for Social Services receives the list each morning. The list is subsequently destroyed.

Registration routines, maintenance of records and statistics

When interviewing patients, social workers use a psychosocial interview/registration form. The form is defined as part of the patient’s medical record. For information concerning confidentiality, see the information leaflet supplied to patients. The registration forms are retained in the files of the Department for Social Services for up to one year, and are then transferred to the hospital’s central record archives. Some information from the registration forms is used anonymously in the annual statistics.

An agreement has been drawn up between the hospital’s Chief Medical Officer and the head of the Department for Social Services delegating the right and duty to make entries in the patient’s medical record and to include the registration form as part of the patient’s medical record.

Referral for an interview with a social worker

Social work consists of crisis intervention, psychosocial monitoring, assessment of suicidal risk, assessment of treatment needs, preparation of proposals for measures and establishment of contact with the assistance apparatus. Measures shall always be discussed with the doctor on duty in the ward. In most cases, the social worker completes the handling of the case. In some cases, this is done in consultation with the psychiatrist. When the patient is to be admitted to a psychiatric hospital, handling of the case must be completed by the doctor on duty.

The psychiatrist

The psychiatrist is employed in a half post at the hospital. He is responsible for providing guidance to the hospital’s social workers for one hour each week. The psychiatrist is also responsible for providing guidance in the team meetings.

Referral to a psychiatrist

The psychiatrist should assess the patient in cases where there is doubt concerning the basis for commitment pursuant to section 3 or section 5 of the Mental Health Care Act.
The psychiatrist should assess the patient in cases where there is doubt concerning the existence of criteria for immediate assistance.

The psychiatrist should assess the patient in cases where mental illness is suspected, but where the pathological picture is unclear and difficult to determine.

The psychiatrist can be consulted for advice and guidance in cases where referral to a psychiatrist is not indicated.

Information to patients, confidentiality

An information leaflet has been prepared that shall be provided to all patients treated following suicide attempts. The leaflet is to be made easily available both in the casualty department and in the residential wards. The leaflet contains information about the suicide prevention teams, how they are composed and how they work. It is made clear in the leaflet that information on all patients is exchanged at the team meetings, and that personal contact with the public health nurse following the stay in hospital is optional. It shall also be easy for the patient to understand that, by signing the leaflet, he or she revokes the duty of confidentiality between the members of the team. The patient is required to sign the information leaflet.

A copy of the signed information leaflet shall be enclosed with the patient's medical record. Patients admitted to resident wards of the hospital are given the information leaflet during the interview with a social worker or psychiatrist. The member of the hospital staff responsible for treating the patient ensures that the routines for signing the leaflet and making a copy for the medical record are followed.

Patients who receive treatment only in the casualty department are given the leaflet by a doctor or nurse there, who ensures that these routines are carried out.

Discharge from hospital

On discharge from hospital, the following measures may be appropriate:

Referral to a previous therapeutic contact.

Referral to a psychiatric outpatients' department:
Adults
- Asker: Trekanten
- Bærum: Sandvika

Children
- Child and Adolescent Psychiatry Clinic for Asker and Bærum

Referral to psychiatrists or psychologists in private practice.

Referral to general practitioners

Admittance to a psychiatric hospital:
Adults
- Blakstad hospital

Children
- Akershus Central Hospital, Nordbyhagen
- National Centre for Child and Adolescent Psychiatry

Referral to family counselling:
- Family Care Centre for Asker and Bærum, Sandvika
- Church of Norway Family Counselling, Sandvika
Referral to a centre for treatment of alcohol and drug problems:
Adults • Clinic for Social Medicine, Sandvika and Åsterud
Young people • PUT (Adolescent Psychiatry Team), Sandvika

Referral to municipal substance abuse-related care measures:
Bærum municipality • Social Guidance Service
• Asker Municipality Social Work Services for Young People – Substance Abuse Team

Referral to social welfare office.
Referral to financial guidance.
Referral to home nursing, including psychiatric nursing or other municipal services, e.g. Asker Activity Centre or Stabekk Activity Centre.
Referral to an employment office and its rehabilitation officers.
Referral to a public health nurse in a suicide prevention team (see below).

**Referral to a public health nurse in a suicide prevention team**

After completion of hospital treatment, the patient shall, where appropriate, be offered aftercare by a public health nurse on the staff of the municipal health authority.

All patients shall be informed about the teams and be given a copy of the information leaflet.

Patients who do not at first wish to have contact with a public health nurse may take contact themselves at a later date should they change their minds. Patients who agree to further contact are referred to a public health nurse by the social worker or psychiatrist. This is either done by telephone after speaking to the patient or at the team meeting.

**The role of the public health nurse following discharge from hospital**

The following tasks are involved:
• Reach patients who discharge themselves from hospital on their own responsibility or who return home without talking to a social worker or psychiatrist.
• Take immediate contact following discharge pending further treatment measures.
• Motivate patients over time in cases where they refuse to be referred to further treatment during the relatively brief stay in hospital. The public health nurse also helps to find a suitable therapist.
• Prevent crises from occurring involving the children of suicide attempters, in cases where the child welfare authorities, educational and psychological counselling services or other services are not already involved in helping the family, or where such services are involved but there is a need for more intensive treatment.
• Keep contact with relatives so as to prevent crises involving the remaining members of the family.
• Mobilize the patient’s network.
2. WHEN THE PATIENT RETURNS STRAIGHT HOME FROM THE CASUALTY DEPARTMENT

If the patient is not admitted to Bærum hospital, but returns home immediately after treatment/observation in the casualty department, the following routines shall be carried out:

1. The patient is referred to a social worker or psychiatrist who if possible visits the patient in the casualty department (the psychiatrist is present only two days a week).

2. When the patient is sent home without having been seen by a social worker or psychiatrist, the doctor on duty must assess the following before sending the patient home:
   - causes/triggering factors
   - reason for the suicidal act
   - continued suicidal risk
   - previous or current treatment or contact with the assistance apparatus
   - that the patient has a care provider who can take responsibility for him/her until contact is established with a therapist. The care provider must promise the hospital to take care of the patient, which involves direct contact between the care provider and the doctor on duty.

Pursuant to section 387 (1) of the Penal Code, the doctor or hospital is duty bound in some cases to notify directly those responsible for following up patients. This may for instance apply in cases where patients return home from the casualty department without any interview or assessment and where the suicidal risk is assumed to be great or to be still present.

Pursuant to section 6-4 of the Act relating to Child Welfare Services, public authorities, including health and social service practitioners, shall on their own initiative, notwithstanding the duty of confidentiality, disclose information to the municipal child welfare service when there is reason to believe that a child is being mistreated at home or is exposed to any other serious deficit of parental care. This may be appropriate when the patient is under the age of 18 and there is reason to believe that maltreatment is the cause of the suicide attempt. It is also appropriate if the suicide attempter is a single parent whose health is too poor for him or her to be able to take proper care of the children.

On returning home from the casualty department without seeing a social worker or psychiatrist, the patient is informed about the suicide prevention teams. The patient is also provided with an information leaflet about the teams. When the patient has read and signed the leaflet, a copy is taken and enclosed with the patient's medical record. Patients who refuse to sign the leaflet are allowed to take it with them.

All appropriate information under point 2 shall be entered in the medical record.

Aftercare by a public health nurse when a patient returns straight home from the casualty department

The social worker notifies the public health nurse immediately of patients who have returned straight home from the casualty department after signing the information leaflet and agreeing to be visited by the public health nurse.

The public health nurse takes contact with the patient to examine the psychosocial situation and to make an assessment of treatment needs.

If the patient has returned home without signing the information leaflet, he or she is sent a letter
by the Department for Social Services at the hospital requesting confirmation that he or she does not require contact with a public health nurse.

This arrangement functions as a safety net so that all patients are made familiar with the teams and receive an offer of help.

THE SUICIDE PREVENTION TEAMS

The teams have formalized and binding cooperation across administrative and agency boundaries.

There are two teams: one for patients residing in Asker and one for patients residing in Bærum. Each team consists of skilled persons from the hospital and from the respective municipal health service.

The team meetings are held at the hospital. Meetings with the Bærum team are held once a fortnight, and with the Asker team once every six weeks.

The teams are composed of the following skilled persons:
- From Bærum hospital: 1 psychiatrist, 2 social workers.
- From Asker municipality: 1 psychiatrist, 1 senior public health nurse and 2 public health nurses.
- From Bærum municipality: 1 psychologist and 3 public health nurses.

Objectives

At the team meetings, the team members discuss diagnosis and treatment of patients they have in common.

Feedback is given on patients that have been referred. What measures have been initiated? Is the patient following the treatment? Have our measures had an effect? (Evaluation and assessment of measures).

Guidance is given by the team’s psychiatrist or psychologist.

Discussions of matters of principle.

Continuous evaluation of activities.

Statistical work / investigations / preparation of reports.

Evaluation of the routines every second year.
THE BÆRUM MODEL

ROUTINES FOR TREATMENT AND AFTERCARE OF PATIENTS TREATED AT
BÆRUM HOSPITAL
FOLLOWING SUICIDE ATTEMPTS

The routines were revised in January 1998

Kari Hasting
Head of Department
for Social Services

Harald Torsvik
Chief Consultant
Medical Department

Fredrik Jakhelln
Psychiatrist
Appendix II

PROJECT IN ASKER MUNICIPALITY

As a stage in the further development of suicide prevention work, Asker Municipal Health Services applied for funds from the “joint programme” for a project involving clients who had attempted suicide.

The aim of the project was:
- To further develop the model established in the municipality for contact and interviews with persons who have attempted suicide, for the purpose of reducing the number of attempts and preventing recurrences
- To gain experience in developing social networks

Target group
- Persons who have attempted suicide

The project was to be developed and given a final assessment during the course of two years. We were granted NOK 150,000 for the work from the joint programme and the same amount from the municipality.

The project was to be under the auspices of the health service, preferably the public health nursing section, and the chief municipal medical officer was to be responsible for the project.

We had cooperated with the hospital for several years on assisting clients who had made one or more suicide attempts, and wished to find alternative ways of helping these clients to deal with their problems.

It was our experience that many people believed themselves to be the only ones to have suicidal thoughts, and found it difficult to talk about it. After reviewing the issues involved and on the basis of the public health nurses’ experience, we agreed on the following objectives:

For the group:
New approach to problem-solving:
- Learn from each other that there are other and better ways of solving problems than committing suicide.
- Determine the factors that gave rise to the suicide attempts of the individual participants.
- Place this in the perspective of the problem-solving approach.

Coping:
- Become aware of the strategy one adopts when solving difficult emotional problems.
- The possibility of changing the strategy.

For the group leaders:
- Determine what cognitive style and way of thinking the clients are governed by.

What do they think?
For example:
  I am superfluous,
unhappy, 
incompetent, 
too old, 
worthless. 
Nobody likes me.

- Are there any cognitive processes that are typical of different individuals? approaches to solving their problems?
- Associate this with an understanding of what happened when they attempted to commit suicide.
- Help them to act differently in given situations – including everyday situations.

Composition:

The group consisted ultimately of four women, all of whom had attempted suicide. Two of them had made many attempts, some of them severe. All four women wished to make an effort to get out of the situation they were in. The women were aged from 22 to 52. They resided in different areas of the municipality and none of them were previously acquainted with each other. Before the first meeting, they were all very tense, and said that they would have liked to withdraw from the project if this had been possible.

Duration:

We decided to work in a closed, time-limited group, since we assumed that this would give the participants a greater sense of security, and because we had limited time available to us. We decided to work towards achieving a therapeutic objective.

We planned to have nine meetings during a period beginning on 15 May and ending on 29 September. The period was broken in the middle by a long summer holiday. It was made clear from the start that this was to be an experimental project of short duration (where it was intended that the participants would continue to function as a self-help group).

Participation in the group was binding.

There was a certain insecurity and groping to begin with in the first group meeting before the summer, but this was soon replaced by a feeling of security and mutual respect.

All of the participants had difficulty in finding solutions for their own problems, and at times also those of the others, although the latter was easier.

Through combined efforts involving listening, asking, thinking and asking again, they provided guidance to each other with the help of the group leaders. At each meeting, all participants received some advice to follow or some tasks to solve before the next meeting.

The meetings were characterized by intensive efforts and hard thinking.

Types of problems and topics taken up by the group:
- Problems from the situations of individual members of the group
- Loneliness, aggressiveness and depression.
- Helplessness in dealing with problematical situations
- Great burden of responsibility
- Lack of self-confidence
• Exaggeration of small problems
• How to escape from habitual approaches to solving problems
• How to organize one’s thoughts to solve problems
• Taking responsibility for oneself
• Looking for available options
• Identifying common agendas, common problems and common rules (loyalty).
• Active mastering of depression
• Clinging to and breaking away from the group
• The importance of the group for the individual members is continually in evidence both in the assessment work and in the establishment and maintenance of contact and support functions by the group members themselves.

The four main findings were:
A. A useful approach involved concentrating on coping patterns and hence also on cognitive strategies.
B. The community spirit of the group proved to be of great importance and to develop unexpectedly rapidly.
C. Individual members of the group took upon themselves more responsibility than we had expected.
D. Humour played a major role, which was a source of pleasure for all concerned.

Both participants and leaders were very satisfied with the results. As time went on, the women gained greater belief in themselves. They now dared to assert their views and to take decisions on the basis of their own opinions and beliefs. One of the women later gave interviews about her experience of the group to a local newspaper and to a journal, where she told that this was the first time she had received treatment without wishing to run away from it all.

The women have gradually taken control over important matters in their lives.

Instead of giving up, they now see other ways of solving their problems. When they are not able to manage this on their own, they receive help from the other members.

They have also begun on their own account to seek help from other parts of the assistance apparatus.

We also see a clear reduction in the number of suicide attempts. Since the group discussions were discontinued, none of these four women has made an attempt resulting in admittance to hospital.

Our experience with this group has been so positive that we recommend further experimentation with the approach.

Our experience with a cognitive approach was positive. It was somewhat unexpected, but positive, to register that the participants took upon themselves responsibility for each other. This may indicate that the development of a self-help group should be initiated right at the beginning. Other group models could also be tried, e.g. a pedagogical group model leading to a self-help group.

Reserve enough time and resources for the work. Use time for planning and follow-up. Take a direct approach. Do not make assumptions — ask questions. Consult the clients — it is they who know where the problem lies buried. Help them to dig it up and do something with it.

“'If you can reduce the degree of pain and sorrow just a little, the person will choose to live'”. (Kalle Achte, professor in psychiatry at Helsinki).
Working with this project has been an incredible challenge. In the middle of all the heartache and depression, we have also experienced humour, joy, warmth, thoughtful consideration and above all hope! It is really worth the effort.

We followed the women's progress for almost two years from the start of the interviews until the end of 1992. It is gratifying to see the progress that they have made in the way they solve their everyday problems. They have taught themselves to ask questions to clear up possible misunderstandings. "What do you mean by that?" and "What's your opinion?" have become important tools in their communication with other people. They also manage to set limits, to say no without feeling guilty, which gives them a great sense of relief – even of victory.

As a result of this, they no longer feel so downhearted and depressive, and are no longer so often plagued by suicidal thoughts.

"We are proud of ourselves. It is unbelievable how much we learned by taking part in the group. Just think how clever we have become at looking after ourselves – we who thought we would never be able to manage on our own! How did we think a year ago?" This is the sort of thing they say when we talk to them today.

We can all have suicidal thoughts, which can result in suicide or attempted suicide. Groupwork is an effective way of helping persons with such thoughts, especially groupwork directed towards the "thoughts that control which self-instructions the client uses".
Appendix III

INFORMATION LEAFLET FOR PATIENTS

When someone attempts to take his or her own life
After a suicide attempt, most people need support and follow-up.

The suicide prevention teams
Since 1984, Bærum hospital has cooperated with the municipal health service in Asker and Bærum on aftercare of persons who have attempted suicide. The teams have regular meetings at the hospital to discuss and assess measures to assist the individual patients.

All team members are obliged to observe confidentiality

AT THE HOSPITAL: After you have received medical treatment from doctors and nurses, you will be able to talk to a social worker or a psychiatrist. You will receive help to find out what kind of support or treatment would benefit you after you leave the hospital. If this is not clarified before you go home, THE PUBLIC HEALTH NURSE, in the suicide prevention team in your home municipality will give you further help. The public health nurse can offer valuable support both to you and to your family in the time following the suicide attempt. Contact with the public health nurse is optional.

I have read the information leaflet, and am aware that by signing here I revoke the duty of confidentiality between the team members.

Signed
Appendix IV

LETTER TO PATIENTS WHO HAVE BEEN DISCHARGED FROM HOSPITAL
WITHOUT CONTACT WITH A PSYCHIATRIST OR SOCIAL WORKER

To Date

The Department for Social Services and the psychiatrist at Bærum hospital are notified of all persons who have been treated in the casualty department or admitted to the hospital following a suicide attempt.

We write to everyone who has not been offered an interview during their stay in hospital.

People who have taken an overdose of medicine, or harmed themselves in some other way are in a crisis.

According to our experience, most of them will need support and follow-up afterwards to solve their problems differently in future.

We cooperate with the health authorities in your municipality. This means that the social workers and psychiatrist from the hospital and the public health nurses and the psychologist or psychiatrist in the municipality work together as a team.

If you go home from the hospital without talking to a social worker or psychiatrist, the public health nurse can contact you at home.

The public health nurse can help you and your family to find a suitable therapist if necessary.

You can read more about the teams in the enclosed leaflet.

You can also take contact with the team in your municipality yourself.

If you do NOT wish the hospital to ask the public health nurse to contact you, you must notify the hospital's Department for Social Services as soon as possible.

Yours sincerely

Bærum Hospital,
Department for Social Services and psychiatrist
Telephone: 67809400
This rapport on the Bærum Model has been prepared by a working group led by Wenche Haukø, the former head of the Department for Social Services at Bærum Hospital. It has been issued as a publication of the Norwegian National Plan for Suicide Prevention.

The Bærum Model is a permanent and binding cooperation between Bærum Hospital and the municipalities of Asker and Bærum on treatment and aftercare of persons who attempt suicide.

The primary intention of the report is to provide information to the administrative and political leadership of Norwegian municipalities and county authorities concerning ways of organizing measures aimed at suicide prevention. The report is also intended to be a source of inspiration to specialists working on suicide problems.

The Norwegian Board of Health has previously issued a publication on the Bærum Model in Report Series 4-94. This earlier publication mainly concerned the organization of work within the municipality and the theoretical framework for the model.

The present report also gives a description of the hospital’s routines.

Norwegian Board of Health
Pb 8128 Dep., 0032 Oslo
Tel. 22 24 88 88