THE NATIONAL PLAN FOR SUICIDE PREVENTION 1994-1998

Handlingsplan mot selvmord 1994–1998
NORWEGIAN NATIONAL PLAN FOR SUICIDE PREVENTION

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Every suicide must be taken seriously. A suicide involves many people and gives rise to suffering for many people. The consequences are considerable.

(Yngve Hammerlin/Georg Schjelderup: When Life becomes a Burden.)
Foreword

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.

This formulation expresses the primary goal of the National Plan for Suicide Prevention. In the National Budget for 1994, the Ministry of Health and Social Affairs proposed an annual allocation of NOK 6 million for a National Plan for Suicide Prevention. The proposal is founded on the report National Programme for Suicide Prevention in Norway, issued by the Directorate of Health. The National Plan is to extend over a five-year period from 1994 to 1998. The Ministry of Health and Social Affairs has delegated the implementation of the National Plan for Suicide Prevention to the Norwegian Board of Health.

The work on suicide prevention cannot be the responsibility of the health service alone. Prophylactic measures, which apply to the whole problem complex around suicidal behaviour must be carried out at both primary and secondary levels. This plan is not intended to encompass primary prevention strategies for the whole population (the public health perspective) or for all sectors of society. The National Plan has its basis in the health services, and aims therefore at development of secondary prevention strategies for individuals within groups prone to suicide.

The National Plan will primarily direct the activities of the subprojects towards people who have shown a high risk of suicidal behaviour. In its definition of subsidiary objectives, the Norwegian Board of Health has emphasized the need for knowledge to be generated through increased and systematic research. It will be of decisive importance to develop the expertise of specialists in municipalities and county municipalities through increased and systematic dissemination of information. A precondition for this is the establishment of regional resource centres. Norwegian County Medical Officers have held post-graduate courses for medical personnel and others in their respective counties. The plan will also give priority to the testing of models in municipalities and county municipalities with an emphasis on efficient organization and opportunities for cross-departmental cooperation. The National Plan recommends that people who have attempted suicide be given after-treatment and follow-up for a period of at least one year.

As the project progresses, its experiences will be made available to municipalities and county municipalities, as well as to other appropriate groups in the work on suicide prevention.

Oslo, October 1995

Anne Alvik
Director of Health
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Prepared by the Norwegian Board of Health
on the instructions of the Ministry of Health and Social Affairs
1 Background

1.1 Initiative from Professor Nils Retterstøl

On 5 October 1989, in response to the increase in the incidence of suicide in Norway during the last twenty years, Professor Nils Retterstøl wrote to the Director of Health requesting the preparation of a national programme for suicide prevention. Professor Retterstøl was at this time the President of the International Association for Suicide Prevention. His letter took as its point of departure a meeting held by the World Health Organization in Hungary in September 1989, where a letter was drafted calling upon member countries of WHO to set up national prevention programmes. The purpose of this initiative was inter alia to reverse the increase in the incidence of suicide in individual countries, as described in WHO subsidiary objective 12 in the European strategy for Health Policy towards the year 2000.

1.2 Report «National Programme for Suicide Prevention in Norway»

At a meeting at the Norwegian Directorate of Public Health on 12 June 1990 it was decided to write to the chairman of the Norwegian Psychiatric Association, Chief Medical Officer Otto W. Steenfeldt-Foss, requesting assistance in identifying appropriate persons to participate in a committee to prepare such a plan. Professor dr.med. Øivind Ekeberg at the Department of Medical Behavioural Science at the University of Oslo was assigned the task of investigating the matter with the support of an interdisciplinary advisory committee.

On 21 March 1991 the final terms of reference were provided by the Norwegian Directorate of Public Health, which assigned to Øivind Ekeberg the task of preparing a proposal for a national programme for suicide prevention in cooperation with an interdisciplinary advisory panel. The task involved defining the objectives of such a programme, and proposing appropriate measures for achieving the objectives in the Health Policy strategy for a reversal of the increase in suicide rates by the year 2000. The report was published as number 1–93 of the report series of the Norwegian Directorate of Public Health, «Nasjonalt program for forebygging av selvmord i Norge» (National programme for suicide prevention in Norway).

The objectives were defined as follows:

- Increase the attention given by politicians and by administrators in the health and social sector to the importance of problems associated with suicide in the context of health and social services, and of the relation to risk factors such as drug and alcohol abuse, and psychiatric and social problems.
- Develop and promote the use of guidance and guidelines that can improve the facilities of the health and social services for helping suicidal patients.
- Promote cooperation with the media so that objective information about these problems can be given to the whole population.
- Promote the development and use of training programmes in suicidology for all appropriate professional groups.
- Promote the coordination of existing national research and encourage new research. Maintain and develop contacts with international professional establishments.
Through cooperation with existing regional organizations (including voluntary organizations), establish regional networks with responsibility for adopting measures at a regional level, and follow these up.

Establish a national coordinating body and a national program for suicide prevention.

1.3 The Bærum model

As part of the National Plan for Suicide Prevention, the Norwegian Board of Health has assigned to the Centre for Social Networks and Health, Ullevål Hospital, the task of presenting the Bærum model. The Bærum model consists of the cooperation between Bærum Hospital and the municipalities of Asker and Bærum. Bærum Hospital commenced its aftercare of suicide patients in 1979, and entered into a cooperation on aftercare with the municipalities of Asker and Bærum in 1984. Number 4–94 of the report series of the Norwegian Board of Health «Selvordsforebyggende arbeid Bærumsmodellen» (Suicide prevention – the Bærum model) presents the Bærum model with a particularly detailed description of the theoretical basis for and function of the aftercare work carried out by the municipal health team. The report was written by Gudrun Dieserud, Bærum Health Authority, Kristin Schjelderup Mathiesen and Odd Steffen Dalgard, Centre for Social Networks and Health. The report provides a model for work on secondary prevention of suicide in municipal health services in cooperation with somatic and psychiatric specialist health services. This model may encourage other somatic hospitals and municipalities to adopt the systematic organization of cooperation with suicidal people. The Bærum model relates to aftercare of suicide patients by the municipal health services, not to treatment.


1.4 The terms of reference and guidelines supplied by the ministry

1.4.1 Background

In the national budget for 1994 a grant of NOK 6 millions was proposed for a plan for suicide prevention. In the Budget Proposition (1993–94) the background for the plan is discussed: «The proposal is based on a report prepared by the Norwegian Directorate of Public Health on the instructions of the Ministry of Health and Social Affairs. A plan is proposed for a period of five years from and including 1994. The number of suicides has increased in recent years, especially among young people. The number is approximately 650 per year, i.e. double that of fatal road accidents. It is assumed that approximately 10 000 attempts per year. The suicide rate has doubled during the last twenty years, and the greatest increase has been among young people. The funds will be used for training programmes and for developing the expertise of professionals in municipalities and county municipalities. Major goals are the development of expertise within health and social services in the municipalities and improvement of cooperation with specialists in the county health services, schools, child welfare and the prison service, as well as in-
volving parents. Experiences from projects that have been carried out will be shared. Work will be carried out on establishing regional expertise centres for suicide prevention measures.»

The Storting (the Norwegian parliament) supported the proposal (see Budget Proposal S 11, 1993–94) for a plan for suicide prevention and made an initial grant of NOK 6 millions. In the letter of allocation from the Ministry of Health and Social Affairs to the Norwegian Board of Health, dated 8 February 1994, the funds were transferred on the following provisions: «In 1994 NOK 6 millions has been granted to the plan for suicide prevention. The plan shall be carried out over a period of five years, and shall have as its aims the development of expertise in municipalities and county municipalities and the improvement of the cooperation between different institutions. The Ministry of Health and Social Affairs will withhold NOK 500 000 of the grant, which will be applied to the telephone helpline service run under the auspices of Mental Health Norway. The sum of NOK 5 300 000 will be transferred to the Norwegian Board of Health on the condition that detailed plans for contents and strategy are submitted in accordance with the guidelines laid down by the Ministry of Health and Social Affairs and the Norwegian Board of Health.»

In Budget Proposal S no. 11 (1994–95), the committee states that it has noted the suicide situation in Norway today. The committee views the increase in the incidence of suicide as being a most serious matter, and regards the adopted five-year plan as an important step towards suicide prevention. The committee agrees that work on the plan shall be directed towards the reinforcement and coordination of the measures taken, so as to enable more rapid help and treatment, and improved cooperation with voluntary organizations.

The Ministry of Health and Social Affairs has delegated the responsibility for implementation of the National Plan for Suicide Prevention to the Norwegian Board of Health.

1.4.2 Objectives

The overall objective of the plan is that the health services shall contribute to a reduction of the incidence of suicide in Norway. The plan is primarily directed towards measures for providing better facilities for groups with an especially high risk of suicide. The measures to be employed in achieving this overall objective are:

1. Gather available knowledge, encourage research and establish regional resource centres.
2. Develop training programmes and spread information to appropriate public bodies and voluntary organizations.
3. Survey and assess the existing models for organized cooperation, spread information about suitable models and, if appropriate, develop new models.

The objectives are described in more detail in the project plan.

1.4.3 Budgets and requirements

The Norwegian Board of Health is responsible for ensuring that the plan is carried out in accordance with the stipulated objectives, time limits and economic frameworks.

Funding of the National Plan for Suicide Prevention is granted over chapter 719 item 66, and is allocated to the Norwegian Board of Health by means of an annual letter of allocation. Initially an annual budget of NOK 6.0 millions has been anticipated for the plan. Of this amount, the Ministry of Health and Social Affairs will transfer NOK 500 000 directly to the telephone helpline service run under the auspices of Mental Health Norway. Allocation of funds to projects must include the usual provisos with regard to the budget deliberations of the Storting.

Material amendments in relation to the project plan can only be made after discussions between the Ministry and the Norwegian Board of Health.

The plan shall not supply funding for ordinary operations. No guarantees can be given, and no economic or other commitments can be made beyond the period of the project. Funding for the purchase of fixtures and other objects of lasting value should be given only in exceptional cases. Overheads should be kept at a reasonable level. There should be a restrictive approach to travel abroad. The Norwegian Board of Health and the Ministry of Health and Social affairs must be free to use the results of projects and research in their work. Arrangements concerning copyright in connection with paid assignments shall be made in whatever way the Norwegian Board of Health finds appropriate.

1.4.4 Plans and reporting requirements

The Norwegian Board of Health shall prepare the project plan in accordance with the guidelines laid down by the Ministry and the Storting. The project plan defines the framework for the National Plan for Suicide Prevention during the period of the plan (1994–98).

The Norwegian Board of Health shall submit a budget for each year, to be sent to the Ministry of Health and Social Affairs, Department of Health Policy, before 15 December.
The report (for the previous year) shall be sent to the Ministry of Health and Social Affairs, Department of Health Policy, by 31 March at the latest. The report shall contain a brief description of projects and measures, the status in relation to the plan and a brief appraisal of progress, cooperation and experiences with the organization of work on the plan. The report shall also contain a report of the accounts for the previous year.

As regards accounts and follow-up of results, we refer to the current general guidelines. For 1995, see the letter of allocation from the Ministry of Health and Social Affairs to the Norwegian Board of Health, dated 25 January 1995.

The final report of the National Plan for Suicide Prevention shall provide a collective description of projects and measures, achievement of objectives/results and experiences. The final report shall be sent to the Ministry within 3 months after completion of the plan. The final accounts shall be submitted to the Ministry at the same time.

1.4.5 Evaluation

The Norwegian Board of Health shall arrange for evaluation of the plan by an external evaluator. The cost of evaluating the plan, including the final evaluation, shall be covered by funds (chapter 719 item 66) granted during the period of the plan.

The final evaluation shall be sent to the Ministry within 9 months after the completion of the plan, at the latest.

1.4.6 Contact person at the Ministry

Questions that arise in connection with the carrying out of the plan shall be addressed to the contact person at the Ministry. The contact person/the Ministry shall not as a rule participate in meetings or be involved in the day-to-day running of the programme. The Ministry can however request such participation when this is seen to be desirable. The officer at the Department of Health Policy with responsibility for contact with the Norwegian Board of Health also has responsibility for contact with the Department of Administrative Affairs in the Ministry of Health and Social Affairs.
## 2 Structure of objectives

### General objective
During the 1990’s the health services shall work to arrest the negative development towards an increase in the suicide rate that has occurred during the period from the end of the 1960’s.

### Specific objectives

#### (4.1) Increased and systematic research (knowledge generation)
- Describe the status of current knowledge
- Reveal areas appropriate for research
- Encourage interdisciplinary research
- Encourage coordination of research
- Encourage the setting up of databases for research-based knowledge
- Encourage the spreading of research results
- Hold research conference

#### (4.2) Establishment of regional resource centres
- Strengthen academic departments by increasing the number of posts
- Responsibility for training and guidance

#### (4.3) Increased and systematic spreading of information (training)
- Course funding 1994, 1995, 1996 to Chief County Medical Officers for post-graduate training and development of the expertise of health and social personnel in the counties
- Develop training programmes for basic training
- Develop training programmes for further training
- Develop training programmes for post-graduate training
- Prepare strategies for organization of training (placing of responsibility)
- Spread information about the National Plan for Suicide Prevention

#### (4.4) Systematic modelling experiments with treatment and follow-up measures
- Support for modelling experiments to be made available on application
- Encourage municipalities/country municipalities through Chief County Medical Officers
- Prepare standard evaluation forms for these projects
- Spread information about the results
- Encourage the health services in municipalities and county municipalities to take responsibility for implementing measures in this area
- Encourage the preparation of local plans for suicide prevention
- Survey relevant models
(4.5) Information and evaluation

- Information about the National Plan for Suicide Prevention will increase knowledge about suicide issues
- Measure the utility value of the plan by means of external evaluation
- Measure the project process by means of internal evaluation
3 Main objectives

3.1 Prevention strategies

The responsibility for work on suicide prevention cannot be carried out by the health services alone. Prophylactic measures, which apply to the whole problem complex, must be carried out at both primary and secondary levels. This plan shall not include primary prevention strategies for the whole population (the public health perspective) or for all sectors of society. The plan has its basis in the health services, and aims therefore at development of secondary prevention strategies for individuals within groups prone to suicide.

Risk factors for suicide are psychological and social as well as biological. Prominent examples of psychological risk factors are depressions, psychiatric disorders, alcohol and drug abuse, personality disorders, anxiety disorders, previous suicide attempts and reduced resources for treatment and follow-up. Examples of social risk factors are crises and relationship problems, homosexuality, incest and violence, poor economy, unemployment and poor social networks. There are also biological risk factors, such as serotonin depletion and high cortisol secretion. These risk factors require preventive measures in several areas of society, and not only in the health services.

The health sector cannot divest other sectors of society of their respective independent responsibilities, but is willing to place its expertise at the disposal of these other sectors. The plan will also survey the contributions that have been made in this area by fields of research outside the medical profession, such as sociology.

The plan will primarily direct the activities of the subprojects towards people who have a high risk of suicidal behaviour. High-risk persons are those who have shown suicidal behaviour either in the form of serious threats or previous attempts, alcohol and drug abusers and people with psychiatric disorders. Specific measures relating to treatment of alcohol and drug abuse are founded on the Social Services Act. Alcohol and drug abusers are however frequent users of health services, and will be an important target group for cooperation between health and social services. The plan will therefore also aim to encourage other central government agencies to show an involvement in suicide issues. This will primarily apply to the ministries with responsibility for the armed forces, the prison service, the educational sector and the social services sector (particularly in the areas of drug abuse and child welfare), as well as the Ministry for Children and Family Affairs. At a later stage, the plan may also reveal a need for encouraging the involvement of other ministries.

The plan will be mainly directed towards increased and systematic research, professional development work and modelling experiments. The plan shall encourage programmes for developing the expertise of relevant professionals in somatic and psychiatric specialist health services in county municipalities and in municipal primary health services. Cooperation shall also be set up with other relevant groups that come into contact with suicidal people. The plan shall also encourage the establishment and organization of treatment and follow-up measures within the framework and resources of the respective
agencies. A close cross-sectoral and interdisciplinary cooperation will be an important precondition for treatment and follow-up, and for ensuring that this is carried out at a sufficiently professional level. By means of modelling experiments, professional staff will be able to experience the organizational framework for cooperation and utilization of their expertise within suicide prevention. By encouraging research the project will also generate and disseminate information.

An important stage in this project work will be to survey what has already been done in Norway within this field. It is also possible to envisage an extension of this survey to include the other Nordic countries or perhaps even other European countries. Norway is the second country in the world (the first was Finland) to introduce a national programme for suicide prevention.

3.2 Incidence

Suicide and suicide attempts constitute considerable health problems for society and for individuals in the form of premature death, suffering and bereavement. Approximately 650 suicides are registered in Norway each year. It is usual to quantify dark figures as 25% of cases registered. Norway is therefore assumed to have a suicide incidence of approximately 800 cases per year. The number of suicide attempts is not systematically registered. The figures are uncertain, but it is usual to assume ten times the number of successful suicides, i.e. approximately 8,000 per year. Prof. Øivind Ekeberg considers that there is reason to assume a minimum of 10,000 cases per year. It is assumed that approximately five people are severely affected by the suicidal behaviour of each of the individuals concerned, but this figure is probably too low. This applies particularly to young people who are still at school, who are involved in sports activities, who are carrying out military service, etc.

Diagnosis of suicide and suicide attempts involves the problem of what shall be included within the concept, for instance in relation to statistical registration. Classification can vary according to different characteristics and criteria, even if there is agreement about how suicide shall be defined. The concept of suicide is also open to various interpretations. Views as to what shall be regarded as suicide vary from country to country, from culture to culture, from period to period. (Hammerlin/Schjelderup 1994).

Hammerlin and Schjelderup are critical of much of the statistical material concerning suicide, both nationally and internationally. They hold the view that we must distinguish between registered and non-registered suicide cases. The actual suicide figures, i.e. for the total number of suicides, include both registered and non-registered cases. We know little about the number of non-registered cases, and therefore know little about the actual figures. It is however important to take the known and registered suicide figures as one's basis, provided that these figures are used with care. A community's actual suicide figures are not apparent from the suicide statistics. Two problems occur: excessive registration and inadequate registration.
The World Health Organization is endeavouring to achieve common registration criteria, so as to enable international comparisons of data.

The most commonly used definitions within medicine/psychiatry/psychology in Norway today are:

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 attempted suicide (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. (Nils Retterstøl: «Suicide» 1990).

With 800 000 cases per year, the World Health Organization ranks suicide as the second most major cause of death for the world as a whole. Only the figure for fatalities in connection with road accidents is higher, at 856 000 cases per year. War is responsible for the loss of 320 000 lives per year, violence 282 000 and HIV/AIDS 291 000. In Europe there are 135 000 suicides per year. Of these, 5 000 take place in the Nordic countries. The resources that are applied to reducing the number of fatal road accidents put the lack of investment in relation to suicide in a frightening perspective.

The suicide rate in Norway has doubled during the last twenty years. The rate is calculated in relation to the number of registered suicides per year per 100 000 inhabitants, and in Norway this figure is currently approximately 16. Norway had a suicide peak in 1988 with a rate of 16.8. It now appears that the rate is in process of decreasing somewhat. The development during this 20-year period has been from a suicide rate of 7, at which time Norway ranked among countries with a low incidence. As compared with the other Nordic countries, Norway has a relatively low incidence of suicide. Statistics from the WHO data bank for suicide rates during the period 1980–86 put Norway’s ranking into perspective: Greenland 117, Hungary 45, Austria 28, Denmark 28, Finland 27, Sweden 19, Norway 14, Iceland 13, USA 12, Egypt 0.1.

Together with Ireland, Norway has experienced the greatest increase in Europe. The increase in Norway affects both sexes and all age groups over 15 years. The greatest relative increase has been in the age group 15–24 years. The highest suicide rate is however that for men over 80 years of age. The average ratio of men to women is 2.8:1. In the case of suicide attempts, the incidence is approximately three times as great for women than for men. There is however a trend towards a narrowing between the figures for women and men both for successful suicides and for suicide attempts.

Regional variations in the total suicide rate are relatively small, and seem to have become smaller during recent decades. Large towns have a higher suicide rate than the rest of the country, but this difference also appears to
have decreased. However, this does not apply to women in Oslo, for which there are still almost double as many suicide fatalities as for women in the rest of the country. The greatest frequencies of suicide among young men (15–29 years) are found in Northern Norway and in Agder. The increase in the number of suicides among older men and among young people, especially young men, is especially worrying and dramatic.

Suicide among medical practitioners in Norway (1960–1990) shows a higher incidence than in the remainder of the population. The suicide rate for female medical practitioners during this period was 32.3. The rate for female academics was 20.1, while the rate for the remainder of the female population was 7.7. During the same period, the rate for male medical practitioners was 46.6, the rate for male academics was 20.1 and the rate for the remainder of the male population was 22.7. As part of the investigation by the Norwegian Medical Association into the conditions for medical practitioners, the suicidal behaviour of medical practitioners is now being monitored. It is aimed to prevent suicide among medical practitioners by means of collegial intervention at an early stage. Collegial efforts will, among other ways, be organized through the county branches of the Norwegian Medical Association as part of the «doctors for doctors» scheme. The Norwegian Medical Association intends to supplement rather than replace the public responsibility in this area.

In order to offer the necessary help to people who contemplate suicide or who have been saved from a suicide attempt, there is a need for information. The ability to understand the signals before it is too late is dependent on being able to recognize them. There is currently too little general knowledge about suicide issues. There are also considerable defects in the organization of measures to help suicidal people. Many suicide attempters are discharged from hospital after life-saving somatic treatment, but with no offer of aftercare and treatment in relation to the problems that lie behind the suicidal behaviour.

Work in relation to people with suicidal behaviour today is to some extent systematic. The Bærum model is the first systematic follow-up and cooperation model between Bærum Hospital and the municipalities of Asker and Bærum. The model has been shown a great deal of interest, and information about the model has been included by many Chief County Medical Officers and others in the training of health and social services personnel. Some hospitals and some municipalities have developed their own routines on the basis of ideas derived from the Bærum model.

The Norwegian Board of Health has an overall supervisory responsibility for ensuring that the primary and specialist health services provide secure and adequate health services for the whole population. It is made clear in the board's strategic plan for 1994–98 that the board shall provide comprehensive advice on medical matters to the public authorities and the health services, work to ensure good health services for socially deprived and vulnerable groups, and be a major force in achieving better health for the population.
The measures adopted by the Ministry of Health and Social Affairs in a decentralized health sector are particularly associated with overall aims, formulation of regulations and strategies and the economic framework. The Ministry of Health and Social Affairs has delegated to the Norwegian Board of Health the responsibility for preparing strategies and for carrying out a plan for suicide prevention. It is proposed that the plan shall have a total economic framework of NOK 30 millions over a five-year period, with an average annual budget of NOK 6 millions.

The plan will encourage efforts at national, county municipal and municipal levels. The Norwegian Board of Health shall be responsible for taking initiatives in this work, but the work itself shall be carried out by appropriate professionals in the field.

3.5 Administrative responsibility in relation to suicide prevention

Reduction of suicide rates will necessitate the definition of responsibility on all levels. It is the intention of the plan that this responsibility be defined through the different subsidiary objectives.
4 Subsidiary objectives

4.1 Increased and systematic research (knowledge generation)

4.1.1 Strategy for research

The research that has been carried out on suicide and suicide attempts, has so far only to a small extent been integrated in an overall national focusing of efforts. There has been too little research in relation to the size of the problem. Little is currently known about suicide, suicide attempts and work on suicide prevention in different professional establishments. Research must however be widely known if it is to reach the relevant professional establishments.

During the period of the project there will still be a need for some basic research. Relevant areas of research are geographical and demographic quantitative comparisons of incidences, and qualitative research on the course of the suicide process. Hammerlin warns against repetitive research. In his view, research must be more creative than it has been so far, and place particular emphasis on evaluation within existing treatment and follow-up of people with suicidal behaviour.

In addition to the research that is already being carried out, there will therefore be a need for a further reinforcement of the investments in research within this field. It is of decisive importance for the work on suicide prevention that it is at all times based on up-to-date research. Without such a foundation, there is a danger that measures can be far too short-term and costly, and fail to provide results in proportion to investments. It is also important that research has a breadth and variety, and that there is more qualitative research on the individual level. Professional establishments other than the health services shall be able to carry out research in cooperation with traditional and existing research establishments.

It is important to reveal the areas where research should be carried out. It is therefore necessary for this project to ensure the supply of research ideas so as to be able to initiate relevant research through assignments to research establishments.

There are several ways of revealing research areas: through an advisory committee, by the project holding a consensus conference for research institutions in Norway, through Nordic and international cooperation, etc.

In Norway, current expertise in relation to suicide issues is limited with regard to treatment, follow-up and prevention as well as research. A necessary precondition for increasing the level of expertise is that existing institutions are reinforced and organized in a national plan. The four universities are natural regional centres of professional expertise. It will however be necessary to have a single national centre for specialized knowledge, so as to avoid an uncoordinated parallel development of four separate centres. It is assumed that it would be most economical to gather specialized knowledge in a single interdisciplinary national centre, which would have responsibility for coordinating all Norwegian research in the field, and for maintaining a comprehensive knowledge base and idea bank. A national centre of this kind
should also take the initiative to build up a pool of varied expertise both in the area of research and in relation to practical measures.

It will be necessary to take as a basis the established research bodies, such as the Norwegian Research Council. The project has been in contact with the Research Council, and will have an initial meeting to discuss potential cooperation. Earmarked funds for suicide research will be an appropriate topic to discuss.

In Norway we must develop a core of expertise in relation to which the regional centres can develop their areas of expertise. By combining different areas of research in the regional centres, represented by the four universities, with core expertise in a national centre, it will be possible, in a professionally stimulating but economical way, to collectively develop a broad interdisciplinary expertise within suicide issues. It would be appropriate to conceive this as being realized in a model where the four universities are given responsibility for suicide research within separate fields, such as medicine/psychiatry, psychology and sociology. These separate fields must then be coordinated to ensure that individual research projects bear relevance to the collective body of knowledge within the field. The total output of knowledge from research carried out by universities must also be coordinated with experiences from practical measures adopted by municipalities and counties.

If all of these functions were to be fulfilled by the regional centres, this would lead to overlapping. The development of four separate centres with roughly the same objectives would also be extremely costly. The regional resource centres are therefore envisaged as having a more limited function. A national centre would necessarily command greater authority than several regional centres. This can be politically advantageous provided that the centre has an interdisciplinary composition, where representatives of different academic disciplines are allowed equal influence. Such a national centre would be able to initiate and stimulate communication between all who have something to contribute within the field, and should also have the responsibility for encouraging all municipalities to organize their resources in such a way that relevant professionals and the remainder of the population know where to find help and information in relation to suicide issues. The national centre will have responsibility for clinical activities, training, guidance, research and coordination.

For both national users of expertise centres (professional and administrative units), and international research centres, it is an advantage that a single institution can initially be approached for information about Norwegian research, training programmes, practical experiences, etc.
4.3 Increased and systematic spreading of information (training)

Improved training for all professional groups that work with suicidal people in preventive or therapeutic activities is one of the important preconditions for work on suicide prevention. The prospect of suicide prevention will primarily be opened up by measures to provide information on suicide issues to groups and individuals in local communities.

It will be important to give non-specialists the confidence to tackle problems that lie within the domain of central specialists. Health and social services need more information about measures that can be directed at individual communities and about factors connected with increased suicide risk. They also need training in observing signals and providing appropriate help, and knowledge of available resources. Within both specialist and primary health services, there is a need for improved diagnosis. This applies for example to judging suicide risk in relation to depression, schizophrenia and alcohol/drug abuse. There is also a need for improved and systematic cooperation in connection with follow-up of persons who have attempted suicide.

Training should also be given to several other groups who come into contact with suicidal people. Examples are police, teachers, clergymen, organizers of activities for young people, ambulance personnel and community planners.

Where development of expertise within suicide issues is concerned, it is important to take into account the fact that suicidal behaviour affects a far greater number of people than the group who actually take their lives. A factor that particularly increases the burden associated with suicide attempters is that, for approximately 20% of this group, the first suicide attempt is followed by one or more further attempts. Such a high percentage of recurrence is also an especial burden for relatives and therapists. It is usual to assume that five people are strongly affected by every suicide or attempted suicide. This is a conservative estimate, which only takes close family into account. Where young people are concerned, it is, for example, known that friends are often affected in such a way as to trigger suicidal behaviour on their part also. When people experience that a person close to them takes his life or attempts to do so, there is a risk that they may copy that person's behaviour. In suicide cases, it is therefore necessary to handle affected persons differently than in cases involving illness or accident.

In the municipalities a training programme will be appropriate for employees of health and social services, schools and family welfare centres. Within the specialist health services such a programme will be appropriate for personnel within both somatic and psychiatric health services. A number of factors necessitate a high level of suicide expertise also within specialist health services:

- suicide risks associated with serious chronic illnesses
- treatment of persons who have attempted suicide
- the fact that some mental disorders and mental problems involve an increased suicide risk.
Specialist health services must be ensured sufficient expertise to fulfil their responsibility for guidance in the municipalities, and functional models must be devised for cooperation between primary and specialist health services.

Higher education institutions have a responsibility for dissemination, and at university level, it is important that the different educational institutions are required to include suicide issues in the basic training within their respective fields. It is also important to include suicide issues in the further training and specialist training within different fields. In cooperation with the national centre, the regional resource centres will have responsibility for preparing training programmes for post-graduate training for different occupational groups in the region, so that training and guidance is strengthened in accordance with the needs in the different regions. The national centre will have responsibility for preparing training programmes for basic and further training for all professional groups that come into contact with suicidal people. This national centre will also have responsibility for giving guidance to the regional centres.

Each training scheme must be tailored to the needs of the target group, and must be continually updated to account for new knowledge.

The responsibility for carrying out the training could lie with the universities and other higher education institutions and with the professional organizations. The universities and other higher education institutions should have responsibility for basic training and research, the professional organizations for specialist training, further training and post-graduate training and guidance. The universities and higher education institutions and other bodies should also have responsibility for spreading existing knowledge and new research results. As part of the plan, it is aimed to prepare a plan for training and information responsibilities.

In order to ensure a high level of expertise, training programmes must be held regularly. Work on course curricula began in 1993, when several courses were run under the auspices of the Norwegian Directorate of Public Health and the Chief County Medical Officers. Courses were offered to health personnel, clergymen and other personnel for whom such training was regarded by the municipalities as appropriate. Courses were also offered in 1994, and will gradually also include courses for social services and schools, as well as other relevant groups. The Chief County Medical Officers will coordinate these course activities, which will be a part of the plan and will be carried out in 1994, 1995 and 1996.

In recent years, voluntary work has been focused upon as a welfare resource. While the level of health and social problems has continued to rise, the growth potential for public welfare schemes has been limited by economic stagnation. One of the causes of the incidence of suicide in Norway today is the steady decrease in social ties. A remedy for the increasing social disintegration may perhaps be found in an improvement of local organization.
The voluntary organizations, the Church and other religious communities will be able to be an important resource in work on suicide prevention, as they already are in grief therapy. Parish workers, clergymen and others are increasingly involved in helping bereaved persons after accidents and suicides. Kirkens SOS (a telephone helpline service run by the Norwegian State Church) has centres in 13 towns, and offers help to people suffering personal crises. The service covers the whole country, and telephones are manned by voluntary workers with expertise in giving emotional support over the telephone. The Norwegian Red Cross and Mental Health Norway have also established help lines for telephone «first aid». The Committee for Care Work of the Association of Norwegian Humanists has made a study of the need for and the consequences of developing facilities for care work, grief therapy and discussions about religious and moral matters. Members with suicidal behaviour will be able to benefit from this care work. The Norwegian Centre for Voluntary Work (FRISAM) was recently established. FRISAM is directed towards the Volunteer Centres (which the Ministry of Health and Social Affairs was involved in establishing) and many other voluntary organizations. The main objective of FRISAM is to mobilize, encourage, coordinate and develop a broad range of voluntary social, humanitarian and community work in Norway, and in preparing the way for improved interaction between all parties. The plan for the disabled (1994—98) will give priority to the establishment of a scheme for providing support persons* for people with psychiatric problems.

It must however be emphasized that there is no intention to integrate voluntary activities in the public service as statutory activities. Voluntary activities are not health services. They must be considered a social resource and not a treatment resource. The voluntary activities must be a supplement to the public responsibility, and not be a replacement for it. The public authorities should cooperate in such a way that voluntary workers receive training in suicide issues, and are given referral possibilities that ensure rapid health service assistance for suicidal people. In the development of expertise, it is important that emphasis is also given to user perspectives. The users' potential knowledge of the issues is a resource that must be made available to professional personnel. Conferences with user organizations are being considered.

Within all areas of health and social services, increased professional expertise in suicide issues forms the basis of work on suicide prevention. However, reinforcement of this expertise is not the only precondition for reducing the incidence of suicide. The organizational framework for the work is an important factor in ensuring that professional expertise can be applied in the best possible way.

Important prerequisites for work on suicide prevention are that the organization of the implemented measures is interdisciplinary, cross-depart-

* Paid local nonprofessional person, whose main function is the provision of social support in daily life.
mentalandintegratedinexistingservices. For the majority of municipalities and county municipalities it would not be appropriate to set up separate teams to deal with all psychosocial problems.

The responsibility for work on suicide prevention in the municipalities must be rooted in the health services, who take the initiative to involve other parties as appropriate. Organizational arrangements and measures must be adapted to local needs and resources. There is a need for improved cooperation both between the different bodies/services at the municipal level and between primary health services and somatic and psychiatric specialist health services.

During the process from contemplating suicide to actually carrying it out, the suicidal person's involvement with the question of suicide is subject to variation. The nonobservable behaviour consists of conscious and unconscious thoughts, impulses or plans of suicide. The observable behaviour consists of suicide threats, unsuccessful and successful suicide attempts. Experiences have shown that, after a suicide attempt, the suicidal person experiences relief and relaxation of tension. It has been found that this feeling can last for up to a year after a suicide attempt. On this basis, and because people who have previously attempted suicide are subsequently more likely than others to attempt suicide, researchers recommend aftercare for at least a year after a suicide attempt.

The Bærum model involves just such a follow-up measure. Experiences from this cooperation between Bærum Hospital and the health authorities in the municipalities of Asker and Bærum show that well organized cooperation can lead to very positive results. The cooperation model ensures adequate treatment and follow-up for a long period after a suicide attempt. The Bærum model provides general information about the organization of this type of cooperation measure, which may not necessarily be appropriate for all somatic hospitals and municipalities, but can be an inspiration for locally adapted models. This model will be evaluated within the scope of the plan.

As a result of efforts in connection with the collective plan for development projects within prophylactic and health-promoting work, there are good models for cooperation between different bodies in several of the country's municipalities. It may be appropriate for the present project to view the coordination of measures for prevention and treatment in relation to these projects, and perhaps to use the results achieved in the area of suicide prevention. It will also be appropriate to assess the cooperative relations between specialist and primary health services in municipalities with especially high suicide rates.

The project wishes a survey and assessment to be made of all models for organized cooperation. Further modelling experiments in counties and municipalities are also desirable. If, during the period of the plan, there is found to be a need for new projects directed specifically towards improved cooperation and coordination of efforts in relation to suicidal people, it will
be possible to allocate funds for this purpose. However, it is primarily appropriate to focus on spreading existing models and experiences within this field.

As regards confidentiality of registration routines, the project will take as its basis the work being carried out in cooperation between the Ministry of Health and Social Affairs, the Ministry for Children and Family Affairs and the Norwegian Board of Health.

4.5 Information and evaluation

4.5.1 Information about the project

It is important that the project manager and information officer in the Norwegian Board of Health ensure that information expertise is involved in the work of the project as early as possible. These persons will have responsibility for the preparation of an information plan and for providing the necessary information about the project.

The target group for information about the National Plan for Suicide Prevention will be relevant professionals and also users.

Development of an information folder must be considered. All matters concerning contact with the press must be clarified between the project manager and the steering group.

4.5.2 Evaluation

The evaluation process must be planned as early as possible.

The National Plan for Suicide Prevention can be evaluated on two levels: on the first level, the plan as a whole; on the second level, the individual projects, which shall be evaluated locally. This will be a precondition for funding, and will be supervised by the central project.

The objectives and results of the subsidiary projects will be the most important subjects for evaluation. However, one area of evaluation will be the question of whether the organization of the project concerned is appropriate for national efforts in a specific problem area, where research, implementation of measures and development of expertise are all involved. The individual aspects of the project to be evaluated must be discussed in detail with the evaluators.

It is desirable that a standard for self-evaluation of local projects be prepared by the evaluator.
We envisage that the following practical steps will be carried out:

• devise an evaluation strategy
• propose and discuss evaluation criteria and methods for the plan
• carry out program evaluation 1994–98 (includes interim status reports with subsequent adjustments of areas of focus/primary objectives)
• advise on evaluation criteria and methods for individual projects under the plan
• draft a final evaluation report
• clarify the relationship between the evaluator, the steering group and the Ministry of Health and Social Affairs.
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The National Plan for Suicide Prevention has been prepared by the Norwegian Board of Health on the instructions of the Ministry of Health and Social Affairs. The National Plan is to extend over a five-year period from 1994 to 1998.

Within the scope of the plan, training programmes will be developed to increase the professional expertise required when dealing with persons with suicide problems. The research is to be increased and systematized, and a number of local modelling experiments are to be carried out. Measures will be evaluated and made widely available. The National Plan recommends that municipalities and county municipalities organize activities and cooperation in such a way that people prone to suicide are helped through examination, treatment and follow-up. Regional resource centres will be developed, which will be given the responsibility for training and guidance, as well as a certain amount of research.

The problem of suicide is one that concerns us all, and is multidisciplinary. An important precondition for dealing with the problem is that specialists, organizations and public authorities cooperate in the organization of measures. It is intended that the national plan shall encourage the provision of the necessary help for people at risk.