FOLKETINGETS
OMBUDSMAND

Thematic Report on Prevention of Suicide and Suicide Attempts

Doc. No. 14/03194-2

What has the theme led to?

Prevention of suicides and suicide attempts was one of the themes for the monitoring visits which the Ombudsman carried out in institutions for adults in 2013 in cooperation with the Danish Institute for Human Rights (IMR) and DIGNITY – Danish Institute Against Torture.

The Ombudsman's overall impression was that the institutions were generally conscious of the need to prevent suicides and suicide attempts.

The Ombudsman has discussed the issue of general guidelines for the suicide risk screening carried out by prison staff within the Department of the Prison and Probation Service. In addition, the Ombudsman has recommended that the Department considers introducing guidelines for the prison staff's monitoring of suicidal inmates.

The Ombudsman has sent this report to the Department of the Prison and Probation Service, the Ministry of Health and Prevention, the Ministry for Children, Gender Equality, Integration and Social Matters and to the National Board of Social Services. The purpose is to notify the authorities of the report so that the authorities can include it in their deliberations concerning this issue.

Please read more about the Ombudsman's work on various themes in the appendix to this report.

Reasons for the choice of theme

The Ombudsman has a number of general focus areas during his monitoring visits. Prevention of suicide and suicide attempts is part of the general focus area regarding health-related matters.

According to an agreement with the Department of the Prison and Probation Service, the Ombudsman has for a number of years been apprised of incidents which have been reported according to the rules on reporting deaths, including suicide, and suicide attempts among inmates in the prison service institutions. The rules now appear from the Department's circular on the institution's treatment and reporting of incidents involving death, suicide, suicide attempt and other suicidal or self-harming behaviour among inmates in the care of the prison service.

When for instance a suicide takes place in a prison service institution, the institution will investigate the incident and send a detailed report to the Department of the Prison and Probation Service which will then make a decision in the case. The Department sends its decision and the case documents to the Ombudsman for assessment.

Similar arrangements have been agreed with the Ministry of Justice in relation to incidents in police holding cells and with Region Zealand with regard to incidents at the secure forensic psychiatric hospital at Nykøbing Sjælland.

With this theme the Ombudsman particularly wished to examine the measures taken to prevent incidents involving suicide and suicide attempts by institutions in other sectors, for instance by accommodation facilities and psychiatric wards.

The Ombudsman's monitoring is particularly aimed at society's most vulnerable citizens. Some of the characteristics of the group of vulnerable citizens are that they usually have very few resources and that their rights may easily be put under pressure. This may also apply to people who are at risk of committing suicide.

What did the Ombudsman do?

In 2014, the Ombudsman chose prevention of suicide and suicide attempts as one of the themes for his monitoring visits to institutions for adults. The theme was cross-sectional, in the sense that prevention of suicide and suicide attempts was relevant in connection with the majority of the visits that year. Consequently, the theme was relevant in connection with visits to local prisons and psychiatric wards but also in connection with visits to for instance accommodation facilities in the social services sector.

The theme included the following topics:

- The Ombudsman asked the institution to provide advance information to a relevant extent on the following:
    - Written material on prevention of and follow-up on suicide and suicide attempts, including any instructions with practical directions for the institution's handling of a person who is or may be suicidal.
    - Number of suicides and suicide attempts within the last three years.

  - Supplementary training of staff in preventing and following up on suicide and suicide attempts.
  - Procedure for screening of whether or not a person is suicidal.

- In addition, the Ombudsman asked the institution to account in advance for the following, when relevant:
  - How does the institution prevent suicide and suicide attempts?
  - How does the institution handle groups which may be at special risk of (attempting) suicide, for instance new inmates/newly hospitalised patients, newly discharged psychiatric patients and persons who have previously attempted suicide?
  - How does the institution handle groups which may present special difficulties in assessing whether they are suicidal (for instance psychotic users, safeguarded users, users with a non-Danish ethnic background and users who do not speak Danish)?

- The talks which the Ombudsman's monitoring team had with the management, staff, relatives and users at the institution were also focused on the prevention of suicide and suicide attempts.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to section 18 of the Ombudsman Act and as part of the Ombudsman's work to prevent people who are or who may be deprived of their liberty being exposed to for instance inhuman or degrading treatment, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The Ombudsman's work to prevent degrading treatment, etc. pursuant to the protocol is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. The Human Rights Institute and DIGNITY contribute to the cooperation with special medical and human rights expertise, meaning that staff with this expertise participates in the planning and execution of and follow-up on monitoring visits on behalf of the two institutes.

What did the Ombudsman find?

On the basis of the completed visits, the Ombudsman noted the following, among other things:

- Psychiatric wards had screening procedures and written instructions, etc. on for instance prevention and suicide risk assessment. Several wards provided relevant supplementary training for staff and some wards were planning to have supplementary training.

- Accommodation facilities did not have written material, screening procedures or supplementary training.

- There were differences between the prison service institutions regarding written material, screening and supplementary training.

- The Ombudsman's overall impression was that the institutions were generally conscious of the need to prevent suicide and suicide attempts.

Recommendations

The 2014 monitoring visits provided the Ombudsman with a long range of data on the prevention of suicide and suicide attempts in the institutions.

The information gave the Ombudsman's monitoring teams cause to make various recommendations.

For instance, it was recommended to some institutions that they draw up a set of guidelines on how to prevent suicide and suicide attempts. It has also been recommended that guidelines be drawn up on screening for suicidal behaviour.

Prior to a monitoring visit to one of the prison service institutions, the Ombudsman received the guidelines for suicide risk assessment by the healthcare staff. The prison staff assessed the suicide risk until the healthcare staff were able to assess the inmate. As the prison staff were not healthcare professionals, and as there were no guidelines for the prison staff's assessment, it could be difficult for the prison staff to carry out a professionally safe assessment.

The Ombudsman's monitoring team therefore recommended adding guidelines for the suicide risk assessment carried out by the prison staff and other staff groups.

At the annual meeting in 2015, the Ombudsman and the Department of the Prison and Probation Service discussed the issue of general guidelines for suicide risk screening carried out by particularly other staff groups than healthcare professionals. The Department stated that admission units have been established in all prisons where newly arrived inmates are screened for the risk of suicide. The case regarding general guidelines is pending.

The issue of fixed guidelines for the observation by prison staff of suicidal inmates was discussed with the Department of the Prison and Probation Service at the annual meeting in 2014. In this context, the Ombudsman recommended that the Department consider establishing guidelines for monitoring at fixed intervals.

At the meeting in 2015, the Department stated that the work of writing such standards was in motion. The case is pending.

Copenhagen, 1 June 2015

Themes for monitoring visits

Every year, the Ombudsman selects one or more themes for the year's monitoring visits in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The selection of a definite theme depends especially on where an additional monitoring effort is required. The Ombudsman often selects a narrow topic such as placement in solitary confinement cell under the Prison and Probation Service. At other times, the Ombudsman selects broad themes such as institutions for adults and treatment of alcohol and drug abuse.

The themes enable the Ombudsman to include current topics in the monitoring visits and to undertake an in-depth investigation of certain issues and to gain experience of practice, including best practice.

A principle aim of the carrying out of monitoring visits during that particular year is to clarify and investigate the themes of the year in question. In consequence of this, the main part of the annual monitoring visits are undertaken in institutions where the topics are relevant.

Thematic Reports

At the end of the year, the Ombudsman reports on the outcome of the monitoring visits during the year in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The themes are especially reported in separate reports on the individual topics. The Ombudsman sums up and communicates the most important results of the themes in the reports.

General recommendations

The outcome of the themes may be general recommendations to the authorities such as, for example, a recommendation to draw up a policy for the prevention of inter-user violence and intimidation.

General recommendations are based on the Ombudsman's experience within the specific field. Such recommendations would normally be given to specific institutions during previous monitoring visits.

In general, the Ombudsman will discuss the follow-up on his general recommendations with key authorities. Furthermore, the Ombudsman will follow up on his recommendations during the monitoring visits.

The general recommendations are aimed at having a preventive effect. The reason for the preventive work within the monitoring area is based on the Ombudsman's task as National Preventive Mechanism pursuant to The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

The thematic reports are published on the Ombudsman's website www.ombudsmanden.dk. In addition to this, the Ombudsman also submits the reports to the relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors.