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WHAT CAN BE LEARNED FROM THE SYSTEMATIC ANALYSIS OF SUICIDES THAT OCCUR IN THE HEALTHCARE SYSTEM?

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Many European countries have a national suicide preventive programme. In June 2008, a new national programme for suicide prevention was approved by the Swedish Parliament in Sweden. One of the nine strategies in this programme is an assignment called 'Lex Maria' - to report all suicides that occur within or 28 days after contact with the healthcare system to The National Board of Health and Welfare (NBHW). Lex Maria guarantees that a systematic evaluation will always occur, providing opportunities to identify components which can be improved when treating suicidal patients. All Lex Maria reports are registered in a separate database at NBHW, allowing systematic analysis at a national level. The methodology used in this analysis will be presented, with examples of individual cases.
Analysis of all suicide cases, which occurred in Sweden in 2006 within the health care system, uncovered the following areas which should be improved when working with suicidal people:

- Better routines for suicide risk assessment;
- Better routines for documentation of suicide risk assessment and changes in patients mood;
- Better routines for the transfer of information within the same unit;
- Better communication between units to ensure correct transfer of information;
- Better routines for collaboration between care givers to ensure a continuity of care.

In order to increase the competence of psychiatric health care staff in caring for suicidal patients, an annual 2 day education programme/course is recommended. The government also has an ambition to increase awareness of suicide prevention in the population.

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