



WHO European Ministerial Conference on Mental Health

Facing the Challenges, Building Solutions

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Briefing



Suicide prevention

“I actually thought that Wendy was getting a little better and that all she had to do was stick it out. I now realise that it is at this very point that people are at their most vulnerable. They have a little energy and can see where they are and, of course, it is light years away from where they want to be. It all seems so hopeless to them and it did to Wendy as she said in her note.”

(Widower, personal communication to Technical Officer, Mental Health, WHO Regional Office for Europe)

Facing the challenges

Suicide is not only a personal tragedy, it represents a serious public health problem, particularly in the WHO European Region. From 1950 to 1995 the global rate of suicide (for men and women combined) increased by 60% (1). Among young and middle-aged people, especially men, suicide is currently a leading cause of death.

According to the latest available data, an estimated 873 000 people around the world, and 163 000 in the European Region, die from suicide each year (2). While suicide was reported to be the thirteenth leading cause of death globally, it was the seventh leading cause of death in the European Region. The highest rates in the European Region are also the highest in the world.

A problem on the rise

There is an increase in mental disorders and self-destructive behaviour in both poor and rich countries (3). All predictions show that a dramatic increase in suicidal behaviour is to be expected in the coming decade unless effective

In the European Region, in the age group 15–35 years, suicide is the second most common cause of death after traffic accidents.

preventive measures are put in place.

In countries in the European Region, the average suicide rate is 17.5 per 100 000 population. The mortality supplement to the WHO Health for All database for the latest available year (4) shows that the rates vary considerably in the Region, from 44.0 in Lithuania, 36.4 in the Russian Federation or 33.9 in Belarus, to 5.9 in Italy, 4.6 in Malta or 2.8 in Greece. The gap between the newly independent states of the former Soviet Union (NIS) and European Union (EU) countries is 15.8 per 100 000 population. There are also huge differences between the genders for all age groups. In Lithuania, for instance, 81.7 out of every 100 000 men commit suicide compared with 11.5 women; corresponding figures in Kazakhstan are 58.8 and 9.1, and in Latvia 48.8 and 10.4.

Social impact and economic costs

The psychological, social and financial impact of suicide on the family and society is immeasurable. On average, a single suicide intimately affects at least six people. If a suicide occurs in a school or workplace, it has an impact on hundreds of people.

Suicide and attempted suicide result in major economic losses.

Besides the direct loss of life, there is the long-lasting psychological trauma of family and friends, and the loss of economic productivity for society.

The burden of suicide can be estimated in DALYs (disability-adjusted life years). In 2002, self-inflicted injury was responsible for 1.4% of the total burden of disease worldwide (2) and for 2.3% of the burden in the European Region. Direct costs reflect treatment and hospitalization following suicide attempts, and indirect costs represent potential lifetime income lost due to suicide-related disability and premature death.

Risk factors

Suicidal behaviour has a large number of underlying causes. It is associated with a complex array of factors that interact with each other and place individuals at risk. These include:

- psychiatric factors such as major depression, schizophrenia, alcohol and other drug use, and anxiety disorders;
- biological factors or genetic traits (family history of suicide);
- life events (loss of a loved one, loss of a job);
- psychological factors such as interpersonal conflict, violence or a history of physical and sexual abuse in childhood, and feelings of hopelessness;
- social and environmental factors, including availability of the means of suicide (firearms, toxic gases, medicines, herbicides and pesticides), social isolation and economic hardship.

Some risk factors vary with age, gender, sexual orientation and ethnic group. Marginalized groups such as minorities, refugees, the unemployed, people in or leaving prisons, and those already with mental health problems, are particularly at risk.

Suicide rates can be reduced if depression and anxiety are treated. Studies have confirmed the beneficial effects of antidepressants and psychotherapy.

Protective factors

However, the presence of sufficiently strong protective factors may reduce the risk of suicide.

Protective factors are related to emotional well-being, social integration through participation in sport, church associations, clubs, etc., connectedness with family and friends, high self-esteem, physical and environmental aspects such as good sleep, a balanced diet, physical exercise and a drug-free environment, as well as various sources of rewarding pleasure.

Building solutions

In response to this serious public health problem, substantial efforts have been made in many countries to prevent suicide (5). WHO has produced an updated inventory of national strategies for suicide prevention in WHO's European Member States (6).

At a WHO meeting on suicide prevention strategies in Europe, held in Brussels on 11 and 12 March 2004, health policy-makers and experts in mental health and suicide behaviour from 36 Member States in the European Region discussed current evidence and practices in suicide prevention and formulated recommendations for suicide prevention strategies.

The conclusions of the meeting can be summarized as follows:

- Suicide and attempted suicide present serious public health problems. In some countries, more people commit suicide than are killed in traffic accidents.
- Age and gender are important aspects of suicide risk and trends and need to be considered in the development of suicide prevention programmes.
- Media reporting that glamorizes suicide adversely influences public attitudes and may contribute to an increase in suicidal behaviour.

The main recommendations were:

- The prevention of suicide and attempted suicide requires a public health approach. The burden of suicide is so large that this should be a responsibility for the entire government, under the leadership of the Ministry of Health.
- Suicide prevention programmes are needed. They should consider specific interventions for different groups at risk (e.g. age- and gender-

related), including tasks allocated to different sectors (education, labour market, social affairs, etc.), and they should be evaluated.

- Health care professionals, especially in emergency services, should be trained to identify suicide risk and proactively collaborate with mental health services.
- Education of both health professionals and the general public should start as early as possible and focus on both risk and protective factors.
- Policy-oriented research and evaluation of suicide prevention programmes are needed.
- The media should be involved and trained in suicide prevention and the WHO code of conduct on media behaviour in relation to suicidality should be promoted (7).

The Action Plan for adoption at the WHO European Ministerial Conference on Mental Health (Helsinki, January 2005) proposes a number of specific measures, including:

- measuring base rates of stress indicators and identifying groups at risk;
- targeting marginalized groups with education, information and support programmes; and
- establishing self-help groups, phone help lines and websites for people in crisis situations.

Strategies for suicide prevention

Suicide prevention strategies are concerned with:

- identifying and reducing availability and access to the means of suicide (handguns, toxic substances, etc);
- improving health care services and promoting supportive and rehabilitation functions for persons affected by suicidal behaviour;
- improving diagnostic procedures and subsequent treatment;
- increasing awareness among health care staff of their own attitudes and taboos towards suicide prevention and mental illness;
- increasing knowledge through public education about mental illness and its recognition at an early stage;
- supporting media reporting on suicide and attempted suicide;

- promoting research on suicide prevention and encouraging collection of data on the causes of suicide, by avoiding duplication of statistical records.

Some examples of suicide prevention

The National Strategy for Suicide Prevention in Finland (1986-1996) (8) was implemented throughout the country, with arrangements for local, regional and national implementation. It was systematically evaluated, both internally and externally, and can be considered a success (9). The strategy included public education, improved access to mental health services, crisis intervention, reduction of access to means of suicide, training of health professionals, training in awareness of co-morbidity factors, monitoring of attempted suicide and recording of individuals at risk requiring preventive intervention. The programme incorporated action by professionals, the social services and statutory agencies, but not specifically by people bereaved by suicide.

Some other examples of ongoing national programmes are given below.

“Choose Life” – the national strategy and action plan to prevent suicide in Scotland (2002) aims to reduce the rate of suicide by 20% by 2013. A national network has been formed with representatives of local councils, police, ambulance, accident and emergency services, prison services and key nongovernmental organizations (NGOs), and a national training and capacity-building programme was established. Implementation is concentrated on 32 local council areas, and the local plans focus on three key objectives:

- achieve coordinated action for suicide prevention across health care services, social care services, education, housing, police, welfare and employment services;
- develop multi-professional training programmes to build capacity for supporting the prevention of suicide;
- provide financial support for local community and neighbourhood interventions (10).

The Action Plan for Preventing Suicidal Behaviour in Estonia is structured on a detailed matrix setting out different strategies for specific target groups and detailing goals, programmes, timing, categories of people responsible, expected results, risks, etc. The plan envisages setting up a national centre with an official mandate and funds for coordinating and developing suicide prevention work in the country. Monitoring of attempted suicide events and recording of individuals at risk who require preventive interventions are included as key elements in the plan.

The German National Suicide Prevention Programme (Nationales Suizidpräventionsprogramm für Deutschland) (2003) (11) is remarkable in terms of the broad set of working groups, administrative agencies and federal institutions covered. The following interventions are indicated: public education, crisis intervention, suicide prevention in children and young people, suicide prevention in workplaces, reduction of access to the means of suicide, detection and treatment of depression and related conditions and dealing with specific psychiatric disorders, training of health professionals and awareness training on comorbidity factors.

Specific working groups are dedicated to substance abuse disorders and populations at risk, as well as to survivors and bereaved family members.

Working with the media is also a key issue covered by the programme.

To prevent suicide among adolescents, **Denmark** has developed an **educational programme** that has initiated pilot projects in schools and other educational institutions. Teachers, youth workers, clergy, doctors, nurses, social workers, etc. are involved.

“Driving licence for a teenager” is a programme aimed at giving parents basic information about dialogue and frustration and teaching them how to bond with their children (12).

Challenging the stigma

Suicide has long been a taboo subject and is still surrounded by feelings of shame, fear, guilt and uneasiness. Many people have difficulties discussing suicidal behaviour, which is not surprising since it is associated with extremely

powerful religious and legal sanctions. Ideas about suicide being noble or detestable, brave or cowardly, rational or irrational, a cry for help or a turning away from support contribute not only to confusion but also to ambivalence towards suicide prevention. In many countries, it was not until as late as the 20th century that religious sanctions were removed and suicidal acts ceased to be criminal. Suicide is often perceived as being predestined and even impossible to prevent.

Such taboos and emotions are important factors hindering the implementation of suicide prevention programmes. When working in suicide prevention, one must be aware that not only is it necessary to increase knowledge in a rational way, one must also work with unconscious ideas and attitudes about suicide prevention. This kind of work is of great importance in paving the way for the development of suicide prevention programmes in which scientific, clinical and practical knowledge concerning suicide prevention can be conveyed.

Stakeholder involvement

Examples of stakeholder involvement can be found throughout the European Region.

The **International Association for Suicide Prevention** (IASP) is an NGO in official relationship with WHO, bringing together professionals and volunteers from more than fifty different countries and dedicated to preventing suicidal behaviour, alleviating its effects, and providing a forum for academics, mental health professionals, crisis workers, volunteers and suicide survivors.

Other organizations play a crucial role in proposing free services to help people who feel suicidal, by telephone, in face-to-face meetings, by letter and by email in a non-judgemental and confidential way. One of the oldest organizations in Europe, the **Samaritans** has developed a network of international support services, run by volunteers trained in the art of listening and empathy to offer confidential emotional support to any person who is suicidal or despairing.

Various **suicide prevention centres** have been set up across Europe, providing early support and intervention: telephone crisis lines, training for front-line workers and general practitioners,

support for survivors (friends and family who experience the death of someone by suicide), undertaking research and campaigning for raising public awareness to suicide.

Verder (“Further On”) is a network that supports suicide survivors in Flanders (Belgium), made up of fifteen support groups throughout the Flemish region that initiate and coordinate activities for suicide survivors to help them resolve their grief and pain. The network published a booklet (13) containing basic information on suicide bereavement and how to support survivors. This is freely distributed among general practitioners, hospitals, mental health centres, help lines, self-help groups, victim care centres and social services, and is announced in the media for the general public.

Other initiatives are a theatre play on survivorship that is presented across the country and a media award for journalists for responsible and respectful portrayal of suicide and suicide survivors. The network launched *The Charter of the Rights of Suicide Survivors*, which has been endorsed and translated by other organizations in Europe.

The survivor has the right:

- to know the truth about the suicide;
- to live, wholly, with joy and sorrow, free of stigma or judgment;
- to find support from relatives, friends, professionals and to place his/her experience in the service of the others;
- to never be as before: there is a life before the suicide, and a life afterwards.

In Ukraine, a country with one of the highest male suicide rates (61.8 per 100 000) (14), the NGO **Human Ecological Health** (Odessa) works particularly with prison services and the Ukrainian army, offering training on suicide prevention for officers and medical doctors working in penitentiaries.

In Serbia and Montenegro, the association **Srce** (“Heart”) has been working for more than ten years in the region of Novi Sad, offering emotional support by telephone for people in crisis and organizing outreach programmes aimed at high-school adolescents.

Mental Health Europe, a European NGO, lobbies to heighten awareness of the burden of suicide and

raise the profile of suicide prevention programmes at the policy-making level. It helps its member organizations, especially in central and eastern European countries, to take action and set up projects with national and local agencies, European academic and research groups, mental health service users and social organizations.

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Further reading¹

International Association for Suicide Prevention
<http://www.med.uio.no/iasp/index.html>

Samaritans
<http://www.samaritans.org.uk/>

Verder
<http://www.werkgroepverder.be/>

Srce
<http://www.centarsrce.org.yu/>

Mental Health Europe
<http://www.mhe-sme.org/>

¹ All web sites accessed 28 October 2004

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