euregenas

European Regions Enforcing Actions Against Suicide

- Work Package 6 -

General Guidelines on Suicide Prevention

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About Euregenas

The **Euregenas project aims at contributing to the prevention of suicidal thoughts and behaviours in Europe** through the development and implementation of strategies for suicide prevention at regional levels which can be of use to the European Union as examples of good practice. The project brings together **15 European partners**, representing 11 European Regions with diverse experiences in suicide prevention (see Figure 1).

Figure 1 – The Euregenas Regions

University Hospital Verona (**AOUI-VR**) – Italy

Flemish Agency for Care and Health (**VAZG**) – Belgium

Region Västra Götaland (**VGR**) - Sweden

Romtens Foundation (**ROMTENS**) - Romania

National Institute for Health and Welfare (**THL**) - Finland

Unit for Suicide Research, University Ghent (**UGENT**) – Belgium

Fundación Intras (**INTRAS**) – Spain

Servicio Andaluz de Salud (**SAS**) – Spain

Fundación Pública Andaluza Progreso Y Salud (**FPS**) - Spain

Mikkeli University of Applied Sciences (**MAMK**) - Finland

Technische Universität Dresden (**TUD**) – Germany

Regional Public Health Institute Maribor (**RPHI MB**) – Slovenia

West Sweden (**WS**) – Sweden

De Leo Fund (**DELEOFUND**) – Italy

Cumbria County Council (**CCC**) - United Kingdom

In line with the '***Second Programme of Community Action in the Field of Health'*** *(European Commission, 2008-2013, see* http://ec.europa.eu/health/programme/policy/2008-2013/*)*, the project promotes the use of regional cluster management as innovative method to improve the existing services.

By encouraging regional interventions and campaigns dedicated to both target groups and non-health stakeholders, **the project aims at implementing the Mental Health Pact** in relation to:

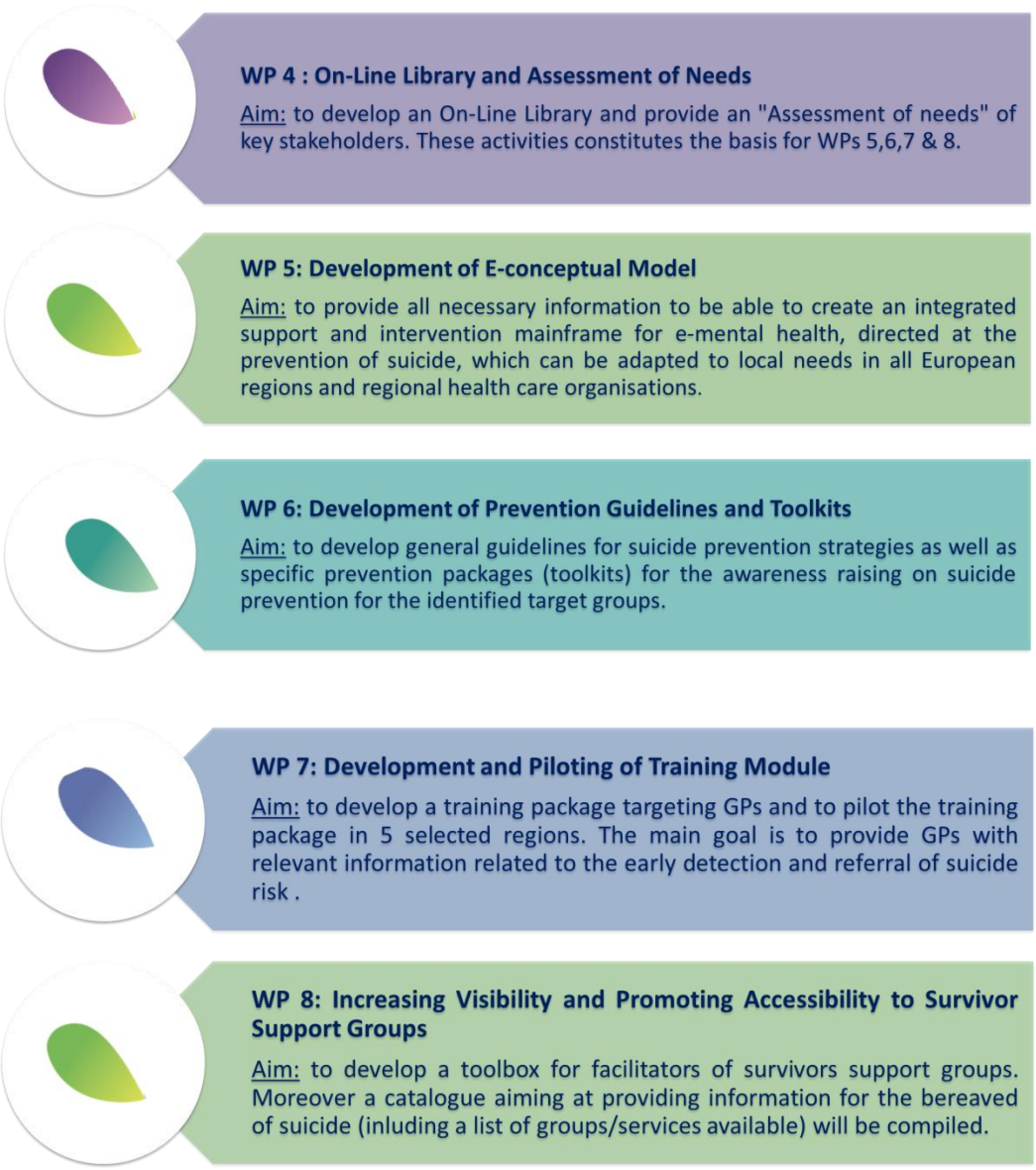
1) Prevention of suicide
2) De-stigmatization of mental health disorders
3) Promoting health in youth

The **specific objectives** of the Euregenas project are the following:

- To identify and catalogue good practices of existing actions and strategies on suicide prevention at a regional and local level;
- To carry out a stakeholders` needs analysis;
- To develop and disseminate guidelines and toolkits on suicide prevention and awareness raising strategies;
- To develop the technical specifications for an integrated model for e-mental healthcare oriented at suicide prevention;
- To improve knowledge and capabilities among local and regional professionals (i.e. psychologists, psychiatrists, GPs).

The project aims at meeting its specific objectives by **a series of Work Packages (WP)**. The Euregenas project includes eight work packages: 3 horizontal work packages, respectively on coordination, dissemination and evaluation and 5 vertical core work packages (see Figure 2).

Figure 2: the Euregenas core work packages



Executive Summary

The general guidelines for suicide prevention described in this document target policy makers and aim at raising awareness of suicide prevention strategies. The key message for policy makers is that suicide prevention is possible and that it involves multi-level, intersectorial policies and programs.

The document includes four main sections:

1. The **introduction**, which includes the background of the general guidelines for suicide prevention.
2. **Key facts on suicidal behaviour** such as epidemiological data, common myths and an explanatory model of suicidal behaviour.
3. A review of the effectiveness of **suicide prevention interventions**, respectively focusing on mental health promotion, providing helplines and online help, educating professionals, specific programmes targeting vulnerable groups and suicidal persons, and limiting the access to lethal means.
4. **Recommendations** for creating a national suicide prevention action plan and conducting research on suicidal behaviour.

This document has been developed by the Unit for Suicide Research at Ghent University, which is the lead partner of Work Package 6 of the Euregenas project, with the valuable collaboration of the other Euregenas Associated Partners and of local experts on suicide prevention, who have been invited to provide their comments and feedback.

I. Introduction

Suicide is a major public health issue in Europe accounting for an average suicide prevalence rate of 13.9 per 100000 (World Health Organization). In many societies the topic of suicide remains a taboo. However, the prevention of suicide receives increasing attention all over the EU, with the development of actions, prevention programmes and national prevention strategies in order to improve mental health and to decrease the number of deaths by suicide.

The 'general guidelines' described in this document aim at contributing to the prevention of suicidal behaviour in Europe. The guidelines are the first deliverable of work package 6 of the Euregenas project.

The following guidelines target **policy makers** working in sectors in which suicide prevention plays a significant role. As suicide prevention demands a multi-sectorial approach, it can be an important issue not only within the health sector, but also in non-health sectors such as education, labour, law, the media, etc. The guidelines aim at offering background information on suicidal behaviour and an overview of suicide prevention strategies and good practices. They provide an outline of potential contributions to the prevention of suicide within a region, country or the European Union.

We encourage policy makers to read these guidelines together with the report of the WHO **'Public Health Action for the prevention of suicide: a framework'**, which includes a stepwise approach in developing suicide prevention strategies (see www.who.int).

The guidelines are based on an **analysis of regional needs** of key stakeholders and a **comprehensive literature and good practice review** embedded in Work Package 4 of the Euregenas project. Additionally, an international literature review of the effectiveness of suicide prevention strategies was conducted, using 'Web of Knowledge'. Furthermore, **regional networks** have been established in five participating regions to support the development and implementation of these guidelines. The networks involved policy-makers, public health experts, community players and stakeholders in the field of suicide prevention.

The general guidelines are available in five languages and can be downloaded from the website www.euregenas.eu

II. Key Facts

Definitions

Suicidal thoughts and behaviour can be defined as a complex process that can range from suicidal ideation, through planning of suicide, to attempting suicide and ending in suicide. Suicidal behaviour is the consequence of interacting biological, genetic, psychological, social, environmental and situational factors (Hawton and van Heeringen, 2009).

Definitions of suicide and suicide attempts have changed over time. De Leo and colleagues (2004) define **suicide** as: "a non-habitual act with a fatal outcome which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes."

Non-fatal suicidal behaviour, including suicide attempts and deliberate self-harm, is defined as follows: "a non-habitual act with non-fatal outcome that the individual, expecting to, or taking the risk, to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes".

Epidemiology

Suicide is a significant public health issue in the European Union accounting for over 58 000 deaths per year (World Health Organization, 2003). Suicide affects people of all ages, cultures and population groups. The World Health Organization (WHO) states that nine of the ten countries in the world with the highest suicide rates are in Europe. Within the European Union, Lithuania, Hungary and Finland show the highest suicide rates. In general, southern countries as Italy and Cyprus show lower rates. Male suicide rates are higher than female suicide rates in all countries of the European Region. Most suicides occur in the age group 35-44 years.

Suicide attempts are much more common than suicides. Studies show that nonfatal suicidal acts occur at least 10 times more frequently than fatal suicides. Unlike fatal suicidal acts, non-fatal suicidal behaviours are most common among adolescents and decrease with age (Nock et al., 2008).

Every suicide and suicide attempt directly or indirectly also affects other people. It has a severe impact on the **survivors**, such as spouses, parents, children, family, friends, co-workers, and peers who are left behind, both immediately and in the long-term.

Common myths

There are many misconceptions about suicidal behaviour. In the list below the most common myths are tackled.

Suicide cannot be prevented

One of the most common myths about suicidal behaviour is that it cannot be prevented. However, most people who are suicidal have mixed feelings about death. Even the most severely depressed persons doubt, until the very last moment, between wanting to live and wanting to end their pain. Moreover, there is scientific evidence for a preventive effect of a substantial number of interventions.

Talking about suicide with someone increases the risk of suicidal behaviour

When a person expresses suicidal thoughts, this should not be considered as merely a cry for attention, but as a cry of pain, which indicates that the person is desperate and feels strong emotional pain. Talking about suicidal thoughts and plans does not increase suicidal intent or hopelessness. On the contrary, openly discussing suicidal ideation in a personal setting can be an effective preventive/therapeutic method. Moreover, talking about suicide can save a life by encouraging help seeking.

Suicide is a normal reaction to an abnormal situation

Suicide is not a normal adequate reaction to e.g. extreme stressors in life. Suicide is an unusual and inadequate reaction to a rather normal situation. In life everyone has to deal with stressful situations or negative life events, which often occur, but not everyone will develop suicidal thoughts and plans.

People who talk about suicide will not complete or attempt suicide

The majority of suicide attempters and suicide victims communicated their suicidal thoughts prior to the suicidal act. It is therefore of great importance to take any expression of suicidal thoughts seriously and encourage help seeking.

Understanding suicidal behaviour

Research has clearly shown that suicidal behaviour constitutes a very complex and multifactorial problem. Suicidal behaviour never has one single cause and always develops due to an interaction between risk factors in combination with a lack of protective factors.

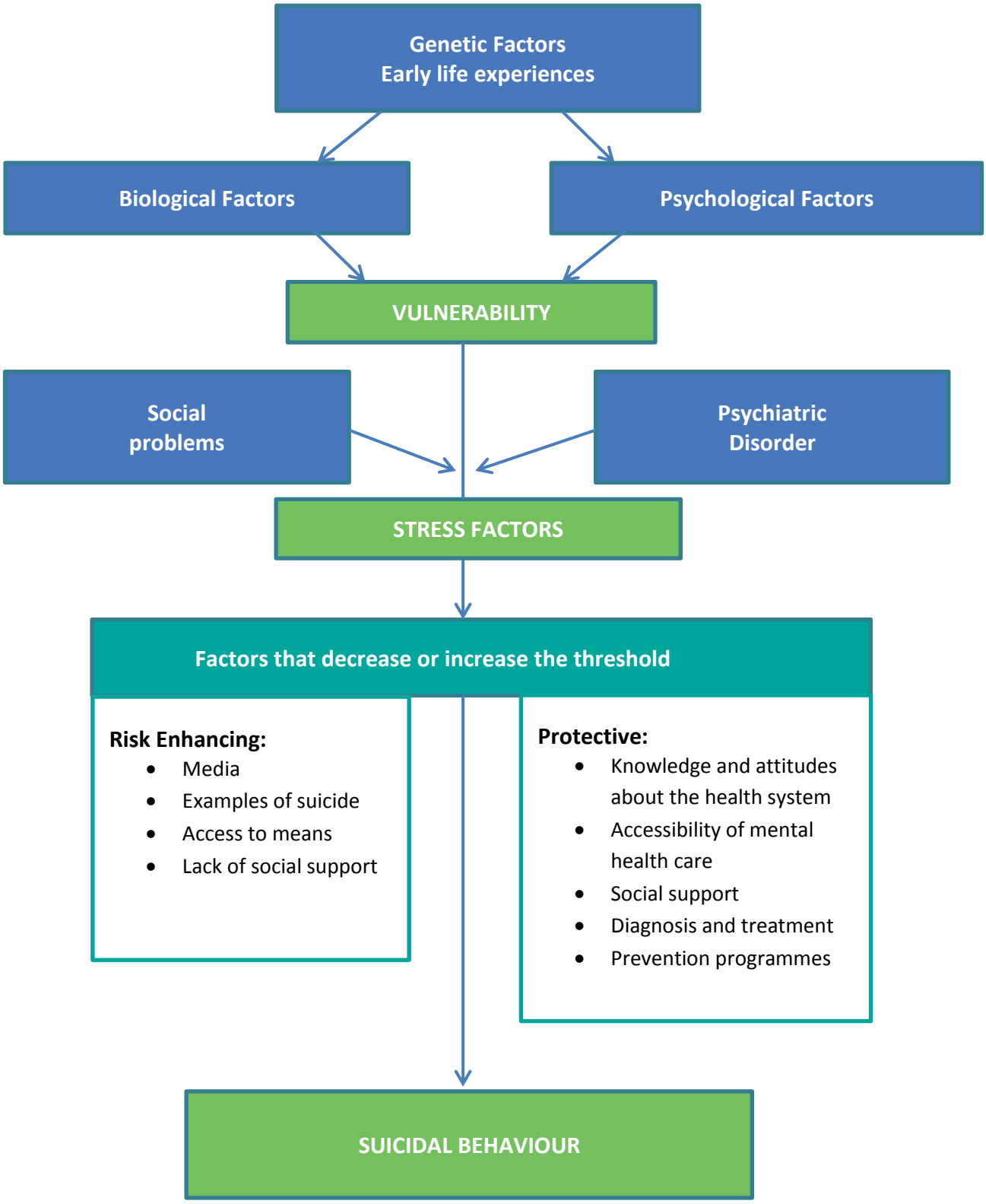
Risk factors include characteristics which increase the likelihood that an individual will consider, attempt, or commit suicide. Risk factors include: a psychiatric disease (e.g. depressive disorder, substance use disorder), a somatic disease (e.g. medical conditions causing chronic pain), early negative life experiences (e.g. losing a parent at an early age, abuse), personal characteristics (e.g. hopelessness, impulsiveness), and previous suicidal behaviour. Risk factors are not static and may differ from country to country.

Protective factors include characteristics which make it less likely that individuals will consider, attempt, or commit suicide. Examples of potential protective factors are: positive self-image, adequate problem-solving behaviour, help-seeking behaviour, social support,…

The **model** described in Figure 3 shows an integrated bio-psycho-social model. It is based on the impact that biological, psychological, psychiatric and social risk factors may have on the development of suicidal behaviour.
The model focuses on three key factors:

- **Trait-dependent factors** such as genetic, biological and psychological factors (e.g. serotonin, personality and cognitive psychological dysfunctions);
- **State-dependent characteristics**, such as depression and hopelessness, influenced by stressors in life (e.g. the economical crisis, social problems, domestic violence) or by a psychiatric disorder;
- **Threshold factors**, which may have a risk enhancing or protective effect. For example, access to lethal means can decrease the threshold to suicidal behaviour, while an accessible health system can have a protective effect and keep persons from developing suicidal behaviour.

Figure 3: An explanatory model of suicidal behaviour (van Heeringen, 2001)

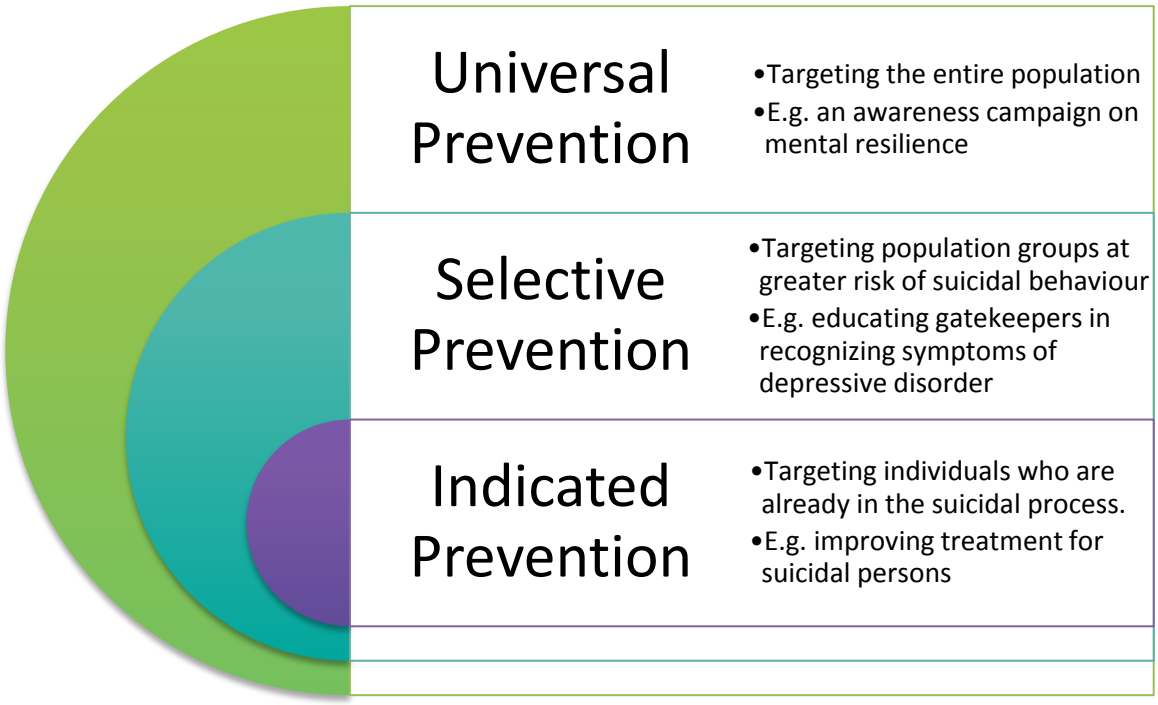


III. Key strategies in the prevention of suicide

In the past two decades a substantial number of suicide prevention strategies have been developed in Europe. This document describes strategies, which are most commonly used and which have proven to be effective in reducing suicide rates.

Levels of intervention

Suicide prevention strategies can be classified in one of three levels of strategies based upon the population they focus on. The USI (Universal-Selective-Indicated) model defines three levels of prevention: universal prevention, selective prevention and indicated prevention (Gordon, 1983; Nordentoft, 2011). To ensure an effective suicide prevention policy, it is recommended to provide actions at all three levels as the prevention of suicide asks for a multi-sectorial approach involving a variety of activities at various intervention levels.



Key strategies in the prevention of suicide

The following strategies are commonly used in national suicide prevention action plans across the EU and beyond. The selection of these strategies is based upon a literature and good practice review which was conducted within the scope of the Euregenas project. Additionally an international literature search has been done using Web of Science (January 2000 to April 2013).

The selected strategies act on different intervention levels, ranging from universal prevention, to selective prevention, to indicated prevention (see Table 1). Some strategies focus on one prevention level (e.g. programmes targeted at vulnerable groups focus on selective prevention), others combine different levels (e.g. mental health promotion can include both universal and selective prevention).

Table 1 Selected strategies and intervention levels

	INTERVENTION LEVELS		
STRATEGIES	UNIVERSAL PREVENTION	SELECTIVE PREVENTION	INDICATED PREVENTION
1. Mental health promotion	X	X	
2. Providing helplines and online help		X	X
3. Educating (mental) health professionals, community facilitators and journalists	X	X	X
4. Programmes targeted at vulnerable groups		X	
5. Programmes targeted at high risk groups			X
6. Restricting access to lethal methods	X	X	X

STRATEGY 1
Mental health promotion

Mental health promotion strategies can contribute to the prevention of suicide as these strategies are often effective in improving factors such as resilience, social inclusion, safe environments (e.g. safe school and work environments), which are protective factors for suicidal behavior.

Balfour (2007) describes mental health promotion as: **"the process of enabling individuals and communities to take control over their lives and improve their mental health. It seeks to increase self-esteem, coping skills and capacities, and family and community supports, as well as modify the broader social and economic environments that influence mental health".**

Mental health promotion covers a variety of strategies, which can be implemented at the individual level, the community level, or both levels:

- Strategies that focus on **individuals** aim at increasing emotional resilience and reducing vulnerability to mental health problems through the development of personal skills, self-esteem, coping strategies, problem solving skills, and self-help, which lead to an increased capacity to cope with life transitions and stress. Examples of these strategies are school-based prevention programmes and on-line self-help tools.
- At **community level**, mental health promotion strategies focus on increasing social inclusion and cohesion. They can include raising awareness, reducing stigma and discrimination, developing supportive environments (e.g. self-help networks) in different settings, e.g. schools, the workplace, the sports club, a community center, older people's residences, etc...
- Some strategies combine actions at **different levels**. Public awareness campaigns, for example, can aim at improving attitudes regarding depressive disorder (community level) and facilitate help seeking behavior (individual level). Studies show modest effects of such campaigns on attitudes regarding depressive disorder, but there is no detectable direct effect on decreasing suicide rates, increased help seeking or more use of antidepressants (Mann et al., 2005; van der Feltz-Cornelis et al., 2011).

[Pictures by FreeDigitalPhotos.net]

STRATEGY 2
Providing helplines and online help

Strategies which improve the accessibility of help for suicidal persons can be helpful in suicide prevention. During the past decades a growing number of countries and regions have started offering help by telephone helplines and online help, which appear to be a good channel to reach suicidal persons, in addition to existing first line health services.

Helplines

Many countries have helplines offering crisis help specifically targeted at suicidal persons. Few studies have examined the effectiveness of these helplines, but most studies show a positive effect (De Leo et al., 2002; Mishara et al., 2007; Kalafat et al., 2007; Leitner et al., 2008). A recent online survey of callers contacting the Samaritans (national suicide prevention helpline of the UK) found that the callers reported high levels of satisfaction with the service and perceived the contact to be helpful (Coveney et al., 2012).

Online help

In the last decade more and more people seek help online. The internet offers a range of possibilities in the prevention of suicide. Many helplines have extended their services with e-mail, chat and outreaching on social network sites. The opportunity to stay anonymous and to get tailored information encourages people to seek help. In this way, e-mental health can contribute to accessible help and lower the threshold to health care and prevention (Christensen et al., 2002; Gilat and Shahar, 2007).

One of the outcomes of the Euregenas project will be the development of ethical guidelines, quality criteria and an e-conceptual model for technology based suicide prevention.

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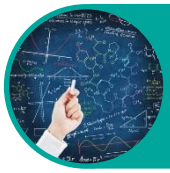

STRATEGY 3

Educating (mental) health professionals, community facilitators and journalists

Educating mental health professionals and community facilitators

Educating (mental) health professionals and community facilitators or gatekeepers is a frequently used strategy for suicide prevention. This is done by providing training or setting up guidelines for these key players.

In general, research shows that providing training on suicide prevention is an effective strategy (Andriessen and van den Brande, 2001; Capp et al., 2001; Matheson et al., 2005; Ramberg and Wasserman, 2004). Trainings have proven to be effective in improving knowledge, attitudes and confidence regarding suicide prevention (Brunero et al., 2008; Gask et al., 2006; Hayes et al., 2008; Oordt et al., 2009).

Training can be provided to different target groups. Educating **general practitioners** (GP's) to recognize and treat depressive disorder and suicidal ideation and behaviours is one of the most effective suicide prevention strategies (van der Feltz-Cornelis et al., 2011).

Further evidence shows that **nurses** (Appleby et al., 2000; Dennis et al., 2001; Fenwick et al., 2004) and **psychology students** (McNiel et al., 2008) benefit from training, as it improves their abilities regarding risk-assessment, assessment of health care needs, and setting up suicide prevention interventions.

But, also **community facilitators** such as teachers, counselors, prevention workers, youth workers and geriatric care providers can play an important role in the detection of at-risk persons and in referring suicidal individuals to healthcare. For example, training teachers and youth workers in how to recognize warning signs of suicidal behaviour and how to intervene and refer in crisis situations, has proven to be effective (Chagnon et al., 2007). Moreover, community facilitators themselves indicate they consider these trainings as necessary (Hawgood et al., 2008; Palmieri et al., 2008; Ramberg and Wasserman, 2004). However, when providing training for teachers it is recommended to integrate these trainings in a broader mental health perspective and policy.

[Pictures by FreeDigitalPhotos.net]

Other gatekeepers that have been involved in suicide prevention training programmes are **priests** (Hegerl et al., 2006), **the police** (Mishara and Martin, 2012; Pinfold et al., 2003; Watson et al., 2004) and **pharmacists** (Bell et al., 2006), and **prison guards** (Pompili et al., 2009).

Educating Journalists

Studies, systematic reviews and meta-analyses regarding the role of media reports on suicide have consistently shown that reporting on suicide can lead to imitative suicidal behaviours, especially when reporting about the suicide method or reporting about the suicide of a celebrity (Pirkis and Blood, 2001; Sisask and Värnik, 2012; Stack, 2000; Stack, 2005).

Therefore many countries have developed guidelines and training programmes for journalists, raising awareness on their crucial role in the prevention of suicide. Media guidelines have proven to have an impact on the quality of media reporting on suicidal behaviour (Niederkrotenthaler and Sonneck, 2007). It must be noted, however, that not all of the studies on educating and providing guidelines for journalists have yielded positive results (Goldney, 2005; Mann et al., 2005).

In addition to media guidelines, some countries (e.g. Australia, Belgium and Denmark) organize media awards to honour journalists for responsible reporting on suicide. Research shows that media awards are positively evaluated by journalists and can as such contribute in a constructive manner to the implementation of media guidelines (Dare et al., 2011).

One of the outcomes of the Euregenas project will be the development of targeted guidelines regarding suicide prevention directed at teachers and school staff as well as guidelines for the workplace, and for journalists.

STRATEGY 4
Programmes targeted at vulnerable groups

Some populations are at increased risk of developing suicidal thoughts and behaviour, e.g. suicide loss survivors, minority groups, and specific age groups. When setting up strategies, it is important to be aware of these vulnerable groups and to set up tailored interventions for them.

It should be noted that the list of vulnerable population groups described below is not limitative and the risk of developing suicidal behaviour within a certain population group can change over time, depending on cultural or societal factors.

Suicide loss survivors

Suicide and psychiatric illness in relatives are identified as risk factors for developing suicidal behaviour. People who lost a relative or significant other by suicide are therefore at higher risk of developing physical and psychological illnesses, and suicidal behaviour (Beautrais, 2004; Qin et al., 2002).

Several countries, e.g. the UK, Belgium and Sweden have developed preventive actions targeting suicide loss survivors, by setting up networks and support groups for survivors, by developing resources for survivors on how to deal with the suicide of a relative or by setting up a helpline for the bereaved.

Minority groups

Minority groups including lesbian, gay, bisexual and transgender people (LGBT) and ethnic minorities have been identified as vulnerable groups for developing suicidal behaviour.

People identified as **lesbian, gay or bisexual** seem to be at higher risk for developing a mental disorder, suicidal ideation, substance misuse, and deliberate self-harm than heterosexual people. At least 16 studies of lesbian, gay, and bisexual (LGB) youth have reported very high rates of suicide attempts, ranging from 20 to 53% (Haas et al., 2011; McDaniel, Purcell and D'Augelli, 2001; Savin-Williams, 2001b; van Heeringen and Vincke, 2000). The same holds for **transgender people,** studies show high rates of suicide attempts (Dhejne et al., 2011; Mathy, 2002).

[Pictures by FreeDigitalPhotos.net]

A European multicenter study showed that **immigrants** in Europe who come from other cultures or from countries with higher number of suicides show higher rates of suicide attempts in comparison with the native population (Bursztein-Lipsicas et al., 2011). Therefore, in some countries, e.g. Germany, specific campaigns targeting immigrants have been set up.

The elderly and the youth

When comparing suicide risks in different age groups, studies show that suicide rates are particularly high among the elderly (De Leo and Spathonis, 2004), while rates of non-fatal suicidal behaviour are higher among youngsters (Nock et al., 2008).

A recent review of prevention programmes targeted at the elderly showed that most (scientifically evaluated) programmes were effective in decreasing depressive thoughts and feelings or suicidal ideation or suicide rates (Lapierre et al., 2011). Most programmes focused on reducing risk factors, e.g. reducing isolation, and improving the screening and treatment of depressive disorder. Few programmes aimed to strengthen protective factors such as improving resilience and positive ageing. This could be an innovative and effective approach. (Lapierre et al., 2011).

The results of suicide prevention programmes targeting adolescents, such as school (curriculum) and community-based programmes, were mixed (Mann et al., 2005).

To conclude, w*hen setting up suicide prevention strategies it is highly recommended to develop targeted and tailored interventions towards vulnerable population groups.* *Interventions can include:*

- ***Enforcing resilience*** *of vulnerable groups;*
- ***Providing specific support*** *for vulnerable groups (through support groups, telephone helplines outreach programmes, leaflets,…);*
- ***Improving accessibility of care*** *for vulnerable groups;*
- ***Raising awareness*** *(and in some cases fighting stigma) on vulnerable groups by educating the population, gatekeepers and (mental) health professionals.*

STRATEGY 5
Programmes targeted at high risk groups

Programmes targeting high risk groups aim at developing strategies for the screening, care and treatment of individuals at increased risk of suicide. The highest risk groups for developing suicidal thoughts and plans include suicide attempters, and individuals with psychiatric disorders.

Improving (after)care for suicide attempters

A history of suicide attempts has consistently been found to be the strongest predictor of future suicidal behaviour (Oquendo, Galfalvy, Russo et al., 2004; Tidemalm et al., 2008). Therefore, effective after-care strategies aimed at individuals who have attempted suicide are very important.

Research shows that follow-up contact with those who have attempted suicide can reduce suicide rates. In their comprehensive review of prevention strategies focusing on follow-up contacts, Luxton, June and Comtois (2013) pointed at the preventive effect of follow-up contacts ranging from making calls and sending postcards, to sending text messages and e-mails.

Improving care for individuals with psychiatric disorders

Suicide has no single cause, although up to 90% of individuals who complete suicide meet the criteria for a psychiatric disorder. Unfortunately up to 80% of such cases were untreated at the time of death (Lopez et al., 2006).

Many psychiatric disorders show an increased risk of suicidal behaviour e.g. depressive disorder, alcohol and substance use disorders, schizophrenia, bipolar disorders, eating disorders and anxiety disorders (Hawton and van Heeringen, 2009).

Prevention of attempted suicide and suicide through adequate diagnostic procedures and treatment of those disorders is, therefore, a high priority in clinical settings. There is, for example, compelling evidence indicating that adequate prevention and treatment of depressive disorder and alcohol and substance abuse can reduce suicide rates (WHO, 2012).

[Pictures by FreeDigitalPhotos.net]

Improving treatment of persons at risk

Data from a recent worldwide survey show that 44% of suicidal people in high income countries do not receive any form of treatment (Bruffaerts, et al., 2011). Investing in both pharmacological and psychotherapeutic treatment of people at-risk should be a priority in mental health care.

Pharmacological treatment has proven to contribute to decrease suicidal risk in individuals with various mental disorders (Mann et al., 2005). For example, higher prescription rates of antidepressants (Moller, 2006) and long term lithium treatment (Baldessarini et al., 2006; Guzzetta et al., 2007) correlate with decreasing suicide rates in depressed patients. However, using antidepressants with depressed youngsters can have adverse effects, so caution has to be taken (Stone et al., 2009).

Many studies and reviews have shown that **psychotherapeutic treatment** is effective for suicidal persons (Brown et al., 2005; Guo and Harstall, 2004; Mann et al., 2005).
Considering the computerized world we live in, technology based suicide prevention is another important and valuable field in the prevention of suicide. E.g. on-line treatment of depressive disorder and suicidal thoughts and behaviours by **self-help interventions** has taken its first steps and has already proven to be effective. A randomized controlled trial of van Spijker (2012) showed a significantly greater improvement in suicidal thoughts, hopelessness, worry and health status of people with suicidal thoughts after participating in a self-help intervention. In New Zealand, a computerized cognitive behavioural therapy intervention game ('SPARX') targeted at depressed adolescents was developed and proved to be as effective as treatment as usual (and in some conditions even more effective) in reducing depressive symptoms (Merry et al., 2012).

STRATEGY 6
Restricting access to lethal methods

Strategies aimed at restricting access to lethal methods are one of the suicide prevention efforts with the most supporting evidence in reducing suicide rates (Mann et al., 2005; Sarchiapone et al., 2011). A possible explanation may be that these strategies can be implemented quite quickly and measured relatively easily, in comparison to other suicide prevention strategies (Florentine and Crane, 2010).

In their review, van der Feltz-Cornelis et al. (2011) listed examples of interventions that aim at limiting physical access to suicide methods:

- Detoxification of domestic gas
- Mandatory use of catalytic converters in motor vehicles
- Restricting the use of firearms, by firearm control legislation
- Restricting the use of pesticides
- Restricting access to jump sites e.g. by installing safety fences at high-rise residential buildings or at high-risk jump sites such as e.g. the Eiffel Tower, Sidney Harbour Bridge and the Empire State Building (Lin and Lu, 2006; Beautrais, 2007)
- Restrictions on prescription and sale of barbiturates and paracetamol
- Use of new, lower-toxicity antidepressants
- Restricting the access to alcohol.

Restriction methods are not without risk. When restricting one method, substitution with other methods of suicide may occur. However, as Nordentoft (2011) points out: “in appropriate contexts, where substitution is less likely to occur, and in conjunction with psychosocial prevention efforts, limitation of physical access to suicide can be an effective suicide prevention strategy”.

[Pictures by FreeDigitalPhotos.net]

IV. Final Recommendations

The benefits of a national action plan for the prevention of suicide

In the last decades many countries and regions have developed comprehensive regional and national suicide prevention programmes e.g. Finland, Sweden, Belgium (region of Flanders), Denmark and the UK.

Having a national strategy can be effective in reducing suicide rates. By analyzing data between 1980 and 2004, Matsubayashi and Ueda (2011) studied if there was a statistically significant difference in the suicide rate before and after the implementation of national suicide prevention programmes. The analysis showed that the overall suicide rates decreased after nationwide suicide prevention programmes were introduced.

In their report 'Public Health Action for the prevention of suicide: a framework' the WHO describes the **key components of a national suicide prevention strategy**. They stress the importance of:

- Clear objectives
- A clear view on risk and protective factors
- Effective interventions
- Prevention strategies at different levels
- Improving case registration and conducting research
- Monitoring and evaluation.

The Flemish action plan for Suicide Prevention additionally includes the following criteria for selecting interventions:

- Suicide specificity of the interventions
- Cost-effectiveness of the interventions
- Quality of evidence of the interventions
- Implementation opportunities of the interventions.

Furthermore, an action plan should be multi-sectorial, as suicide prevention is an important issue within and beyond the health sector. A common numerical health target (e.g. the aim to decrease the suicide rate by a certain percentage over a certain amount of time) could be encouraging to take action. Finally, special attention is needed to ensure the sustainability of the developed strategies and actions.

"Suicide prevention interventions should be multimodal, evidence-based, guided by specific testable hypotheses, and implemented among populations of sufficient size to yield generalizable and reliable results." (Mann et al., 2005)

The need for research

More research is needed in the field of suicide prevention. It is therefore highly recommended to include research within a prevention strategy. Research can contribute to improving our knowledge of:

- Epidemiology of suicides and suicide attempts
- Risk and protective factors of suicidal behaviour
- The neurobiology of suicidal behaviour
- Effectiveness of prevention strategies and actions.

In addition, more research at local and regional levels is encouraged, as significant sociocultural differences in suicidal ideation can occur.

Euregenas on-line library

Under Work Package 4 of the Euregenas project, an on-line library has been developed. The online library, including literature and best practices, provides a comprehensive and up to date overview of the current situation in the European Union regarding suicide prevention.

www.euregenas.eu/online-library

Links

More information on suicide prevention can be found at the websites of the World Health Organization and the International Association for Suicide Prevention.

WORLD HEALTH ORGANIZATION (WHO)

WHO is the directing and coordinating authority for health within the United Nations. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. WHO has many resources in the field of suicide prevention.

www.who.com

INTERNATIONAL ASSOCIATION FOR SUICIDE PREVENTION (IASP)

IASP is a Non-Governmental Organization in official relationship with the World Health Organization (WHO) concerned with suicide prevention. It is dedicated to preventing suicidal behaviour, alleviating its effects, and providing a forum for academics, mental health professionals, crisis workers, volunteers and suicide survivors. Founded by the late Professor Erwin Ringel and Dr. Norman Farberow in 1960, IASP now includes professionals and volunteers from more than 50 different countries.

Annually on September 10th IASP organizes 'World Suicide Prevention Day', which is an opportunity for all sectors of the community to join with the IASP and the WHO to focus public attention on the unacceptable burden and costs of suicidal behaviours with diverse activities to promote understanding about suicide and highlight effective prevention activities.

www.iasp.info

Glossary

Contagion. A phenomenon whereby persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Gatekeepers. Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Mental Health. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (WHO, 2010).

Mental (health) disorder / psychiatric disorder / mental illness. A mental (health) disorder or psychiatric disorderis a diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities.

Mental health problem. Diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.

Non-fatal suicidal behaviour. A non-habitual act with non-fatal outcome that the individual, expecting to, or taking the risk, to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes (De Leo et al., 2004). Non-fatal suicidal behaviour can include attempted suicide, deliberate self-harm and deliberate self-poisoning, with our without injuries.

Postvention. A strategy or approach that is implemented after a crisis or traumatic event has occurred.

Prevention. A strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors (for suicidal behaviour). Factors that make it less likely that individuals will develop suicidal thoughts and/or attempt suicide. Protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Risk assessment. The process of quantifying the probability of an individual harming himself or others.

Risk factors (for suicidal behaviour). Those factors that make it more likely that individuals will develop suicidal thoughts and/or attempt suicide. Risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Self-destructive behavior/deliberate self-harm/self-injury. The various methods by which individuals injure themselves, such as self-cutting, self-battering, taking overdoses or exhibiting deliberate recklessness.

Suicidal ideation and behaviours. A complex process that can range from suicidal thoughts, through planning of suicide, to attempting suicide and ending in suicide. Suicidal behaviour is the consequence of interacting biological, genetic, psychological, social, environmental and situational factors (Hawton and van Heeringen, 2009).

Suicidal intent. Subjective expectation and desire for a self-destructive act to end in death.

Suicide (or 'fatal suicidal behaviour'). An act with a fatal outcome which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes (De Leo et al., 2004).

Suicide attempt survivors. Individuals who have survived a prior suicide attempt.

Suicide risk. The degree of danger to self an individual faces based on the absence or presence of suicidal behaviors and factors associated with the likelihood of suicide.

Suicide (loss) survivors. Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide. Sometimes the term 'suicide survivors' is also used to mean suicide attempt survivors.

Suicide warning signs. Indications that an individual is at risk for suicide.

Technology Based Suicide Prevention (TBSP). Technology-based suicide prevention (TBSP) programmes are programmes designed for the prevention of suicide which can be used by different types of advanced technologies such as the Internet, smartphones and tablets. Technology-based programs include educational and interactive websites, serious games, online treatment, etc…

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