Suicide in Europe: Facts and Recommendations

World Suicide Prevention Day - 10th September 2017

The Facts

1. The epidemiology of suicide in European countries

More than 150,000 people in Europe die by suicide every year. **Suicide is, in some European countries, the leading cause of death amongst young people aged 15–24 years.** The standardized death rate for intentional self-harm in the EU-28 is higher for persons aged 65 and over than for younger people. **Globally, the countries of Eastern Europe have the highest suicide rates in the world (21-35/100000).** It should be noted that the comparability of data on intentional self-harm is limited due to underreporting of suicides in certain EU Member States.

2. Suicide Risk Factors include:

History and family history of suicide; stressful life events and discrimination; somatic comorbidity; psychiatric comorbidity. In adolescents: **pathological internet use, school bullying, domestic violence**, overweight, depression, anxiety, drug and alcohol abuse;
Protective factors include: cognitive flexibility coping strategies; **healthy lifestyle (good diet, good sleeping patterns, active life including physical exercise); social and family support. School-based protective factors include:** school safety, relationships with caring adults at school, school connectedness.

3. Social aspect of risk: Suicide at the workplace

High occupational suicide rates are often linked to people working in **protective service occupations** (e.g. law enforcement officers and firefighters), those with easy occupational **access to lethal means** (e.g. doctors, pharmacists, police, farmers), and in **jobs with high stress and low control**.

4. Warning signs of imminent suicide

Identifying "warning signs" increases the overall number of suicidal individuals accessing care. Among the most important ones are: preparation behaviours, rehearsal behaviours, risk-taking behaviours, observable and objective signs of rage/anger, withdrawal, anxiety/agitation, insomnia/nightmares, substance use, dramatic mood changes and explicit communication of suicidal thoughts.

The Recommendations

1. Prevention of suicide through Education and Training

Education and training programs have been successful in reducing suicidal behaviour, improving the care of at-risk populations and preventing suicide. Campaigns promoting help-seeking should target personal attitudes towards mental health stigma. School-based universal mental health promoting programs significantly decrease suicidality and therefore are an opportunity to target youth for suicide prevention. Gatekeeper training programs and education of general practitioners and other health care providers is another key area for suicide prevention.

2. Prevention of suicide through digital tools

This includes three different approaches: Monitoring through **"Facebook" and other channels** on the internet for words or sentences that might indicate suicide risk. **Recruiting social media** to help in cases where suicide issues are surfaced. Creating a **targeted patient WhatsApp group** that focuses on support and help for a specific patient.

3. Psychosocial interventions

These are better achieved through Collaborative Assessment and Management of Suicidality (CAMS) programs, along with the implementation of active **outreach means: sending postcards, telephone calls, and/or home visits.**

4. Psychotherapeutic interventions

Considered together, **different psychotherapies seem to be efficacious in the reduction of both suicide attempts (SA) and non-suicidal self-injuries** which are risk factors for subsequent SA. Interventions directly addressing suicidal thoughts and behaviour during treatment are effective immediately and in the long term on SA and suicide death, whereas treatments addressing symptoms indirectly associated with suicide (e.g. hopelessness, depression, anxiety, quality of life) are only effective in the long term.

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5. Pharmacotherapeutic Intervention

Randomized controlled trials show that **lithium is effective in reducing the risk of suicidal behavior in people with mood and bipolar disorders. Clozapine** in comparison with other dopamine and serotonin-receptor antagonists has demonstrated **its anti-suicidal effect in schizophrenia.** Initiation of **treatment with antidepressants is not associated with an increased risk of suicide,** however, youth should be followed carefully. Continuation of pharmacotherapy for depression is associated with a reduced risk of suicide. Moreover, an evaluation of the **relationship between changes in the prescription of drugs for depression and changes in suicide prevalence found a clear inverse correlation** in 29 European countries. **Ketamine** shows promising results but effects on suicidal ideation longer than a few days have not yet been demonstrated.

6. The role of patient organization

Patient organisations can play a major role in supporting people with poor mental health and at high risk of suicide. Patient organizations can provide the **additional support post-diagnosis** with health education (or "psycho-education") and provide a **sense of community and peer support** that many high-risk suicidal patients lack. Awareness campaigns aimed at the general public and policymakers for healthcare systems can **educate and reduce stigma and lack of knowledge in relation to mental health problems.**

7. The role of family organizations

Family members are often **in a position to notice the risk factors** but may not always be aware. Suicide causes profound and long lasting psychological trauma and, **on average, a single suicide affects a minimum of six persons**. Family members and friends **require support**. A **no-blame approach** towards family members is essential. Family members should have **access to information, training, quality consultation services, and to local support groups. Family organizations** can play a similar role to that of patient organizations, as they can **provide a community and further support** for those affected by suicide, as well as **help educate the general public about risk factors, preventive measures, and the societal impact of suicide.**

8. Relationships with the media

Media reports which glamorize, romanticize, or portray suicide as a normal response to stress, may encourage suicides, especially among vulnerable individuals. WHO has introduced a set of guidelines for responsible media reporting which are detailed in the joined document.

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