Suicide Prevention in Europe

The WHO European monitoring survey on national suicide prevention programmes and strategies

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KEYWORDS

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SUMMARY

In 1996 more than 150 000 people committed suicide in 38 countries of the WHO European Region. Suicide is currently one of the most important causes of death in Europe among young and middle-aged people, especially men. As early as 1984, WHO's European Member States drafted a health policy document *(1)* that included, as one of its main targets, the reduction of suicide:

> By the year 2000 there should be a sustained and continuing reduction in the prevalence of mental disorders, and improvement in the quality of life of all people with such disorders and a reversal of the rising trends in suicide and attempted suicide.

Subsequently, this goal was strongly reinforced as target 6 of HEALTH21 *(2)*, ratified in 1998 by the European Ministers of Health, in several position papers of WHO's European programme on mental health and recently in *The world health report 2001 (3)*.

In 1989, a European multicentre study began by monitoring parasuicide/attempted suicide in defined epidemiological catchment areas. To implement the results of the monitoring study and to stimulate the initiation of suicide prevention programmes, the WHO European network on suicide prevention was established in December 2000 by the mental health programme of the WHO Regional Office for Europe. The aim of the network was to integrate, follow up and complement the research of the multicentre study and link it to activities directed to the development of suicide prevention strategies. Thus the main tasks of the network today include research on and monitoring of suicide and attempted suicide in European countries, the initiation of suicide prevention programmes, assistance in the development of new strategies, and the development of new tools for evaluating suicide prevention efforts and the establishment of educational programmes.

To assess the level of suicide prevention activities in countries of the WHO European Region, questionnaires were sent to contact persons in 48 of the 51 Member States in October/November 2001; reminders were sent in February 2002. The contact persons were members of the WHO European Multicentre Study on Suicidal Behaviour, WHO national counterparts for mental health, or national representatives of the International Association for Suicide Prevention. No contact persons were identified for Luxembourg, Tajikistan and Uzbekistan. Answers were received from 38 of the 48 countries contacted. These were divided into two groups with respect to the existence of national suicide prevention initiatives. Those with such initiatives have countrywide integrated activities carried out by government bodies. Countries without national initiatives carry out isolated activities in different parts of the country. Eleven national suicide prevention initiatives are supported by government policy and six are approved by parliament.

There were some common themes that can be identified in the national suicide prevention initiatives. A variety of activities are aimed at improving access to health care services. Also, education of health care staff is included in all national suicide prevention initiatives. Not all countries, however, have public health suicide prevention activities that include a distinct media policy and/or regulations to control access to means of suicide. All countries provide some kind of public education to increase knowledge and awareness regarding suicide prevention and mental illness in the community. Schools are the preferred arenas for public health programmes aimed at suicide prevention.

Ministries and national/regional public health institutes and agencies on the one hand, and nongovernmental organizations such as help-lines and psychiatric associations on the other, are involved in implementing national suicide prevention initiatives in most countries. In some countries, such as Finland, Norway and Sweden, a multisectoral approach is used: most of the national suicide prevention initiatives focus on research, education, surveillance, treatment and aftercare.

Also, in countries without national suicide prevention activities, similarities could be found with the priorities of national initiatives, especially with respect to activities within the mental health care system and the public health perspective. There is great variation in agencies implementing regional suicide prevention initiatives, ranging from governmental organizations and intervention centres to mental health associations and help-lines.

Several requests for WHO support were received from responding countries, mainly regarding financial and technical support for organizing professional training or consultations and improving government awareness.

This overview of suicide prevention activities in countries of the WHO European Region will be continuously reviewed and updated and issued regularly.

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FOREWORD

The prevention of suicide and suicidal behaviour is today one of the main public health concerns in Europe. Even if the problem of suicide has to been seen in a comprehensive context of despair, helplessness and depression, resulting in self-destructive behaviour and lifestyles, data on suicide as such are of the utmost importance.

Following intensive data collection, monitoring and research into the background factors of suicidal behaviour, carried out and published by the WHO European Multicentre Study on Suicidal Behaviour for more than a decade, WHO recently took an important further step by restructuring the Study and integrating it into the WHO European Network on Suicide Prevention and Research, established in December 2000. Thus, by continuing earlier monitoring and research and, in addition, preparing concrete national initiatives in suicide prevention by making an inventory of the situation in Europe with regard to existing local, regional and national suicide prevention activities, the Network aims to stimulate national comprehensive action, disseminate evidence-based examples of good practice in suicide prevention, and develop further effective strategies.

As one of the first outcomes of this new direction of work, WHO has the pleasure of presenting this first inventory of national strategies in suicide prevention in the WHO European Member States. An increased emphasis has been placed on the new members of the Network, mainly countries from central and eastern Europe, where problems are significant and the need for action urgent.

With this booklet, prepared by the WHO collaborating centre on suicide research and Prevention at the Karolinska Institute in Stockholm, an interesting picture is given on the comprehensiveness of national initiatives and the complexity and richness of practical experience in the countries. The need is reflected for continuous monitoring and the necessity to expand the Network further to include all WHO European Member States where suicidal behaviour is a problem, either in society as a whole or in certain populations at risk.

Despite its great value, this review has certain limitations. WHO focal points on suicide have not yet been officially nominated in all investigated countries. In these countries, responses were collected from mental health experts who are in contact with WHO and are generally involved in mental health issues in their country; they are often the officially nominated WHO national counterparts for mental health. The process of further data collection is continuing, however, as well as a further exchange of experience within the Network.

This first picture of the situation of suicide prevention in WHO European Member States will be continuously followed up, monitored and updated, considering the intensive expansion of the Network, with new members joining every year and the increasing awareness about suicide as an important public health problem in many countries.

The provision of even more sophisticated and reliable data in countries, as well as increasing government demands for WHO assistance in suicide prevention, is to be expected. Thus, an annual edition of this booklet is planned in order to give a continuous picture of developments and successes achieved in the field of suicide prevention in Europe.

For the preparation of this booklet, WHO is particularly indebted to Professor Danuta Wasserman, Head of the Swedish National Centre for Suicide Research and Prevention, Karolinska Institute, Stockholm, Sweden (a WHO collaborating centre), responsible for coordinating the prevention activities of the Network, and to Professor Armin Schmidtke, Head of the Department of Suicidology, Psychiatric Department, University of Würzburg, Germany, responsible for coordinating the monitoring part of the Network. Thanks are also due to Ellenor Mittendorfer, M.Sc, Ph.D student, responsible for data collection and drafting of this report, and to Guo-Xin Jiang, M.D., Ph.D, senior researcher, responsible for statistical analysis of suicide rates and trends, both at the National Swedish Centre for Suicide Research and Prevention at the Karolinska Institute.

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INTRODUCTION

In 1996 more than 150 000 people died as a result of suicide in 38 countries of the WHO European Region. Various estimates indicate that attempted suicide, which is the strongest of all known predictors of suicide, is at least ten times more common than completed suicide. Suicide is currently one of the most important causes of death in Europe for young and middle-aged people, especially men, as result of the declining mortality in accidents. In the age group 15–34 years, suicide ranks second in some of the European countries among the most common causes of death, following transport and other accidents. Suicide and attempted suicide are serious public health problems and demand everybody's attention. Nevertheless, prevention of suicide is not an easy task.

1. Suicides in Europe – scope of the problem

Suicide rates per 100 000 population for 15-year-olds and over in European countries varied considerably in 1995, according to information from the WHO Mortality Database (Fig. 1). Fig. 2–4 show changes in male, female and total suicide rates per 100 000 for 15-year-olds and over in each European country with available information from 1989/1990 to 1995/1996. Decreasing overall suicide trends were observed in Austria, Croatia, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Israel, Luxembourg, Malta, Norway, Portugal, Slovenia, Sweden and the United Kingdom. Suicide trends increased among both males and females in Belarus, Bulgaria, Estonia, Latvia, Lithuania, Poland, the Russian Federation and Ukraine. Self-destructive behaviour pertains in both poor and rich countries, and if no action is taken all predictions show that a dramatic increase in suicidal behaviour is to be expected in the coming years.

As early as 1984, WHO's European Member States drafted a health policy document with 38 targets for attaining health for all. Target 12 states: "By the year 2000 there should be a sustained and continuing reduction in the prevalence of mental disorders, and improvement in the quality of life of all people with such disorders and a reversal of the rising trends in suicide and attempted suicide".

In 1986, a working group on suicide prevention practices was established and a meeting was held in York, United Kingdom. During the meeting the idea of a multicentre European study on parasuicide/attempted suicide was put forward. The study has been successfully carried out since 1989 in specific epidemiological catchment areas with a population of at least 250 000 inhabitants *(4, 5)*. Several international meetings with suicide prevention as the theme have been organized by the Regional Office: in 1989 in Szeged, Hungary, in 1990 in Bologna, Italy, and two more in 1993 in the Netherlands and in Stockholm, Sweden.

2. WHO European Network on Suicide Prevention

To implement the results of the Multicentre Study and to stimulate the initiation of suicide prevention programmes, the WHO European Network on Suicide Prevention was established in December 2000 within the framework of the European mental health programme. The Network consists of two parts. The first concerns the monitoring of suicide and attempted suicide in different regions of European countries, and is chaired by Professor Armin Schmidtke, Psychiatric Department, University of Würzburg, Germany. Part two, chaired by Professor Danuta Wasserman of the Swedish National Centre for Suicide Research and Prevention,

Karolinska Institute, Stockholm, comprises the initiation of programmes for the prevention of suicide in those European countries currently lacking such programmes. The task of the network also involves stimulating the implementation of existing programmes, assisting in the development of new strategies, and developing new tools for evaluating suicide prevention efforts. The network further aims to establish educational programmes, an information system and research projects focusing on the etiology of suicidal behaviour as well as on the evaluation of intervention programmes.

3. Taboos surrounding suicide

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

Taboos and emotions evoked by suicide in individuals are important factors that hinder the implementation of suicide prevention programmes. When working in suicide prevention, one must be aware that is it not only necessary to increase knowledge in a rational way, but that one must also work with unconscious ideas about suicide prevention in an integrated way. 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.

4. Strategies for suicide prevention

Strategies for suicide prevention can be divided into a health care approach and a public health approach *(6)*. In successful suicide prevention, both strategies should be combined for optimal impact. Health care approaches aim to improve health care services and diagnostic procedures, and consequently to improve the treatment, follow-up and rehabilitation of psychiatric patients, those who attempt suicide, and those in psychological distress with suicidal thoughts. In suicide prevention work one should strive to increase awareness among health care staff of their own attitudes and taboos towards suicide prevention and mental illnesses.

Public health perspectives are concerned not only with controlling access to means of suicide and a responsible media policy, but also with changing condemnatory attitudes in society to mental illness and suicide prevention. One strategy is to increase knowledge through public education about mental illness and its recognition at an early stage, as well as the role of acute and chronic psychosocial stress and the importance of protective factors against psychological stress and suicidal behaviour. Factors that protect against mental ill health include psychosocial factors, such as good supportive networks and adequate coping abilities, as well as physical and environmental factors such as good sleep, a balanced diet, physical exercise and a drug-free environment.

Target groups for suicide prevention efforts according to the public health perspective can be very broad but they can also be quite specific, focusing for example on schools, military

organizations, etc. According to the health care perspective, target groups for suicide prevention not only comprise patients and relatives but also health care personnel and those (politicians and health care administrators) who decide the economics of health care services. Prevention of suicide should always involve a whole series of activities, ranging from improving conditions for bringing up children and young people, to controlling environmental risk factors, to giving the best effective treatment of mental disorders both in the community and in hospital.

5. Examples of successful suicide prevention

Despite the fact that more studies are needed, there is evidence that suicide can be prevented, both through adequate treatment of psychiatric disorders in psychiatric clinics as well as through better and earlier detection and treatment of psychiatric illnesses in the general population *(6).* Several studies have shown that treatment with antidepressants for depression, lithium for bipolar disorders and neuroleptics for schizophrenia and other psychotic illnesses can prevent both suicide and attempted suicide. These treatments should therefore be utilized to a greater extent in clinical work.

Encouraging results of dialectical behavioural therapy and promising results with cognitive behavioural psychotherapy for reducing the repetition of suicide attempts indicate that they should be utilized much more broadly, especially with personality disorders who attempt suicide. Problem-solving therapies and the use of emergency help cards, giving easy access to treatment in contrast to standard after-care procedures, are also good examples of how repetition of attempted suicide can be reduced. Yet another example was a training programme for general practitioners on the Swedish island of Gotland, which succeeded in reducing suicide rates.

Several general public health programmes *(6),* such as the reduction of alcohol consumption during *perestroika* in the former Soviet Union (the most effective suicide prevention programme for males of the 20th century) are of great interest. Controlling the environment by removing the means of suicide (gun control, decreased availability of toxic medications, etc.) has also been shown to be effective in suicide prevention. Controlling the environment through responsible media reporting is another important way of preventing suicidal acts in susceptible individuals. Identification with and even imitation of suicide or attempted suicide can take place when such acts occur in the immediate vicinity of vulnerable persons, in places such as schools, medical wards, military units, prisons, etc. In Israel, Sweden and the United States, suicide prevention programmes in schools have led to encouraging reductions in attempted suicide. In specific environments, such as the military and prisons, suicide prevention programmes aimed at enhancing the knowledge of the responsible personnel may result in a substantial reduction in suicide rates. Such examples may be seen in Greece, Lithuania, Norway and Ukraine.

Fig. 1. Total suicide rates per 100 000 among those aged 15 years and over in European countries, latest available year
Source: World Health Statistics Annuals

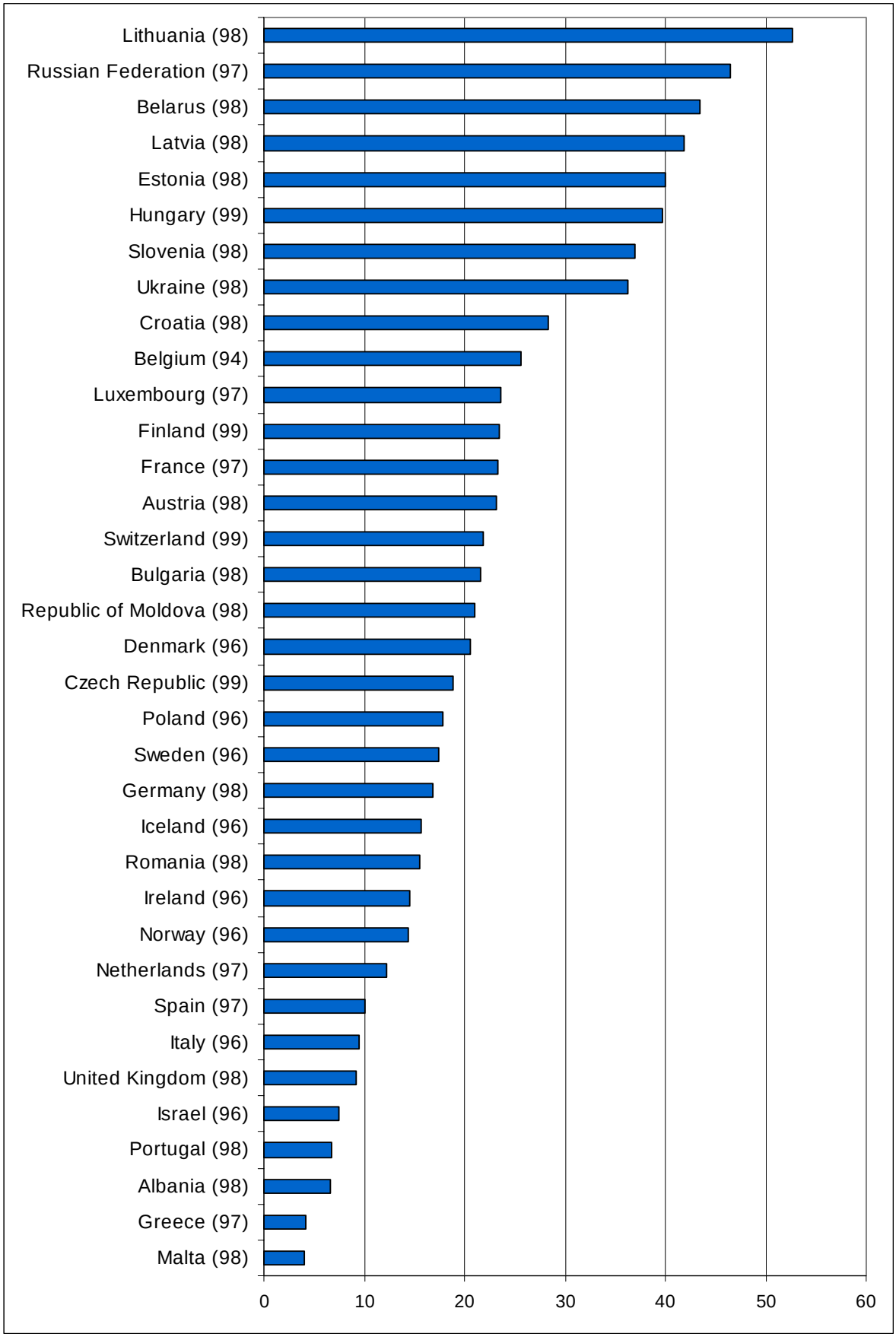


Fig. 2. Change in percentage suicide rates among males aged 15 years and over in European countries between 1989–1990 and 1995–1996
Source: World Health Statistics Annuals

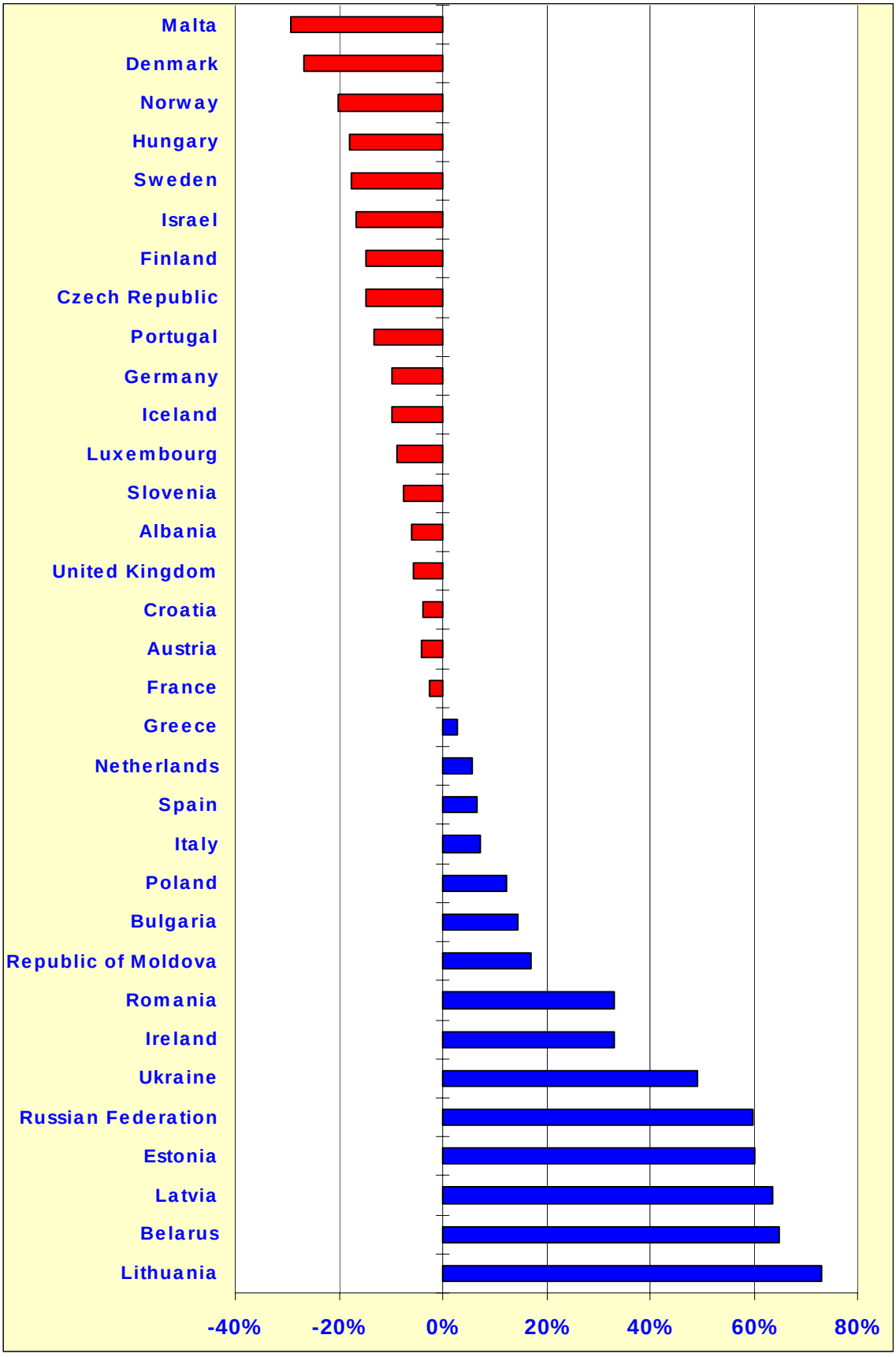


Fig. 3. Change in percentage suicide rates among females aged 15 years and over in European countries between 1989–1990 and 1995–1996
Source: World Health Statistics Annuals

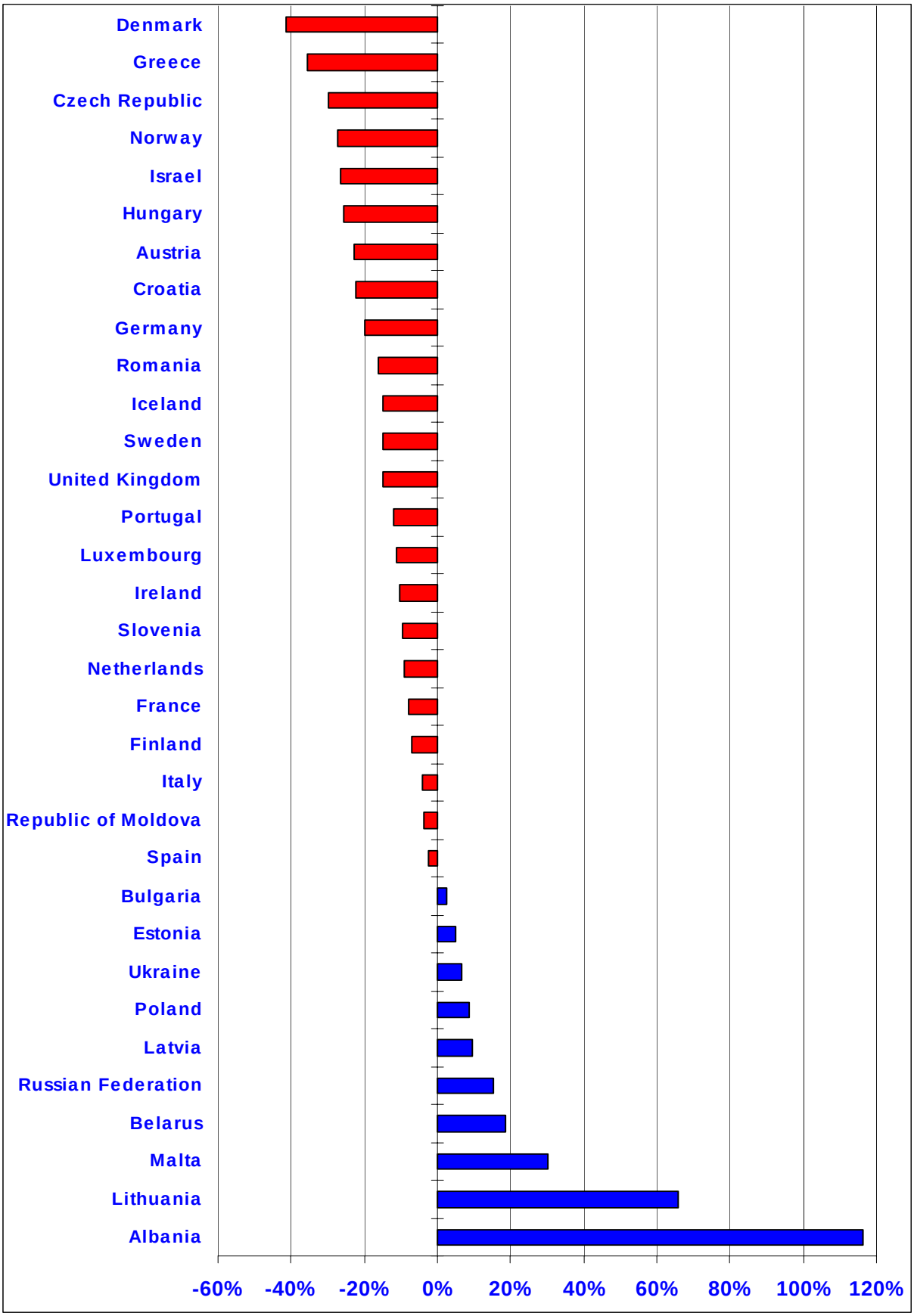
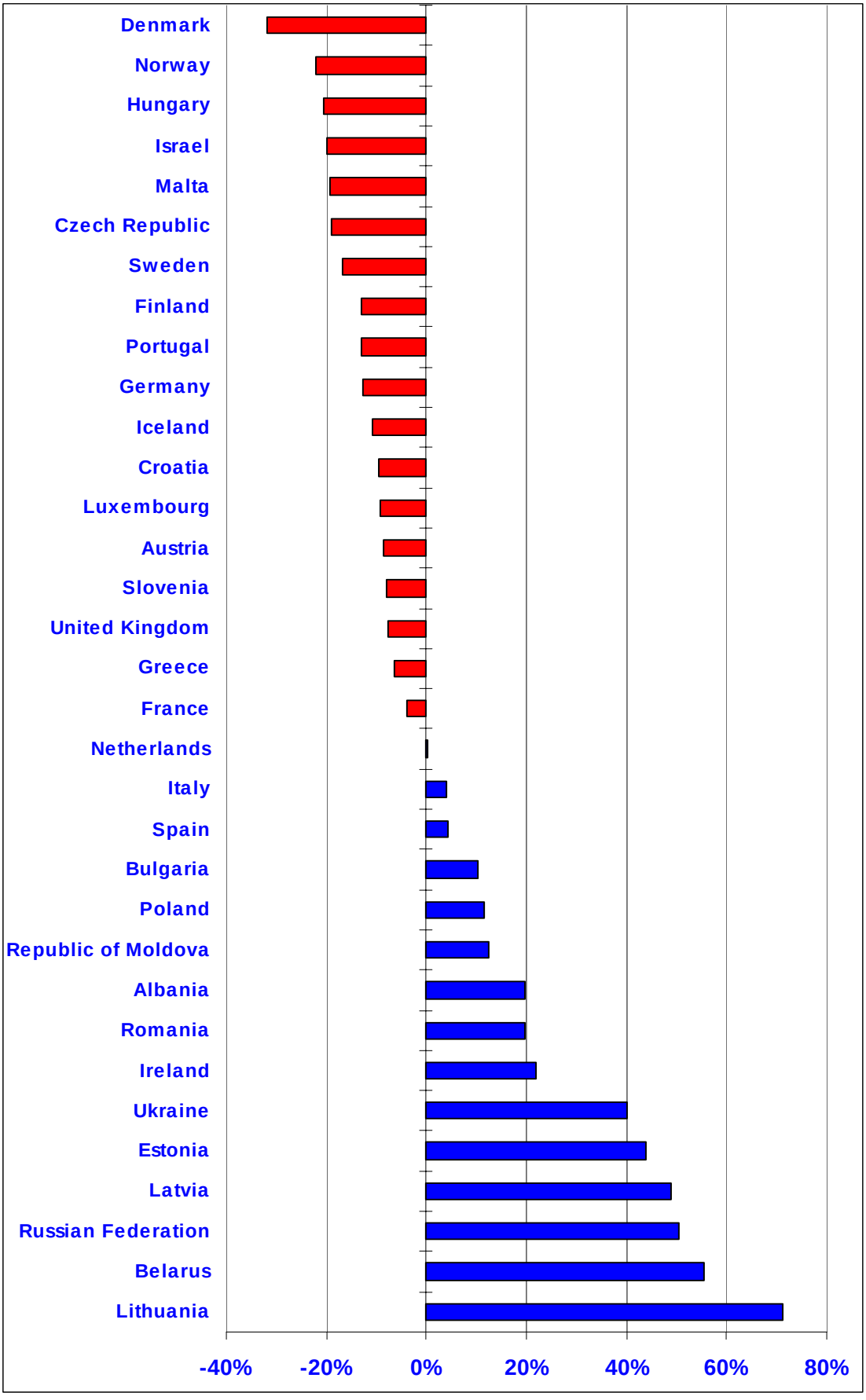


Fig. 4. Change in percentage suicide rates among those aged 15 years and over in European countries between 1989–1990 and 1995–1996
Source: World Health Statistics Annuals



CURRENT ACTIVITIES OF THE WHO EUROPEAN NETWORK ON SUICIDE PREVENTION

WHO European monitoring survey on national suicide prevention programmes and strategies

To assess the level of suicide prevention activities in countries of the WHO European Region, questionnaires were sent to contact persons in 48 of the 51 Member States in October/November 2001; reminders were sent in February 2002. The contact persons were members of the WHO European Multicentre Study, WHO national counterparts for mental health, or national representatives of the International Association for Suicide Prevention. No contact persons were identified for Luxembourg, Tajikistan and Uzbekistan.

Answers were received from 38 of the 48 countries contacted. These were divided into two groups with respect to the existence of national suicide prevention initiatives (Table 1). Those with such initiatives have countrywide integrated activities carried out by government bodies. Countries without national initiatives carry out isolated activities in different parts of the country.

Of the 18 countries with national suicide prevention initiatives 11 have official documents issued by governments or administrative bodies such as ministries (Table 1). The answers from the United Kingdom refer to the national programme launched in the spring of 2002. Six of the national suicide prevention initiatives are approved by parliament (i.e. there is legislation on suicide prevention). In some countries, such as Sweden, only parts of the programme (for example suicide prevention in young people) are approved by parliament.

The comprehensiveness and coordination of national suicide prevention activities vary considerably between the countries. In Bulgaria, Denmark, Finland, France, Ireland, Norway, Sweden and the United Kingdom, national programmes with a variety of strategies have been established. Programmes are here understood as concise action plans, combining various specific national strategies in order to achieve predefined goals and objectives, whereas national strategies are defined as different preventive approaches established nationally in different settings. Estonia, Lithuania and Slovenia report having different national suicide prevention strategies and also having started to draft national programmes. The remaining countries with national initiatives report having strategies on the national level. In 3 out of 20 countries, suicide prevention activities on county or community level are official documents (Table 1) and 4 countries have started to prepare plans for national action.

Table 1. Level of national action on suicide prevention

Country	Official documents	Approved by parliament
With national prevention initiatives		
Belarus	–	–
Bulgaria[a]	+	–
Czech Republic	–	–
Denmark[a]	+	+
Estonia[b]	–	–
Finland[a]	+	–
France[a]	+	–
Georgia	+	+
Hungary	–	–
Ireland[a]	+	+
Latvia	–	–
Lithuania[b]	+	+
Norway[a]	+	+
Romania	–	–
Slovenia[b]	–	–
Sweden[a]	+	+ (in part)
Turkey	+	–
United Kingdom (launched in spring 2002)[a]	+	–
Without national action		
Andorra	–	–
Austria[c]	–	–
Azerbaijan	–	–
Belgium	+	–
Croatia	–	–
Germany[c]	+	–
Greece	–	–
Iceland[c]	–	–
Israel	–	–
Italy	–	–
Kyrgyzstan	–	–
Netherlands	–	–
Poland[c]	–	–
Republic of Moldova	–	–
Russian Federation	+	–
Slovakia	–	–
Spain	–	–
Switzerland	–	–
Ukraine	–	–
Yugoslavia	–	–

[a] Countries with a comprehensive national suicide prevention programme.
[b] Countries with national strategies and a draft national programme.
[c] Countries with plans for national action.

Countries with national suicide prevention initiatives

Mental health care

A variety of strategies to improve health care services are included in all national suicide prevention initiatives (Table 2). These range from projects to increase the consciousness of health care providers about early detection of suicide risk and adequate treatment, to improved access to mental health services, to improvements in crisis intervention and telephone crisis lines.

Table 2. Themes of intervention in mental health care and public health in national suicide prevention activities

	Health care perspective		Public health perspective		
Countries	**Services**[a]	**Education**[a]	**Media**	**Access**	**Awareness**[a]
Belarus	+	+	–	–	+
Bulgaria	+	+	+	–	+
Czech Republic	+	+	–	–	+
Denmark	+	+	–	–	+
Estonia	+	+	–	–	+
Finland	+	+	+	–	+
France	+	+	+	+	+
Georgia	+	+	+	–	+
Hungary	+	+	–	–	+
Ireland	+	+	+	+	+
Latvia	+	+	+	+	+
Lithuania	+	+	+	–	+
Norway	+	+	+	+	+
Romania	+	+	–	–	+
Slovenia	+	+	+	–	+
Sweden	+	+	+	–	+
Turkey	+	+	+	–	+
United Kingdom	+	+	+	+	+

[a] In the event that one of the strategies mentioned in the questionnaire was reported carried out, the answer was considered to be positive (+) for the country in question.

All countries with national suicide prevention initiatives have an educational project either on improving the diagnosis of psychiatric illness or on the adequate treatment, follow-up and rehabilitation of psychiatric patients, those who attempt suicide and people in psychological distress (Table 2). Five countries report that they focus on only one educational theme. The main target groups for these educational projects are, with few exceptions, general practitioners and psychiatric personnel, while social workers seem to be involved in these projects in only about half of the countries. The inclusion of relatives, politicians and health care administrators as groups of special interest in these educational projects is seldom a general choice.

Public health perspective

Public health suicide prevention activities, including responsible media policy and regulations controlling access to means of suicide, are carried out in less than one third of the countries (Table 2).

In all countries, some sort of public education is performed in order to increase knowledge and awareness regarding suicide prevention and mental illness (Table 2). All countries with national suicide prevention activities have public education focusing on the prevention, early recognition and treatment of mental illness. All except four countries include information on the role of chronic psychosocial stress. Most of these public education projects include some sort of information on the role of environmental protective factors.

Schools are the preferred arenas for public health interventions on suicide prevention, while only a few countries carry out educational projects in workplaces, housing areas and within the military (Table 3). Only three countries target politicians with educational activities, and only seven target administrators. Further reported settings for educational projects are prisons (Slovenia), the police (Estonia, Lithuania, Norway), the church (Finland) and the media. Finland has developed a special model that includes close collaboration with the church and the police.

Table 3: Arenas for public health interventions on suicide prevention

Country	Schools	Workplaces	Housing	Military
Belarus	+	–	–	+
Bulgaria	+	–	–	+
Czech Republic	+	–	–	–
Denmark	+	+	–	+
Estonia	+	…	…	…
Finland	+	+	+	+
France	+	…	+	–
Hungary	+	–	–	+
Ireland	+	–	–	–
Latvia	+	+	+	+
Lithuania	+	–	+	+
Norway	+	+	–	+
Romania	+	+	–	–
Slovenia	+	–	–	–
Sweden	+	–	–	–
Turkey	+	–	–	+
United Kingdom	+	…	…	…

… = no answer.

While only a few countries have public health interventions on suicide prevention that cover the entire population, most of the countries focus on children and adolescents, the elderly, families and special risk groups including suicide attempters, the depressed and the unemployed.

Monitoring and evaluation

It is not only important in suicide prevention to initiate and implement suicide prevention activities, but also to continuously monitor cases of suicide and attempted suicide in order to identify trends, risk groups and protective factors. Extensive research is carried out within the WHO European Multicentre Study, which included 32 centres in 26 European countries at the time this report was prepared. More centres are on the way to joining the project. In addition, the work involves the evaluation of suicide prevention activities, both on the European and national levels and in different regions of every European country.

Table 4. Level of coordination, evaluation and monitoring in countries with national suicide prevention activities

Country	National institute	Evaluation	Monitoring	
			National	County/ community
Belarus	+	–	+	+
Bulgaria	+	–	+	+
Czech Republic	–	–	+	–
Denmark	+	–	+	+
Estonia	+	–	+	+
Finland	+	+	+	+
France	+	–	+	+
Georgia	–	–	+	…
Hungary	…	+	+	+
Ireland	+	–	+	+
Latvia	–	–	+	+
Lithuania	–	–	+	+
Norway	+	+	+	+
Romania	–	+	+	+
Slovenia	–	–	+	–
Sweden	+	+	+	+
Turkey	+	–	+	+
United Kingdom	…	…	+	…

… = no answer.

In all countries, suicides are monitored on the national level and in most of them on the regional level as well (Table 4). Evaluation of national suicide prevention initiatives has been carried out in less than one third of countries. In more than half of the countries a national institute is involved in coordinating suicide prevention activities.

Agencies implementing national suicide prevention initiatives

Ministries and national/regional public health institutes and agencies on the one hand, and nongovernmental organizations such as help-lines and psychiatric associations on the other, are involved in implementing the national suicide prevention initiatives in most of the countries. Finland and Norway have a pronounced multisectoral approach that also involves universities, hospitals, the church, the military, the police and the school system.

National suicide prevention activities aim to lower the rates of completed and attempted suicide, and focus on research, surveillance, education, treatment and aftercare.

Countries without national suicide prevention activities

Various suicide prevention activities are carried out under regional health care and public health initiatives, and many of these regional projects function as nuclei for further activities and their coordination.

Regional suicide prevention activities aim to lower the rates of completed and attempted suicide. A combination of strategies to improve health care services can be identified in most of these countries, including improved access to mental health services and crisis intervention, but also improvement of the awareness of health care providers concerning suicide prevention. In some countries, however, only single initiatives have been established and a broader array of activities to improve health care services remain to be initiated and included in the regional projects. Some initiatives focus on patients with depression and schizophrenia (Spain) or on the prescription of antidepressants and the number of admissions (Germany).

The main target groups for the educational projects are general practitioners (in 75% of countries) and psychiatric personnel (in around half of the countries). The projects focus primarily on improving the diagnosis of psychiatric illness and on adequate treatment, follow-up and rehabilitation of psychiatric patients and those who attempt suicide.

Public health activities, including public education, a responsible media policy and controlling access to means of suicide, are applied to different degrees in regional suicide prevention activities. While all countries report some kind of public education in their regional activities, projects that control media reporting or access to means of suicide are rarely applied. Austria, Azerbaijan, the Republic of Moldova and the Russian Federation report having established the latter activities, and Andorra, Croatia, Germany, Greece, Israel, Switzerland and Ukraine include one of these strategies in their regional prevention activities.

Public education projects, intended to increase knowledge not only on prevention of suicidal behaviour but also on the treatment of mental illness in the community, are primarily carried out in schools. Other settings are workplaces, housing areas, the military, prisons, the police offices, the church and the media. The number of different arenas in which regional educational projects are reported to be carried out varies considerably between countries, ranging from 3–5 in Germany, Greece, the Netherlands, the Russian Federation and Ukraine to none in Italy and Switzerland. The remaining countries carry out their educational projects in one or two arenas.

While only Andorra, Belgium (Flemish region), Iceland (planned) and Spain have public health interventions covering the whole population, most of the countries focus on children and adolescents, the elderly, families and special risk groups including suicide attempters, prisoners (Germany, Ukraine), children of alcoholics and victims of violence (Poland) and drug abusers, alcoholics, unskilled workers and participants in combat operations (Russian Federation).

In many of these countries, reported regional suicide prevention activities are comprehensive and form a basis for further initiatives in the countries. In Belgium, for example, owing to the federal nature of the country and regional responsibility for preventive health policy, a comprehensive programme exists in the Flemish region whereas isolated activities are carried out in the Walloon region.

There is a great variation in agencies implementing regional suicide prevention initiatives. In most of the countries ministerial agencies (Austria, Kyrgyzstan), national research centres (Greece, Russian Federation) and national and regional public health institutes and agencies (Iceland, Israel, Switzerland) on the one hand, and nongovernmental organizations such as help-lines (Azerbaijan, Italy, Russian Federation, Ukraine) and psychiatric and medical associations (Azerbaijan, Croatia, Spain, Switzerland, Ukraine) on the other, are involved in implementation. In some countries prevention or intervention centres and associations at regional level (Austria, Belgium, Germany, Kyrgyzstan, Ukraine, Yugoslavia) or local medical agencies (Kyrgyzstan,

Russian Federation) are also involved. In Andorra, Belgium and the Netherlands, mental health services and institutes are the main prevention institutions. Several programmes in Poland and Ukraine are carried out within the prison, military and police services.

Azerbaijan, Belgium, Germany and Switzerland report having evaluated their regional suicide prevention activities. In all countries suicides are monitored at national level, and in more than half of them at regional level as well. In Austria, Germany, Iceland and Poland plans for national action have already been laid. In Austria, Belgium, Greece, Iceland, Israel and the Russian Federation national institutes are available and could be involved in coordinating national activities.

WHO support needed

A question on requests for WHO support in the planning, implementation and evaluation of suicide prevention programmes was included in the questionnaire. The most frequently expressed requests from the countries concerning support from WHO concerned:

- raising government awareness;
- financial support; and
- technical support in:
  - developing suicide prevention programmes
  - establishing recommendations based on clinical and scientific evidence
  - national assessments
  - professional training
  - expert exchange and consultations
  - organization of meetings and inclusion in the network

REFERENCES

1. Targets for health for all. Targets in support of the European regional strategy for health for all. Copenhagen, WHO Regional Office for Europe, 1985 (European Health for All Series, No. 1).
2. HEALTH21. The health for all policy framework for the WHO European Region. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).
3. The world health report 2001: mental health: new understanding, new hope. Geneva, World Health Organization, 2001.
4. KERKHOF, A.J.F.M. ET AL. Attempted suicide in Europe. Leiden, DSWO Press, 1994.
5. BILLE-BRAHE, U. WHO/EURO multicentre study on parasuicide: facts and figures, 2nd ed. Copenhagen, WHO Regional Office for Europe, 1999 (document EUR/ICP/HPSA 01 06 03).
6. WASSERMAN, D. Suicide – an unnecessary death. London, Martin Dunitz, 2001.

7. Preventing suicide: a resource series. Geneva, World Health Organization, 2000
   1. *A resource for general physicians*
   2. *A resource for media professionals*
   3. *A resource for teachers and other school staff*
   4. *A resource for primary health care workers*
   5. *A resource for prison officers*
   6. *How to start a survivors group*

Annex 1

LIST OF CONTACT PERSONS

Countries with national prevention initiatives	**Persons responding**
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Czech Republic	Professor C. Höschl
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Estonia	Professor A. Värnik
Finland	Professor J. Lönnqvist, Professor V. Taipale
France	Professor J.P. Soubrier
Georgia	Professor G. B. Naneishvili
Hungary	Dr S. Fekete
Ireland	Dr M. Kellerher
Latvia	Dr L Stoligvo
Lithuania	Professor D. Gailiene
Norway	Professor L. Mehlum, Dr H. Hjelmeland
Romania	Dr C. Scripcaru
Slovenia	Professor O. Grad, Dr A. Marusic
Sweden	Professor D. Wasserman
Turkey	Dr I. Sayil
United Kingdom	Professor L. Appleby, Dr R. Berry, Professor K. Hawton
Countries without national action	
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Austria	Dr R. Fartacek
Azerbaijan	Professor A. Sultanov
Belgium	Professor P. Cosyns, Professor C. van Heeringen
Croatia	Dr N. Heningsberg
Germany	Professor A. Schmidtke
Greece	Assistant Professor A. Botsis
Iceland	Dr S. Páll Pálsson, Dr W. Nordfjord
Israel	Professor A. Apter
Italy	Professor D. Deleo
Kyrgyzstan	Dr B. Makenbaeva
Netherlands	Professor A. Kerkhof, Dr D. van Sambeek
Poland	Professor S. Puzynski
Republic of Moldova	Dr M. Hotineanu
Russian Federation	Dr A. Stepanov, Dr V. Voyceh, Dr V. Ostroglazov, Professor V. Kraznov, Professor V. Yastrebov, Dr L. Arkhangelskaya
Slovakia	Dr P. Breier
Spain	Professor J. Bobes, Dr B. Sarro, Dr J. Querejeta
Switzerland	Assistant Professor K. Michel
Ukraine	Professor V. Rozanov
Yugoslavia	Professor S. Selakovic-Bursic

Annex 2

THE MEMBER STATES OF THE WHO EUROPEAN REGION

Balkan countries	**Baltic countries**	**Central Asian republics (CAR)**	**Central and eastern Europe**	**Commonwealth of Independent States (excluding CAR)**	**Nordic countries**	**Southern Europe**	**Western Europe**
Albania	Estonia	Kazakhstan	Bulgaria	Armenia	Denmark	Andorra	Austria
Bosnia and Herzegovina	Latvia	Kyrgyzstan	Czech Republic	Azerbaijan	Finland	Greece	Belgium
Croatia	Lithuania	Tajikistan	Hungary	Belarus	Iceland	Israel	France
Slovenia		Turkmenistan	Poland	Georgia	Norway	Italy	Germany
The former Yugoslav Republic of Macedonia		Uzbekistan	Romania	Republic of Moldova	Sweden	Malta	Ireland
Yugoslavia			Slovakia	Russian Federation		Monaco	Luxembourg
				Ukraine		Portugal	Netherlands
						San Marino	Switzerland
						Spain	United Kingdom
						Turkey	

Annex 3

WHO QUESTIONNAIRE ON SUICIDE PREVENTION IN EUROPE, IN ORDER TO SCREEN FOR THE EXISTENCE OF NATIONAL SUICIDE PREVENTION PROGRAMMES AND STRATEGIES IN EUROPE

Definition: National suicide prevention programmes are aimed at single or complex targets, and are initiated nation-wide by governmental bodies, in contrast to several isolated program initiatives in delineated parts of the country. Observe that the national strategies are integrative suicide prevention activities initiated by governmental bodies, but that they can be co-ordinated and implemented on different administrative levels, i.e. on the county level, community level or nation-wide.

I. Suicide Prevention Programmes

I a. Do you have a national program for suicide prevention? Yes ____ No ____
I b. Are they official documents issued by governments or administrative bodies like ministries? Yes ____ No ____
I c. Is the suicide prevention programme approved by the parliament (legislation on suicide prevention)? Yes ____ No ____
I d. If no national programmes exist, have separate prevention programmes, for example on the county or community level, been introduced? Yes ____ No ____
Please specify.

II. Suicide Prevention Strategies

II a. Do you have national suicide-prevention strategies in your country? Yes ____ No ____
Which of the strategies mentioned below are applied in your country in suicide prevention?
II a1. Health Care Perspective
II a1.1. Increased consciousness of health care providers concerning attitudes towards suicide prevention and mental illness? Yes ____ No ____
II a1.2. Improvement of health care services? Yes ____ No ____
Examples
Improvement of access to mental health services? Yes ____ No ____
Improvement of crisis intervention? Yes ____ No ____
Introduction or improvement of telephone crisis lines? Yes ____ No ____
Others– which? Specify briefly.

II a1.3 Introduction of Educational Projects On (?):
Improvement of diagnoses of psychiatric illnesses? Yes ____ No ____
Adequate treatment, follow-up and rehabilitation of psychiatric patients, suicide attempters, and persons in psychological distress? Yes ____ No ____
Educational projects for GPs? Yes ____ No ____

Educational projects for psychiatric personnel? Yes ____ No ____
Educational projects for social care workers? Yes ____ No ____

Educational projects for personnel working in institutions outside the health care system?
Yes ____ No ____ Which?

II a2. Which target groups are of special interest?

Patients? Yes ____ No ____
Relatives? Yes ____ No ____
Health care personnel? Yes ____ No ____
Politicians? Yes ____ No ____
Health care administrators? Yes ____ No ____

II b1. Public Health Perspective

Responsible media policy? Yes ____ No ____
Controlling access to means of suicide? Yes ____ No ____
Increased knowledge regarding suicide prevention and mental illness through public education concerning:

-Suicidal behaviour and means of prevention? Yes ____ No ____
-Prevention, early recognition, and treatment of mental illness? Yes ____ No ____
-The role of chronic psychosocial stress such as poverty, unemployment, violence, etc. on suicidality? Yes ____ No ____
-The role of environmental protective factors for psychic health such as:
-Good parenting? Yes ____ No ____
-Good relationships? Yes ____ No ____
-Good school and work conditions? Yes ____ No ____
-Good diet, sleep, light, physical exercise? Yes ____ No ____
-Drug-free environment? Yes ____ No ____

II b2. Which target groups are high-priority?

Schools? Yes ____ No ____
Workplaces? Yes ____ No ____
Different organisations? Yes ____ No ____
Housing arena? Yes ____ No ____
Military services? Yes ____ No ____
Politicians? Yes ____ No ____
Administrators? Yes ____ No ____
General public? Yes ____ No ____
Do they cover the whole population? Yes ____ No ____
Do they cover special risk groups (children, elderly, etc.)? Yes ____ No ____
If yes, which?

III. Implementation in your country of existing suicide-prevention programs

III a. Which agencies are involved in carrying out the implementation activities in your country? Please specify briefly.

III b. How far have your national suicide-prevention programmes been implemented? Please describe briefly.

III c. What major obstacles for implementation have occurred? Please describe briefly.
If yes, which?

III d. Is there a national institution/institutions implementing and coordinating the national programme on suicide prevention? Yes ____ No ____

IV. Evaluation

IV a. Do you have continuous evaluation of your suicide prevention programme?
Yes ____ No ____ Which? Specify briefly.

IV b. Do you continuously follow trends of suicide and suicide attempt?
A) On a national level? Yes ____ No ____
B) On a county level? Yes ____ No ____
C) On a community level? Yes ____ No ____

IV c. Does your programme have special targets and measurable objectives?
Yes ____ No ____ Which?

V. Need for further support

V a. How can the WHO help you if no national suicide prevention programme exists in your country? What steps should be taken to assist your country? Please specify briefly.

V b. How can the WHO help you in implementing the existing suicide prevention programme. Please specify briefly.

Thank you very much for your collaboration.

Annex 4

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