

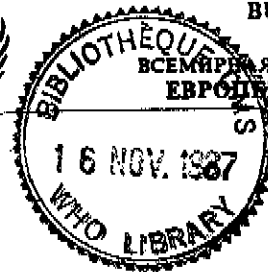
WORLD HEALTH ORGANIZATION
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ORGANISATION MONDIALE DE LA SANTÉ
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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО



5588

Working Group on Preventive Practices
in Suicide and Attempted Suicide

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[SUMMARY REPORT]

The Working Group was attended by 31 participants from 15 countries, among them 16 temporary advisers, 2 representatives from WHO collaborating centres, 5 representatives of international organizations and 2 observers.

The framework for the Group's discussions was set by target 12 of the WHO regional strategy for attaining health for all: "By the year 2000 the current rising trends in suicides and attempted suicides in the Region should be reversed". The major purposes of the meeting were to consider official suicide data from European countries and update the WHO report on changing patterns in suicide behaviour (EURO Reports and Studies No. 74); to consider proposals for collecting internationally comparable data on trends in attempted suicide and the factors influencing those trends; and to devise preventive strategies appropriate to the achievement of target 12.

Background

Between 1972 and 1984 the median male suicide rate in 24 European countries rose by 42% from 23.4% to 33.2% per 100 000, while corresponding rates among women were 8.9% and 12.1%, an increase of 36%. Particularly noteworthy were trends in Ireland and Northern Ireland, where the male suicide rate more than doubled. In general, the incidence of suicide tended to increase with age, the highest rates being found most often among those aged 65 years and over. However, a second peak in the age group 45-54 years was beginning to appear. Over the period, there was an increase in suicide in the majority of countries for virtually all age groups. Significant trends were noted particularly among men aged 15-44 years and women aged 25-44 and 65-74 years.

Recent reports from a number of centres had suggested that the incidence of parasuicide (nonfatal deliberate self-harm or "attempted suicide") was declining from the "epidemic" rates of the early 1970s, when this behaviour constituted a major public health problem. However, a special review of the epidemiology of parasuicide in four European countries produced inconsistent findings. Among men, parasuicide rates rose steadily in the Netherlands and in the county of Funen, Denmark, over the period 1974-1984, while the upward trend ceased and went into reverse in both Edinburgh, United Kingdom (peak year 1981) and Mannheim, Federal Republic of Germany (peak year 1977). In Denmark and the Netherlands, the continuously upward movement was even more pronounced among women, while in Edinburgh and Mannheim the highest incidence was noted in 1976 and 1977 respectively. Overall, rates in Edinburgh were markedly higher than in the other three countries. Despite doubts about the quality and comparability of data, it was concluded that the incidence of parasuicide in Great Britain was probably higher than elsewhere.

Conclusions

1. Disagreement about nomenclature and definition remains a stumbling block in comparative suicide research. The Working Group preferred the term "parasuicide" for acts of nonfatal deliberate self-harm (poisoning or injury). Provisional definitions of parasuicide and suicide were agreed. Parasuicide was defined as "an act with nonfatal outcome, in which an individual deliberately initiates a nonhabitual behaviour that, without intervention by others, will cause self-harm, or ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which he/she desired via the actual or expected physical consequences".

Suicide was defined as "an act with fatal outcome, which was deliberately initiated and performed by the deceased, in the knowledge or expectation of its fatal outcome, and through which the deceased aimed at realizing changes he/she desired".

Parasuicide

2. After considering problems in undertaking comparative research on clinical and epidemiological aspects of parasuicide, the Working Group concluded that there was a need for a coordinated multinational European project covering two broad areas of research:

- monitoring of recent trends in the epidemiology of parasuicide, including the recognition of risk factors;
- follow-up studies of parasuicide populations, with a view to identifying social and personal characteristics predictive of future suicidal behaviour.

3. Recent research continues to underline the importance of socioeconomic factors in parasuicide, e.g. poverty, unemployment, and lack of social integration.

4. The Working Group heard evidence suggesting that repetition of parasuicide was on the increase and that for most age groups the parasuicide rate among repeaters was actually higher than the rate among first-timers.

5. The failure of parasuicides to seek help from professionals was of considerable concern to the Working Group. It was suggested that the reaction of hospital staff might have a bearing on this, although recent research challenges the stereotype of negative medical attitudes towards parasuicide. Fear of being labelled mentally ill might also deter some from accepting medical (especially hospital) treatment. It would be of considerable interest to discover whether parasuicide handled successfully within the family had a better prognosis, e.g. in terms of repetition, than parasuicide treated by medical agencies.

Suicide

6. In general, the Working Group endorsed the view that official suicide statistics from European countries were sufficiently reliable to be used to establish trends over time in a particular country. A close analysis of national suicide data also suggested that differences between Scandinavian countries was not an artefact of different methods of death registration and classification. However, it was noted that certain countries produced multiple counts of suicide deaths compiled from different sources, and these were not always in agreement. In at least one European country, the

inadequacy of published suicide data was recognized officially. Finally, an analysis of trends in suicide and undetermined deaths within the United Kingdom in England and Wales compared to Scotland suggests that international comparison of change in suicide incidence may be unreliable.

7. The following trends were identified and considered worthy of further investigation:

- rising rates of suicide in the majority of European countries: suicide incidence was now extremely high in Austria, Denmark, Hungary and Switzerland;
- exceptional increases in rates in Ireland and Northern Ireland;
- Norway continues to have a lower suicide rate than neighbouring Scandinavian countries, but differences are far less marked than a decade ago, especially among men;
- narrowing of age differentials in suicide, with the rate among younger age groups increasing more rapidly than among older age groups;
- a suggestion of a rising trend among children under 15 years of age.

8. Considerable concern was voiced about a possible "media imitation effect", in view of research evidence suggesting that suicide rates increase after the portrayal of fictional and real suicides in newspapers and on television.

9. The Working Group considered research concerning the possible deleterious social and medical effects of the psychiatric reform in Italy (rapid rundown of mental hospitals and a switch to community care). A recent study failed to discover any relationship between changes in the suicide rate and changes in the regional provision of mental hospital beds.

10. The Working Group identified a number of vulnerable groups for whom experiments in suicide prevention were considered appropriate and urgent. Some of these have long been recognized, e.g. those suffering from a unipolar depressive illness; those dependent on, or addicted to, alcohol; psychiatric inpatients; and parasuicides. Others have only recently emerged as being at high risk, including adolescents and young adults (particularly those with personality or conduct disorders and those with a homosexual orientation) and drug abusers.

Recommendations

1. Nomenclature and definitions of different types of suicidal behaviour should be standardized and used uniformly in research and clinical practice. The codes E950 to E959 (suicide and self-inflicted injury) in the ninth revision of the ICD should be thoroughly revised before the tenth edition is published. WHO should play a major role in encouraging and coordinating this revision.

2. While the World Health Organization should continue to collect and compare official national statistics on suicide, the recommendation for the Regional Office for Europe to use hospital or police records to monitor parasuicide incidence is not endorsed by the Working Group. Instead, WHO is urged to encourage and support a multinational research project incorporating catchment-area surveys of parasuicide treated in all types of health facility. In the long term, it is hoped that national governments will consider more effective and reliable means to estimate parasuicide incidence, whether medically treated or not.

3. The Working Group recommended that WHO help to stimulate and coordinate a continuing research effort into:

- a possible mass media imitation effect;
- determinants of suicidal behaviour among adolescents and young adults;
- the impact of the closure of the mental hospital;
- the role of social and economic factors, particularly (long-term) unemployment and poverty;
- predictors of repeated parasuicide;
- the role of personality and conduct disorders, particularly in young people who turn to suicide.

4. WHO should encourage collaboration among information centres throughout the world and attempt to achieve a clearing-house for articles, books, etc., on suicidal behaviour in all major world languages.

Primary prevention strategies - the role of the state

5. The state has a major role to play in creating optimal conditions for healthy lifestyles and reducing the risk of self-harming behaviour. Possible measures include: reducing the availability of drugs of abuse, poisons, medicaments that are dangerous in overdose (available without prescription in many countries) and weapons; raising the price of alcohol; controlling and reversing the growth of unemployment, especially long-term, and increasing the level of economic activity; providing an adequate financial and welfare safety net for the whole population; combating physical disintegration and social disorganization in inner city areas; and seeking to alter public attitudes that increase the vulnerability of high-risk groups, e.g. victimization and stigmatization of the unemployed and mentally ill.

6. The state should increase provision from the health and other services for the relief of mental health problems in general. This might include epidemiological research to promote mental health as a public health priority. If a national health service is in existence, it should incorporate the psychiatric sector, since where this is not the case it is more difficult to encourage patients or general practitioners to make use of mental health facilities.

7. A major effort should be undertaken at all levels of the educational sector to disseminate information about better lifestyles, including coping skills for dealing with feelings of hopelessness, failure and suicide, and health risks arising from the use of alcohol and illegal drugs. It may be necessary to change the relationship between health and education systems in order to deliver the right kind of education in the most effective way.

8. The state should coordinate a national campaign to inform the general public about the epidemiology, causes and consequences of suicidal behaviour, and should endeavour to replace prejudiced and ignorant attitudes with compassion, understanding and a greater willingness to help.

Secondary prevention strategies

9. Improvements should be made to the education and training of medical personnel, including general practitioners and those working in hospitals, and others involved in crisis intervention, such as the police and fire services.

In particular, further guidance is required about the identification of high-risk groups, e.g. depressives, and about treatment (including resuscitation techniques) and aftercare of those who have actually harmed themselves.

10. Further investigations should be carried out on inmates or residents of institutions, such as prisons and mental hospitals, to improve ways of reducing their high rate of suicidal behaviour.

11. Evaluative studies of well designed interventions for all high-risk groups should be undertaken. These will require greater coordination of the helping professions in order to deliver what the individual client requires at the right time by the person with the skills to do it properly. Further thought will need to be given to the conceptual, methodological and technical issues involved in evaluating the success or failure of these interventions.

12. Training programmes and methods of dealing with crises should be subject to proper evaluation. Helping agencies need to be taught how to interpret the message of the despairing and suicidal and how to react in ways that reduce, rather than increase, the risk of self-harming behaviour.

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