The WHO European monitoring surveys on national suicide preventive programmes and strategies

By Ellenor Mittendorfer Rutz and Danuta Wasserman

The results of the two WHO European monitoring surveys on national suicide preventive programmes and strategies carried out in 52 WHO member states in October 2001 – February 2002 and October 2003 – February 2004 are summarised. Countries are divided into two groups with respect to the existence of national suicide preventive initiatives. Suicide preventive activities within the mental health care services as well as public health prevention initiatives are presented.

Introduction

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 52 Member States (including Former Soviet and Central Asian Republics) in October/November 2001; reminders were sent in February 2002. The follow-up survey took place from October 2003 till February 2004. 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, Cyprus, Tajikistan and Uzbekistan.

Answers were received from 39 of the 48 countries contacted. Results from both surveys are summarised. The countries were divided into two groups with respect to the existence of national suicide prevention initiatives, to reflect the level of comprehensiveness and co-ordination of preventive activities in the countries (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 17 countries with national suicide prevention initiatives 14 have official documents issued by governments or administrative bodies such as ministries (Table 1). Seven of the national suicide prevention initiatives are approved by parliament. In Sweden, only parts of the programme (suicide prevention in young people) are approved by parliament.

National programmes with a variety of strategies have been established in Austria, Bulgaria, Czech Republic, Denmark, Finland, France, Germany, Iceland, Lithuania, Norway, Sweden and the United Kingdom (Table 1). 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. Some of the other countries with national suicide preventive strategies, like Estonia and Slovenia, report having started to draft national programmes. In 3 out of 22 countries, suicide prevention activities on county or community level are official documents (Table 1) and in Israel, Switzerland and Poland plans for national action have already been laid.

Countries with national suicide prevention initiatives

a) 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.

b) 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 hotlines.

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.

c) Public health perspective

While Public health suicide prevention activities like responsible media policy are increasingly introduced, 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 psycho-social 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. 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 (Iceland, Finland) and the media. Finland has developed a special model that includes close collaboration with the church and the police.

Table 1. Level of national action on suicide prevention

Countries with national prevention initiatives	Official documents	Approved by parliament
Austria ^a	+	—
Bulgaria ^a	+	—
Czech Republic ^a	+	—
Denmark ^a	+	+
Estonia ^b	+	—
Finland ^a	+	—
France ^a	+	—
Georgia	+	+
Germany ^a	—	—
Hungary		—
Ireland	+	+
Iceland ^a	+	—
Lithuania ^a	+	+
Norway ^a	+	+
Slovenia ^b	—	—
Sweden ^a	+	+
United Kingdom ^a	+	+
Countries without national action	Official documents	Approved by parliament
Andorra	—	—
Azerbaijan	—	—
Belarus	—	—
Belgium	+	—
Bosnia & Herzegovina	—	—
Croatia	—	—
Greece	—	—
Israel ^c	—	—
Italy	—	—
Kyrgyzstan	—	—
Latvia	—	—
Netherlands	—	—
Poland ^c	—	—
Republic of Moldova	—	—
Romania		—
Russian Federation	+	—
Slovakia	—	—
Spain	—	—
Switzerland ^c	—	—
Turkey	+	—
Ukraine	—	—
Yugoslavia (Serbia and Montenegro)	—	—

^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.

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

Countries	Health care perspective		Public health perspective		
	Services ^a	Education ^a	Media	Access	Awareness ^a
Austria	+	+	+	+	+
Bulgaria	+	+	+	—	+
Czech Republic	+	+	—	+	+
Denmark	+	+	—	—	+
Estonia	+	+	—	—	+
Finland	+	+	+	—	+
France	+	+	+	+	+
Germany	+	+	+	—	+
Georgia	+	+	+	—	+
Hungary	+	+	+	—	+
Iceland	+	+	—	—	+
Ireland	+	+	+	+	+
Lithuania	+	+	+	—	+
Norway	+	+	+	+	+
Slovenia	+	+	+	—	+
Sweden	+	+	+	—	+
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.

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.

d) 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 join 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. In all countries, suicides are monitored on the national level, and in most of them on the regional level as well. 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.

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 remains to be initiated and included in the regional projects.

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.

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. 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.

While only few countries 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 (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 (Kyrgyzstan), national research centres (Greece, Russian Federation) and national and regional public health institutes and agencies (Iceland and Switzerland) on the one hand, and non-governmental 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 (Belgium, Kyrgyzstan, Ukraine, Serbia and Montenegro) 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.

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

Obstacles experience and WHO support expressed

Several obstacles for implementation of suicide preventive activities have been reported from the countries, like lack of governmental support, financial constraints, lack of co-ordination and specialised staff, as well as poorly developed mental health services. Therefore, the most frequently expressed requests from the countries concerning support from WHO are: 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 organization of meetings.

Summary and outlook

The results of these monitoring surveys give an interesting picture of the comprehensiveness of national initiatives and the complexity and richness of practical experience in the countries. They reflect a need 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. This picture of the situation of suicide prevention in WHO European Member States will be continuously followed up, monitored and updated.

This unique summary of suicide preventive activities in the WHO European Region is intended to serve European policy makers in the area of Mental Health as an important document. Furthermore, the continuously updated documentation of

national efforts in suicide prevention in relation to the situation in other countries in the WHO/EURO network on suicide prevention, will help member states to raise governmental awareness and support.

Recommended reading

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Georgia	+	+
Germany ^a	—	—
Hungary		—
Ireland	+	+
Iceland ^a	+	—
Lithuania ^a	+	+
Norway ^a	+	+
Slovenia ^b	—	—
Sweden ^a	+	+
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Belarus	—	—
Belgium	+	—
Bosnia & Herzegovina	—	—
Croatia	—	—
Greece	—	—
Israel ^c	—	—
Italy	—	—
Kyrgyzstan	—	—
Latvia	—	—
Netherlands	—	—
Poland ^c	—	—
Republic of Moldova	—	—
Romania		—
Russian Federation	+	—
Slovakia	—	—
Spain	—	—
Switzerland ^c	—	—
Turkey	+	—
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Germany	+	+	+	—	+
Georgia	+	+	+	—	+
Hungary	+	+	+	—	+
Iceland	+	+	—	—	+
Ireland	+	+	+	+	+
Lithuania	+	+	+	—	+
Norway	+	+	+	+	+
Slovenia	+	+	+	—	+
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