

# Newsletter

## International Association for Suicide Prevention

From The President  
Professor Diego de Leo

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*“Growing number of countries are putting in operation their national strategies.”*

Dear Colleagues and Friends,

Suicide rates are declining in a number of Western and non-Western countries. Particularly in youth (below 25 years of age), these decreases are remarkable. Since 1997, Australia has witnessed a 32% decline in this age group. Other important declines have been recorded in New Zealand, USA, Canada, England and Wales. Parallel decreases have not been noticed in the 25-34, nor in the 35-44, which have not declined at all in Australia. This fact has raised speculations about the possible presence of a cohort effect, but it is unclear which components of these supposed cohorts can actually make a difference. It is also unclear why suicide rates are declining. We formulated reasonably convincing hypotheses about the motives for past increasing rates in youth suicide, but now we face perplexing questions about the possible role that increased antidepressant treatments, increased number of mental health operators (with better training), and the increased number of psychotherapy opportunities may play. Can the current decline be attributed to these factors?

The recently released WHO World Report on Violence and Health (Brussels, 3<sup>rd</sup> October 2002) estimated that the global number of suicides was 815,000. While still an enormous issue, compared to the previous Health Report, 20,000 less cases were reported. I had the honour of coordinating the production of the chapter on suicide (“Self-Directed Violence”), which was facilitated through the contributions of Jose’ Bertolote and David Lester.

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- Editorial Board
- Lars Mehlum
- Lanny Berman
- Onja Grad
- Thomas Bronisch

This newsletter was compiled by

Onja Grad and Vanda Scott

## From Central Administrative Office,



As we reach the end of 2002 may I remind those that have not paid their membership dues for this year that it is not too late! Please do so immediately as we are dependent on your contribution. CRISIS journal will be sent to you as soon as we receive your fee. Please also be reminded that if you wish to sponsor one of our Associate Members for one year you may do so at a reduced fee for yourself (\$90) plus the fee (also \$90) for the person you sponsor. This scheme has been popular and has allowed those members for whom the membership fee is not possible for them to pay in their economic environment to receive the benefits of full membership. A special thanks to those who participated in 2002. And from the desk of the GS, a very peaceful New Year to all throughout the world. *Vanda*

## Summary of 9<sup>th</sup> European Symposium on Suicide and Suicidal Behaviour, Warwick, September, 2002

Professor Mark Williams



### 9<sup>th</sup> European Symposium on Suicide and Suicidal Behaviour

University of Warwick Sept. 14-17 2002

I live on an island, the Isle of Anglesey, off the North West coast of Wales. It is around 20 miles square (or diamond). There are many cliffs and beaches and dunes around the edge of the island, and a road runs all the way around the coast. At times, when driving along the road, you can see a piece of beach that looks accessible. As the road gets close, you can see more detail. Surely the road will lead you to that spot! But to your annoyance, you find the road has started to lead away from the sea, and you are looking at your target over your shoulder as it recedes into the distance.

Suicide research can be like this. We seem to be getting closer to understanding the mechanisms that will help us reduce the rates of suicide or DSH, only to find the targets getting away from us. We need to find the pathways that will get us from the road down to the sea. What did the 9<sup>th</sup> European Symposium allow us to say about our progress? Some say that a major barrier to our progress is that suicide is a rare event (as Rachel Jenkins said it was). Others (such as Kay Jamieson) disagreed. Just look at the comparative rarity of deaths due to traffic accidents. Well, both comments are true, of course. It is rare if you want to conduct a Randomised Controlled Trial to try and show a decline. It is common if you are a parent of a teenager or young adult, worried about their safety and well-being, and realising that if they were to die, it would probably be by suicide rather than any other means, including death on the roads.

How did the Symposium shed light on these issues? Let us look at some of the major themes that emerged from the

meeting.

#### *Integration*

“In the beginning”, it was said, “was the individual risk factor; then there was the pathway; then there was the integrated pathway – and then factors affecting the integrated pathway”.

Integration included *linking the past and the present*: the Danish register research was showing what factors might explain that country’s reduction in suicide rates, and what factors were being protective of suicide (such as the birth of a child). But it was also being supplemented by research to evaluate a suicide prevention service, and further research to follow up an intervention for first episode psychosis.

Integration could also be seen in *research methodology*: for example, between qualitative and quantitative approaches. In the suite of projects on railway suicides conducted by the Sheffield team, for example, we saw how research into such a tragic event could combine scientific excellence with practical outcome (such as discussion of whose responsibility it was to deal with the immediate and long term aftermath of such an event). This issue integrated two other themes, the care for the survivors of suicide (spoken of by Onja Grad), and the issue of availability of means. For the Sheffield team had found that those who kill themselves on the railway live close to it (most live around 6 kms away). But the team had also gone further, to compare these distances with the distance that other people, who kill themselves by jumping, live from the site of death. It turns out to be around 6kms as well. It reminds us of the general issue of available means, an issue that was vividly brought up for the conference by David Shaffer’s presentation of the statistic that around 10% of teenagers in the USA have handled a gun in the last 30 days.

Integration between the fields of *biology and psychology* was a theme of Kees

van Heeringen’s presentation. He showed how a theory-driven approach to neurological and neurobiological research could yield exciting results. Who would have thought it possible to observe correlations of over 0.5 between personality and hopelessness on the one hand, and 5-HT receptor binding in the prefrontal cortex on the other? With colleagues in Ghent, Kees was beginning to wonder, as other colleagues in Lund have started to wonder, how it is possible to do treatment with people who have such deficits in brain function. It is an empirical question whether people who have such deficits in brain function will turn out to be less responsive to either pharmacotherapy or psychotherapy.

#### *Availability of Means: from observers to change agents*

We noticed an important change from previous conferences, in regard to data on availability. Previously, we knew what dangerous things were around, but could only be observers. Now, things had been done to bring about change. Change in the laws relating to pack sizes of paracetamol and aspirin had happened, and the effects been evaluated in the UK since we last met, and had been shown to reduce deaths and liver transplants due to paracetamol overdose. In India, researchers were on the trail of the pesticide companies; in Bristol there are barriers on the Clifton suspension bridge the effects of which are being evaluated; in psychiatric units in the UK, ligature points are being (or have been) dealt with; the effect of catalytic converters on car exhaust deaths is being evaluated, and is showing that this method of dying is decreasing. There is a new urgency for action around; we are no longer observers, but agents of change; and the combination of researchers and volunteers, user groups and NGOs are making themselves felt.

Of course quantitative data does not always tell an encouraging story. The rise in death by hanging that seems to be happening simultaneously in many

countries is an enormous cause for concern. It seems so difficult to reduce the availability of this method. Australia has known this for some years, since their young aboriginal population discovered this method of dying some years ago. Further discussion between all concerned, researchers, voluntary agencies and government departments, is urgently needed to find a way forward with this problem. In these discussions, we need to heed David Gunnell's warning to look behind the overall figures to the statistics for subgroups. A trend up or down in one subgroup is often masked by the overall trends.

#### *The scandal of exclusion.*

Several speakers alluded to the continuing fact that drug trials tend to exclude those who are suicidal, worried about litigation. Well, okay. We understand their concern. But no drug company should be allowed to make claims for its product around the issue of reduced suicide potential, unless it has allowed the at risk groups into its trials. As Kay Jamieson said, there'd be an outcry if the most severe cancer patients were denied the opportunity to participate in a trial of a new product that might reduce the death rate. And, of course, as we saw from the Novartis trial of Clozapine in schizophrenics with a high risk of suicide, it is possible to design a trial that takes account of the risk of suicide and attempted suicide. Their study found a 25% reduction in suicide 'events' (attempted or emergency hospitalisation for increased suicide risk, blind rated). This means that the number needed to treat (NNT) to save one such event was 12. Other companies have no excuse, now, for excluding suicidal people. The Board of IASP might take this point up with drug companies, and our National Institutes of Health or equivalent government agencies might be asked to address this issue urgently.

#### *Epidemiology and opportunity*

There has been a lot of progress in the sophistication in interpreting epidemiological data. It was not so long ago that many presentations at a meeting like this consisted of people showing the trends that were happening in their region or country, with little attempt to think about what such trends might mean. No longer. Look at David Gunnell's work: see how it is possible to compare rates in UK, France and Germany, where there

are differences in the pattern of data despite similarities in sociodemographic indicators. It only takes one observation to refute the casual generalisation that we might have made, for example, about increase being due to the divorce rate, or the alcohol rate. We need such data to be set in the whole context, and there are signs that this is being done.

Such data is showing, for example, that cohort effects are stronger than we might have supposed. If an age group is showing a decline over a decade or two, then it seems from a number of studies that the best explanation is likely to be that there is a lower risk cohort beginning to come of age, and fill up that age slot. Look, then, at the next age group up, and very often you will see the more vulnerable cohort start to fill up that age slot (the suicide rate for that age group begins to rise). Whereas we used to say that the older age groups were more at risk, it is now important that we update our statistics every five years so we can say, of any individual, whether they belong to a vulnerable cohort.

#### *Genetics, Lithium and CBT*

It is always useful, at a conference such as this, to see where research in a particular domain has got to. We saw reference to Roy and Segal's 2001 (*J.Affective Disorder*) update on studies of MZ vs DZ twins. In total, 168 MZ and 294 DZ twins have been studied, one of the pair of which died by suicide. Of the MZ pairs, 31 also died by suicide, compared with only 2 of the DZ pair. Elsewhere, Andrej Marusic quoted a heritability figure for suicide of 43%.

Such summary studies can be tantalising. We saw reference to the reviews of Lithium clinics; 28 studies comprising, in all, 17,294 patients. The risk of suicide without lithium is represented by an SMR of 3.39. The risk of suicide if you are on lithium is 0.37. This ninefold difference is tantalising because it does not arise from an RC T. Such figures could, of course, simply be a marker of attendance at clinic of those who are, at the outset, determined to control their moods, natural problem solvers that do well in using the Health Service to best effect. Perhaps they were never going to die any-

way.

That was not Kay Jamieson's view. She knew from the inside what it was like to give up on lithium, and find herself giving up on life too. And, anyway, is it not valuable to know that we have such a clear marker of suicide risk in those who suffer from bipolar disorder?

And what do we do if patients do not want to choose lithium, even though it seems to make such a difference? We heard of a (now old) small trial combining CBT with lithium, in which, of the nine patients who had CBT, only one was rehospitalised. Of the twelve who did not have the CBT with their lithium, eight were rehospitalised. We need more such studies. The health economics alone demand such studies. A course in CBT (16 sessions) has been costed at 350 GBPounds. How much is hospitalisation?

And CBT for suicidal behaviour is moving on. David Rudd reported on a new Suicide Cognitions scale that can assess more accurately whether the cognitions that need to be targeted in therapy are actually changing. He and his team distinguish between a sense of unlovability ("I don't deserve to live"), helplessness ("I can't solve my problems"), poor tolerance of distress ("I can't stand how badly I feel"), and perceived burdensomeness ("Everyone would be better off if I were dead"). He is on the way to making significant improvements to what CBT may offer patients. A patient may recover in some respects, but the continuing vulnerability may remain, nested in that one domain that has not changed. This sounds very plausible, and he has a way of measuring it. This is a promising new "pathway to the sea".

#### *Research strategies*

Some years ago, presentations at such conferences would be obsessed with whether suicide ideation was really a proxy for suicidal behaviour, and whether suicidal behaviour could be taken as a proxy for suicide. There is now much greater awareness that suicide ideation is sometimes the only indicator of suicide intent and planning, that looking back (e.g. on those

discharged from psychiatric units who die by suicide over the next few months), that talking about suicide is a significant distinguishing feature. It cannot be ignored, especially when it occurs in high risk group (as for anyone with a diagnosable psychiatric disorder).

Similarly, deliberate self harm (DSH) remains the best predictor of eventual suicide. Even if we do not like using DSH to understand completed suicide, we have the option of studying those whose DSH was sufficiently severe that death would have been probable had they not been found. These might have entered the suicide statistics, but they are still alive. What proportion of the DSH population is this? Camilla Haw told us from a sample of 150 in the EPSIS study. Although in that sample there were none where death would have been certain if no intervention was forthcoming, there were 17% where death was probable - about the same proportion where survival would have been certain. Inbetween we have a large group (65%) where death was unlikely. This and other studies of serious self harm show that the near death subpopulation shares many more characteristics (age and sex ratio) of the population (for that country) of those who complete suicides. More studies that focus on this sub-population will be an important step forward.

#### ***Political Strategy***

Out of such an evidence base that we now have, the National Suicide Prevention Strategy for England was devised, and launched at the meeting (see it on [www.doh.gov.uk/mentalhealth](http://www.doh.gov.uk/mentalhealth)). Louis Appleby and colleagues were responsible for getting much of the evidence together and developing the strategy for England, and the Minister for Health, Jacqui Smith was there to launch it. It is a model strategy, not only setting targets, but also combining both community and NHS initiatives. And in her responses to often challenging questions from the floor, the Minister showed that she understood the evidence from the inside. "This could never happen in our country", some said in the lobby afterwards, not only referring to the strategy itself, but referring to the willingness of a Minister to answer questions about it in open session with experts in the field.

#### ***Environment issues: the effect of chaos and trauma***

Steve Platt challenged the meeting to consider the possibility that we were looking in the wrong direction. What, he said, about the social context in which DSH occurs. For us as professionals or volunteers, we think DSH is important. For those who harm themselves, it may be simply a small aspect of a chaotic life. In one study of his, out of a sample of 50 people who had harmed themselves, only 4 were in paid employment. He reminded us that a small geographical area could have a rate of DSH that remained stable for decades. What is it about such a place? We need to know.

So it was interesting to hear an unexpected finding from an RCT that didn't work by Richard Harrington. How on earth can a failed RCT make an impact on the chaotic social factors that abound in the lives of our patients and clients? It turns out that a psychological treatment that had no apparent effect on repeated DSH, reduced the social care costs from £140 per person to £54 per person. Now, I do not know how much social care you can buy for £140 - but such a 61% decline in any outcome measure deserves to be taken very seriously indeed, and it is just possible that this figure represents a genuine decline in the amount of chaos experienced by these participants as a result of the intervention. It reminds us that our outcome measures should be broad.

The other important impact of the environment we heard about was the continuing tragedy of abuse suffered by young children. Lars Mehlum quote from the suicide note of a young man of 17 who had committed suicide. He had been abused between the ages of 4 and 9. He felt he was being driven mad by the pictures in his mind "I can't stand it anymore...the pictures are so vivid...it is as if my self confidence has been crushed against a rock".

It is not difficult to see why such a person sees death as an escape from such continuing trauma. Here is a case where the ease with which we empathise needs to lead on to some urgent questions...most notably, what can be done to help such young people to process such trauma so that they can live their lives without the constant

reminders and vivid pictures. Mark Williams talked of the research on rumination - the vicious circle by which people end up trying to combat their awful imagery with strategies that only serve to make them worse. When we ruminate, we lock up the mind in loops that make it more difficult to exit, and lock up the images of trauma so they cannot change or extinguish. Furthermore, the evidence suggests that moment to moment rumination actually reduces the specificity of autobiographical memory (known already to be damaged by the occurrence of past trauma) and makes problem solving even more difficult.

#### ***Statistics and insight***

The symposium heard how statistics on suicide were being subjected to critical scrutiny. The result is that original estimate of a 15% death rate following major depression (originally calculated from deaths in the years following admission to psychiatric hospital) had now been revised, and was more likely to be around 5 or 6 per cent. In a similar way, deaths in those diagnosed with alcohol abuse was more likely to be between 4 and 10 per cent, not the 10 per cent that is often quoted. The problem seems to be not only, as for depressed patients, that early estimates were based on hospitalised patients, but also that death rates were worked out on the basis of what proportion of *people who died from any cause* had died by suicide (proportionate mortality analysis). A better estimate is to use case fatality analysis (following the number of suicides seen in a given sample over time, taking account of illness time course and mortality from other causes (B.A. Palmer, Mayo Clinic, Rochester). Palmer and Bostwick presented data for schizophrenics, showing how this analysis revises the estimates for such patients to 4.9%. However, because death by suicide comes early in the course of the illness, it remains true that 83% of those who will die by suicide are dead within 10 years of onset.

Alan Apter and colleagues have studied young schizophrenics, and talked of the tragic paradox that those with the best prognosis for their schizophrenia, are more likely to kill themselves. Such young people often have

the greatest 'insight' into their illness, as defined by knowledge that their hallucinations and delusions were due to an illness process. However, given their prognosis, we need to ask whether calling this 'insight' is really appropriate. Should not this be called partial insight, to contrast it with the full insight that would both see their disability, but also see their potential, even creative potential, that is left. Can we work towards giving such young people a sense that, 'while I am still breathing, there is more right with me than wrong with me'. True insight may be about seeing how it may be possible to live a fulfilling life despite the disability.

### *The Role of Anti-depressants*

Finally we come to the issue that probably divided the Symposium more than any other...the place, relevance and effectiveness of antidepressant medication (especially the newer antidepressants that are now prescribed in large quantities in certain areas of the world). It was not that a great deal was said on the topic, but what was said was so divergent that not both sides can be true. Herman van Praag was sure that the rise in prescription of antidepressants was not having any noticeable effect. He seemed highly critical of the use that is being made of studies such as that of Isaacson and colleagues. Perhaps, he said, it is not their fault that others misunderstand or misrepresent their findings, but a fall in one graph while another graph rises is shaky ground on which to build conclusions of causal connection.

On the other hand, there was David Shaffer talking about whether suicide might one day become a thing of the past. He was particularly interested in the fall in the rates of suicide in 15-19 year olds in many parts of the world since around 1990, especially in the USA, following several years of alarming rises. Perhaps, he said, it was due to change in risk factors, or an interference with mechanisms, or regression to the mean. None of these appeared to be the case, though it remains possible that a vulnerable cohort, born between 1960 and 1975, was now growing through the system, and might now appear in the 20-35 year old sample.

But there was better data to be had on the role of ADMs. David Shaffer shared with the meeting some data from a report that has just been submitted (Ofson et al),

a small area study, using a zip code analysis (581 zip codes). In all, there had been a rise across the areas from 590,000 prescriptions to 10-19 year olds in 1989, to 1,300,000 in 2001 (a rise of 220 per cent). The zip code analysis showed that, for males (only) there was a significant association between those areas that had seen the greatest rise in ADM prescription, and a reduction in the suicide rate. He was able to calculate that a 1% rise in treated adolescents would result in a fall of 2 per million in the suicide rate. This urgently needs replication in other centres. But meanwhile, he and his colleagues might rule out the possible explanation that a cohort effect was responsible by looking at the figures for 20-30 year olds over the same period. For we would predict that, if what was causing the decline was that, area by area, a vulnerable cohort was growing up into the next age bracket, then, area by area, the suicide rate would have *risen* for 20-30 year olds. Of course, if there had been a rise in antidepressants for this age group too, then the data will look as if the rise in prescribing has resulted in a rise in the suicide rate in this, next older, age group.

### *Concluding remarks*

A busy symposium, with a sense of growing maturity of understanding suicide and suicidal behaviour. The organisers deserve to be congratulated on a first rate scientific programme, and a social programme that provided the context within which friendly debate could carry on outside the academic meeting halls.

The pathways to the sea, of which I spoke at the outset, are being mapped. We are not there yet, but at least we

have stopped driving past, back and forth, looking into the distance in professional despair.

*Professor Keith Hawton of the Centre for Suicide Research, University of Oxford and Simon Armson of The Samaritans both wish to convey their sincere thanks to Professor Williams and his team, for capturing the essence of the symposium and conveying it so clearly in the final presentation. The theme "From Science to Practice" was a constant reminder to all the participants throughout the scientific meeting as so clearly shown in this report.*

*We cannot live only for ourselves. A thousand fibers connect us with our fellow men; and among those fibers, as sympathetic threads, our actions run as causes, and they come back to us as effects.*

*Herman Melville*

## Launch of the National Suicide Prevention Strategy for England

Simon Armson, IASP National Representative for the UK

Between 14<sup>th</sup> and 17<sup>th</sup> September this year, Samaritans and the Oxford Centre for Suicide Research jointly hosted the 9th European Symposium on Suicide and Suicidal Behaviour at Warwick University. Over 350 delegates attended the four-day event to hear nearly 230 presentations from academics and practitioners on a very wide range of subjects relating to suicide.

The common theme that underpinned the conference, as indicated in its title, was 'from science to practice'. The event sought to bring together those who undertake research into all aspects of suicide and those who put research findings into practice. In his summing up of the symposium, Professor Mark Williams said "A busy symposium, with a sense of growing maturity of understanding suicide and suicidal behaviour. The organisers deserve to be congratulated on a first rate scientific programme, and a social programme that provided the context within which friendly debate could carry on outside the academic meeting halls."

Apart from the scientific input, one of the highlights of the symposium was the visit made by the Minister of State for Health, the Right Honourable Jacqui Smith MP who chose the occasion to launch the government's suicide prevention strategy for England. This was particularly appropriate for both Samaritans and the Oxford Centre for Suicide Research who had each been represented on the advisory group which oversaw the development of the strategy.

The strategy is the result of many months of research and development that involved consultation with a wide range of practitioners and academics. This approach was vital in order to ensure that the many different professions who deal with suicide had the opportunity to add value to the strategy by informing its development in this way. Only by working

together is it possible to be successful in reducing the current levels of suicide today.

The six goals outlined in the strategy represent a flexible, realistic and measurable approach by the government. They incorporate a flexibility that will allow the strategy to be implemented easily by the diverse range of organisations and practitioners that need to be involved for it to be effective.

The six goals are:

- Goal 1: To reduce risk in key high risk areas
- Goal 2: To promote mental well-being in the wider population
- Goal 3: To reduce the availability and lethality of suicide methods
- Goal 4: To improve reporting of suicidal behaviour in the media
- Goal 5: To promote research on suicide and suicide prevention
- Goal 6: To improve monitoring of progress towards the achievement of the government's target of reducing suicide by 20% by 2010.

Clearly the successful achievement of these goals will need to involve all those who work in the field of suicide prevention, whether they are scientists or practitioners. The task of overseeing the implementation of the strategy will be that of the National Institute for Mental Health in England, in conjunction with the strategy group. This strategy makes a significant contribution in putting suicide on the public agenda, in doing so it will help to reduce the continuing stigma that surrounds the issue. After all, suicide is everyone's business and not just the preserve

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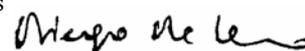
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I would also like to warmly thank Annette Beauvais, Danuta Wasserman, Rachel Jenkins, Antoon Leenaars, Ernest Hunter, Alec Roy, and Michael Phillips. For reasons beyond my will and control, not all their names have been my gratitude to them. I believe the Report is a great achievement, and having a chapter on suicide seems to me of relevant importance in attracting governmental and public attention to the problem, which is one of the main scopes of IASP.

At this stage, it appears quite probable that WHO will announce the World Day for Suicide Prevention during the next Stockholm IASP conference.

It is also of great satisfaction to notice that a growing number of countries are putting in operation their national strategies. After the recent implementation of the USA strategy, England has presented its plan in Warwick, in the context of the European Symposium on Suicide. It was an exceptional occasion for such an initiative, and the State Minister of Health Jacqui Smith validly answered a good number of questions from a well-informed public.

Warwick also hosted a board meeting of IASP executives, which has been fully dedicated to the organisation of the next Swedish congress, and to the South African 2005 edition. Both occasions look very exciting, and IASP overall relies on them for its future growth. Thus, we have to make every effort to guarantee the best possible success to these events. We have much to do in 2003. Many greetings to all *and Ciao*



## From around the World

### France

Jean-Pierre Soubrier, Paris

The Union National pour la Prévention du Suicide (UNPS) organized its 6<sup>th</sup> meeting at UNESCO Palace in Paris in February 2002; the theme: "Suicide and the human relationship".

Three Government Ministers attended and made significant contributions to meeting:

- Elizabeth Guigou, Ministry of Social Affairs gave the opening speech.
- Bernard Kouchner, Ministry of Health gave the closing speech.
- Mrs Kunsten, Ministry for the Handicapped chaired a round table and made a speech.

Mrs Elizabeth Guigou confirmed the participation of France to the European project of suicide prevention and confirmed that the suicide prevention programme launched in France in 2000 would continue as expected until 2005. She thanked Professor Jean Pierre Soubrier for accepting to represent France within WHO Europe.

The main topics at the meeting were:

- Suicide at the workplace: violence, professional stress
- Privation and exclusion: gender, old age, cultural differences, prison
- Education: family, schools, sexual abuse
- Care: depression, euthanasia, hospital network

- Intimacy, loss, bereavement.

It was important as it provided the opportunity to suicidologists from

different areas, who do not usually meet at IASP congresses and are not known by the International Academy of

Suicide Research, to exchange their views. IASP member Professor

Danuta Wasserman and General

Secretary, Vanda Scott, represented IASP, and made many contacts on the international forum. Discussions were held with colleagues from Algeria and Uruguay on the development of

suicide prevention strategies and the call for greater exchange of knowledge and skills among researchers and

practitioners. Collaboration across the sectors was a strong theme and the need for effective prevention

strategies to be critically evaluated and

effectively monitored was constantly endorsed.

Among the nearly 800 participants of this international meeting were suicidologists from different countries

### Japan

The XI<sup>th</sup> Congress of the World Psychiatric Association was held in Yokohama, Japan last August. There were 3 paper sessions on suicidology, including a symposium attended by WHO representatives, José Manuel Bertolote and Wolfgang Rutz.

The New Scientific Section of Suicidology was officially created on August 29, 2002.

The board will be directed by:

- President: Professor Jean Pierre Soubrier, France
- Vice-President: Dr Nicoletta Tataru, Romania
- Secretary General: Professor Alexander Botsis, Greece.

Board members will include:

- Dr Nelson Moreno Ceballos, Dominican Republic
- Professor Sergio De Risio, Italy
- Professor Danuta Wasserman, Sweden
- Dr Sergio Perez Barrero, Cuba
- Dr Sylvia Pelaez, Uruguay

*WHO Consultants:*

- Dr José Manuel Bertolote
- Dr Wolfgang Rutz.

The next WPA meeting: Cairo, Egypt, September 10 – 15, 2005.

Different regional symposia are expected meantime.

## Suicide: Interplay of Genes and Environment

Report of an international meeting held in Portoroz, Slovenia, 9-12 May, 2002.

Professor C. van Heeringen, Belgium

Jointly organised by the Institute of Public Health of Slovenia, the National Council of Slovenia, the Institute of Psychiatry at the Maudsley, and the University of Gent (Belgium) this meeting was a truly international scientific happening. Twelve invited lectures, workshops, poster presentations and contributions from a large number of European countries and the USA resulted in stimulating discussions about the topics of the meeting, i.e. suicide between genome and environment, the neural substrate of suicidal ideation and behaviour, and cross-cultural issues in suicide. Additional topics included suicidal behaviour in eating disorders, risk assessment and prevention by GP's and hospital staff, and bereavement after suicide. Andrej Marusic and his co-workers from the Slovenian Institute

## From around the World

### Russia

#### Launching World Suicide Prevention Day in Russia

Professor Ludmilla Arkhangelskava, IASP National Representative for Russia

World Suicide Prevention Day was launched at a conference held in September in the city of Rostov-on-Don, Russia. Attending were 30 psychiatrists and psychologists working in the field of suicide prevention.

Five papers were presented at the conference:

1. Freud's psychoanalytic views on suicide behavior. Modern psychoanalytic theories (M.Klein, O.Kernberg) - Ludmila Arkhangelskaya.
2. The case of a treatment of a suicidal borderline patient with symbol-dramatic psychotherapy - Kolokoltseva Ludmila.
3. A treatment of a suicidal patient with religious psychotherapy approach - Smolin Alexandr.
4. Psychiatric approach to the administration of the suicidal patient— Melanie Baiburtian.
5. Psychotherapeutic approach with creative rest to child and adolescent risk groups as a measure of suicide prevention - Marina Kirnos.

These papers were followed by a round table discussion about preventative strategies in addressing suicidal behaviour.

### Slovenia

#### Proposal for the National Programme for Suicide Prevention in Slovenia

Professor Onja Grad, IASP National Representative for Slovenia

On October 15 and 16, 2002 there was an important event organised by the Slovenian Association for Suicide Prevention called The First Lev Milčinski Memorial, after the late Slovenian pioneer and mentor in suicidology.

The *first* day the draft of the national strategy for suicide prevention was presented in the Parliament to its president, MPs, professional and lay audience and to the press. Three Norwegian colleagues presented the Norwegian National Plan for Suicide Prevention from different perspectives: Heidi Hjelmeland, Lars Mehlum and Nils Petter Reinholdt explained the organisational pathway and the current state of art that has been working efficiently in Norway.

The President of Slovenian Association, Onja Grad, gave an overview of possible activities that should be combined into the proposal, written and given to the Parliament to acknowledge, finance and implement. The Minister of Health and the member of the Committee for Health of the Parliament strongly supported the idea from the political point of view, thus it was concluded that a small group of people will be appointed to prepare the written official document for the Parliament.

In the afternoon all the participants were included in the workshops. The main topics were all connected to the problems with the national strategy from three standpoints: politics, public awareness and media involvement. The posters were presented and the home page of the Slovenian Association for Suicide Prevention was launched. [www.zrc-sazu.si/prepreci-samomor](http://www.zrc-sazu.si/prepreci-samomor)

The *second* day, that was held in the Slovenian Academy of Arts and Sciences, where the late Professor used to be a member, different very eminent speakers (some of them knew him for 70 years) talked about his life, personality and his work. We concluded the two day Memorial with vignettes and impressions that the late charismatic academic left on contemporary colleagues. His work was devoted to suicidal patients and to development of suicidology in Slovenia, with many efforts to establish the National Programme.

Maybe now time finally has arrived for his enlightening ideas to become reality. With the suicide rate of 30/100.000 for the past thirty years, Slovenians deserve to implement the national strategy as soon as possible.

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## FORTHCOMING EVENTS

- XXII IASP Congress, September 10 – 14, 2003, Stockholm, Sweden:  
Crossing Borders in Suicide Prevention — From the Genes to the Human Soul
  - 36th Annual Conference AAS, April 23 – 26, 2003, Santa Fe, New Mexico, USA
  - 7<sup>th</sup> World Congress on Stress, Trauma & Coping: Crisis Intervention in a Changing World. February 12 – 16, 2003. Baltimore, Maryland, USA. Contact ICISF on [www.icisf.org](http://www.icisf.org).
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## From around the World

### Suicide Prevention Activities in Turkey

Professor Dr. Isik Sayil, IASP National Representative for Turkey

Turkey is a rapidly developing country, extending from Asia to Europe. Due to population explosion, high rate of internal migration and contact with the western world, our socio-cultural system, traditional customs and ways of belief, attitude and behavior began to shake. In addition, last economic crisis forced people to undergo great difficulties and tension while they were trying to survive and adjust their way of life. Ankara, the city where I work, is the capital of Turkey and such difficulties and problems as indicated above take place frequently.

Suicide problem in Türkiye can be discussed on the basis of state institute of statistics data which has been collected since 1962.

Suicidal behavior is a growing problem especially in the big cities in our country. Our work in prevention activities consisted of three steps. The first step consists of stimulation and education of society, education of professionals and administrators on the suicidal behaviour were especially chosen. As a second step the studies that had been done about suicides in the country has been collected. From 1900 till 2000, a period of 100 years was evaluated and a bibliographic book was prepared about the published material on suicide - we published Suicide Bibliographies in 1990 as well as in 1995 and also in 2000, which made it easier to reach Turkish papers published in this field.

The improvement of the services for the suicidal patients was the third target of our activities in this area. Starting from this point of view we began our work to establish a Crisis Intervention Center in 1980. We contacted the crisis intervention center of Vienna and a professional from Turkey was educated by the team of the center which was under the leadership Prof. Dr. G. Sonneck. In 1989 we established our crisis intervention center based on the Vienna Model in Ankara University.

Since 1992, "Kriz Dergisi" (Crisis Journal) has been published twice a year. This journal is the only periodical in Turkey which accepts papers on suicidal behavior and crisis intervention.

On the other side in 1995, to reach the suicidal patients directly in the Emergency Unit, a crisis room was founded in university of Ankara Medical School. This unit is part of crisis intervention center. At the same time crisis intervention room workers educate emergency department and re-animation center staff on relevant issues. In addition they try to solve the staff's communication problems and finally they help these teams with the burn out problems which are very common.

The activities of the Crisis Center are not limited to therapeutic process of the patients. Doing research, publishing the books on suicide, giving courses to professionals to improve their skills while working with suicidal patients, working with the risk groups, etc were the other activities of the team of Crisis Center. For example after the earthquake disaster in August 1999 a crisis team was sent to the region to support working with the victims and the professionals working on the area. Our working group participated in WHO/EURO multicentre study of suicidal behavior on December 1996. This activity forms a new step of our work on the area. Last month, a study group from crisis center, with the collaboration of Department of Psychiatry of Ankara

University, designed a research project to examine the suicide attempts in Southeast of Türkiye. This is already finished and a report is being prepared.

#### **Future Planning**

Our plans for the future are to improve records and psychosocial intervention for suicidal patients which is insufficient at the moment in other emergency departments of hospital. Nowadays we are discussing with the Ministry of Health to improve the service given to suicidal patients in the emergency rooms. In our



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**The objectives of I.A.S.P. are:**

to provide a common platform for all representatives of different professions and volunteers who are engaged in the field of Suicide Prevention and Crisis Intervention;

to allow interchange of acquired experience in this area in various countries, especially through exchange of literature;

to promote the establishment of national Organisations for Suicide Prevention;

to facilitate the wider dissemination of the fundamentals of effective suicide prevention, not only to professional groups and volunteers, but also to the general public;

to arrange for specialised training of selected persons in the area of suicide prevention, in selected training centres, where desired;

- and to carry out programs of research, especially those which can be pursued through international joint co-operation.

**The Executive board of I.A.S.P. is elected each two years and at present comprises:**

- |  |  |
|--|--|
| <b>Diego de Leo</b> (Australia)              | President  |
| <b>Lakshmi Vijayakumar</b> (India)           | Vice President                                   |
| <b>Onja Grad</b> (Slovenia)                  | Vice President                                   |
| <b>Lanny Berman</b> (USA)                    | Vice President                                   |
| <b>Lars Mehlum</b> (Norway)                  | Treasurer  |
| <b>Vanda Scott</b> (France)                  | General Secretary                                |
| <b>Simon Armson (England)</b>                |  |
|  | Chair, Council of National Representatives       |
| <b>Slavica Selakovic-Bursic</b> (Yugoslavia) |  |
|  | Chair, Council of Organisational Representatives |

***IASP Membership 2002***

<b>Individuals</b>	
Full Members	237
Honorary Members	6
Associate Members	22
<b>Organisations</b>	
Full Members	26
Associate Members	14
<b>Total</b>	<b>305</b>

***IASP Membership 2003***

***Memberships Dues***

Individual membership in IASP, including a subscription to the journal CRISIS,  
 US \$100.00 per year.

Organisational membership in IASP,  
 including a subscription to the journal CRISIS,  
 US \$100 per year.

Please remember that for an organisation to be a member of IASP, there must be two IASP individual members as representatives within the organisation.

If you wish to sponsor an Associate Member of IASP to become a Full Member (and therefore be entitled to vote and receive CRISIS journal) a discounted membership fee (US\$90) will be made available to you and also to your Associate Member (also US\$90).

# Suicide Prevention Activities in Austria

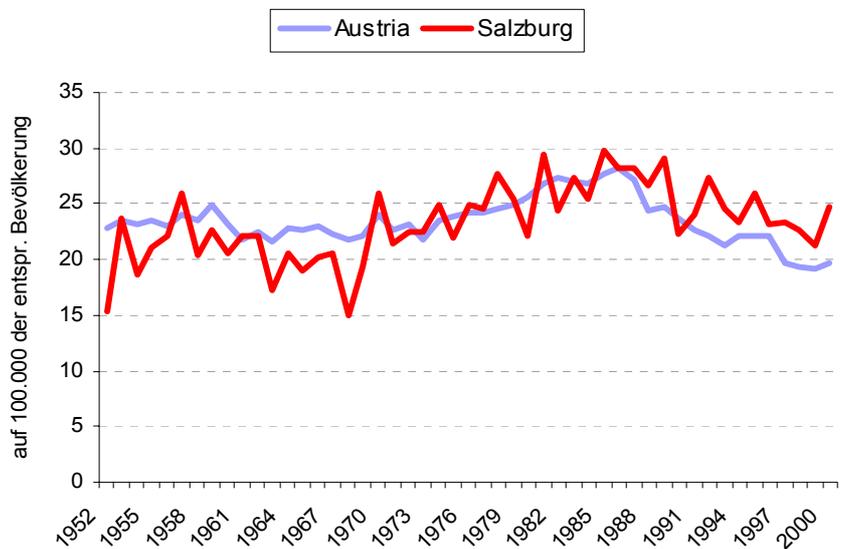
Reinhold Fartacek, IASP National Representative for Austria

## Austrian Suicide Statistics:

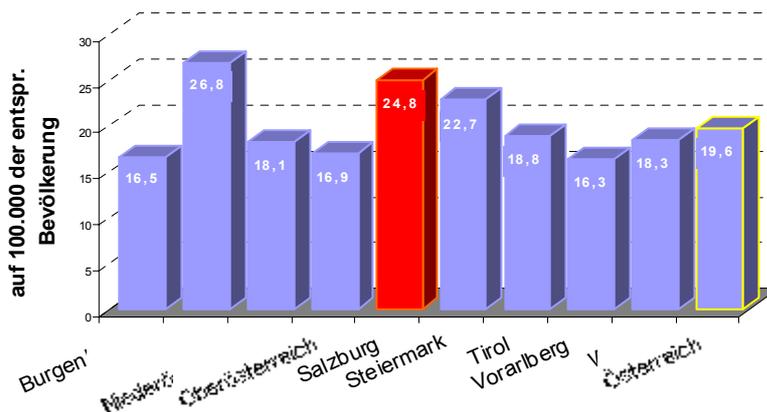
In the period 1990 – 2000 there was a slight decrease in suicide mortality (see figures). If we observe longer time periods suicide rates remain quite stable.

WHO-Euro-Task force on suicide prevention: Participants from the city of Innsbruck (C. Haring, D. Dunkel) and the province of Salzburg (R. Fartacek, R. Rohrer) attended the meeting in Würzburg in December 2000. In Salzburg at the beginning of October 2001 the monitoring of Parasuicide will start. All hospitals in the city and in the rural areas and then all GP's will take part in this project. The Parasuicide monitoring project is part of the project: Suicide Prevention Salzburg, a large suicide

Suicide Rates 1952-2000



Suicide Rates - Austria 2000



moment there are no regular discussions with the ministry.

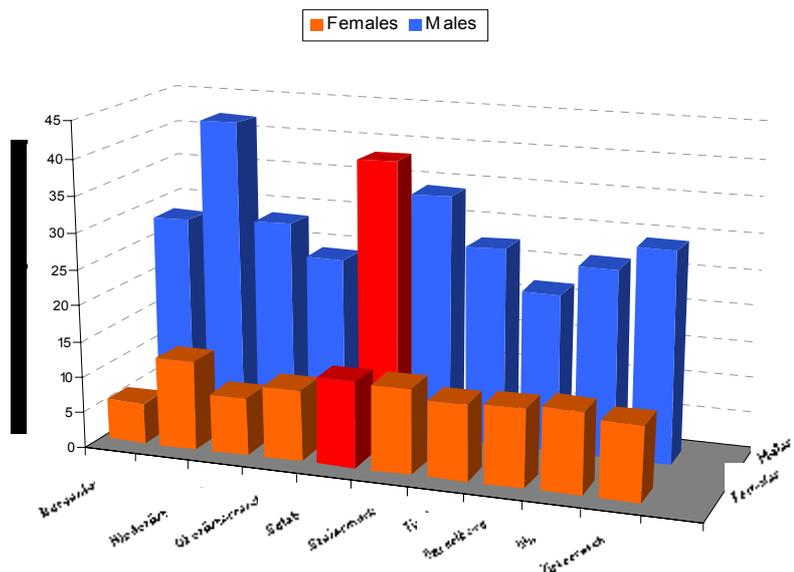
prevention network in the province of Salzburg.

## S U I C I D E P R E V E N T I O N S A L Z B U R G:

This project is financed by the government of Salzburg since April 2000. The budget this year amounts to approx. 110.000 Euro.

National Suicide Prevention Programme: On behalf of the Ministry of Health and Social Affairs Gernot Sonneck developed a draft of a national suicide prevention programme (140 pages). This draft contains important recommendations for further political discussions. At the

Suicide Rates Austria 2000



## *Crossing borders in Suicide Prevention:*



XXII IASP Congress  
September 2003  
Stockholm, Sweden

The XXII International Association for Suicide Prevention (IASP) Congress will be hosted by IASP and the Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health in Stockholm, Sweden, on 10–14 September 2003. It will take place at the City Conference Centre, in Folkets Hus and Norra Latin — two of Stockholm's most highly appreciated congress venues, equipped with the latest technology and facilities. The Congress theme, *Crossing Borders in Suicide Prevention — From the Genes to the Human Soul*, reflects the aim of holistically synthesising the biological, psychosocial and ethical aspects of suicide for a better understanding of its aetiology.

### SCIENTIFIC PROGRAMME

The International Scientific Committee is currently drawing up a programme of the highest international standard, with a variety of symposia, workshops, and parallel and plenary sessions. We are delighted to inform you that key international professionals in the various scientific fields to be covered have agreed to make presentations in plenary sessions. Symposia are planned for the mornings, followed by plenary sessions and, finally, parallel sessions and workshops in the late afternoons.

## *From the Genes to the Human Soul*

On the first day, which will focus on cultural aspects and the public-health perspective in suicide prevention, eminent scientists and policymakers will give key presentations. Parallel sessions will deal with the development of culture-specific suicide prevention programmes. This day will mark the first time parallel sessions in all four official WHO languages, French, English, Spanish and Russian, have been held in an IASP congress.

The second day will be dedicated to biological and genetic research and the healthcare approach to suicide prevention, while the third will focus on ethical and legal aspects, and prevention of suicide among children and adolescents. The key presentations on the last morning (Sunday) will be made by representatives of voluntary and survivors' organisations.

### Participation of delegates from low-income countries

The Congress seeks to attain an equal geographical representation of speakers and delegates and stimulate the formation of networks that transcend professional as well as national boundaries. To facilitate participation from low-income countries, the organising committee of the Congress adopted a four-point scale of registration fees for delegates according to their countries of origin. With this scale, delegates from developing countries will pay only around half the registration fee payable by those from the USA, Canada, Western Europe and elsewhere.

A comprehensive selection of low-cost accommodation will be accessible through the Congress web site.

### Social events

Various social events to present the beautiful scenery of Stockholm and its environs to complement the inspiring scientific programme have been arranged by the Organising Committee.

The opening ceremony will be held in Norra Latin, a former grammar school founded in 1880. The building has recently been renovated and is now considered one of Europe's most beautiful congress venues. The delegates will be invited to a standing buffet in Stockholm City Hall, with its beautiful waterfront location in central Stockholm, which is renowned mainly for the Nobel Prize festivities held there annually on 10 December.

A banquet will take place at the Vasa Museum, which houses one of the world's most remarkable and awe-inspiring historical sights — the Royal Warship *Vasa*. The *Vasa* was to have been Sweden's largest and most prestigious warship, but shortly after setting sail on her maiden voyage in 1628 she sank in Stockholm harbour. After spending the next 333 years lying on the seabed, she was finally located and salvaged. For accompanying persons various tours, including visits to some of Stockholm's most fascinating attractions, will be organised.

### SECOND ANNOUNCEMENT

The Second Announcement, including the preliminary programme, registration and accommodation forms, will be distributed in December. The abstracts