



IASP Newsletter

International Association for Suicide Prevention

From The President Professor Diego de Leo

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This newsletter issue was compiled by Vanda Scott

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The International Association for Suicide Prevention is gathering support for an International World Day for Suicide Prevention. This day will promote and expand international awareness of the need to increase suicide prevention efforts, appropriate research and effective interventions.

Suicide is one of the greatest killers of people throughout the world. In 2000, suicide claimed the lives of approximately 815,000 persons worldwide and global suicide rates are increasing, going up 60% over the last five decades.

IASP will put forward a pro-

posal to the United Nations and the World Health Organisation for an International World Day for Suicide Prevention, and needs *your* help in reaching a consensus on the date and also need to demonstrate *your* support for such a day to the above mentioned organisations.

The proposed date to hold the International World Day for Suicide Prevention is in September. The month is relevant for a number of reasons; most notably it commemorates the inception of the International Association for Suicide Prevention in 1960.

There is a great deal of bureaucracy involved in finalising the International World Day for Suicide Prevention, so please provide your response as soon as is possible.

I thank you for taking the time to consider this matter and look forward to the op-

portunity of creating greater International understanding of the need for increased suicide prevention efforts.

I would also like to take this opportunity to convey my heartfelt thanks to both Professors Norman Farberow and Nils Rettersol for their true dedication to IASP in their many years of service on the Election Committee. I would like to express my deep gratitude for the works that they undertook, in a magistral way, in co-ordinating and collecting the votes for the elections of the National Representatives and Executive Board members. They not only guaranteed effective sanctuary of the entire procedure but their reputation and stature really validated the entire election process.

Thank you our two special friends.

From Central Administrative Office, France Vanda Scott, IASP General Secretary

The Central Administrative Office continues to receive enquiries from the membership and requests for information from researchers, medics and policy makers in suicide prevention on the work being undertaken both from within IASP and from associated organisations. The increase is partially due to the activities of National Representatives who clearly are identifying colleagues in their country who are looking for networks in which to share their work. Elections for National Representatives will be called for a few countries (Australia, France, The Netherlands and Pakistan) during this month and will be supervised under the auspices



The Flemish Suicide Survivor Day

Karl Andriessen & Nico De fauw

Support for suicide survivors in the Flemish region in Belgium was never developed to the extent of the need. With a suicide rate of 20/100,000 we estimate the number of survivors at 6,000 a year. In contrast only a handful of pioneer support groups and clinicians were specifically targeting the survivors. At the beginning of the year 2000 a Working Group on Suicide Survivors was established, consisting of the survivor support groups, the self-help umbrella, help lines, victim care and mental health centres. Funds are granted for three years (2000-2002) by the Cera-Foundation. The general goal is to increase the support for suicide survivors at different levels: by making the groups more widely known, by organising interchange and training sessions with group leaders, by writing a manual on guiding a support group, by increasing the collaboration between volunteers/peer facilitators of suicide survivor groups and clinicians/professional workers, and by presenting a Charter with the Rights of Suicide Survivors.

The cue of the strategy will be the establishing of a **Suicide Survivor Day**, to be held for the first time on Saturday 16th November 2002. The purpose of the day is to bring together suicide survivors, caregivers and policy makers; to share experiences and points of view; and to learn from and to support each other. The programme includes a few plenary presentations on suicide and suicide bereavement, followed by a variety of workshops discussing different topics, e.g., risk factors of suicide, methods in group guiding, bereavement and grief of children after loss by suicide, parents who have lost a child by suicide, the caregiver/helper as survivor. The Flemish Minister of Health will explain her point of view and policy, which is currently in preparation. The climate of the day should be kind-hearted, offering safety, warmth, and opportunities to listen, to find support, to be oneself, meaning e.g. to be a suicide survivor. The date chosen serves as a symbolic link with suicide survivors around the world, as on the same day the US suicide survivor day will be held. With our first edition we hope to reach approximately 150 to 200 participants. Surely this day will be evaluated with participants and with the organising team, after which we will decide whether it will become an annual or a biannual event, as well as whether to choose new accents or targets.

Karl Andriessen & Nico De fauw, UMHC, Triomflaan 74, 1160 Brussels, Belgium

AAS Celebrates 35th Annual Conference

- Lanny Berman, IASP Vice President

The first Annual Conference of the American Association of Suicidology (AAS) was held in Chicago, Illinois in March, 1968 and presented 24 speakers in four panels in addition to a Symposium on Suicide chaired by AAS's founding president Ed Shneidman and featuring such luminaries as philosopher Jacques Choron, world-renowned psychiatrists Lawrence Kubie and Karl Menninger, and the then-vice president of IASP, Erwin Stengel. The AAS was conceived and born during that single day's meeting.

This past April, the AAS held its 35th Annual Conference in Bethesda, Maryland, an immediate suburb of Washington, DC. At this meeting, more than 130 research presentations, workshops, panels, and posters were offered featuring state-of-the-art findings and training opportunities to more than 500 conference registrants. Also presented were nine full and half-day pre-conference workshops on themes ranging from "The School Shooter" to "Understanding, Managing, and Treating Self-Injury."

The Conference was keynoted by author Andrew Solomon whose book *The Noonday Demon: An Atlas of Depression* has been an international best-seller. IASP and AAS member Israel Orbach, Ph.D. received the association's Louis I. Dublin Award for outstanding services/contributions to the field of suicide prevention. Founding IASP member Norman Farberow, Ph.D. was this year's recipient of the Roger Tierney Award for service. The AAS Award for Public Policy Leadership was given to Minnesota Senator Paul Wellstone who has championed the issue of mental health parity in the U.S., arguing forcefully for insurance benefits equal to those given for physical illnesses.

Among the highlights of the Conference was a lively interactive session facilitated by medical ethicist Peggy Battin (University of Utah Department of Philosophy) regarding suicide and self-sacrifice, with specific reference to suicidal bombers and martyrdom. Featured at this year's Suicide Update program, a day-long series of major presentations of cutting-edge research, was a presentation by Dr. Fred Goodwin, former director of the National Institutes of Mental Health, on recent advances in our understanding of "Suicide and Manic Depressive Illness." Greg Brown, Ph.D. (University of Pennsylvania) and Jane Pearson, Ph.D. (NIMH) presented recent findings from ongoing randomized clinical trials on suicide prevention with adults and older adults; and Ken Conner, PsyD (University of Rochester School of Medicine) spoke on "Alcohol, Regression, and Suicide."

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From Around the World: Canada

Dr Antoon Leenaars, IASP National Representative for Canada

Canada's national suicide prevention strategy: a historical look.

Suicide is a major health problem globally. It constitutes a serious mental health problem and public health problem. In many countries suicide ranks among the top ten causes of death – this is true in Canada. The World Health Organization (WHO) stated that by the year 2020, 1.5 million people will kill themselves annually worldwide (Bertolote, 1999). The sheer numbers make suicide and suicidal behavior a top health issue. The WHO has, in fact, made suicide prevention, along with public prevention of malaria and tobacco related diseases, the top priorities for the first decade of this millennium (Bertolote, 1999). The WHO started the WHO Initiative on Suicide Prevention – SUPRE-WHO - among many other global and national initiatives. A hallmark of these efforts is the development of national strategies. Most countries have started such initiatives (there being too many effective programs to mention any one). Canada has, however, none. This is regrettable because its suicide rate is even higher than its neighbour, the USA – in young males, it is 50 to 60% higher (Leenaars, Wenckstern, Sakinofsky, Dyck, Kral & Bland, 1999). Despite these tragic facts, the government of Canada has done little, and has no plans to initiate a national strategy. As an aside, I am always amazed that my international colleagues from numerous countries have assumed that Canada would have a national strategy. The history of the federal government's action may shed some light on what is – is not – happening in Canada.

Canada has a major suicide problem. The recognition of this fact is quite new. Marc LaLonde, Minister of Health in the 1970's, had commissioned a study on major public health problems. In what came to be called the White Paper, the government identified suicide as a major health problem (LaLonde, 1974). Suicide was found to be a primary cause of early death (i.e., death before age 70). This was a surprise to most Canadians, including the government. Suicide had rarely been discussed as a public health problem before. The finding that suicide was the 2nd cause of death under age 35 in Canada was especially alarming. Although the credibility of the data has been questioned, Canada in the 1970's awoke to its malaise; although, at the same time, a deep taboo on the topic arose.

Recognizing the problem, Health and Welfare Canada in the 1980's, established the National Task Force on Suicide "to investigate and better define the dimensions of suicide, and to consider effective strategies of response to the problem" (National Task Force, 1987, p.1). The National Task Force first met on March 7, 1980, and in 1987 released the document "Suicide in Canada" (National Task Force, 1987). The Task Force concluded that Canada's suicide problem was indeed at an epidemic level, well above that of many nations. There are major problems in the report, however. As an example, Canada's elderly are identified as a high-risk group, but the document provided little Canadian content on older adults (and similar observations can be made on most topics in the report). Most of the document cited American studies on the elderly, with exceptions of the early work of Isaac Sakinofsky, and Diane Syer-Solursh.

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Upcoming Events

◆ *From Science to Practice*

The 9th European Symposium on Suicide and Suicidal Behaviour
University of Warwick, UK.
September 14th - 17th, 2002.

www.sciencetopractice@samaritans.org

◆ *Crossing Borders in Suicide Prevention - From the Genes to the Human Soul*

The XXII IASP Congress
Stockholm, Sweden
September 10, 2003

www.ki.se/iasp2003

From Central Administrative Office

of the new Election Committee: Dr Morton Silverman from the USA and Professor Oivind Ekeberg from Norway.

Members who have not paid their 2002 membership fees will note that they are not receiving the IASP journal: CRISIS. Please do so as soon as possible as your contribution assists the sharing of information and knowledge.

Thank you the four members who have sponsored an Associate Member this year and enabled them to receive full membership benefits. Please consider this gift next year or even this year.

Surrounding the office, you will all be very pleased to read, the sunflowers are 2 metres high and in full bloom - it is a sunny world!

Vanda

From Around the World: Belgium

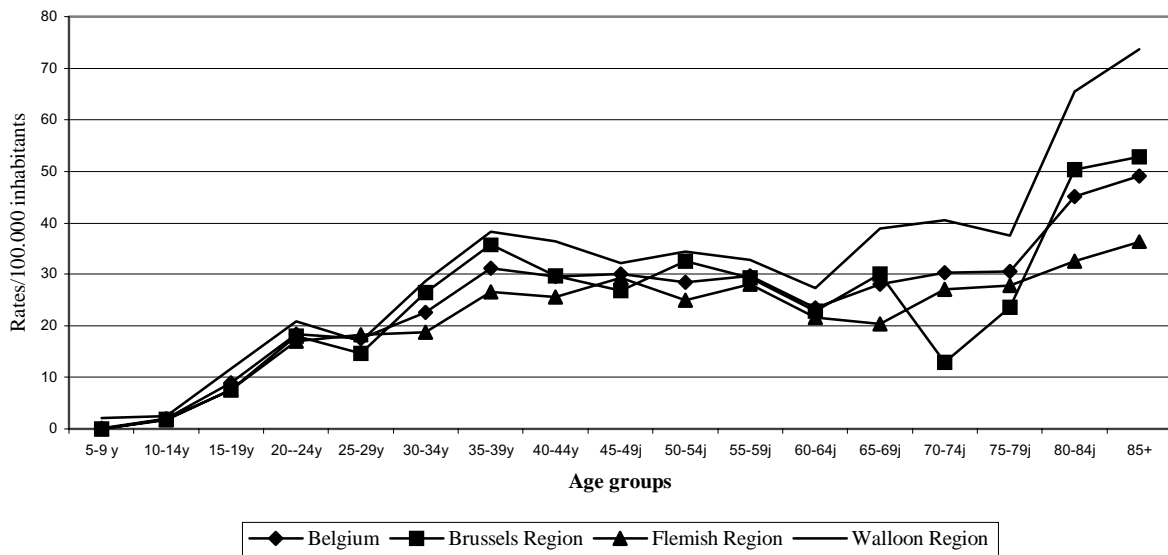
Professor Kees van Heeringen, IASP National Representative for Belgium

Suicidal behaviour in Belgium: epidemiology and prevention initiatives

Epidemiology

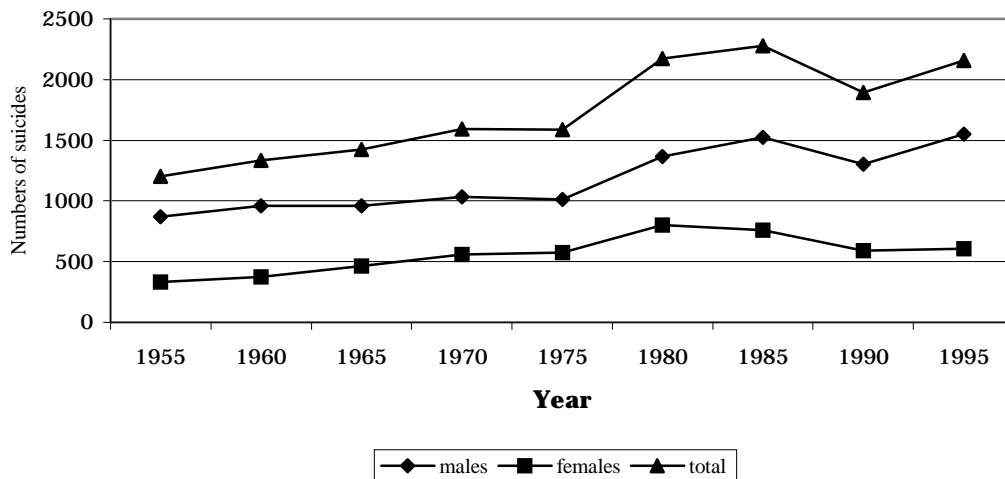
The overall suicide rate in Belgium in 1995 (last year available) was 21.2 per 100.000 inhabitants (males: 31.3; females: 11.7), the rate being substantially higher in the southern French-speaking Walloon region than in the Dutch-speaking northern part Flanders. In the latter region in 1997 suicide rates were 17.9, 9.6 and 26.4 for the total population, females, and males, respectively.

Rates of suicide in Belgium in 1995, by region and age group



Absolute numbers of suicide have nearly doubled between 1955 and 1995 and increases have been particularly notable among males in the 30 – 39 year age group, followed by males in the 20 - 29 year and 15 – 19 year age groups.

Numbers of suicide in Belgium, 1955- 1995, by gender

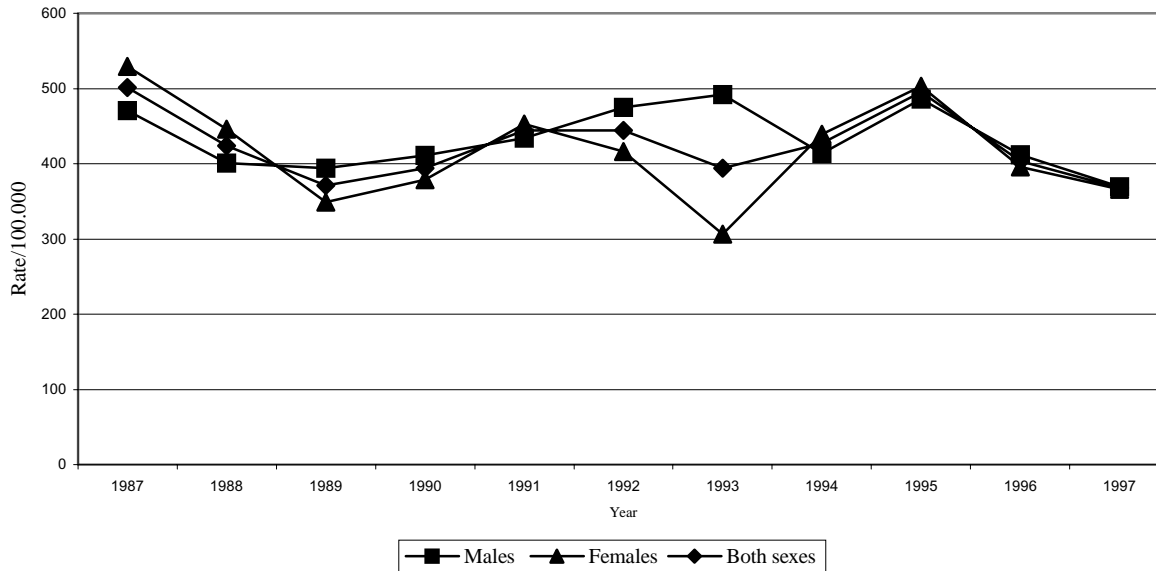


From Around the World: Belgium

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No nationwide data regarding the epidemiology of attempted suicide are available. Monitoring in the Gent region since 1986 has shown the following trend of attempted suicide rates:

Event based rates of attempted suicide in Gent (aged 15+ years), 1987-1997, by gender



Prevention initiatives

Belgium is a federal state and many issues related to prevention and health care are dealt with at a regional level. As shown above, suicide rates have historically been substantially higher in the French-speaking Walloon region than in Dutch-speaking Flanders, but a region-wide programme aiming at the prevention of suicide has been developed, implemented and evaluated only in the Flemish region. Since 1996 the Flemish Minister of Health has indeed funded a programme in which the Community Mental Health Services (CMHS) play a crucial role. Twenty of the nearly 84 centres received additional funding in order to employ a 'project collaborator' who is responsible for the sub-regional development of the programme. Implementation of the programme is supervised by a coordination group consisting of mental health experts and delegates from the Ministry of Health and of the associations of CMHS. Three major aims have been described for the programme,

- (1) optimising the care of (potentially) suicidal patients in CMHS (including e.g. risk assessment, follow-up of attempted suicide patients)
- (2) increase know-how in 'intermediates' (e.g. hospitals, police, GP's, school psychologists, prison staff; by developing and implementing training programmes, and by creating care circuits for suicidal persons)
- (3) increase awareness and involvement in regional suicide prevention initiatives (by e.g. media, GP's, schools, health boards).

A systematic evaluation showed an important increase in awareness and collaborative initiatives, but also revealed substantial differences in achievements between regions with regard to e.g. development of care circuits and involvement of 'intermediates'. Based on the results of the evaluation the programme has been restructured where necessary, and the implementation is now monitored more closely by the coordination group. Following a request from the Minister of Health this group is developing long-term goals for the prevention programme, which, in view of the above mentioned suicide rates in the region, reflects a justified ongoing concern regarding the prevention of suicide.

Prof. C. van Heeringen
Unit for Suicide Research – Gent University - Belgium

From Around the World: Canada

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Antoon A. Leenaars IASP National Representative for Canada

The problem is not only that we do not know much about suicide in the Canadian elderly, but also that the government document does not cite the Canadian literature that was available; thus, leaving us to understand suicide in Canada, based on American data. The whole volume should be called, "Suicide in Canada, Based on American Data" (could you imagine, "Suicide in Lithuania, Based on American Data"?). A recent update (National Task Force, 1994) does no better, despite, to continue with the example, an array of professional Canadian studies on the topic of the elderly. The other topics in the volume (e.g., Aboriginal people, youth, two other high risk groups) are treated no different.

There is, however, a deeper problem. The Task Force made numerous important recommendations. At the release of "Suicide in Canada" - which took place at the meeting of the International Association for Suicide Prevention in San Francisco in 1987 - I predicted, as the invited responder to the document, that few, if any, of the recommendations would be implemented. Subsequently, other Canadians such as Bryan Tanney and the late Roger Tierney have made the same observation. The Royal Commission on Aboriginal Peoples (1995) similarly called for strong action to address suicide, at the release of its document, Choosing Life. Yet, Marlene Brant-Castellano, Rosalee Tizya, and Edward Connors have, for example, expressed grave concern about the lack of action to that report too. Canada, at a federal level, has done little. Is this a reflection of the larger Canadian taboo?

This is not to imply that the federal government has done nothing. There have been a few federal efforts that may have had an impact on suicide rates; for examples, the decriminalization of attempted suicide, and gun control measures. In the first example, suicide in the last millennium had been seen as a crime against society in Canada and there were major sanctions and penalties against suicide attempters and their families. Attempted suicide remained a crime in Canada, punishable by 6 months in jail and/or a fine, until 1972, under the Criminal Code of Canada. In 1972, Bill C-2 removed section (213) from the Criminal Code. Subsequently, suicide was seen differently by the majority - and regrettably, as normal, by young Canadians (at least, more so than American youth) . Research by David Lester has shown that Bill C-2 itself, in fact, did not increase or decrease the rate of suicide.

As a second example, in the last decades, a popular proposal for reducing the incidence of suicide has been restricting the availability of method. Firearms are the preferred method for suicide in Canada and it was proposed, first by Erwin Stengel, that means restriction may reduce the incidence of suicide. Bill C-51 of 1977, implemented in 1978, introduced stricter gun control in Canada. Research, mainly by Leenaars and Lester, showed that Bill C-51 has been effective in reducing suicide, especially in the young. Although this bill was never intended by the authors to address suicide, the government's actions clearly had a preventive impact. Despite these efforts, Canada's own recommendations (National Task Force, 1987, 1994) called for much more action.

These studies should not be read to imply that there is much federal support for research on suicide. Indeed, there is a lack of support for necessary research on any topic in Canada. Canada has a lack of research intensive universities and private funding institutions. Government funding is negligible. Support for any research now is less than in the 1990's, which was less than in the 1980's, which was less than in the 1970's. Support for (primary) suicide prevention fares no better. But then, of course, funding for any health promotion is at an all time low in Canada.

Advocacy for Canadian action is ongoing and already marked in history. In June of 1991, a group of suicide preventionists that I headed as president of the Canadian Association for Suicide Prevention (CASP), met with Perrin Beatty, then Minister of Health and Welfare. CASP, having surveyed many diverse sources across Canada (e.g., individuals, groups, government agencies, etc.), presented the people's ideas about suicide prevention in Canada. These included the following:

- Setting a realistic goal of percentage reduction in the overall suicide rate
- Addressing the problem of unreliable reporting of suicide
- Establishing the means for surveillance of clinically treated suicide attempters
- Addressing the problem of Aboriginal suicide.

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From the Chair for the Council of Organisational Representatives Professor Slavica Selakovic-Bursic

SRCE" (Yugoslavia) celebrates its 10th anniversary. Over the weekend of April 26-28, centre SRCE, a member of Be-frienders International, celebrated its 10th anniversary. Founded in 1992 by Prof. S. Stankovic and S. Selakovic-Bursic, the centre provides emotional support to people in crisis and works in the field of suicide prevention in general. It is operated by selected and trained volunteers from all walks of life and currently offers help by telephone, letters and e-mail. During the past 10 years it has survived some very difficult and trying times and today continues to grow with now 45 active volunteers. The celebration was marked by 4 workshops under the general topic of "Youth suicide". The first entitled "Self-harm in adolescents" was led by Pam Blackwood, an experienced volunteer from Central London Branch and a psychiatric social worker. The second led by Carole Spiers, a professional counsellor in stress management from London was called "Improving communication in Youth". The third workshop dedicated to e-mail befriending was presented by John Leonard, a volunteer from Winchester, while Pam Blackwood presented another workshop on difficult and demanding callers. In addition to these presenters, the celebration was attended by delegates from Guilford and Northwich in the UK and delegates from Poland and Cyprus. It was well represented in the mass media and successfully raised awareness of the suicide problem in the province of Vojvodina, where the current rate is about 30 per 100,000 inhabitants per year.

Abiadang Jones, Executive Director of Liberian National Association for Suicide Prevention, gave some details of the organization and activities on suicide prevention. LNASP was founded in March 1995 and despite facing numerous problems of a country in disarray, is forging forward at a slow pace. In 1998 a training workshop for volunteers and professionals interested in suicide prevention was held, aiming to give more information on suicide-related issues. It was attended by 68 participants. They also operate a walk-in centre in Monrovia offering help for people in crisis. The centre is open every day, though not on a 24-hour basis and on average at least 10 people are offered face-to-face contact. They also respond to letters from clients, but have not been able to install a telephone help-line so far. In October 2000, they organized an outreach Suicide Prevention Unit, which visits targeted communities (hospitals, recreational gatherings, rural areas, market places, etc.). They are planning to reach out to schools in Monrovia to highlight suicide and HIV/AIDS awareness education. Also, a team of 15 volunteers, 4 social workers and a psychiatrist are working hard towards the advocacy against drug abuse, a unit of LNASP. Presently, LNASP has seven staff, ten social workers and 30 loyal volunteers and they all work on a voluntary basis, looking to promote suicide prevention activities in Liberia. They are interested in finding out more about the WHO/Supre-Miss project and would like to be present at future IASP conferences. They would welcome any possibility to liaise with organizations which would help them fund raise and they need office equipment, generator and mobiles to ease their movements. They can be contacted at the following address: LNASP, 25 McDonald Street, P.O.Box 1156, Monrovia, Liberia, West Africa, E-mail:lnasp2000@yahoo.com.

Slavica Selakovic-Bursic
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AAS Celebrates 35th Annual Conference

Lanny Berman, IASP Vice President

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Significant research findings presented at this year's meeting reinforced the role of social isolation as a risk factor for suicide even when mental health problems are absent and, when symptoms are present, particularly for males; the relationship between reading disabilities and both suicide ideation and behavior among teens; and a revised estimate of 5%, about half that of previous estimates of the lifetime risk of suicide among persons with schizophrenia.

Concurrent with the AAS conference each year is the one-day Healing After Suicide Conference for survivors. This year marked the 12th Healing Conference and featured a luncheon presentation by fashion designer and survivor Gloria Vanderbilt. Most attendees at the AAS Annual Conference comment that these meetings offer wonderful opportunities to network and share among colleagues, both that of ongoing work and personal friendship. The next such opportunity will occur in April, 2003 in Santa Fe, New Mexico, the oldest state capital city in the U.S. and consistently rated among the top three tourist destinations in this country. The AAS looks forward to welcoming all IASP members to join us next year in Santa Fe.

From Around the World: Canada

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The 1991 meeting is the last known meeting at such a level of government and, regrettably, these same recommendations from the community must still be made. Once more, little has been done. Does the secrecy of suicide that LaLonde discovered 30 years ago, continue? Or are there other mundane reasons for this? Bureaucratic and political inactivity, competing priorities, lack of money, racism, may be some other problematic factors related to the lack of response. Why does Canada not have a National Policy?

Despite the Canadian government's inertia, public advocacy continues, most often spurred on by CASP. The current president, David Masecar, leads the way. Preventionists in Canada are determined. The government is equally determined. The topic, CASP and specific preventionists – including me – have been black listed (again, not an uncommon general practice). The taboo continues, maybe it is not okay to ask the bureaucrats in Ottawa, "How many young people are we going to allow to die needlessly?" (We asked the same question about Aboriginal people, elderly, and so on. We also asked what they planned to do for survivors, etc.). I could tell more stories (Leenaars, 2000); let me here cite a few more personal ones. When we met with the bureaucrats in Ottawa, they told us that there were, at least, 82 other topics ahead of us. This is not a topic, but it is about needless, preventable deaths (and why 82, why not 72, or...?). And, after the release of "Suicide in Canada" in San Francisco, when I asked a bureaucrat as he was leaving the conference, "What will you do about suicide?", he responded, "You are not important." Many others could tell more important stories; our native people could, for example, tell how they were delegated as a topic to an appendix of the 1994 edition of "Suicide in Canada." I welcome these narratives, not only from Canada. This newsletter may be an excellent vehicle to inform about our nation's efforts to prevent suicide or the lack thereof. Finally, I apologize, as a Canadian, for us doing too little nationally. We need a National Strategy.

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Leenaars, A. (2000). Suicide prevention in Canada: A history of a community approach. Canadian Journal of Community Mental Health, 19, 57-74.

Leenaars, A., Wenckstern, S., Sakinofsky, I., Dyck, R., Kral, M., & Bland, R. (Eds.) (1998). Suicide in Canada. Toronto: University of Toronto Press.

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IASP Membership

Would you like to Sponsor an IASP Associate Member?

Would you, or your institute, be prepared to pay the membership fee for one Associate Member this year?

There are over 40 Associates who would like the opportunity of full membership to IASP.

Many are working in economically deprived areas and full membership would enable them to participate fully in IASP activities (have voting rights, become a representative of their country) and receive the IASP journal, *Crisis*.

If you are interested in this scheme and can find \$100 please contact **Central Administrative Office**.

Individuals	
Full Members	233
Honorary Members	6
Associate Members	24
Organisations	
Full Members	25
Associate Members	9
Total	307

From Around the World: Portugal

Drs Francisco Alte da Veiga and Carlos Braz Saraiva

Suicide in Portugal

In the European context, the suicide rates in Portugal have remained within the low ranges characteristic of southern countries (Spain, Italy, Greece). The total values were relatively stable throughout the 80's, and declined during the 90's (8.8 per 100,000 in 1990, 5.6 in 1998), following the trends observed in most Western Europe countries. In 1998, the rates by sex were 8.7 per 100,000 for males and 2.7 for females; interestingly, this male to female ratio (3:1) remained virtually unchanged over the last two decades of the century.

Portugal presents the oldest suicidal profile among all European countries. We have developed a general indicator of death profile as a function of age: the Standardised Average Death Age (SADA)¹. As the designation suggests, the indicator is age-standardised, so that it can be compared over time and across different populations. The total SADA value for Portugal concerning suicide was, in 1998, 57.4 years (57.2 for males and 58.3 for females). For comparison, the SADA values for the European countries with the youngest suicidal profiles (Ireland, Albania) are about 40 years.

The age-specific rates curve is characteristic of such a high SADA, showing little increase between the 15-29 and the 50-59 age groups (2.6 and 6 per 100,000, respectively), and a marked increase afterwards (16.6 for the 70-79 age group and 23.9 for 80+). About 30% of all suicides occur after the age of 70.

In a longitudinal view, the SADA values remained stable for males and increased for females (from 50.8 in 1990 to 58.3 in 1998). The reason for this finding is the following: while the age-specific rates for males decreased uniformly across all age groups, the decline in female rates was very substantial at younger ages but virtually non-existent in the elderly.

Within Portuguese borders, major contrasts are found between regions. It is usual to consider the river Tejo as geographically defining two main regions, North and South. Total rates are as low as 2 to 4 per 100,000 (1998) in the North, and reach 20 per 100,000 in Alentejo, the largest southern region (where the rate for males was 32 per 100,000 in that same year). Within the global European context, this finding is at least uncommon and justifies some comment.

On a cross-sectional view, the SADA value for Alentejo is even higher (62 years, 1998) than the national average, indicating a very old suicidal profile. Furthermore, several studies using sociodemographic and economic indicators (1998) show that the North vs. South contrasts, regarding suicide rates, hold clearly stronger correlations with factors somehow denoting "social support" (e.g. population density, birth rate, marriage rate, life surplus, % of population under 25) than with purely economic ones (e.g. GDP). These quantitative appraisals reflect the following reality: Alentejo is an extremely rural, poorly populated region, where younger people keep migrating to large urban centres, searching for more favourable economic conditions; the result is demographic desertification, where older people tend to be left behind in growing isolation and lack of general support.

Though this actual social context certainly provides an important basis for a deeper understanding of the causes behind the figures in Alentejo, we cannot forget that, in a longitudinal view, this region has always presented the highest suicide rates of the country, as long as mortality records are kept. Several authors have stressed the role of a strong cultural heritage, where features such as a melancholic character (well expressed in the music, dances, costumes and poetry), a weak gregarious tradition, small families and low religiousness would provide vulnerable grounds. Frequently, the suicidal act itself involves a kind of cult or symbolism (e.g. hanging from a specific tree).

This culture-bound interpretation becomes particularly consistent when we compare Alentejo with its neighbour Spanish region of Andalucia, which has a similar physical geography but significantly lower suicide rates - about 10 per 100,000 (1998). History brings some insights into this contrast. The political border between Portugal and Spain is probably the oldest in Europe, dating back to the 13th century, which has decisively contributed to the development of well-defined national identities and very distinct cultural sensibilities. Furthermore, Andalucia was strongly christianised from the 15th century, initially as part of the Spanish war effort to push the Arab Empire back into North Africa. Such pressure or need was never particularly felt in Portugal, and the Roman Catholic practice, influence and tradition always remained considerably more visible in the North than in the South.

From the Chair for the Council of National Representatives

Simon Armson, National Representative for the United Kingdom

News of activities in your country is greatly welcomed. I would be most grateful if you would let me have a note of any item of interest that could be shared with the membership more widely, this can then be submitted for inclusion in the Newsletter. In this way the work that we are all engaged in can be of benefit to a much wider group than would otherwise be possible. Please write to me or e-mail to the address shown below. I would also be very pleased to receive any comments or issues that you would like me to raise on your behalf with colleagues on the Executive Committee.

IASP Congress 2005 & 2007

The Executive Committee has recently concluded its deliberations about the venue for the congress to be held in 2005 (you may recall that at the congress in Chennai, the Executive Committee was deputed to make the final decision on this matter). After very careful consideration it has been decided that the congress should be held in South Africa in 2005 and in Ireland in 2007. In this way the tradition of alternating the venue between Europe and other parts of the world will be maintained. No doubt in due course there will be further information about these arrangements, but I wanted to let you know the outcome of the decision process without delay.

World Day for Suicide Prevention

You may well be aware of discussions that have been going on for some time about the creation of a World Day for Suicide Prevention. You will see from the President's comments on Page 1 that support for this idea is urgently sought. I would be very grateful therefore if you would encourage all members in your country to write to the President with their views on this matter as soon as possible and anyway before 1st September. Letters should be addressed to the Central Administrative Office in France and e-mails sent to iasp1960@aol.com.

NATIONAL REPRESENTATIVES 2002

Australia	Awaiting Elections	Liechtenstein	Dr Andreas Nagele
Austria	Dr Reinhold Fartacek	Lithuania	Prof Danute Gailiene
Belgium	Prof Kees Van Heeringen	Malaysia	Prof T Maniam
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XXII IASP CONGRESS: Stockholm 2003



XXII IASP Congress
September 2003
Stockholm, Sweden

The Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health will be hosting the Congress. The overall theme for this Congress is

***”Crossing borders in Suicide Prevention –
From the Genes to the Human Soul”.***

From Around the World: Portugal

contd. from page 9

Drs Francisco Alte da Veiga and Carlos Braz Saraiva

As a brief note, the islands (Madeira and Azores) are the Portuguese regions presenting the youngest suicidal profile (SADA value around 45 years). It is interesting to notice how this same contrast occurs in other countries having mainland and island territories (Spain, France, Italy, Greece). This finding will probably justify further research and clarification.

Regarding methods, hanging and self-poisoning with pesticides together have accounted for 60 to 80% of all suicides in Portugal throughout the last decade.

Although there is no government-level strategy for suicide prevention in Portugal, extensive work and research has been conducted for decades by a wide range of professionals (doctors, psychologists, sociologists, nurses, social workers) and volunteers (e.g. Suicide Helplines). All these efforts and experiences have converged on the foundation, in December 2000, of the Portuguese Society of Suicidology².

¹ Veiga, F.A. and Saraiva, C.B., "Geographic Epidemiology of Suicide in the European Union: spatial patterns, temporal trends and demographic/economic correlations", *XXI Congress of the International Association for Suicide Prevention*, Chennai, India (2001).

² Sociedade Portuguesa de Suicidologia, Liga dos Amigos dos Hospitais da Universidade de Coimbra, Praceta Prof Mota Pinto.



**9th European Symposium on
Suicide and Suicidal Behaviour**

University of Warwick Sept. 14-17 2002



**International
Association for
Suicide Prevention**



IASP Priorities 1998-2002:

- ◆ Participate in the international debate on suicidal behaviour in order to influence and keep in touch with current developments in suicide prevention.
- ◆ Task force on research
- ◆ Task force on euthanasia and assisted suicide
- ◆ Task force on development of suicide prevention agencies
- ◆ Task force on definition and classification on suicide and related self-destructive behaviour
- ◆ Provide a traveling scholarship programme in order to strengthen suicide prevention in the more isolated regions.

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