Superior Health Council

REPORT OF THE SUPERIOR HEALTH COUNCIL

Depression, depressiveness and suicide

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ABSTRACT AND KEYWORDS

Depression, depressiveness and suicide are worrying public health issues. The following report aims at improving our understanding of these phenomena and attempts to gain a better insight into what is at issue. From this starting point it proposes several areas on which to focus first and in which it would be useful to develop new models or at the very least, to optimise the facilities currently being used. These different actions may make it possible to reduce the negative impact of the disability caused by depression and suicide in this country.

The recommendations made in this report are based on the available epidemiological data, the main observations that have been made with regard to the problem and an inventory of the actions already put in place in Belgium. It follows that they were formulated with the intent of being realistic and pragmatic, an aim in which the composition of the working group itself played a part, as it involved both experts from the academic world and "field" experts.

The working group met on 17.03.2005, 26.04.2005, 31.05.2005, 28.06.2005, 20.09.2006, 6.12.2006, 23.02.2006.

Keywords: depression, depressiveness, suicide, attempted suicides, suicidal individuals, suicidal thoughts, suicidality.

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1. INTRODUCTION – CONTEXT OF THE PROJECT

Psychosocial factors have been playing an increasingly important role in the public health issues of our contemporary society. In such parts of the world as Western Europe, the rate of depression, depressiveness, and suicide, which reflect poor levels of well-being, is relatively high, especially in the youngest and the oldest age groups.

On the whole, the suicide rate in Europe has either shown a downward trend or has remained unchanged over the past ten years. Nevertheless, suicide rates are known to have a tendency to rise by stages over longer periods of time. Thus, on the whole, the suicide rate showed a significant increase in the eighties, but fell afterwards and stabilised at a level that is nonetheless higher than that of the late seventies.

Thus, following estimations made by the WHO, over two thousand people worldwide put an end to their own lives every day, which amounts to one death by suicide every forty seconds. According to serious estimates, the number of attempted suicides is ten to twenty times higher. In most European countries and North America, suicide has been amongst the five to ten most frequent causes of death across all populations for a long time. Statistics show that in countries with a high standard of living, suicide usually ranges amongst the top three most common causes of death amongst fifteen to thirty-four year-olds, and that at least twice as many males as females commit suicide. In 1980, approximately 28 males took their own lives compared to 11 females, in 1999, the ratio was 26 to 9.

In Belgium, there was a rate of 21,08 per hundred thousand population in 1997, which boils down to an average of nearly 6 suicides a day. In France, 30 people die every day as a result of their own decision. In Germany, the 1999 rate was 20,2 males and 7,3 females per hundred thousand population. As for Hungary, which is traditionally heavily affected by this problem, there are 32 deaths by suicide per hundred thousand population. In these different countries the number of deaths by suicide is considerably higher than that of fatal road accidents. Moreover, it is generally believed that certain road accidents are in fact suicides. Compared with its neighbours, Belgium is one of the countries in Europe with the highest rate of suicide.

In contrast to a widely spread notion, most suicides are not committed by young people but by the middle-aged (especially men between the ages of 40 and 59) and the elderly. Still, the public remains deeply affected by the increased number of suicides amongst young people, the sudden ending of a life that was just beginning being felt as an even greater tragedy.

These facts throw light on a problem for which there is no unambiguous explanation (such as the usual reference to loss of sanity). Indeed, this would require the explaining of a whole series of paradoxical empirical results: the suicide rate varies considerably from one country to another; it is subjected to long-term fluctuations in some countries, but remains remarkably stable when compared to other countries; in times of war the rate goes down, etc.

Based on this first general observation, this reports aims at drawing a picture of the situation in Belgium. What is the scale of the problem in this country? What are the statistics that are available on this subject? Are certain population groups more vulnerable than others and are there factors that predispose to depression? Which prevention and support programmes are available? What programmes would still need to developed?

This report attempts to give a survey of existing research on these questions, to draw a list of all that already exists in the field of prevention and assistance, and, based on this information, to provide an overview of the recommendations on which the experts of the working group have agreed.

2. DEFINING THE TERMS

2.1 Depression[1]

Depression is one of the most common psychiatric disorders. However, this pathology is still very misunderstood, partially because it is a poorly identified disorder that is certainly still being treated inadequately.

Even though there now are classifications available that allow the clinical identification of different types of depression, it still remains a fact that it is difficult to recognise one in care practice, especially in primary health care, with there being numerous ways in which this pathology can present itself (masked depression, depression that manifests itself through diffuse and persistent somatic signs…). What is more, the term "depression" is often thought to involve quite a variety of disorders by the general public.

Most health professionals use the medical model to define depression. In this model the diagnosis is based on certain symptoms, independently of the causes that brought about the depressive state.

The criteria that are generally used and that currently prevail in psychiatric diagnosis are defined by the *American Psychiatric Association* in the *DSM-IV (Diagnostic Statistical Manual of Mental Health, 4th edition 1994).*

The other classification system frequently used is the *International Classification of Diseases*, which deals with mental and behavioural disorders, 10th revision, developed by the WHO and published in 1992.

2.1.1 Criteria of the DSM-IV

According to the DSM-IV, depression is a thymic disorder (or mood disorder). This classification describes, on the one hand, the thymic episodes and, on the other, the mood disorders. The episodes are not diagnosed as autonomous entities, but they are elements that are used for diagnosing disorders. The DSM-IV draws a distinction between several depressive disorders.

- a major depressive disorder (single episode and recurrent)
- a dysthymic disorder
- a depressive disorder, not otherwise specified

A major depressive disorder is made up of one or several major depressive episodes. The difference between an isolated major depressive disorder and recurrent major depressive disorder is based on the number of major depressive episodes observed in one and the same person. The major recurrent depressive disorder may have a seasonal pattern. The concept of "major depression" makes it possible to differentiate depressive disorders that are characterised by the fact that they involve more serious symptoms than others.

[1] Fragments from: Bayingana, K, Tafforeau J. La Dépression: Etat des connaissances et données disponibles pour le développement d'une politique de santé en Belgique. Institut Scientifique de Santé Publique – Ministère de la Communauté française ; 2002.

A dysthymic disorder is essentially characterised by a chronic depressive mood that occurs more than one day out of two for at least two years. Its symptoms are less severe than those associated with major depressive disorders. The distinction between dysthymic disorders and major depressive disorders is based on their severity and persistence. Nonetheless, it is difficult to differentiate between them – for the symptoms observed are similar and such differences as they present in their onset, duration and severity are not easy to assess in retrospect. Generally, when the diagnosis is made, the dysthymic disorder has existed for such a long time that the patients themselves refer to it as forming part of their usual functioning, hence the confusion between a personality trait and a depressive state.

The notion of depressive disorder, not otherwise specified, has been introduced in order to make it possible to codify disorders that show some of the characteristics of depression but do not meet the criteria of a major depressive disorder, a dysthymic disorder or an adjustment disorder (e.g. premenstrual dysphoric disorder, minor depressive disorder…). The term "minor depressive disorder", which is often diagnosed in studies on depression, is used for describing the syndromes that are situated below the cut-off score that is used for a major depression. The definition of a minor depression is not included in a distinct category in the DSM-IV. The criteria for mild depression are described under the mild depressive episodes in the International Classification of Diseases, 10th revision.

2.1.2 Criteria of the ICD-10

In the International Classification of Diseases (ICD-10) mood disorders include manic episodes, bipolar disorders, depressive episodes, recurrent depressive disorders, persistent mood disorders, unspecified mood disorders.

Depressive episodes are classified under the following labels:

F32 Depressive episodes
- F32.0 Mild depressive episode
- F32.1 Moderate depressive episode
- F32.2 Severe depressive episode without psychotic symptoms
- F32.3 Severe depressive episode with psychotic symptoms
- F32.8 Other depressive episodes
- F32.9 Depressive episode, unspecified

F33 Recurrent depressive disorder
- F33.0 Recurrent depressive disorder, current episode mild
- F33.1 Recurrent depressive disorder, current episode moderate
- F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms
- F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms
- F33.4 Recurrent depressive disorder, currently in remission
- F33.8 Other recurrent depressive disorders
- F33.9 Recurrent depressive disorder, unspecified

F34 Persistent mood disorders
- F34.0 Cyclothymia
- F34.1 Dysthymia
- F34.8 Other persistent mood disorders
- F34.9 Persistent mood disorder, unspecified

F38 Other mood disorders

F39 Unspecified mood disorders

2.1.3 Correspondence between the DSM-IV and ICD-10

The experts who drew up the ICD-10 and the DSM-IV worked in collaboration, thus being able to increase the correspondence between the two systems. The codes and the terms used in the DSM-IV are compatible with those used in the ICD-10.

The DSM-IV offers a number of specifications that aim at increasing the specificity of the diagnosis, providing assistance in the choice of the treatment or improving the prognostic expectations. The following specifications have been used for major depressive disorders:

The major depressive episode may be

- mild;
- moderate;
- severe without psychotic features;
- severe with psychotic features;
- in partial remission;
- in full remission;
- chronic;
- with seasonal pattern: seasonal depression is thought to be linked to the quantity of light received by a person, the symptoms encountered are those of lack of energy, fatigue, increased appetite when the days are shorter and there is no sunlight;
- with catatonic features: major psychomotor disorders, stupor, agitation…;
- with melancholic features: formerly referred to as being of “endogenous origin”, which requires medication treatment;
- with atypical features;
- With postpartum onset: this generally affects women several weeks, or even months after giving birth.

As regards depression, the ICD-10 diagnostic criteria consist of ten symptoms. The severity thresholds of the episode are determined by the presence of a certain number of symptoms. The difference with the DSM-IV is that the ICD-10 offers a series of independent criteria for each level of severity (mild, moderate, severe) of a major depressive episode.

Another difference between the DSM-IV and the ICD-10 has to do with the symptoms which must necessarily be observed for there to be any diagnosis of depression: with the DSM-IV it is necessary to observe a “depressed mood” and a “reduced level of interest or pleasure”. The ICD-10 takes into account another symptom, viz. “decreased energy and increased tiredness”, in addition to the two previous symptoms.

Generally speaking, people suffering from depression have been found to mention their feeling tired more readily to their doctor than any other symptoms of a psychic nature. Therefore, not including tiredness as one of the symptoms to be looked for during the diagnosis could result in there being a risk of failing to recognise the depression. This would tip the balance in favour of the ICD-10. Nevertheless, it is necessary to stress the fact that, even though patients with depression often emphasise the increased tiredness they feel, this is also one of the least specific symptoms of depression.

2.2 Depressiveness

Though we have just seen that there is a large consensus on the definition of depression and that there are diagnostic assessment tools available that have been validated internationally, things are entirely different with the term “depressiveness”.

First of all, we need to point out in this context that, whereas the French term is becoming ever more current, its Dutch counterpart is, by contrast, much less frequently used.

Over the last few years, the term “depressiveness”, which is treated as a synonym of depression by some and as a term indicating a specific and independent state by others, has appeared in various national and international articles in order to provide a better definition for an intermediate state that does not fit into the category of depression in the strict sense but which is nevertheless characterised by psychic suffering and a difficulty with life.

For some authors, depressiveness is mainly typical of adolescence (Rufo, 2000, Choquet, 1994). It refers to a specific state characterised by the vulnerability and the psychic changes that affect these individuals during this period of self-development.

Others look upon depressiveness as a susceptibility to depressed affect, some kind of propensity towards depression or a simple transitory state that can either occur before the return to a “normal” state or herald a genuine depression (Ferreri, 2002).

Generally speaking, we could say that depressiveness stands for a psychic state of self-depreciation that forms an integral part of psychological suffering. Nevertheless, this suffering is often ill defined. It is often mentioned without its contents being explained. This state is characterised by depressive symptoms, whereas there can be no clear diagnosis of depression.

Thus, even though depressiveness and depression are closely related, this notion cannot simply be reduced to either a simple pre-depressive state or a simple passing feeling of existential ill-being.

It follows that there is no agreement over this notion as far as either its definition or its assessment are concerned. Nevertheless, it strikes us as relevant in so far as it makes possible the identification of a whole series of individuals who cannot be diagnosed as suffering from depression, yet do experience a psychic suffering that needs paying attention to.

2.3 Suicide

In its latest world health report (2001), the WHO defines suicide as follows: “Suicide is the result of an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome”.

Moreover, in the WHO report on self-directed violence (2002), we find the notion **“suicidal behaviour”**: “Suicidal behaviour ranges in degree from merely thinking about ending one’s life, through developing a plan to commit suicide and obtaining the means to do so, attempting to kill oneself, to finally carrying out the act (‘completed suicide’).”

Generally speaking, as the intention and the result are not necessarily correlated, the definition of suicide is a complex one.

A distinction should be made between:

1. fatal suicidal behaviour, which leads to death (**completed suicide**)
2. non-fatal suicidal behaviour, which does not lead to death and which is also called **“attempted suicide”**, “parasuicide” or “deliberate self-injury”.

Apart from these two notions, there is the term “suicidal ideation”, which refers to thoughts of killing oneself, in varying degrees of intensity and/or elaboration. It implies the feeling of being tired with life. This ideation may vary greatly in intensity and is not an essential criterion during an attempted suicide.

Historically, suicide has evolved from a psychiatric to a psychodynamic concept. Whereas for years suicide was intimately connected, or even attributed to the mental illness of which it is only a component, we have gradually come to define suicide by using the notion of suicidal crisis. Though an essential topic in any discussion on suicide, the suicidal crisis has been and still is the subject matter of numerous studies. It is of crucial importance for anyone working in this area to have sufficient knowledge about it and have the ability to recognise it in order to prevent a suicidal act from being carried out. Underlying all suicidal conduct is a suicidal crisis, which can also be its outcome. Both in suicide related issues and in general psychology, the term conduct implies a certain evolution in a type of behaviour that is itself believed to be more instinctive.

The term suicidal crisis was introduced into psychiatry in analogy to the medical sense and refers to a “period of crisis”. Traditionally, it denotes a sudden change in the evolution of an illness that indicates either deterioration or improvement, but also the emergence of pathological manifestations in subjects considered to be sane. It denotes a moment of elusion during which the patients’ state is such that they are not sufficiently able to defend themselves, are vulnerable, find themselves in a situation that causes them to break down and suffer, and which is not necessarily theatrical or noisy; some patients even look upon this moment as the most fruitful of their lives.

Numerous disciplines have thus attempted to analyse, understand, and explain these suicidal phenomena. More precisely, they have tried to account for “successful” suicides, which, for a long time, constituted the only object of investigation. We will not dwell on the other definitions of suicide that have been provided by these different disciplines, but will look at one, viz. the one given by Baechler (Baechler, 1975), which goes as follows: “**Suicide denotes all behaviour that seeks and finds the solution to an existential problem by making an attempt on the life of the subject**”.

In contrast to what is the case in many other definitions of suicide, the author refers to suicide as a type of behaviour and not as an act. This is an important specification. Thus, suicide rarely restricts itself to the precise moment when it is committed. The term “behaviour” reflects the entire

process that drives a person to commit suicide. Moreover, this process may have started a long time ago in the subject's history.

Moreover, this definition mentions the notion of a solution to a problem. A problem is any situation that forces an individual to make a choice and find a way out. This problem may be an internal or an external one:

- it is said to be internal when it occurs when the subject is faced with his/her own internal difficulties;
- it is said to be external if it is caused by a situation that is external to the individual and forces him/her to find a way out.

In addition, this problem may be either real or imaginary. Yet for the person contemplating suicide, the problem is always a real one in the sense that he/she is seriously affected by it.

Finally, this definition refers to an "existential" problem. It is existential because it has to do with the subject's entire existence, the way in which the latter lives through it and in which he/she experiences the relationship with the social, emotional, and professional environment.

The problem under discussion will therefore not necessarily be linked to any given situation but much rather to its impact on the life of that person in terms of choice and conflict (e.g. conflict between the subject's aspirations and a reality that does not allow for them to be fulfilled, or a conflict that arises when reality imposes choices that the subject does not feel able to take).

The definition proposed looks upon suicidal behaviour as a solution to an existential problem. It should be pointed out that the person faced with the problem always considers the sort of solution that he/she can find in suicide to be an adequate one. In the eyes of the subject who is trapped in the problem, there is no alternative solution and the suicidal behaviour strikes him/her as the solution that is best suited to solve it.

One final aspect of this definition that is felt to be important to discuss has to do with the fact that the solution to the existential problem consists in "making an attempt on one's life". The expression "make an attempt on one's life" makes it possible to interpret the meaning of the word suicide in a broad sense. Thus, suicide may be either completed or symbolic with various intermediate stages. A completed suicide is one that ends with death. A suicide is symbolic or verbal if the subject dreams of killing himself/herself or threatens to do so. Attempted suicides can be placed between completed suicides and symbolic suicides.

Imperfect though it may be, it was interesting to have another look at Baechler's definition that treats suicide as all behaviour that seeks and finds the solution to an existential problem by making an attempt on the life of the subject. There were several reasons for this:

- first of all, it enables us to lay a first basis for the understanding of suicidal phenomena;
- next, it provides us with a notion of suicide and a way to come to grips with suicidal phenomena that are very close to the most recent approaches;
- finally, it allows us to view suicide not only as the point in time when the act is being carried out, but also as a process that has a beginning, an evolution and an end.

A suicidal person is no longer simply someone who puts an end to their life, but also someone who goes through difficult times and is looking for a solution. Consequently, they are not isolated, but go through this process as a member of society, with social and/or family surroundings.

3. EPIDEMIOLOGICAL DATA

3.1. Depression

There are few studies available in Belgium that have been carried out a national level and deal with the general population. Still, we do have at our disposal some figures on the basis of which the scale of this phenomenon can be assessed.

3.1.1. The Health Interview Survey - Belgium 2004

In 1997, 2001, 2004 a health survey was carried out by interview in the various Regions and Communities in Belgium. These surveys aimed to obtain information on five major topics:

- the state of health of the population
- lifestyles and behaviour
- preventive measures
- medical consumption
- the relation between health and society

The data were collected by means of interviews and standardised questionnaires from 12 945 informants selected at random from the national register.

The part of the survey that deals with mental health only concerns non-institutionalised individuals over the age of fifteen. It "*vise à estimer les troubles de la santé mentale pour lesquels une admission dans un centre spécialisé n'est pas exigée. Les questions abordent les troubles qui sont les plus couramment rencontrés dans la population générale, notamment les troubles dits 'émotionnels'. L'enquête de santé s'est attachée à analyser les dimensions suivantes de la santé mentale : le bien-être psychologique global, la santé mentale positive, les problèmes somatiques, anxieux, dépressifs et du sommeil, les idées suicidaires et les tentatives de suicide. Ce volet de l'enquête s'est également intéressé à l'usage des psychotropes*." ((i.e. "it aims to assess the mental disorders for which no admission in a specialised centre is required. The questions refer to disorders that are most frequently found in the general population, especially "emotional" disorders. The Health Survey concentrates on the analysis of the following aspects of mental health: overall psychological well-being, positive mental health, somatic problems, anxiety, depression and sleep disorders, suicidal thoughts and attempted suicides. This part of the survey also looks at the use of psychotropic drugs"). Book II, chapter 3 of the Health Interview Survey – Belgium – 2004 – pp. 192-368).

<u>Results concerning depression</u>

"The indicator for depressive disorders follows from the responses to a subscale of the SCL-90-R (Symptom Check List 90-R). According to the author of the questionnaire, depressive disorders as they are assessed here, correspond to the general concept of "depressive syndrome", of which the main features are mood changes or changes in affect (in the sense of depression), reduced energy and decreased level of general activity, as well as a reduced ability to feel pleasure and interest in things, diminished ability to concentrate and unexplained tiredness.

On the basis of this criterion, which is used to define cases of depression, it appears that 8 percent of the population aged fifteen and over suffers from depressive disorders.

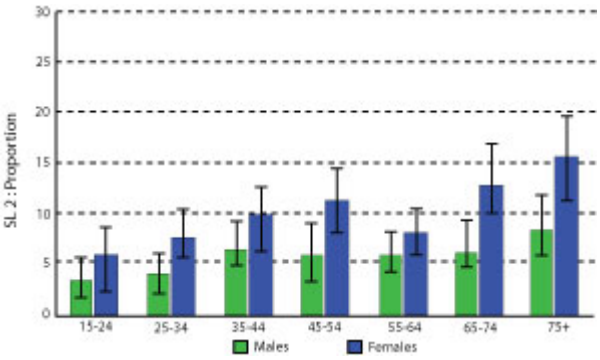
Analysis by gender and by age

Women are more frequently affected by depressive disorders than men (10% as opposed to 6%), a difference that is significant when taking into account age standardisation. Depressive disorders increase with age: whereas they are observed in only 5 percent of young people (aged 15-

24 years), they affect 13% of the elderly (aged 75 and over). This increase is linear and significant after adjustment for gender.

The age distribution is somewhat different between men and women. With the latter the progression through the different age groups is almost linear, going from 6% to 16%, with, however, a reduction amongst the 55-64 year-olds (8%).
For men the prevalence of these disorders is 4% amongst 14-34 year-olds and then stabilises at around 6 to 7% until the age of 75. Above this age, 8% of men experience depressive disorders.

Figure 1: Percentage of the population (aged 15 and over) suffering from a depressive disorder, in terms of the SCL-90R score, by age and gender. Health Interview Survey, 2004. Belgium.



Analysis according to level of education
Depressive disorders are most frequent amongst the least educated layers of the population (it affects 13% of those with primary education only, as opposed to 5% of those with higher education). This relation remains significant after age and gender standardisation." [2]
(Note: it seems that the opposite is true for bipolar disorders, which are more frequent amongst patients with a high level of education (International Review of Bipolar Disorders, 2006)).

Analysis according to degree of urbanisation
"The prevalence of depressive disorders does not vary significantly according to the level of urbanisation of the surroundings (7% to 8%).

Evolution in time
A slight decrease in depressive disorders can be observed in the course of time, but this does not turn out to be statistically significant after age and gender standardisation.

Analysis according to region
Depressive disorders are proportionately less frequent in the Flemish Region (7%) than in the two other regions (10%), a difference that is significant after age and gender standardisation." [3]

3.1.2 European Study on Epidemiology of Mental Disorders (ESEMeD)

The *European Study on Epidemiology of Mental Disorders* (ESEMeD) is a study focussing on the mental disorders in the population of six European countries (Belgium, France, Germany, Italy, the Netherlands and Spain).

[2] Translated from original in French.
[3] Translated from original in French.

The diagnosis has been established by means of the CIDI-2000 (Composite International Diagnostic Interview).

Pressing further its investigations in the field of mental health than the more generalised Belgian health surveys, this survey contains an instrument to measure mental health disorders.

As regards the Belgian part of the survey (Bruffaerts et al, 2003), a representative sample of 2419 non-institutionalised adults (aged over 18) was chosen on the basis of the national register and was interviewed between April 2001 and June 2002. The authors distinguish:

- mental disorders (all three of the disorder categories);
- mood disorders: depressive disorder, dysthymia;
- anxiety disorders: generalised anxiety, social phobia, specific phobia, disorder linked to post-traumatic stress factors, agoraphobia, panic;
- any disorder linked to excessive consumption of alcohol.

Table 1. The prevalence of psychiatric disorders **within a year** according to demographic characteristics. Source: Bruffaerts et al. La prévalence des troubles mentaux dans la population belge. Results of the *European Study on Epidemiology of Mental Disorders (ESEMeD), Louvain Med.* 2003; 122:321-334.

	Total	**At least one disorder**	**Mood disorder**	**Anxiety disorder**	**Disorder linked to excessive consumption of alcohol**
Total	2 419	257 (10,7%)	119 (5,0%)	148 (6,0%)	41 (1,8%)
Gender					
Male	1 190	110 (10,6%)	40 (3,7%)	58 (5,5%)	32 (3,0%)
Female	1 229	147 (10,8%)	79 (6,2%)	90 (6,5%)	9 (0,7%)
Age group					
18-24	167	32 (15,9%)	12 (6,0%)	17 (8,4%)	8 (4,5%)
25-34	406	47 (12,1%)	21 (5,8%)	29 (6,9%)	5 (2,0%)
35-49	775	93 (11,4%)	43 (5,3%)	50 (6,2%)	19 (2,3%)
50-64	570	60 (11,2%)	28 (5,1%)	37 (6,9%)	9 (1,3%)
65+	501	25 (5,6%)	15 (3,3%)	15 (3,0%)	0 (0,00%)
Trend Test z (p-value)		*-5,00 (p<0,001)*	*-2,23 (p=0,03)*	*-3,37 (p<0,001)*	*-3,49 (p<0,001)*
Marital status[1]					
Single	528	67 (12,3%)	28 (4,8%)	39 (6,7%)	17 (3,7%)
Separated	250	37 (14,6%)	20 (8,6%)	20 (8,2%)	7 (3,2%)
Widowed	208	18 (9,0%)	12 (6,1%)	9 (4,5%)	1 (0,9%)
Married or cohabitant	1 359	122 (9,5%)	55 (4,4%)	72 (5,5%)	13 (0,8%)
Living situation					
Single	672	77 (11,5%)	35 (6,1%)	46 (7,0%)	13 (1,3%)
Cohabitant	1 747	180 (10,5%)	84 (4,7%)	102 (5,8%)	28 (1,9%)
Occupation[2]					
Paid work	1298	141 (11,0%)	54 (3,9%)	79 (6,4%)	27 (2,3%)
Unemployed	95	20 (23,7%)	9 (10,6%)	12 (15,0%)	4 (4,4%)
Retired	529	25 (5,2%)	14 (3,4%)	15 (2,4%)	0 (0,00%)
Housewife/husband	119	11 (8,1%)	7 (4,2%)	8 (6,1%)	0 (0,00%)
Student	9	3 (34,8%)	2 (14,9%)	1 (19,9%)	0 (0,00%)
Others	119	33 (21,4%)	19 (14,9%)	21 (12,6%)	5 (3,0%)
Never been employed for over 6 months	224	26 (10,4%)	14 (6,1%)	12 (4,6%)	5 (2,1%)
Degree of urbanisation					
Rural	346	48 (15,5%)	21 (6,5%)	28 (8,5%)	7 (2,9%)
Semi-rural	1 814	171 (9,5%)	81 (4,6%)	94 (5,2%)	30 (1,6%)
Urban	259	38 (13,7%)	17 (6,0%)	26 (9,3%)	4 (1,6%)
Trend Test z (p-value)		*-0,10 (p = 0,92)*	*0,05 (p = 0,96)*	*0,57 (p= 0,57)*	*-0,48 (p= 0,63)*

[1] 74 "missing values"; [2] 26 "missing values"

According to this study, **13,6**% of the respondents mentioned their having suffered a depressive disorder (a subcategory of mood disorders) **in the course of their lives**, *4,6%* of which occurred *in the twelve last months preceding the survey*. Extrapolating these data to the Belgian population "*signifie qu'entre 1,1 et 1,2 millions de Belges ont souffert d'un trouble dépressif au cours de leur vie, dont presque 400 000 au cours des 12 derniers mois*" (i.e. "shows that between 1,1 and 1,2 million Belgians have suffered a depressive disorder in the course of their lives, with almost 400 000 having done so in the course of the last twelve months.*"*)

This study also indicates that "*les troubles dépressifs sont deux fois plus frequents chez les **femmes** que chez les hommes; plus d'une femme sur six rapportent la presence d'un trouble dépressif au cours de leur vie*" (i.e. "depressive disorders are twice as frequent in **women** as they are in men, with more than one woman out of six reporting a depressive disorder in the course of their lives").

Those who are **separated** or **widowed** appear to be more likely to develop mood disorders. By contrast, these disorders are less frequent amongst people living in a **small or average-size** town.

As regards **age**, there is no perfect match between the data of the ESEMeD study and those of the Belgian Health Survey. However, the figures at our disposal cannot easily be compared. The sections of the population investigated cannot necessarily be compared with respect to their age, the measuring instruments used, and the diagnosis under consideration.

Also, it is not easy to find any evolution in time.

Although studies have been carried out in the past, our knowledge on the prevalence of this disorder needs to be updated.

It can also be said that the incidence data we have at our disposal are scarce. Nevertheless, studies on the basis of which the incidence of depression can be determined are necessary, as they facilitate the study of risk factors and allow an increased knowledge of the aetiology of depression. Also, the occurrence of depression over time can be monitored on the basis of longitudinal studies.

3.2 Depressiveness

As mentioned in the definition of the terms used, the notion of depressiveness has not been defined in a clear and internationally recognised way. It follows that few studies allow an exact quantification of the concrete realities behind it.

Nevertheless, some studies, including the 2004 Belgian Health Survey discussed above, throw some light on this problem in so far as they focus on measuring notions such as psychological ill-being (Book II of the Health Interview Survey – Belgium 2004, pp 204-209):
"The psychological well-being assessed in the 2004 Belgian Health Survey is measured by means of an instrument (GHQ-12, General Health Questionnaire) that uses scores ranging from 0 to 12. A higher score indicates a higher probability/severity of psychological ill-being. In fact, each unit represents the presence of a symptom of psychological disorder. Two case definitions have been used, one to express the prevalence of psychological difficulties (cut-off at [2+]), the other to express more severe psychological disorders (cut-off at [4+]).

In Belgium the average score is 1,3 amongst the over fifteen year-olds. Based on a cut-off score score of [2+], proportionally 24% of the population, i.e. one person out of four, experience

psychological difficulties, with half of them, i.e. 13% of the population, going through a fase marked by more severe mental disorders (cut-off score [4+]).” [4]

Analysis according to gender and age

On average, women show a less favourable score for psychological well-being than men (1,5 vs. 1,0) and a significantly higher number of them experience confirmed psychological difficulties (28% as opposed to 21% as regards the [2+] cut-off and 15% as opposed to 10% as regards the [4+] cut-off). These differences are significant after age standardisation.”

Whatever the intensity, psychological well-being varies significantly according to age, after adjustment to gender. As a rule, the psychological state of the 35-44 year-olds is found to be less favourable, especially as far as the more severe [4+] affections are concerned, which hit 16% of those belonging to this age group. In contrast, the 55-74 year-olds are less affected by psychological morbidity, whatever its intensity, than those belonging to the other age groups.

The age distribution of psychological problems (cut-off of [2+]) amongst men and women is given in figure 2 below and that of more severe psychological disorders (cut-off of [4+]) in figure 3.

Figure 2 Percentage of the population (aged 15 and over) with recent psychological difficulties, according to the dichotomised GHQ-12 score [2+], by age and gender. Health Survey, Belgium, 2004.

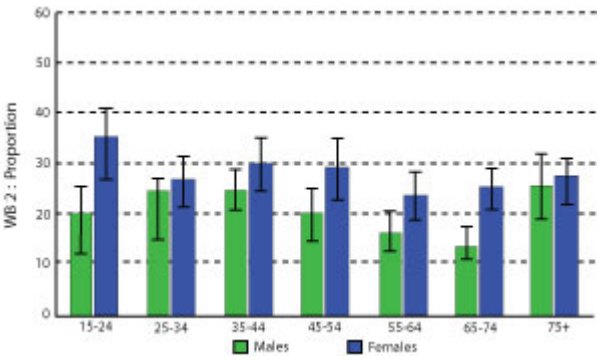
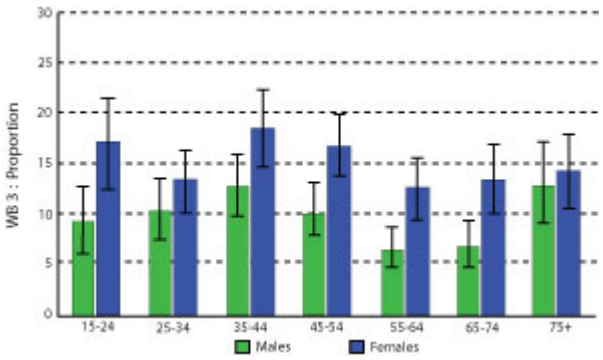


Figure 3 Percentage of the population (aged 15 and over) with a likely psychiatric disorder, according to the dichotomised GHQ-12 score [4+]), by age and gender. Health Survey, Belgium, 2004.



“Splitting up genders shows that there are considerable (and significant) differences between men and women with regard to psychological difficulties (cut-off [2+]) amongst young people aged 15-24 (+ 15% amongst women), amongst the 45-54 year-olds (+10% amongst women) and amongst the 65-74 year-olds (+11% amongst women). By contrast, after the age of 75, the number of men experiencing psychological difficulties equals the number of women who do so, with one person out of four affected. This reflects a considerable increase in the prevalence of problems affecting men, which rises from 7% amongst the 65 to 74 year-olds to 13% amongst the over 75 year-olds. Figure 3, which shows the more severe disorders (cut-off [4+]), exhibits a similar profile.” [5]

Analysis according to the level of education

“There is little variation in the average scores and prevalence of psychological difficulties in terms of level of education. The differences in terms of level of education are not significant after age and gender standardisation.” [6]

[4] Translated from original in French.
[5] Translated from original in French.
[6] Translated from original in French.

Analysis according to degree of urbanisation

"The prevalence of psychological ill-being seems to be higher in urban areas (1,4) than in semi-rural and rural areas (1,2) but this difference is not significant after age and gender adjustment".[7]

Evolution over time

"The average score of psychological well-being showed a significant drop between 1997 and 2001 (1,6 as opposed to 1,3) but the figures for 2004 (1,3) are the same as those for 2001. This evolution in time is referred to "quadratic". This quadratic evolution is also confirmed for psychological difficulties (cut-off [2+]) and more severe disorders (cut-off [4+])". [8]

Analysis by region

"Analyses carried out on psychological well-being at a regional level show a more favourable situation in the Flemish region than in the other regions. Thus, the average GHQ score is 1,1 in the Flemish region, compared to 1,6 in Brussels and 1,5 in the Walloon region, a difference that is significant after adjustment for age and gender. Moreover, there are fewer people with psychological difficulties in the Flemish region: 21% as opposed to 31% in Brussels and 30% in the Walloon region as regards the cut-off of [2+] and 12%, 16% and 15%, respectively, as regards the cut-off of [4+]. These differences are confirmed by analyses that were standardised for age and gender." [9]

3.3 Suicide and attempted suicides[10]

Completed suicides are measured in terms of the mortality data: i.e. the deaths and their causes.

By contrast, collecting data about **attempted suicides** is a much more delicate matter, as not all attempted suicides are taken to the hospitals' emergency services, or even to a doctor. With no systematic records available of the attempted suicides that have been seen by a doctor, the data concerning attempted suicides are also often collected by means of general population surveys.

Suicidal ideation is also measured by means of questionnaires in which the people being interviewed are asked if they ever happen to think of killing themselves. Apart from the classical biases of this method, such as dissimulation, the Rosenthal effect, instrumentalisation… the formulation of the question itself is important. In fact, a good example for this is the analysis of the available data for Belgium.

3.3.1 Suicide

A. International comparisons of fatal suicidal behaviour

In chapter 7 of "Self-directed violence", the WHO world report on violence and health measures the extent of the phenomenon of fatal suicidal behaviour by comparing the figures in different countries and regions (75 areas) for which these data are available, on the basis of the most recent year available (between 1990 and 2000)

Belgium, which has a suicide rate of 24 per 100 000 population, is above the world average (14,5 per 100 000 population)

7 Translated from original in French.
8 Translated from original in French.
9 Translated from original in French.
10 Fragment from the report: Steinberg, P. Les jeunes et la santé mentale en Belgique: le suicide. WHO Collaborating Centre on Health – Belgium; 2005.

Table 2: International comparison of the suicide rates per 100 000 population. Source “Violence and health”. WHO, 2002.

	Suicide rates per 100 000 population				
Country	Year	Total	Male	Female	Male: female ratio
Belgium	1995	24,0	36,3	12,7	2,9
France	1998	20,0	31,3	9,9	3,2
Netherlands	1999	11,0	15,2	7,1	2,1
Canada	1997	15,0	24,1	6,1	3,9
Denmark	1996	18,4	27,2	10,1	2,7
Finland	1998	28,4	45,8	11,7	3,9
Germany	1999	14,3	22,5	6,9	3,3
Italy	1997	8,4	13,4	3,8	3,5
Russian Federation	1998	43,1	77,8	12,6	6,2
Thailand	1994	5,6	8,0	3,3	2,4
United States	1998	13,9	23,2	5,3	4,4

The Eastern European countries have the highest, Latin America the lowest rates. Western Europe and North America have intermediate figures. There are few figures available concerning African regions. Among the Western European countries, Belgium, along with Finland, exhibits the highest rates.

B. National level

The most recent data on deaths by suicide for the entire Belgian population go back to 1997.

It should be added that there are more recent data available for the Flemish region and for Brussels. The projections that can be made on the basis of these figures show that the suicide rate evolves slowly. But given the fact that the suicide rate is sometimes subject to strong regional or local variations, it strikes us as safer to stick to the last figures available for the whole of Belgium. These figures are available for Flanders on http://www.wvc.vlaanderen.be/gezondsheidsindicatoren/sterfte/specifiek/uitwendig/suicide.htm and for Brussels on http://www.observatbru.be.

A registration system should be set up for deaths by suicide in which the information can be regularly updated at a federal level.

Suicide as compared with other causes of death

Taking into account the entire population, there were 2 146 deaths by suicide in 1997 out of a total of 103 800 deaths. This makes suicide the 10th most frequent cause of death (after, in decreasing order, diseases of the circulatory system, tumours, diseases of the respiratory system, cerebrovascular diseases, diseases of the gastrointestinal tract, diseases of the nervous system and the sense organs, endocrine and blood diseases, mental disorders, ill-defined symptoms and clinical pictures) (see table 3).

This means that, in 1997, an average of six people a day committed suicide in Belgium.

Table 3: Causes of death per age.
Source: Data from the National Institute of Statistics, 1997.

	Total	Under 20	20-39	40-59	60-79	80-99	100 and over
Total number of deaths (all causes)	103 800	1 265	2 853	10 341	42 371	46 577	393
Total internal causes	97 508	891	1 152	8 798	40 899	45 384	384
Infectious and parasitic diseases (except tuberculosis)	1 308	30	59	112	498	600	9
Tumours	28 041	104	421	4 258	15 422	7 824	12
Endocrine and blood diseases	2 828	25	35	159	1 128	1 471	10
Mental disorders	2 464	4	61	163	561	1 664	11
Diseases of the nervous system and the sense organs	3 419	58	73	195	1 268	1 818	7
Diseases of the circulatory system except cerebrovascular diseases	28 501	20	180	1 875	11 117	15 157	152
Cerebrovascular diseases	9 453	11	63	460	3 296	5 594	29
Diseases of the respiratory system	10 672	26	46	456	4 275	5 808	61
Diseases of the gastrointestinal tract	4 519	5	112	799	1 711	1 882	10
Diseases of the genitourinary apparatus	1 504	1	13	54	533	896	7
Pregnancy, childbirth, and puerperium	10	/	10	/	/	/	/
Congenital malformations, infantile diseases	565	492	27	32	11	3	0
Ill-defined symptoms, signs and clinical pictures, except senility without mention of psychosis	2 353	114	46	191	705	1 267	30
Other internal causes	1 070	1	6	31	282	741	9
Total external causes	6 292	374	1 701	1 543	1 472	1 193	9
Road accidents	1 483	177	640	292	293	81	/
Accidental poisoning	174	15	73	47	25	14	/
Accidents or complications during medical or surgical interventions	194	2	8	27	83	74	/
Accidental falls	1 293	11	50	136	367	722	7
Accidents caused by fire	106	13	23	19	35	16	/
Accidents caused by submersion, suffocation and foreign objects	259	36	21	53	82	66	1
Suicides	2 146	64	668	787	472	155	/
Manslaughter	177	22	83	51	19	2	/
Other external causes	460	34	135	131	96	63	1

The National Institute of Statistics (NIS) distinguishes internal from external causes. It should be noted here that the position of suicide compared to the other causes depends on the degree of precision of the categories used to do the typology. The more one refines the categories used for causes of death other than suicide, the more prominent the category “suicide” becomes in the classification.

It should be added that, although suicide is the 10th most frequent cause of death in the general population, **it is the most frequent cause of death in the NIS external cause typology**. However, suicide ranks second amongst the causes of the majority of domestic accidents (accidental poisoning, accidental falls, accidents caused by fire, accidents caused by submersion, suffocation and foreign objects and some of the other external causes) taken together.

Accordingly, the number of deaths by suicide is much higher than the number of deaths caused by road accidents, accidental falls, and other accidents. Moreover, as has been said already, some road accidents are in fact hidden suicides. However, more people die as a result of domestic accidents than by car accidents or suicide.

Table 4. Evolution of some causes of death from 1994 to1997
Source: NIS, demographic statistics.

	1994		**1995**		**1996**		**1997**	
Cause of death	Males	Females	Males	Females	Males	Females	Males	Females
Total	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00
Suicides	**2,95**	**1,14**	**2,92**	**1,17**	**2,78**	**1,07**	**2,99**	**1,15**
Tumours	30,79	23,06	30,81	23,16	30,57	22,66	31,10	22,93
Diseases of the circulatory system	33,33	41,47	33,22	41,37	33,80	41,31	32,82	40,30
Road accidents	2,58	0,90	2,23	0,79	2,09	0,74	2,05	0,75
Accidental falls	1,13	1,63	1,00	1,40	1,06	1,47	1,09	1,40
Accidents caused by fire	0,11	0,11	0,13	0,08	0,12	0,09	0,13	0,08
Manslaughter	0,20	0,15	0,19	0,13	0,20	0,19	0,19	0,15

The following table compares suicide with other age-related causes of death.

Table 5. Suicide as compared to other causes of death
Source: “Les jeunes et la santé mentale en Belgique: le suicide”, P. Steinberg, WHO Collaborating Centre on Health, 2005.

Age group	Suicide as compared to other causes of death (NIS typology)
Total population	Suicide = **10th** cause but first external cause
Under 20	Suicide = **4th** cause of death (all causes of death taken together) 2nd external cause of death (after road accidents)
20-39	Suicide= **1st** external cause of death, before internal causes (all causes taken together)

The NIS data allow the registered suicides to be divided up according to gender and age groups as well as the setting up of a distinction according to the type of suicide.

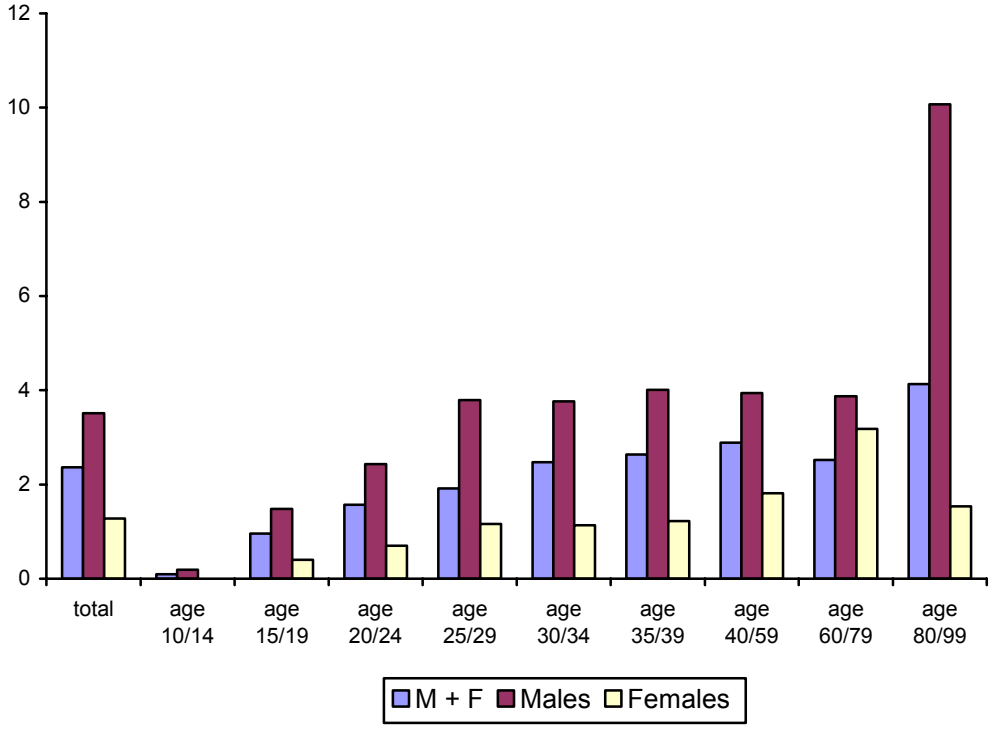
Suicide according to gender:
On the whole, there are three times as many **males** who commit suicide than there are females.

Table 6. Evolution of the number of suicides in Belgium according to gender
Source: NIS data for 1993-1997.

	1993	**1994**	**1995**	**1996**	**1997**
Total suicides	2 142	2 131	2 155	2 013	2 146
Males	1 552	1 543	1 550	1 458	1 551
Females	590	588	605	555	595
Total deaths	106 824	103 778	104 897	104 370	103 800
Percentage of suicides as compared to the number of deaths	2,0%	2,0%	2,0%	1,9%	2,1%

Suicide according to age:
Generally speaking, the frequency of suicides increases in a linear fashion with age.

Figure 4: Frequency of suicides per 10 000 population belonging to the same age group.
Source: NIS data, 1997.



Type of suicide:
As regards the means used to commit suicide, there are important differences according to the gender of the deceased.

Table 7: Deaths by suicide in Belgium according to gender and age groups on the one hand and the methods used on the other.
Source: NIS data, 1997.

	Total			Under 20			20- 39			40 - 59			60- 79			80-99		
	M+F	M	F	M+F	M	F	M+F	M	F	M+F	M	F	M+F	M	F	M+F	M	F
Total suicides	2 146	1 551	595	64	52	12	668	516	152	787	541	246	472	327	145	155	115	40
Solid and liquid substances	348	190	158	5	3	2	115	70	45	142	73	69	68	32	36	18	12	6
Gas for domestic use	5	3	2	-	-	-	2	1	1	3	2	1	-	-	-	-	-	-
Other types of gas	35	24	11	1	1	-	14	11	3	14	8	6	5	3	2	1	1	-
Hanging, strangulation and suffocation	984	784	200	25	20	5	338	279	59	370	287	83	184	142	42	67	56	11

Submersion (drowning)	204	106	98	1	1	-	31	23	8	86	42	44	71	34	37	15	6	9
Firearms or explosives	310	283	27	17	14	3	78	73	5	105	88	17	90	88	2	20	20	-
Cutting or piercing instruments	26	16	10	-	-	-	6	5	1	13	6	7	6	4	2	1	1	-
Jumping from heights	122	60	62	5	4	1	35	18	17	24	12	12	34	14	20	24	12	12
Other, unspecified means	111	84	27	10	9	1	49	36	13	30	23	7	13	9	4	9	7	2

Thus, women prefer putting an end to their lives by jumping from heights or ingesting substances. By contrast, men more frequently use methods that are referred to as "more violent", such as hanging, strangulation and suffocation, and firearms or explosives.

3.3.2. Attempted suicides

Even though there are a number of problems with recording the data relating to suicide, collecting data on attempted suicides and suicidal ideation turns out to be even more difficult.

There are several reasons for this:

- A person who has attempted to commit suicide is not necessarily sent to a medical facility. What is more, in some countries, such an admission to a medical facility involves a certain degree of risk, as it may lead to criminal sanctions. Yet, given the importance of the "recurrence" factor, it is essential for the prevention of suicide that these data be recorded.
- Therefore, the data available in health care are only partial and are completed by demographic surveys.
- The data recorded in medical facilities are incomplete: the WHO believes that only one person out of four who has attempted to commit suicide is admitted into hospital.
- Most of the information is collected through surveys amongst the general population. This is particularly due to the fact that this item often occurs in the different diagnostic tools for mental health. In this case the person being interviewed is asked whether he/she has already attempted to put an end to his/her life (attempted suicide) or whether he/she has already thought of it (suicidal ideation). The question may be formulated in various ways. It is obvious that the answers to this type of question are often underestimated, in so far as the persons being interviewed may be tempted not to give the correct answer to this type of question. In fact, for cases such as these, there is a whole range of methodological precautions available which make it possible to reduce this effect (guaranteed confidentiality, putting the interviewee at ease, setting, methodology used in conducting the survey…)

However, some data, such as those of the 2004 health survey mentioned above, can provide us with some items of information.

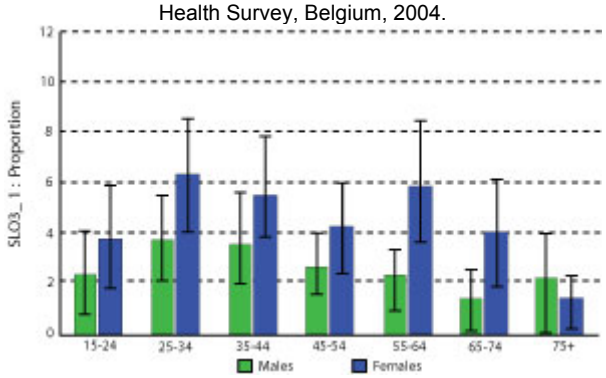
Analysis according to gender and age

- "There are more women than men who have attempted to commit suicide at least once in their lives (4,6% as opposed to 2,7%).
- Individuals aged between 25 and 44 are the most frequent to report having attempted to commit suicide during their lives (around 5% of this age group). However, three out of a hundred young people aged between 15 and 24 have already attempted to put an end to their lives, with five out of a thousand (5‰) having done so in the

course of the 12 months preceding the survey. Recent attempted suicides are most frequent amongst the 25-35 year-olds (8‰).

The figure below shows the distribution of attempted suicides in the course of a lifetime according to age and gender.

Figure 5: Percentage of the population (aged 15 and over) who have already attempted to commit suicide, by age and gender. Health Survey, Belgium, 2004.



Analysis according to level of education

Attempted suicides are more frequent amongst the least educated (4 to 5%) compared to individuals who have enjoyed higher education (3%). This difference is significant after age and gender standardisation. Recent attempted suicides clearly reflect this social-economic gradient: their prevalence passes from 0,9% amongst the least educated to 0,2% amongst the most highly educated. The difference is significant after age and gender standardisation.

Analysis according to degree of urbanisation

Those living in cities are the most frequent to report having attempted to commit suicide in the course of their lives (5% as opposed to 3% in the least urbanised areas). This difference is significant after age and gender standardisation. Brussels is no longer the only city affected by this: the degree of urbanisation also plays a role in the rate of attempted suicides in the Walloon region. As for recent attempted suicides, these tend to be less frequent in rural areas, but the differences are not statistically significant, probably because the number of cases is too small.

Analysis by region

Attempted suicides, both those that have been committed sometime during one's existence and those that have been committed recently, are less frequent in the Flemish region (2% and 0,3% respectively) than in the other two regions (6% and 0,6% in each of the other regions, respectively). These differences are significant after age and gender standardisation." [11]

Data from the "sentinel general practitioners" (Scientific Institute of Public Health).

Sentinel general practitioners form a network of general practitioners who are responsible to the various communities and register medical data including, amongst other things, suicides and attempted suicides.

About 150 general practitioners, who are representative for the profile of their colleagues in terms of age and gender, constitute this network on a voluntary basis, which covers 1,5% of Belgian patients. The data thus recorded are extrapolated to the entire population. Comparisons with other statistical sources show that both the records made by these sentinel general practitioners and the extrapolation method applied to the entire population are reliable.

[11] Translated from original in French

Dividing the prevalence of attempted suicides according to age shows that attempted suicides are more frequent amongst women at any age. It also shows that young women aged 15-29 constitute a high-risk group.

Table 8: Prevalence of attempted suicides according to age
Sentinel general practitioners 2000/2001.

Age	Males	Females
0/14	-	33
15/29	75	173
30/64	71	112
65/79	28	38
80 and over	52	118

There is some regional variation: thus, the Walloon population has the highest figures, both as regards suicides and attempted suicides, except for "completed suicides", which are proportionally more frequent amongst Flemish women.

Table 9: Prevalence of suicides and attempted suicides according to sex and region.
Sentinel general practitioners 2000/2001.

Prevalence (per 100 000)	Regions	Males	Females
Suicides	Flanders	31	11
	Wallonia	43	8
Attempts	Flanders	53	100
	Wallonia	89	214

It follows that on the whole, attempted suicides are four times more frequent than completed suicides. Yet there are some important gender-related differences: thus, there are twice as many attempted suicides by men than there are "completed suicides", whereas for women, the number of attempted suicides is fourteen times higher than the number of completed suicides.

"A Four Country Survey regarding Suicide: consumer's beliefs; attitudes and behaviours" (2003):
In 2003, test santé (Joolen et al., 2003) took part in an international survey (Belgium, Italy, Portugal and Spain) into the social image of suicide, the methods used, the prevalence of suicidal behaviour (attempts, suicidal thoughts) and into the experiences and assessment of individuals in search of professional help.

This survey was conducted with a representative sample of the adult Belgian population, aged between 18 and 70. As regards the Belgian part of the survey, 2 034 (out of a total of 12 356 individuals) were interviewed.

Some data:

- 19% of those interviewed said they had thought about committing suicide in the course of the last year.
- 42% of those who often thought about committing suicide had never mentioned it to people around them (22% to friends, 20% to their partner, 14% to acquaintances, and 5% to their colleagues).

- 20% of those who often thought about committing suicide called in the help of a health professional.
- 10% of those interviewed had already attempted to commit suicide. Especially young people, and in particular young women, were the most frequent to make an attempt on their lives. 16,4% of young women aged 20-24 had already tried to commit suicide.

Among those who had already tried to commit suicide:

- 32% had not been referred to a health professional after this attempt;
- 24% had had their stomachs pumped;
- 24% had received psychotherapy or psychological advice;
- 19% had been prescribed medicine;
- 7% had had surgery.

The survey also shows that there are many preconceived notions concerning the social image of suicide:

- "The risk that someone with a failed attempted suicide behind them should try again is minimal" (14%).
- "Anyone who has ever had suicidal thoughts will continue to have them for the rest of their lives" (45%).
- "The main objective of attempted suicides is to draw attention" (51%).
- "Those who say they will commit suicide rarely do so" (45%).
- "Discussing their suicidal thoughts with someone can only make things worse" (7%).

Generally speaking, the data thus recorded suggest that:

- Even though the data do not always agree, it would seem that the prevalence of attempted suicides higher amongst young people (both relatively speaking as well as in absolute terms).
- The rate of "success" is believed to be 1 out of 2 or 3 for those over the age of 65, whereas it would seem to be 1 out of 100 to 200 for those under 25. Thus, whereas young people are far more inclined to attempt to commit suicide, attempted suicides have a considerably more frequently fatal outcome amongst older individuals.
- Non-fatal suicide attempts are two to three times more current amongst women than men, with men "succeeding" more often in their attempt to commit suicide. Putting it differently, although young people and women try to put an end to their lives more frequently, men and elderly individuals succeed more often.

Summary of the main epidemiological data

With regard to depression it should be noted that the prevalence of depressive disorders is higher:

- amongst women
- amongst the least educated layers of the population
- amongst those separated or widowed
- in Wallonia and Brussels compared to Flanders.

With regard to depressiveness, this seems to occur more frequently:

- amongst women and particularly young women (aged 15 to 24)
- amongst the 35-44 year-olds for the entire population
- in Wallonia and Brussels.

With regard to suicide:

- The suicide rate in Belgium is above the world average: 24 as opposed to 14,5 per 100 000 population (late nineties).
- According to statistics, an average of 6 people committed suicide every day in Belgium in 1997.
- Taking into account the entire population, suicide is the 10th most frequent cause of death, all causes of death taken together, but the first external cause of death. Amongst the under 20 year-olds, it is the fourth cause of death, all causes of death taken together, and the second external cause of death (after road accidents). Finally, amongst 20 to 39 year-olds, suicide is the first external cause of death, before internal causes (all causes taken together).
- "Completed" suicides are in general more frequent amongst men. Moreover, they use more "violent" means of committing suicide than women.
- By contrast, attempted suicides are much more frequent amongst women.
- The number of "completed" suicides increases with age in an almost linear fashion.
- By contrast, the number of recent attempted suicides appears to be the highest amongst 15-29 year-olds.
- Attempted suicides are more current in less educated environments, in cities with a high degree of urbanisation, in Wallonia and in Brussels.

4. GENERAL OBSERVATIONS

4.1. Risk and protective factors

A classical approach to mental health consists in attempting to specify which sections of the population constitute “high-risk groups”. Thus, young people, the elderly, immigrants, and homosexuals are often looked upon as specific groups that are at an increased risk of committing suicide. Even though at first sight, this approach offers the advantage of targeting a specific group, thereby facilitating the approaches available, it also contains numerous pitfalls.

In actual fact, the problem with this approach is that it tends to reduce individuals to a general type of behaviour. Moreover, some of the characteristics of these high-risk groups simply cannot be changed. Thus, no prevention campaign will be able to alter the fact that a person happens to be young or old. This approach also presents the problem as following a causal pattern. Yet, practice has shown that, as far as depression and suicide are concerned, this pattern is much more complicated, and that the fact that a particular individual belongs to a high-risk group does suffice for him or her to be at an increased risk of committing suicide.

Therefore, no use will be made in this report of the notion “high-risk groups”. Indeed, the figures available are not sufficiently reliable to determine with certainty what constitutes a “high-risk group”. Moreover, these groups are rarely homogenous, which in turn means that they cannot be referred to in general terms (e.g. as regards immigrants: it is certainly not the fact that one is an “immigrant” that puts one at risk of depression or suicide. Instead, this may be the consequence of broken social ties, which are a potential outcome of this type of situation). It follows that it is much more appropriate to talk about “risk factors” (such as broken social ties) as well as “protective factors”.

Thus, a prevention programme should attempt to reduce the risk factors and increase the protective factors. What is more, it should do so amongst the population in general.

This section will therefore present an overview of a model of the risk and protective factors that was devised as means to understand the dynamics behind depression. Next, it will turn to a model of the risk and protective factors from the *Suicide Prevention Resource Centre* of the *American foundation for Suicide Prevention* that focuses specifically on suicide. Finally, it will examine the link between antidepressants and the increased risk of suicide.

4.1.1 Risk and protective factors for depression

A recent Belgian publication has looked into this side of the problem (Corveleyn al., 2005):

According to the biopsychosocial concept, depression is a form of “increasing vulnerability”. Its clinical manifestations are looked upon as the final result of a negative spiral that sets in if the risk factors can no longer be counterbalanced by the protective factors that each individual possesses to a certain extent.

It follows that each individual must possess some vulnerability to depression. This vulnerability mainly results from genetic predisposition and a disturbed developmental process in which the important events of life can play a crucial role.

Vulnerable individuals may have the ability to handle this during many periods of their lives or even their entire lives thanks to the protective factors, which are either inherent or which they may have acquired during the events they have faced throughout their lives or thanks to the support of those close to them.

During one's lifetime, there may be interference from potential triggering stressors, which may be of a biogenetic, psychological, somatic, or social nature. Many people vulnerable to depression are believed to possess an intrinsic hypersensitivity to stress, but they will also make a very negative, subjective evaluation of certain events, circumstances, and messages. If this turns out to be too difficult to handle, lasts for too long or is not sufficiently counterbalanced by the protective reflexes, things will go wrong. This is also true if certain protective factors grow weaker or disappear altogether.

At a given moment, a "negative spiral" sets in that ends in depression. Both perception factors and interpersonal events play a role in this process.

4.1.2 Risk and protective factors for suicide

"Risk factors may be thought of as "leading to" or "being associated with" suicide; that is, people "possessing" the risk factor are at greater risk of suicidal behaviour. Protective factors, on the other hand, reduce the likelihood of suicide. They enhance resilience[12] and may serve to counterbalance the risk factors. Risk and protective factors may be biopsychosocial, environmental or sociocultural in nature. Although this division is somewhat arbitrary, it provides the opportunity to consider these factors from different perspectives. Understanding the interactive relationship between risk and protective factors in suicidal behavior and how this interaction can be modified are challenges to suicide prevention (Móscicki, 1997).

Unfortunately, the scientific studies that demonstrate the suicide prevention effect of altering specific risk or protective factors remain limited in number. However, the impact of some risk factors can clearly be reduced by certain interventions such as providing lithium for manic-depressive illness or strengthening social support in a community (Baldessarini, Tando, & Hennen, 1999). Risk factors that cannot be changed (such as a previous attempted suicide) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder following a particularly stressful life event (Oquendo et al., 1999). Protective factors are quite varied and include an individual's attitudinal and behavioural characteristics, as well as attributes of the environment and culture (Plutchik & Van Praag, 1994). Some of the most important risk and protective factors are outlined below.

Risk Factors for Suicide

Biopsychosocial Risk Factors:

- mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders;
- alcohol and other substance use disorders;
- hopelessness;
- impulsive and/or aggressive tendencies;
- history of trauma or abuse;
- some major physical illnesses;
- previous attempted suicide;
- family history of suicide.

[12] This term comes from physics, where it is used to denote the property of materials to regain their initial state after a shock or continued pressure. Used in mental health, resilience denotes the ability of an individual to overcome traumatisms. This is a dynamic process that is therefore never permanently acquired.

Environmental Risk Factors:

• job or financial loss;
• relational or social loss;
• easy access to lethal means;
• local clusters of suicide that have a contagious influence.

Sociocultural Risk Factors:

• lack of social support and sense of isolation;
• stigma associated with help-seeking behaviour;
• barriers to accessing health care, especially mental health and substance abuse treatment;
• certain cultural and religious beliefs (for instance, the belief that suicide is a noble solution to a personal dilemma);
• exposure to suicides, including through the media, and influence of others who have died by suicide.

Protective Factors for Suicide

• effective clinical care for mental, physical and substance abuse disorders;
• easy access to a variety of clinical interventions and support for help seeking;
• restricted access to highly lethal means of suicide;
• strong connections to family and community support;
• support through ongoing medical and mental health care relationships;
• skills in problem solving, conflict resolution, and non-violent handling of disputes;
• cultural and religious beliefs that discourage suicide.
However, positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing."

Generally speaking, the **development of psychological competences** seems to be a recognised and efficient general "protection" strategy. "Psychological competence is a person's ability to deal effectively with the demands and challenges of everyday life. It is a person's ability to maintain a state of mental well-being and to demonstrate this in adaptive and positive behavior while interacting with others, his/her culture environment. Psychological competence has an important role to play in the promotion of health in its broadest sense; in terms of physical, mental, and social well-being. In particular, where health problems are related to behavior, and where the behavior is related to an inability to deal effectively with stresses and pressures in life, the enhancement of psychosocial competence could make an important contribution. This is especially important for health promotion at a time when behavior is more implicated as the source of health problems". (WHO, 1993). "Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves. […]" (WHO, Ottawa charter, 1986).

Depending on the age group, other specific risk and protective factors can be significant. However, the factors that have just been mentioned are general risk and protective factors that are widely accepted. Other factors can be considered in the case of a prevention programme targeted at a particular section of the population.

"Information about risk and protective factors for attempted suicide is more limited than that on suicide. One problem in studying non-lethal suicidal behaviors is a lack of consensus about what actually constitutes suicidal behavior (O'Carroll et al., 1996). Should self-injurious behavior in

which there is no intent to die be classified as suicidal behavior? If intent defines suicidal behavior, how is it possible to quantify a person's intent to die? The lack of agreement on such issues makes valid research difficult to conduct. As a result, it is not yet possible to say with certainty that risk and protective factors for suicide and non-lethal forms of self-injury are the same. Some authors argue that they are, whereas others accentuate differences (Duberstein et al., 2000; Linehan, 1986)." (*Suicide Prevention Ressource Center)*

4.1.3 Do antidepressants constitute a risk factor?

The question whether there is a link between Selective Serotonin Reuptake Inhibitors (SSRIs) (a type of antidepressant) and suicide has been subject to a lot of debate. In an article published in the journal for Evidence Based Medicine *Minerva* (February 2006) G. Pieters, a Belgian specialist on the subject, looks into this possibility: "*SSRI's worden beschouwd als effectief en veilig voor de behandeling van tal van aandoeningen. Sinds 1990 bestaat er echter ongerustheid over een mogelijke associatie van SSRI's met suïcidaliteit. Intussen werd een dergelijk verband aangetoond in een systematische review van placebogecontroleerde RCT's bij kinderen*" (i.e. "SSRIs are considered to be safe and efficient in the treatment of numerous affections. However, since 1990, there has been concern over a potential link between the use of SSRIs and suicide. Since then, the existence of such a link has been confirmed by means of a systematic review of placebo-controlled RCTs (Randomised Controlled Trials) with children").

By contrast, "*RCT's en systematische reviews bij volwassenen komen tot tegenstrijdige besluiten en kampen met een tekort aan statistische power of andere methodologische tekortkomingen*" (i.e. RCTs and systematic reviews with adults arrive at conflicting conclusions and suffer from a lack of statistical power or other methodological shortcomings"). Two recent meta-analyses assessing the increased risk of suicide in adults treated with SSRIs show that these "*twee systematische reviews wijzen op een mogelijk verhoogd risico van suïcidepogingen bij volwassenen die worden behandeld met een SSRI voor om het even welke indicatie. Daarom is het aan te bevelen om de indicatie voor het voorschrijven van SSRI's zorgvuldig te overwegen en patiënten die hiermee worden behandeld nauwgezet op te volgen*" (i.e. "two systematic reviews show a potentially increased risk of attempted suicide amongst adults who are being treated SSRIs, regardless of the indication. It is therefore recommended to consider the indication for prescribing SSRIs carefully and to ensure a close follow-up of patients who are being treated with them".)

"*Een verklaring voor een mogelijke relatie tussen SSRI's en suïcidaliteit is misschien het (motorisch) activerende effect in een periode waarin nog geen duidelijke stemmingsverbetering is opgetreden, of de agitatie die vooral in het begin van de behandeling suïcidegedachten kan verergeren en suïcidepogingen kan uitlokken*." (i.e. "a possible explanation for the potential link between SSRIs and the risk of suicide is the revitalising (locomotive) effect during a period of time in which there is still no clear mood improvement. An alternative explanation is the agitation that may worsen suicidal thoughts – especially in early treatment – and lead to attempted suicides".)

It follows that, as regards **children and teenagers,** it is of crucial importance that the health professional in charge of the patient be thoroughly experienced and trained to recognise the early signs of depression, and therefore also the symptoms of a risk of suicide, in time. Such symptoms should be tackled within a multidimensional approach (child, family, school, environment, medication) and need to be treated by a specialist (child psychiatrist). The latter will follow the child or teenager very closely so as to prevent any attempt to commit suicide. Indeed, during their phase of psychological maturation, children and teenagers still have very limited mechanisms of self-control well as means to control their impulsiveness at their disposal. As a result, one should constantly be aware of the possibility that they might commit the act.

The same phenomenon of reduced self-control can be observed in **the elderly**, this time as a result of disability. It follows that here too, close observation during treatment is recommended.

As regards adults, Pieters holds that "*in de opbouwfase van een behandeling met SSRI's voor om het even welke indicatie, een intensieve opvolging met frequente consultaties en inschakeling van omgeving of andere hulpverlening moet worden voorzien. Recente twijfels over de validiteit van studies die de werkzaamheid van antidepressiva (zowel SSRI's als TCA's) aantonen, onderschrijven tevens de nood aan zorgvuldige indicatiestelling (Moncrieff et al., 2005) In eerste instantie dienen ook evidence-based psychosociale interventies, rekening houdende met de voorkeur van de patiënt, te worden overwogen"* (i.e. "during early treatment with SSRIs, there must be an intensive follow-up with frequent consultations that involves the environment or other types of medical care, regardless of the indication. Recent doubts about the validity of studies demonstrating the efficiency of antidepressants (SSRIs as well was TCAs) highlight the need to assess the indications carefully (Moncrieff et al., 2005). First of all, evidence-based psychosocial treatments must be considered, taking into account the patient's preferences").

We wish to point out that one should avoid prescribing an anxiolytic agent only to treat a depression. This causes the patients' general anxiety to settle, whilst their mood level has not sufficiently recovered. As a result, they may resort to committing suicide, an act that would then be performed within a climate of increased "serenity".

It is a well-known fact from clinical practice (and one that is supported by all the research) that, when drugs are being prescribed, the prognosis is improved if there is at least some psychological follow-up. In certain cases an appropriate psychotherapy also contributes to an improvement. The efficacy of the various psychotherapeutic approaches usually recognised and validated is described in a previous report of the SHC "Psychotherapies: definitions, practice, and conditions for accreditation".

Be that as it may, care should be taken that patients do not have free access to antidepressants. Also, the patients should always be monitored to ensure that they are taking their medication correctly.

Identifying the risk and protective factors plays an important role in preventing suicides and depressions. An overview of these factors could be provided to any health professional who is likely to be faced with the issue of suicide or depression.

4.2 Mental disorders and suicide [13]

4.2.1. The relationship between mental disorders and suicide

As has been shown in the previous section, mental disorders are an important risk factor for suicide. The psychiatric disorders that are usually linked with suicide are depressive states, anxious states, acute or chronic psychotic states, and psycho-organic states of dementia or confusion. Ingesting toxic substances, alcohol or other, whilst suffering from a DSM-IV axis I or II pathology, can constitute an important risk factor, regardless of whether this happens occasionally or as a result of regular abuse or dependence.

Research carried out with those bereaved by suicide has revealed that those who have put an end to their lives showed symptoms of psychiatric disorders in the months or years preceding their fatal suicide attempt:

- major depression
- other mood disorders, such as bipolar disorder
- schizophrenia
- anxiety, behaviour and personality disorders
- impulsiveness
- a feeling of helplessness.

The co-existence of several disorders increases the risk.

As regards **schizophrenia**, the risk of suicide is greater with male patients in the first stages of the disorder, especially with patients who were particularly dynamic before the disorder started, and with patients who suffer chronic relapses. The rate of death by suicide amongst schizophrenics is usually believed to be 10% to 13%, with the number of attempted suicides ranging between 18% and 55%.

Similarly, the suicide risk is higher amongst people who suffer from **bipolar disorders**. Needless to say this doesn't only concern periods of major depression, but also mood changes, which are unpredictable. Compliance and co-morbidity play a crucial role in this.

Furthermore, it is a well-known fact that **alcohol and drug related problems** increase the risk of suicide, particularly in young people. There are biological, psychological, and social explanations for the correlation between substance abuse and suicide. Moreover, there is a connection between this type of abusive behaviour and depression, with the latter either its cause (in that case, the abuse is the result of the individual's seeking a solution in "self-medication") or its consequence (with excessive consumption leading to depression). Unlike depressive disorders, alcohol dependency influences suicide at a later stage of the disease, and often at a time when other factors intervene (separation, job loss, social marginalisation, physical deterioration…).

Depression is the psychiatric disorder that is most frequently associated with suicide. Some research shows that 80% of those who attempt to commit suicide exhibit several symptoms of depression (WHO, 2001). Different studies (Cremniter et al.,1998; Lejoyeux et al., 1994; Fawcett et al., 1990) have revealed that suicide is closely related to psychiatric disorders and that generally, depression is the final common stage towards suicide, whatever the disorder.

Nevertheless, the quantitative evaluation of the links between depression and suicide is only on an estimate. The reasons for this are methodological in nature: on the one hand, the data are

[13] This section is largely based on the report "La Dépression: état des connaissances et données disponibles pour le développement d'une politique de santé en Belgique", K. Bayingana & J Tafforeau, Institut Scientifique de la Santé Publique, 2002.

collected retrospectively and it is not always easy to determine the extent to which the person who committed suicide suffered from depression. On the other, the methods for diagnosing depression and the cut-offs used differ. Depression is an important risk factor for suicide, especially amongst teenagers and the elderly. People who develop a depression late in life run a higher risk of committing suicide. Moreover, relapses into depression and co-morbidity with other disorders, such as anxiety, increase the risk of suicide (Angst et al., 1999).

There are also age-related differences with respect to the form that the depression may take: children and young people more frequently express depression than adults, both through their schooling (frequency of attendance and results), and their behaviour (violence, alcohol consumption, use of psychotropic substances). They also tend to eat and sleep more. However, it should be pointed out that some eating disorders (anorexia) can be linked with an increased risk of committing suicide.

Depression in the elderly deserves special attention. Though it is quite widespread amongst the elderly, especially amongst women, depression is more difficult to detect and diagnose in this age group. More detailed explanations on this phenomenon are found in the appendix.

Gender-related differences have also been observed in the form the depression can take in so far as men seek less medical help than women do (who, as a result of their role as a mother and a cultural "predisposition" to express what they feel, are more likely to call on doctors); depression in males is therefore more difficult to detect. Moreover, depression in males is often associated with violent behaviour and substance abuse.

There is no doubt that suicide is the most serious complication of depression. Although suicide is looked upon as a multi-determined act, depression patients remain the group that is most at risk.

The presence of some risk factors mentioned in the previous section increases the risk of committing suicide for those suffering from depression (Stoff et al., 1997). To this should be added the clinical and progressive characteristics of the depressive episode (type of depression, seriousness, presence of a co-morbid pathology, previous history of attempted suicides). As regards the biological factors, reduced serotoninergic activity would seem to be an element that favours a violent suicidal act (Stoff et al., 1997). Dopamine is believed to play a potential role in the biology of suicide committed in a state of depression (Pitchot et al., 2001).

The conclusions drawn on the relation between mental disorders and suicide clearly indicate that an efficient strategy of suicide prevention is the early diagnosis and adequate treatment of mental disorders.

What makes the importance of this conclusion all the more fundamental is that, as the ESEMeD study (cf. 3.1.) has shown, almost a third of the Belgian population appears to have suffered from a mental disorder in the course of their lives and about one in ten did so in the course of the year preceding this study.

There is one final aspect concerning mental disorders that is worth looking into within the framework of this report. It has to do with applying for help for and the treatment of mental disorders. Indeed, there was shown to be a high prevalence of mental disorders in Belgium. Yet these disorders constitute a serious risk factor for suicide. It therefore seems relevant to analyse how help is applied for and how these disorders are being treated.

4.2.2 Use of health services and the treatment of mental disorders

The ESEMeD study has also looked into this aspect of the issue. Let us therefore repeat the results of this study.

- "Use of health services" is defined by the ESEMeD study as having consulted a health professional for emotional or mental health problems at least once during the 12 months that preceded the interview: 33% of those who had suffered at least one such disorder made use of health services.
- Use of mental health services according to the type of disorder: amongst those who had made use of mental health services, a number of differences can be observed depending on the type of disorder: 43% for mood disorders, 38% for anxiety disorders and 17% for alcohol disorders.
- Up to 77% of those who seek professional help on a psychological level consult their GP, possibly in combination with a psychologist, psychiatrist, or psycho-therapist.
- The presence of more than one disorder leads to increased consultations with health professionals.
- A considerable number of individuals who do not meet the criteria for the disorders nevertheless seek help for their emotional problems (6%).
- Women seek professional help twice as often as men.
- Invoking professional help for emotional reasons is least frequent in the age categories between 18 and 24 years (and with those over 65).

Thus, this part of the study concludes that those suffering from mental disorders in Belgium only make limited use of health services. Moreover, many of those who did seek help did not receive adequate treatment.

As regards the treatment of disorders, the study shows that:

- Treatment with drugs only is the most frequent: 34,9% of those who applied for professional help for emotional reasons only receive drug treatment. This is even more true for those suffering from disorders linked to alcohol and mood disorders.
- 26,9% receive mere psychological treatment. This is even more so for those suffering from anxiety disorders.
- A combination of drug treatment and psychological treatment is provided to 13,8% of those who seek help for emotional reasons.
- Finally, 24,4% of these individuals receive no treatment at all. This means that one person out of four who suffers from a mental disorder has no access to professional help.

The authors conclude:

"In any case, our observations have no doubt a great social value: in spite of the fact that Belgium has a widespread offer of medical care for emotional problems and mental disorders, it is clear from the ESEMeD data that the resources are not used optimally. **Not only do only a minority of people apply for professional help, but a considerable number of them do not receive any form of treatment.** In concrete terms, this means that out of a hundred individuals who suffer from a mental disorder, 33 seek professional help, whereas only 27 really do receive treatment. […] The fact that between 6 and 8 out of 10 of those who suffer from a mental disorder do not receive treatment suggests that the access to mental health care is littered with stumbling blocks that have an inhibiting effect, such as the attitude towards mental health, the availability of medical care, financial considerations or the extent to which individuals think they need help.") (Bruffaerts et al., 2004) [14]

The promotion of mental health and the use of health services for mental disorders, the fight against the stigmatising of these disorders and the access to care are therefore the cornerstones of a policy that aims at reducing the prevalence of depression and suicide.

[14] Translated from original in French.

4.3 Attempted suicides and the importance of follow-up care

An attempted suicide is the most important element predicting fatal suicidal behaviour. Putting it differently, the fact that someone tries to put an end to his or her life is the best variable that allows to predict a suicide that results in the death of that individual.

Nearly 10% of the attempts to commit suicide have a fatal outcome. The risks are higher during the six months that follow the attempted suicide. Although a former attempted suicide does increase the risk of someone putting an end to his or her life, most completed suicides were not preceded by a previous attempt.

According to a study conducted in 1998 by the *Coordination des Urgences*, the *Ligue Bruxelloise Francophone pour la Santé Mentale* (i.e. francophone Brussels league for mental health) and the "Adolescence" department of the *Service de Santé mentale de l'Université Libre de Bruxelles* (i.e. the Mental Health Service of the Free University of Brussels), only one out of six attempted suicides is treated by a hospital emergency service. However, in two thirds of these cases, this does not result in the patient being examined by a psychiatrist. This means that only 5,68% of all those who have attempted to commit suicide say that they have been examined by a psychiatrist or a psychologist after this attempt.

Bearing in mind the importance in secondary prevention of immediate and intensive follow-up care, this is a very worrying finding.

The same study mentions that at the time it was being conducted, general hospitals had, on the whole, barely developed any specific formal procedures to provide adequate care for attempted suicides

If the psychiatric symptomatology is not severe or if the somatic consequences of the attempted suicide are not too serious, the liaison psychiatrist is often not even called in. As a result, patients are often sent home without their psychological suffering having been taken into account. Yet, we know that any attempted suicide, even such as do not involve a high medical risk, should be taken seriously, expressing as they do very real distress, i.e. a psychological morbidity that is likely to continue. In addition, failing to take action quickly allows the psychological affects caused by the attempted suicide to grow less intense. The patients are left with the impression that the care provided depends on the intensity of the somatic "affect". This in turn results in increased somatic damage, should they ever attempt to commit suicide again.

Also we know that many of those who have tried to commit suicide do not consult a psychologist, psychiatrist, or psychotherapist upon leaving the hospital emergency service. The reason for this is that therapeutic follow-up needs preparing, which is but rarely and poorly done after a single short intervention by the hospital emergency service. Yet if there is no follow-up care, the risk of recurrence is high. Indeed, those who are sent back to their former lives will find themselves faced once again with their problems and ill-being; these same causes are therefore very likely to lead to the same results.

There is a high rate of recurrence after a first attempted suicide and it increases exponentially after the third, mainly amongst individuals for whom no follow-up care was provided. What makes this phenomenon all the more worrying is that the death rate increases with the number of attempted suicides, desperate individuals making use of increasingly violent means.

With attempted suicides the clearest and most significant predictive risk factor for fatal suicidal behaviour, particular attention should be paid to providing adequate care and follow-up. This is especially true in view of the fact that, as will be shown in the next chapter, the actions aimed optimising the quality of the care and follow-up provided for attempted suicides turn out to be particularly efficient. Systematising the psychosocial care provided to those who have tried to commit suicide in our country is of crucial importance.

4.4 Access to means of suicide

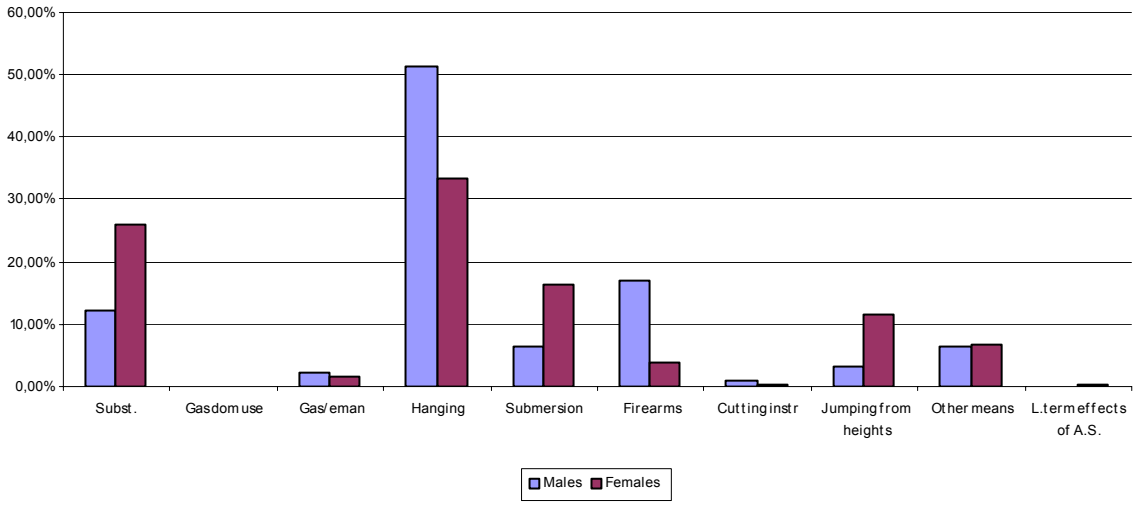
Some studies show that access to means of suicide has a decisive influence on the rate of suicide. Studies into this phenomenon have been primarily concerned with firearms; a high mortality from suicide was found to exist among those who had recently purchased a firearm (Wintemute et al., 1999). 54% of all those who died from injuries caused by firearms in the United States in 1997 had in fact committed suicide (Rosenberg et al., 1999).

Likewise, research carried out up to now has shown that there appears to be a definite connection in all countries, both industrial and developing countries, between alcohol consumption (notably in the Russian Federation and the Baltic states), free access to certain toxic substances (e.g. in China, India and Sri Lanka.) and firearms (e.g. in El Salvador and the United States) on the one hand, and the rate of suicide on the other. Once again, the overall figures may hide important differences, e.g. between rural and urban areas (this is the case in China and the Islamic Republic of Iran).

Another aspect of this finding which has to do with the relation between depression and suicide concerns the means used to carry out the act: sometimes antidepressants prescribed for treating depression are used to commit suicide. According to a study carried out in Sweden, 4,4% of all suicides (232/5 281) appear to be caused by ingesting a substantial amount of antidepressants (Isacsson at al., 1997). But this only concerns a minority of all suicides and antidepressants are not the only drugs used in attempted suicides. The most serious problems with antidepressants have to do with *undertreatment* and failing treatments, rather than overdoses.

Moreover, whereas in certain countries such as the United States and Columbia, access to means like firearms constitutes a real problem, things are rather different in our country. The following figure mentions the means used in Belgium. It shows how difficult it is to reduce the access to means of suicide, the reason being that the means that are most frequently used to commit suicide are also substances or objects that are used in daily life.

Figure 6. Gender-based comparison of the percentages of the means used in 1995.



Even if the results of these studies are not being questioned, their use in suicide prevention and more importantly their actual efficiency in stopping as complex a phenomenon as suicide strikes many as rather limited in time. It certainly does not allow the subject to be understood in its full complexity. There is a risk that dealing with access to means might only affect the external causes involved in committing the act, without taking into account the other factors. Though attention needs to be paid to access to means, it must form part of an overall policy consisting of a variety of strategies.

4.5 The central part played by primary health care professionals

As mentioned in section 4.2.2 “Use of health services and the treatment of mental disorders”, the ESEMeD study, like other studies, emphasises the central role played by primary health care. More than anyone else, the general practitioner is of crucial importance in the Belgian health care system. Patients consult their GP more often than they do any specialists, even if the disorders pertain to their mental health.

Accordingly, primary health care professionals play a central part in preventing suicides in so far as they can more easily detect worrying signs and discuss them with the patients and/or those close to them. The WHO has published a very interesting document on this subject entitled “Preventing Suicide: A Resource for Primary Health Care Professionals”. It aims at making these professionals aware of this issue and helping them make a diagnosis and take appropriate action.

Needless to say, managing patients with mental disorders or with suicidal thoughts is more time-consuming than a regular consultation. The preceding pages have shown how important it is to deal with these pathologies at an early stage. Therefore, it is absolutely essential that there should be a NISII[15]-code available for mental health consultations. This is also recommended in a previous SHC report (N° 7814: ”Aide aux médecins généralistes, praticiens de première ligne

[15] National Institute of Sickness and Invalidity Insurance, French INAMI.

pour les questions de santé mentale" (i.e. Help for general practitioners, the primary health care practitioners in matters of mental health).[16]
It goes without saying that a general practitioner does not have the time, during a ten to fifteen minute consultation, to provide adequate primary health care to a patient suffering from psychological or even psychiatric disorders. One suggestion to solve this problem would be to make specific consultations carried out by general practitioners more financially attractive when they involve patients suffering from such disorders. This type of consultation, which is more time-consuming, might be called a "medical and psychosocial consultation".

In order to qualify as such, the consultation would be required to contain some of the following elements:

- an assessment of the patient's medical and psychosocial condition
- an (integrated and overall) medical and psychosocial diagnosis
- a psychological treatment approach, which potentially involves
    - referring the patient for psychotherapy
    - prescribing psychotropic drugs
    - referring the patient to a psychiatrist
- a longer consultation (e.g. +/- 40 minutes)
- multidisciplinary contacts.

It stands to reason that general practitioners who wish to carry out medical and psychosocial consultations should, apart from their initial specialist training in general medicine,

- receive further training on this subject
- take part in a multidisciplinary mental health care network."

General practitioners play such an important part in this issue that various steps have already been taken to increase their expertise in this field or to give them practical help. These will be discussed in section 5.

General practitioners are the health professionals who are most frequently consulted, even for emotional reasons. As a result, they play a key role in:

- the early diagnosis and treatment of depression and other mental disorders
- preventing suicides
- the follow-up care provided after attempted suicides.

Yet they have to be given the means to perform this function properly (continued training, back-up, making medical and psychosocial consultations more financially attractive…).

4.6 The care provided to suicidal patients by the emergency services

Nowadays, the manner in which suicidal patients are received and taken care of in Belgian emergency services as well as the prevention of recurrence depends, among other things, on the hospital to which those who have tried to put an end to their lives have been referred.

In many cases those who have made a suicide attempt are sent to an emergency service. Though the quality of the somatic and medical care administered upon admittance does not differ from that provided for other emergencies, we do know that there are a series difficulties involved in the manner in which suicidal patients are to be managed and that these difficulties are not or badly taken into account by some emergency services:

[16] Report available in French and Dutch on the website of the SHC (www.health.fgov.be/CSS_HGR), by entering the keywords "médecins généralistes" or "huisartsen" in the search engine in the section entitled "Avis et recommandations"/"Adviezen en aanbevelingen" (i.e. "Advisory reports and recommendations").

- **lack of training**: as a result of their lack of sufficient theoretical training in this area as well as the absence of practical means for intervention, such as an analysis grid, the hospital staff cannot detect the key elements of an interview.
- **unavailability**: on-duty staff are overwhelmed by emergencies that are more of a psychiatric (or even psychosocial) than medical nature. As a result of this lack of availability, the care provided is often restricted to a vague nosographic diagnosis and a decision to admit the patients in question to the psychiatric department (the cost of which might have been saved) or to send them to a consultation. Attention is only paid to the "identified patient" rather than to devising a real therapeutic follow-up that involves the complete system.
- **poor knowledge of the resources of the psychosocial network**: "*Travailler avec des structures ambulatoires et essayer de trouver des solutions alternatives demande du temps, ce dont manquent cruellement les intervenants de garde occasionnelle*" (i.e. working with outpatient facilities and trying to find alternative solutions requires time, which those who are only occasionally on duty critically do not have"*)* (De Clercq, 1997). It follows that there has been a lack of collaboration between general hospitals and other health professionals.
- **negative countertransference feelings** with regard to an attempted suicide:
    1) Emergency doctors may feel alienated from their usual duties, they may fail to fully understand what is expected of them or feel vaguely manipulated. They are likely to react with confusion and sometimes with a kind of "sadistic and punitive" aggressiveness (cf. rigorous stomach pumping, suturing up without anaesthetics, etc.).
    2) The sometimes nervous, noisy, and aggressive behaviour of these patients may trigger a feeling of pointless harassment.
    3) Another issue that causes the nursing staff to feel somewhat uneasy towards these patients has to do with the fact that on the one hand, psychological suffering is less tangible than somatic suffering and that, on the other hand, any injuries that need looking after have been caused by the patients themselves.
    4) The saving role and the satisfaction that are generally felt when dealing with somatic emergencies are jeopardised when faced with an attempted suicide. Indeed, the basic meaning of this action suggests a wish to die, at least in appearance.
    5) It is difficult to forgive those who tried to commit suicide for having harboured, through the act of suicide, the death fantasies that inspire fear to those around them and to the nursing staff. There is a risk that the latter might react in an aggressive manner.
- **stress, nervous weariness linked to issues like these.**

Various studies and experiences have shown that it is absolutely essential that those who have attempted to commit suicide should be received in an appropriate manner, that they should be given adequate care and that there should be an appropriate follow-up once they have been treated in the hospital.

The act of suicide expresses unbearable suffering, which those committing suicide want to put an end to at all costs. In doing so, they do not (generally) convey a desire for death as such, but a need for peace which only death seems to be able to provide. It is therefore important to be fully aware of this process, for it determines the type of response that needs to be given to these attempted suicides. Indeed, simply taking care of the body does not suffice: one also needs to provide the means that will allow the psychological suffering that has triggered the suicidal act to be understood and appeased. Without this, the suicidal individuals who are sent back to their former lives will be faced once again with their problems and ill-being; these same causes are therefore very likely to lead to the same results.

It follows that the suicidal person needs to be provided with real therapeutic counselling. On the one hand, the latter should aim at deciphering the intrapsychic and interpersonal aspects of the crisis and, on the other, it should aim at making it easier to express the emotions and difficulties

that go with suicidal decompensation. It should allow suicidal individuals to deduce the meaning of the crisis they are going through from their life stories, to become aware of the repetitive patterns which they themselves and those around them are faced with and, on that basis, make changes in their personal and family lives. In doing so, the emphasis will have to be on the context in which the symptom emerged rather than on the symptom as such. Such therapeutic counselling cannot be provided by the emergency services. Nevertheless, the latter are required to ensure that it is provided through various types of co-operation.

As regards those who have attempted to commit suicide, their relatives, and the hospital staff, it is absolutely necessary to avoid trivialising, dramatising or denying the act and to try to search for solutions instead.

Over the last few years, certain emergency services have considerably improved the quality of the manner in which suicidal individuals are received and taken care of. Micro-networks have been formed in an informal fashion. Nevertheless, it is necessary to generalise and systematise these practices in order to prevent these patients from simply being sent home after their attempted suicide, on the ground that their physical health has been restored. One could also consider organising training, raising emergency service staff consciousness, and providing support to relieve the stress involved in such situations.

4.7 The bereaved

4.7.1 Postvention: those bereaved by suicide.

Those bereaved by suicide possibly form the largest group affected by suicide and yet, they are often forgotten. According to careful estimates, for every suicide, there are on average six bereaved individuals, whose lives have changed forever. Every year this group increases considerably. The taboo on suicide persists as a stigma on the bereaved. They themselves often do not have the energy to look for help or support and those around them often do not know what to do. Thus, during the mourning period many bereaved are left to their own devices or enjoy the support of a very restricted circle. Feelings of sadness, despair, guilt, shame, rage, as well as being haunted by the question “why” are frequent occurrences, though these feelings may also arise amongst other mourners. The term postvention is the generic term that denotes the activities, the care, and the help that are put in place for the bereaved or in collaboration with them and that aim at providing support or giving them some assistance in trying to find a new state of balance and sense in their lives. The bereaved constitute a specific high-risk group for suicide. Accordingly, postvention is a form of prevention for the next decade and later generations.

4.7.2 The health professional as one of the bereaved

“For health professionals too, suicide is a confrontation, both on the personal and the professional level. They may feel overwhelmed by the emotional chaos that the bereaved are faced with. A suicide remains stamped in one’s memory and can have a profound and long-lasting influence on one’s professional behaviour. It is important to realise that health professionals too may require follow-up care. Depending on how long and intense the relationship between the health professional and the deceased patient was, many health professionals experience the same sort of emotional reaction that friends and family do: sadness, anger, fear, a sense of guilt, and occasionally even relief when the suicide was preceded by a long period of suffering.

Apart from these reactions of grief they also question their own professional competence. A suicide often generates a feeling of professional failure. All the bereaved – especially health professionals – seem to be torn by the question whether the suicide could have been prevented

and to what extent they are personally responsible for the fact that it was allowed to occur anyway.

Discussing the suicide with those close to them as well as with other health professionals seems to be essential to accelerate the process of dealing with the events. In doing so, health professionals may also partially prevent the past from having a negative influence on their professional activities when faced with similar requests for help." [17] (http://www.zelfdoding.be).

4.7.3 The role of the general practitioner after a case of suicide

In the event of a suicide GPs are often among the first to be on the scene. They play a key role in the contact with the close surviving relatives. They are often the obvious person for the bereaved to turn to, as they usually know the family well. Also, the GPs can inform them about certain formalities that need to be fulfilled. At this stage, GPs are advised to take active measures that are aimed at the bereaved. Making a house call shortly after the suicide may be of considerable help. It is important that the bereaved, as well as the GPs, talk about the suicide with the other people concerned. Research (Van Dongen, 1991 and Gradat et al., 1996) has shown that most of those bereaved by suicide greatly appreciate the visit of their GP after a suicide. However, GPs ought to be prepared for the bereaved to react aggressively because of their feeling of anger and their tendency to put the blame on someone. Still, this type of reaction is unusual and mourning together is usually felt to have a positive value. This may also help the GPs themselves to deal with their trauma.

Providing support means above all giving the bereaved the opportunity to talk about the suicide, their dismay, their feelings of guilt, shame, relief and their sense of isolation from their friends and family. Another subject that one should be able to discuss openly are the prejudices about suicide.

The bereaved may be encouraged to seek to contact others themselves and ask for support. Indeed, friends and family often tend to adopt a rather reticent attitude. Moreover, GPs can also determine whether it is advisable to refer them to a discussion group for the bereaved". [18] (http://www.zelfdoding.be).

Research has clearly shown that those bereaved by suicide form an important high-risk group for suicide. Therefore, it is essential to take strong action in order to provide support to these individuals.

4.8 The media

It is a well-known fact that the way in which the media present cases of suicide may trigger new ones. Scientific research has shown that the spreading of information about suicides by the media has a greater impact on the method used to commit suicide than on its frequency. But, on the other hand, clear and well-directed information can improve public knowledge on this issue, thus strengthening the protective factors.

These last few years the WHO has published a series of recommendations for those working in the media. They aim to highlight the impact of reports on suicides, to provide reliable sources of information, to give suggestions about how to report on suicides both in general and in specific circumstances and to point out which pitfalls to avoid when reporting on suicide.

[17] Translated from original in Dutch
[18] Translated from original in Dutch

Generally speaking, the specific considerations that must be taken into account when reporting on suicide are the following:

- statistics must be interpreted carefully and correctly;
- generalisations based on small numbers ought to be handled with great care and expressions like “suicide epidemics” or “the place that has the highest suicide rate in the world” should be avoided;
- suicidal behaviour should not be presented as an understandable response to social or cultural changes or a recession;
- suicide should not be presented as a way to find a solution to such personal problems as bankruptcy, academic failure or sexual abuse;
- the report should take into consideration the effect which suicide has on the families and the bereaved, who suffer from both psychological and moral pain.

Moreover, the WHO recommends that the information be as restricted as possible. Everything possible should be done to avoid exaggerated statements. Pictures of the deceased, the method used, or the place where the suicide was committed should be avoided.

5. ACTIONS ALREADY TAKEN IN BELGIUM

The issue of depression, suicide, and prevention forms a part of health care, which is partially regionalised in Belgium. This means that the initiatives taken differ according to community and region.

In Flanders, there was a large-scale debate on this issue and measures were taken by the public authorities. In December 2002, the Flemish authorities organised a Health Conference on this subject (www.wvc.vlaanderen.be/gezondheidsconferentie). In 2003 a **plan of action** aiming at an 8% reduction of the number of suicides by 2010 was developed. This means that reducing the number of suicides has become one of the top priorities of the health policy in Flanders.

In the Wallonia-Brussels Community and the Walloon region, this problem has not yet been made the issue of a public debate. The different projects that have been developed are either based on private initiatives or organised and subsidised on a local level (local authorities, province…).

Accordingly, what follows is not meant as an exhaustive inventory of all the initiatives that have already been taken at all the levels of authority, but as a grouping together of various examples of initiatives taken in this field, based on the most important courses of action.

5.1 Promoting mental health

The following experiment aims at familiarising young people with mental health by giving them the opportunity of meeting people with mental disorders. This is done via the Flemish education system and through various activities. “Hoe anders is anders?” (“How different is different?”) is a project of the VVGG (Vlaamse Vereniging Geestelijke Gezondheid) (i.e. *Flemish Mental Health Organisation*) that aims at breaking the stigma on mental disorders and allowing young people to form a better image of mental health.

5.1.1 “Hoe anders is anders?” - An experiment by the Flemish Community

This project, which was first set up by the VVGG in 1991, addresses young students of all disciplines in the last two forms of secondary education.

Its aim is to make young people acquainted with mental health care patients through a variety of activities in which they can take part. Interacting with these patients plays a central part, thus allowing these young people to realise that mental health issues do not constitute a self-contained world but are a part of society. By sharing their activities with the patients and making fulfilling connections, these teenagers can overcome their fears and prejudices, get to know these patients and discover resemblances with themselves, in spite of their differences.

How does this work?

- Every year a VVGG representative visits all the participating classes in order to give information on mental health, such as the various mental health disorders, treatment, and the location of the mental health institutions. Every student receives a folder containing the most important information and teachers are provided with more detailed booklets.
- Next, a patient or a relative of a patient visits the class to talk about his or her personal experience with mental health.
- Then a project is organised with a group of patients living in mental health care centres, institutions, or hospitals. The latter are free to decline to participate in the project, but this is rarely the case. The project lasts for three consecutive days.

- At the end of the school year, a conference is organised in Brussels during which all participating students and patients meet in order to present their projects.

The activities are very diverse and include a basketball tournament, the preparation of a Christmas party in an institution, cycling trips, painting exhibitions …

During the 2003-2004 school year over 1 500 teenagers from 46 schools took part in this project.

Both students and patients benefit from this project. It allows the patients to break out of their isolation, not only in a physical sense, but also at a social and emotional level. As for the teenagers, it offers them emotional, social, and moral education. Meeting psychiatric patients in the course of the project improves their image of mental disorders. This project clearly forms part of an attempt to fight the stigma on mental disorders.

The project "*Hoe anders is anders?*" is an interesting initiative that aims at promoting mental health and fighting the stigma on mental disorders.

5.1.2 Information and awareness raising on suicide (Centrum ter Preventie van Zelfmoord/ Centre de Prévention du Suicide)[19]

The Flemish *Centrum ter Preventie van Zelfmoord* (CPZ) and the francophone *Centre de Prévention du Suicide* (CPS) (i.e. "Centre for Suicide Prevention") also provide information about mental health and suicide and create the necessary awareness of the problem. These two centres:

- have at their disposal a library specialised in suicide and its prevention;
- distribute booklets about suicide and the way to handle it;
- organise awareness raising projects.

Raising public awareness plays an important role in the primary prevention of suicide. The first thing to do is to break the law of silence and have the courage to tackle the taboo on suicide as well as the many prejudices around it.

Awareness raising primarily involves talking about suicide, i.e. creating an atmosphere, time and place where words, questions, fears and emotions can be expressed and listened to.

In order to be efficient, prevention requires among other things the spreading of information, viz. the broadcasting of quality information via the media, colloquia, conferences, and debates. In other words, this involves constantly repeating basic notions, talking about experiences of life and death in which everyone, if they are willing to, can recognise themselves or someone else.

This information is meant for all, as anyone can find themselves in a situation where they have to deal with the issue of suicide at their own level and within their own surroundings. The interest and the efficacy of primary prevention lie in the population taking charge, which leads to the creation, at all levels, of networks of contact persons.

The CPZ is now in the process of preparing a report on the attitude of the Flemish towards suicide.

In addition, the CPS organises every year the *Journées de la Prévention du Suicide en Communauté française de Belgique* (i.e. Meetings devoted to the Prevention of Suicide in the

[19] The CPZ and CPS have a website: www.zelfmoordpreventie.be and www.preventionsuicide.be with additional information on suicide and suicide prevention.

French Community of Belgium), which is a large-scale information and awareness raising campaign on the issue of suicide. These meetings focus on two topics:

- Exchanging thoughts during thematic study days with all parties involved on the act of suicide and on the counselling of suicidal individuals.
- Raising public awareness on the issue of suicide by arranging meetings with prevention professionals that focus on questions that they are faced with in their personal lives.

The study day and the meeting with prevention professionals traditionally take place around February 5th, a date chosen by various international partners in the French-speaking world (France, Switzerland, Canada).

5.1.3 Awareness raising campaigns on depression aimed at the general public: La Dépression en question: *two campaigns involving 30 radio spots organised by the* Ligue Belge de la Depression *(i.e. the Belgian League against Depression)*

In 2004 the fortnight devoted to depression *La Dépression en Question: 15 questions fondamentales* (i.e. "Depression in Question: 15 basic questions") took place from 15 to 30 November. It aimed at raising the awareness of and providing information to the public on what depression is and what it is not, on whom it may affect, on what to do and what not to do when one is faced with it after all.

The aim was to incite the public to talk to those who are able to offer them efficient help. Therefore, the intention was by no means to encourage them to make their own diagnoses or to resort to unjustified or inappropriate treatments.

The target group was indeed the entire Belgian population. This explains the setting up of a new structure using messages of very general interest (15 questions - 15 answers) aimed at all listeners belonging to all age groups, and especially isolated people, who do not read papers or magazines and do not listen to broadcasts about depression, which require a personal choice and selection to begin with.

Following the success of this campaign on its launch in November 2004, a second fortnight on depression was organised on the same dates in 2005, the topic being *Dépression et maladies physiques: Soigner sa depression, c'est aussi prendre soin de sa santé*. (i.e. Depression and Physical Illness: Taking Care of one's Depression is also taking Care of one's Health).

This time the aim was to show that "body and mind form a unit", that, in addition to illness, pain and chronicity, there is also the mental exhaustion of the sick person, even sometimes a masked depression.

These two campaigns were broadcast via the press and the Internet (www.depressionenquestion.be); the results were remarkable, increasing as they did the number of both the visitors on the League's website and the calls received during these periods.

5.2 An intervention programme for depression: a project of the European Alliance Against Depression

The European Alliance Against Depression is a 4-year (2004-2008) European intervention programme that aims at improving both the prevention and the treatment of depression as well as reducing the number of suicides and attempted suicides**.** It originated as a pilot project realised in Nuremberg (Germany) by Munich University (01/2001–12/2002). The positive evaluation of this project has led to its extension to other regions in Germany and other countries. At the moment, the EAAD project is conducted in 16 regions of 15 European countries and is financed by the European Union. In Flanders, it is being carried out in the Bruges – Ieper region. The actions and their assessment follow a framework and methodology common to all the participating regions. This common approach allows experiences to be exchanged and compared and the results of the different regions to be put together. This last aspect is an advantage, especially with regard to suicide, taking into account the relatively small number of suicides and attempted suicides.

The common conceptual framework involves implementing a four-level intervention programme, as was the case with the Nuremberg pilot project:

- Level 1: Improving the general practitioners' competence

The GP is often the first person people suffering from depression contact. For an adequate treatment it is important that the GP is sufficiently competent to detect and diagnose the depression. In this project, GPs are trained to detect and diagnose depression and suicidality. Among other things, they are provided with the means to detect and diagnose depression in a quick and easy way.

- Level 2: Improving the competence of society's key figures

Training sessions on depression and suicide are offered to various occupational groups who, without having any specific training, come into contact with individuals suffering from depression or suicidal thoughts, viz. pharmacists, teachers, PMS (Psycho-Medico-Social) centres, pastoral workers, hospital staff, police agents, prison officers, etc. These occupational groups can contribute to providing better support to these individuals, as well as to the early detection of problems and possible guidance.

- Level 3: Informing the public on suicide and depression

There is still a great taboo on psychological problems (and talking about them). This has a stigmatising effect on those suffering from depression or suicidal thoughts, thus making it harder for them to receive help. Among other things, the EAAD seeks to promote the relevant knowledge and understanding by providing the target groups with correct and adequate information on the symptoms, the causes and possible treatment of depression and suicidality. Public awareness is raised by means of information booklets, press articles, a website, and public events.

- Level 4: Improving the care for the patients and those close to them

The care provided to patients suffering from depression and suicidal problems can be improved, among other things, by optimising the collaboration between health professionals and working with "emergency cards". In addition, this line of action of the EAAD includes providing support to self-help groups and offering psychological education on depression and suicide to patients, those close to them or those bereaved by suicide.

The choice of these lines of action is based on the Gotland study, which proves that continued extensive GP training may enhance the detection and treatment of depressions by GPs and result in a reduction of the number of suicides and attempted suicides (Rutz, 2001; Rutz et al., 1989, Rutz et al., 1990). The Nuremberg project opted for a more extensive approach in which action was also taken on other levels and in which other deciding factors of depression and

suicide were assessed. The actions at the different levels were connected and influenced each other, thus leading to synergistic effects.

In all the regions taking part, action is taken on the four above-mentioned levels. The aim is not to create a completely new offer if there are already activities and programmes in place. Indeed, the long-term results are better if local participants take structural action, rather than having external participants organise short-lived actions. The EAAD prefers to promote collaboration and avoid fragmentation by harmonising the existing offer and combining forces in the same framework. In order to achieve this, a network of local and regional participants is being developed. The regional co-ordinators may give fresh impetus to new forms of action and fill in possible gaps. Finally, the aim is not to create a new structure of care or offer direct help.

With regard to the evaluation of the EAAD project, a common methodology has been worked out in order to measure its effects, which both includes epidemiological results such as the number of (attempted) suicides, and the effects of the project on the knowledge, attitude and skills of professionals and the general public. Thanks to the evaluation of these effects, we can obtain information about the effectiveness of a particular intervention. These results may lead to directives for the future implementation of action programmes in other regions.

Not all EAAD partners apply the programme to the same extent. Flanders, like some regions in Estonia, Iceland, Italy, and Slovenia, participates in the EAAD project as a "Level-1 partner". This means that activities are carried out on all four levels and that there is an evaluation of the programme.

The EAAD project in Flanders:
In Flanders, the co-ordinator of the EAAD project is the interfaculty research centre LUCAS (KU Leuven). The Bruges - Ieper region has been chosen as an intervention region, which comprises the districts of Bruges, Ostend, Ieper, Dixmuide and Veurne. The "Westhoek", the coastal villages and the Bruges area are regions with specific socio-demographic characteristics. The choice of this region is based on the following arguments:

- The most important argument is that the issue of depression and suicide is bigger in West-Flanders than in the rest of Flanders, with the Westhoek having the highest rate.
    - o According to the 2001 Health Survey (Demarest et al., 2002), the prevalence of depression mentioned by the patients themselves is higher (7,1%) in West-Flanders than in the whole of the Flemish Community (5,3%).
    - o Although there are relatively fewer deaths in West-Flanders, the standardised mortality ratio (SMR) for suicide during the 1990-1999 period is higher here than in the rest of Flanders, especially amongst men. About half of the municipalities, especially in the Westhoek, can be found in the upper quartile of this suicide rate.
    - o The monitoring study *Eenheid voor Zelfmoordonderzoek* (Unit for the Research on Suicide) carried out by Ghent university shows that the number of attempted suicide patients per 100 000 population is considerably higher in the AZ St. Jan AV in Bruges than in any other emergency service in Flanders.
  - Thanks to the projects called *Tussen de Lijnen* (Between the Lines) and *Stepped Care*, LUCAS has acquired great experience in developing the GPs' competence in this region. The EAAD project makes it possible to extend this experience on a larger scale. This experience also offers advantages with respect to the setting up of networks, which is very important within the framework of this project.
- With about 630 000 inhabitants, this region easily reaches the minimum of 250 000 inhabitants required by the EAAD. The district-based demarcation used corresponds to a large extent to how the division of working areas is set up for such groups as GPs, local divisions of the National Health Service and (potential) patients of the regional hospitals.

In this region there is very good co-operation from key figures who have already worked together with LUCAS on previous projects.

In order to set up a regional network, an inventory was first made of all the important parties involved in the region. The latter received information on the project, were asked whether they were interested and were invited to an *Invitational Conference* held in Bruges on the 29th of October 2004. During this meeting the aims and the methods used were explained. About 80 participants belonging to over 40 organisations attended it, with 15 of them giving a public discussion of what they did in order to prevent and treat depression and suicide. With the help of these interested partners, the *Vlaams Netwerk tegen Depressie* (Flemish Network against Depression) was formed. Taking part in this network are a large number of the parties involved, including several master organisations such as the *Centra voor Geestelijke Gezondheidszorg* (CGG: (Centres for Mental Health Care), psychiatric and general hospitals, GP associations, branches of the National Health Service, the SITs (Integrated services of home care), the CAWs (Centres for general well-being), services for home care, PMS centres, pharmacists, police agents, pastoral workers, self-help organisations, patient organisations and specialised centres such as the *Centrum ter Preventie van Zelfmoord*.

Actions are organised in collaboration with the regional network on the four levels of the EAAD framework. These extend the existing actions and initiatives. Until some ten years ago, prevention in mental health care was at its beginnings in Flanders, but for the last couple of years a change has been taking place, especially in the field of depression and suicide prevention, with e.g. the *Gezondheidsconferentie* (Health Conference) and the CGG's *Project Suicidepreventie* (Suicide Prevention Project) resulting in numerous initiatives being taken. The EAAD project continues to support the existing actions and encourages the exchange, collaboration, harmonisation, and extension of these. Moreover, innovative initiatives are set up and a media campaign is led on this subject in the region. The emphasis is on scientific foundation and assessment to ensure that the EAAD project stands for a real increase in value.

The same evaluation methodology is used to assess the EAAD project in Flanders as that used for the other European EAAD participants.

On the one hand, the epidemiological data on suicides and attempted suicides before and after the intervention period are observed. Given the various methodological limitations, these data do not form the focus of the evaluation. On the other hand, more proximal indicators are collected in order to measure the effect of some specific interventions such as knowledge, attitude, and skills. LUCAS also aims to use the EAAD project for more detailed research, thereby contributing to this domain in an innovative matter.

Achievements of the EAAD project in Flanders (2004-2006):

1) *Developing GP competence*

In September 2005, LUCAS organised a survey amongst all the general practitioners of the "Waasland" region in collaboration with the working group "Depression" of the *Psychiatrisch Centrum St. Hiëronymus* (Sint-Niklaas). This survey assessed the diagnostic process for depression, as well as the manner in which GPs treated and referred their patients. The GPs' personal attitude towards depression was also considered, as well as their collaboration with the *Psychiatrisch Centrum*.

Following the positive dynamics created by the training programme on depression *Tussen de Lijnen* (Between the Lines), a similar training programme was organised on suicide for the GPs of the Bruges region. This training took place in the spring of 2006 and consisted of four sessions. The starting point is provided by personal experiences, exchange with GP colleagues, stimulation

of the collaboration between lines of care and the training of reference doctors in the domain of suicide prevention.

The experiences gleaned from the survey and the trainings also served as the basis of a handbook on depression for GPs, which is to be published shortly.

2) Developing the key figures' competence.

- Pharmacists

In order to ensure that continued training is best suited to the needs of pharmacists, a preliminary survey was organised amongst a representative sample of 200 pharmacists in the Bruges-Ieper area. This survey looked at current practice concerning the relationship between pharmacists and patients suffering from depression or suicidal thoughts, and highlighted the points that needed to be dealt with. Next, a brainstorming session was organised with some highly involved pharmacists on the content and organisation of a programme for continued training on this issue. This continued training programme consists of three sessions (a practice-based conference on depression and suicide, the acquisition of conversational skills to provide psychosocial support to the patients, the exchange of experiences with partners in the area) and took place in Bruges and Kortrijk during the first half of 2006. The roles that pharmacists could play in this issue are: the ability to recognise risk factors such as a previous attempted suicide or the abusive use of medication, referring patients to health professionals when suspecting the early stages of a depression, and also to a certain extent following-up compliance and providing information on the side effects of the medicine. Pharmacists have at their disposal efficient institutes for continued training (www.sspf.be for Wallonia, www.ipsa.be for Flanders), where community pharmacists are adequately trained for the tasks assigned to them.

- *Centra voor Geestelijke Gezondheidszorg (CGG)*

Within the framework of the EAAD, the Flemish authorities subsidise a project that studies and strengthens the role of the *Centra voor Geestelijke Gezondheidszorg* in dealing with depression and suicide. This project is conducted amongst the four merged CGG in West-Flanders. In 2005 the way in which the CGG carried out this function when receiving, diagnosing and treating a person with depression was analysed. In order to do so, the registration data of the CGG patients suffering from depression (from 2004) were examined (treatment) and incoming patients (from 2005) were followed-up (reception). On the basis of these results, a series of suggestions for improvement have been made, initiatives for collaboration worked out and training offered to the health professionals from these *Centra.*

3) Informing the public about depression

LUCAS was the co-organiser of an information day on mental health that took place at Nieuwpoort on the 19th of January 2006. This information day was addressed to senior level secondary education students (aged 16/17) and specifically dealt with depression and suicide. The programme consisted of an information fair, a panel debate, personal accounts, and a conference in the evening. LUCAS is also a consultant for the *10-Stappen Campagne* (10-Steps Campaign) against depression organised by the Flemish authorities, as well as for other initiatives concerning the image of depression and for guidelines for the media on how to give information on depression and suicide.

4) Providing support to the patients and those close to them

In the Bruges area, the initiative of starting collaboration on the prevention of suicide was first taken by hospitals and general practitioners. A good follow-up and the prevention of recurrence are of great importance for suicidal patients, as an attempted suicide is the most important risk

factor leading to a “successful” suicide. However, preventing the recurrence of suicidal behaviour is not an easy task, with suicidal persons usually showing very low compliance rates and having poor quality contacts with health facilities. It is therefore desirable that the various parties involved should collaborate with each other in order to adjust the care provided in the best way possible. GPs can be important key figures in the networks surrounding suicidal individuals because of their relatively frequent contacts with these patients, both before and after an attempted suicide. In order to facilitate this co-operation, the decision was made to work with a case-manager for suicidal patients. This case-manager’s tasks consist of 1) following-up on the assessment and the counselling of suicidal patients at the hospital, 2) informing the GP, 3) co-ordinating the follow-up care provided once the patient has left hospital, 4) giving advice to the GPs on suicide prevention.

5) Research carried out within the framework of the EAAD

- The stigmatisation experienced by patients suffering from depression

LUCAS participates, within the EAAD framework, in an international study (INDIGO) on the stigmatisation and discrimination felt by those affected by psychological problems. This survey is conducted in 24 European countries. Patients are asked by means of a structured interview in what domains (such as work, friendship, marriage, accommodation, leisure activities and religion) they experience discrimination and to what extent. The data were subjected to both qualitative and qualitative analysis. This has provided insight into the nature and incidence of this stigmatisation and the way these patients perceive it. The experiences of people suffering from schizophrenia are compared with those of people suffering from depression.

- Developing an instrument for measuring the ability to deal with suicide.

Several trainings are organised within the EAAD framework to increase health professionals’ ability to deal with suicidal patients. In order to evaluate these trainings, it is desirable to have at one’s disposal an instrument for measuring these medical professionals’ competence in this area. This allows for the progress made by the participants of the training to be assessed. Yet such an instrument is not available in Flanders, though there is an English instrument, the Suicide Intervention Response Inventory (SIRI-2), which has good psychometric qualities. LUCAS is now working on a Flemish version of the SIRI-2, one that is adapted to the Flemish context.

- Methodology for a systematic assessment of the risk of suicide.

Assessing the risk of suicide is a crucial component of the care provided to those suffering from depression or suicidal thoughts. However, making a predictive and reliable assessment of this risk is very difficult, taking into account how complex the risk factors are, how unpredictable attempted suicides are and how relatively infrequent death by suicide is. As there is no standardised Flemish instrument for assessing the risk of suicide, this is generally done by means of ad hoc questionnaires or is left to the health professional’s clinical judgment. LUCAS has studied the literature on the measuring instruments available and on the points of special interest when assessing that risk (context, objective, the health professional’s attitude and skills…). Current practice in Flanders is assessed by means of interviews, which will be conducted with various occupational groups (GPs, pharmacists, CGG staff, telephone help line staff…) as well as students. In some groups a measurement is made before and after the training programmes on suicide, in collaboration with the *Centrum ter Preventie van Zelfmoord (CPZ)*, which organises several trainings on this topic.

5.3 Centres offering help and support by telephone or the Internet

A suicide is hardly ever a sudden or unpredictable event. Mostly, it is the end of a long and complex process in which the individuals concerned try, in vain, to find help and solutions to their problems. Their repeated failures progressively increase their tensions and anxiety. It takes only one unhappy event (the loss of a dear person, the loss of a job, the end of a love affair, a conflict with their parents, some marital dispute, an illness…), which adds to the existing problems and unsolved difficulties, for those concerned to slip into an anxiety crisis that can lead to suicide, which seems to them to be the best manner of putting an end to a state that has become unbearable. At that moment, there is no other way for them to react and they turn their despair, anger and fears into action.

Before this final stage and as long as these individuals can use language as a means of expressing themselves, one can (try to) prevent their suicidal act. This is where the telephone help lines come in (*Centre de Prévention du Suicide*, *Zelfmoordlijn* "Suicide Line" of the *Centrum ter Preventie van Zelfmoord*, *Télé-Accueil/ Tele-Onthaal* "Tele-Reception").

Rather than giving therapeutic advice, these telephone help lines, which guarantee the anonymity and the confidentiality of the conversations, offer psychological help. They intervene in a crisis, with the dialogue helping the callers to get over moments of immense tension, so as to make them feel calmer, less anxious and ready to consider other solutions than suicide once they hang up.

The first thing to do is to listen to the callers expressing their ill-being. Next, a dialogue and an atmosphere of trust must be established, where no judgment is made and understanding is shown for the callers' suffering. Based on the information given by the callers, an attempt will be made to solve their problems by helping them try to find a way out of a situation that they represent and experience as a deadlock. The aim is not to decide in their place, nor to try to solve their problems for them, but to help them look at the situation differently.

Initially, most calls were made by the suicidal individuals themselves, as if, isolated as they were as a result of the taboo and fear, they were the only ones affected by the issue of suicide. Little by little, this perception changed: the taboo faded, giving a better insight into the fears, questions and sufferings involved, thus enabling the suicidal individuals and those close to them to start to talk. One group has learned to listen; the other has learned to talk.

Nowadays, suicidal individuals are no longer – or at least less often – compelled to lead isolated lives. They are no longer the outcast one has to protect oneself against at all cost; they have people close to them, and generally have both a working and a social environment. Those around them suffer, try to understand, and want to know what to do… But sometimes a tragedy does occur, and the suicide is committed. In those cases, the bereaved find themselves having to face a very painful mourning process… In either case, dialogue, the opportunity to talk without fear of condemnation and consequences, offers invaluable help.

Answering callers belonging to all these categories, listening to the despair of the suicidal individuals, as well as the unrest, lack of understanding or the feelings of guilt felt by those close to them is an experience that takes aback and shatters those listening and involves them in a constant stream of paradoxes. They constantly question themselves and are invariably being required to be flexible. This means that the staff of these centres are faced with the crucial task of enabling the volunteers who take these calls to provide a quality service, 24 hours a day, 7 days a week. Considerable efforts are constantly having to be made to recruit, select and train new candidates.

Suicidal individuals are not the only ones to call the help lines, also those close to them and those providing care call for help and advice. Psycho-educating those close to suicidal individuals and removing the stigma on suicide are very important tasks in which telephone help lines play a crucial part. Moreover, during each conversation with a third party, the listener will consider what advice to give to the caller on how to deal with a suicidal person close to them and potentially refer them to appropriate care. However, when dealing with a third party, it is important not to focus the conversation on the problematic situation and/or the third party's suicidal thoughts only. Each conversation, regardless what it is about, is a cry for help from a person in need:

- callers may pretend to be someone who considers a third party's situation objectively whilst they are in fact going through a crisis themselves;
- being confronted with the suicidal behaviour of someone close has a great impact on callers, who feel responsible, guilty, worried, helpless or in despair themselves…

In addition to telephone assistance, several other services (such as *Zelfmoordlijn, Tele-Onthaal, Kinder- en Jongerentelefoon, i.e. Children and Teenager Phone)* also offer online assistance, with the Internet becoming THE way of communicating. This medium is also being increasingly used by young people in particular, in the hope of finding someone who will listen. Moreover, the barriers against seeking help for mental health problems are usually very high. Yet it seems that young people are often reluctant to look for help. They will therefore be more inclined to seek help that is more easily accessible, such as telephone assistance and, even more often, the Internet.

People with a speech or hearing impairment, who cannot be helped by telephone, can find the assistance they need thanks to the online conversations.

De Zelfmoordlijn online

The online assistance provided by the *Zelfmoordlijn* reaches young girls in particular (77% of those who use it are female). This group constitutes the largest high-risk group for attempted suicide. An analysis of the online conversations in 2005 shows how serious they are. All the callers had suicidal thoughts and 27% of them had concrete suicide plans, which means that the risk of committing suicide is very high. In fact, 2 chatters out of 3 had already made such an attempt (compared to 1 in 4 callers of the *Zelfmoordlijn).*

It is difficult to talk about one's suicidal thoughts with close ones. In fact, only 1 caller out of 4 does so, which just goes to show how very important easily accessible anonymous help is.

The easy accessibility of online help encourages young people to talk about very serious problems. Thus, 13% of the chatters turn out to have a history of sexual abuse.

For some time now there has been a range of websites and forums available on which people can express their problems and feelings. Yet it is worrying that many of these sites and forums are not monitored by experts. However, the CPZ devotes a lot of attention to the training and constant improvement of the skills of the volunteers working for the *Zelfmoordlijn* and those providing online assistance.

Those answering the online help line are recruited amongst those answering the *Zelfmoordlijn* and therefore have had training not only in the techniques of conversation and coping but also in how to deal with suicidal behaviour (e.g. *lethality assessment,* making it possible for someone to talk about their suicidal thoughts…).

The volunteers for online assistance have had training in online communication. They not only receive information about the medium and the programme, but also learn about the most

important pitfalls of the medium and ways of avoiding them. Communicating via the Internet requires an approach that is somewhat different from that needed when doing so by telephone. With even less input about the callers available than is the case for telephone conversations (there is no way of either seeing or hearing them), the emotional distance between the two persons concerned is even greater and the risk of misunderstanding higher. The kind of language typically used by young people, the use of emoticons, abbreviations, and punctuation signs are dealt with in detail in the course of the training.

The Forum of the Centre de Prévention du Suicide

Since 2004, the *Centre de Prévention du Suicide* has also been setting up a means of prevention that is specific to the Internet, using writing as a mediator and employing the typical resources of the Internet to bring the users into "virtual" contact with each other. The aim is to reach an audience that would not use the telephone and, more particularly, an audience that is both young and male.

Another argument is that at present there are many sites that glorify suicide or personal sites that provide rather "brutal" descriptions of suicidal thoughts or acts. In fact, the medical and psychosocial sector has made little use of this medium out of either fear or lack of familiarity.

Bearing this in mind, the *Centre de Prévention du Suicide* has decided to offer a forum for free expression directly on its website. The basic idea was that the use of writing is a first way of creating a distance that is likely to have a calming – some will even call it therapeutic – effect in itself. Sharing one's experience with others can turn out to be interesting, and more importantly, these "others" can provide adequate answers to the questions raised.

The Forum therefore offers a space for dialogue and exchange between users, thus enabling them to exchange views and feelings on its website on www.preventionsuicide.be.

In spite of there having been no advertising and hardly any information spread about its launch, the Forum was highly successful from the very start: not only did it attract a great number of visitors and messages, but, more importantly, a genuine "support community" was found to emerge as a result of the exchange of views and feelings. It was equally successful with regard to the compliance with operational rules: messages hardly ever require "editing" (i.e. need to be sent back to their sender for correction before being published on the web).

5.4 Training, providing assistance to professionals and improving their competence and co-operation

5.4.1 The Zelfmoordpreventie project

The *Zelfmoordpreventie* project set up by the *Centra voor Geestelijke Gezondheidszorg* aims at a long-term policy and practice of preventing suicide. Since 1997, it has developed several strategies concerned with:

- developing competence;
- optimising the care provided both within the CGG (recording of information, training within the CGG teams, workshops organised for the CGG health professionals) and outside the CGG (promoting and implementing co-operation agreements, networks that provide assistance and continued care);
- providing care to those bereaved by suicide.

In 2000 the project launched a strategy of improving competence through the conference called *Zelfmoordpreventie in Vlaanderen: van machteloosheid naar gerichte actie* (Preventing suicide in Flanders: from helplessness to targeted action). The CGG project was the first to offer specific

training modules aimed at increasing competence for intermediate target groups and key figures like GPs, hospitals, the police and youth workers.

The technical knowledge acquired by the CGG's *Zelfmoordpreventieproject* has been used in other projects such as Cera-Domus-Medica and the EAAD (cf. section 5.3.). In concrete terms, this means that it is those operating in the CGG's *Zelfmoordpreventieproject* who visit the *Locale Kwaliteitsgroepen (LOK)* (Local Quality Groups) of the GPs and who provide the trainings. Given its e-learning strategy, the project has contributed to setting up a helpdesk and interactive thematic training courses on the prevention of suicide (iTOL) for general practitioners; CGG project workers also act as facilitators in these training cycles. The project is operative in several steering committees, working groups and advisory groups at a local and regional level in Flanders.

The concept behind the campaign "*Fit in je hoofd goed in je vel*" (Mentally fit, physically fit) has been worked out within the CGG's suicide prevention project. The campaign, which was launched in the spring of 2006, targets the general public and aims to link "normal life" with mental health.

The suicide prevention project is involved in the development and implementation of such pilot projects as '*Recidivepreventie in samenwerking met huisartsen bij suïcidepogers na ontslag uit het AZ'* (i.e. "Preventing the recurrence of attempted suicide after dismissal from the General Hospital in collaboration with GPs") and "*Psychosociale opvang en evaluatie van suïcidepogers"* (Psychosocial treatment and assessment of those who have attempted to commit suicide) (for further details see later in this report).

Improving the competence of hospital staff, general practitioners, youth workers, police services and the *Centra voor Geestelijke Gezondheidszorg* – CGG.

The *Project Zelfmoordpreventie* aims to achieve maximally integrated prevention with long-term effects. This explains why the various training programmes offered usually last for several days and those taking part are limited in number, making it is possible to address the topic both thoroughly and interactively. The starting point is provided by the participants' personal experience. These trainings are often the start or the result of setting up a network around a suicidal patient.

These training modules broadly address the following topics:
- basic information about suicide: statistics, historical evolution…;
- the suicidal process;
- risk factors and signs of suicidal behaviour;
- making it possible for suicidal behaviour to be discussed;
- crisis intervention;
- strategy: "How to react to suicidal behaviour in the work context?";
- providing care to the bereaved;
- working out a network.

These training programmes are usually highly interactive and include group discussions, exercises, role-playing, video observation…

A. Developing competence in hospitals

Training module

The working group "Ziekenhuizen" set up a module called "Suïcidepreventie in ziekenhuizen" (Preventing suicides in hospitals), which offers both theoretical information and didactic

guidelines. The members of the project can use this module as a basis for in-hospital trainings. It was partially revised in late 2005 and will be completely adapted and integrated in a Powerpoint presentation in 2006.

Implementation partners
In several areas, training has been proposed to hospital staff. This offer was mainly intended for general hospitals but occasionally also for psychiatric hospitals. This training is nearly always given by project workers, sometimes in collaboration with the hospital staff. When possible, those who have had the training can share the knowledge they have acquired with the staff of their hospital. The groups receiving training often consist of a mixed audience with different kinds of basic training and working in various departments. Everything possible is done for the training to be part of a larger form of co-operation with hospitals aimed at preventing suicide.

Achievements
In each of the provinces, training was given to hospital staff. Sometimes an active offer was made, but it was occasionally the result of a spontaneous request on the part of the hospitals themselves. In some places, efforts are being made to organise the training for hospitals in a more structured manner. This is already the case in the province of Antwerp. In 2005, over 450 hospital staff members took training that was organised by the project in Flanders.

In 2005 the activities of the project that focus on hospitals were integrated more closely within a larger context of network creation. An important objective for 2006 is to increase the co-operation (which involves training) with the hospitals even further. A new training module is also being prepared.

B. Improving the general practitioners' competence

Training module
The following GP organisations have co-operated in view of providing support to general practitioners, as well as improving their competence: the "*Vlaams Huisartsen Navormingsinstituut"* (VHNI), the "*Interuniversitair Centrum voor Huisartsenvorming"* (ICHO) and the "*Wetenschappelijke Verenining voor Vlaamse Huisartsen"* (WVVH) (recently integrated in Domus Medica), as well as the "LOGO" doctors. A training module offered to groups of general practitioners and local quality groups (GLEM/LOK) was set up. Project workers have been organising the training evenings.
A computer course (ITOL) on the prevention of suicide is now operational. A great number of doctors have already taken this intensive e-learning programme on suicide prevention.

Implementation partners
In 2005, the ICHO and the WVVH have continued their collaboration. These partners receive financial aid from the Cera Foundation and the Flemish authorities, enabling them to implement the *Gezondheidsconferentie: Preventie van depressie en zelfmoord* (i.e. Health Conference: Prevention of Depression and Suicide). This strategy was presented and approved by the electronic helpdesk. A steering committee, which involves representatives of the CGG project, supervises the work.

Since 2001, the *Project Zelfmoordpreventie* has been in the process of creating an e-learning programme (*Internetondersteunde Thematische Opleidingslijn;* ITOL) for general practitioners in professional training (HIBO) in collaboration with the ICHO. In December 2003, the e-learning programme *Zelfmoordpreventie* got through the last stages of its development and a first course was organised. In 2004, changes were made to adapt this training programme so as to make it fit the general practitioners' practical needs. This three-week course was run five times in 2005, with the project workers acting as "facilitators". Those taking this course are coached by means of a

discussion and a case forum, and receive feedback on the "homework" they return. This new method for continued training was recognised by the accreditation commission in the "ethics and economy" section.

The project also looks into other possibilities. Together with the WVVH, it was involved in the Delfi study, which aims to record the weak points in the co-operation of various forms of health care provided to patients with a suicide risk. The goal is to achieve a consensus on how these high-risk patients should be dealt with. General practitioners, hospital staff, psychiatrists, and psychologists (also within the CGG) have been asked for their opinions. On the basis of this consultation, advice will be given on how to improve co-operation.

Through the CGG, regional forms of co-operation with GPs have been created with the intent of setting up networks. Information and training sessions for groups of local GPs were organised, in co-operation with LOGO doctors, in two areas (North Antwerp and the province of Limburg).

New points of emphasis
Within the e-learning programme *Zelfmoordpreventie* a new course programme, meant for both practising psychiatrists and psychiatrists in training, is being worked out.

An interactive computer helpdesk has also been set up. On www.gachet.be, general practitioners as well as other health professionals can find information on critical incidents (e.g. a patient's attempted suicide), a list of recommended foreign texts, a list of useful addresses and even a real expert helpdesk which answers additional questions.

Future projects
In 2006, efforts will continue to be made in co-operation with the ICHO and the WVVH towards optimising the care provided to suicide patients and people with suicidal tendencies as well as their relatives. This pioneering and innovative comprehensive project should lead to an increased number of individuals actually receiving help from their GPs as well as to improved co-operation with specialised care. The GPs' crucial role in the suicidal patients' follow-up will be taken into account in the networks and the co-operation implemented in the various regions.

C. Developing the competence of youth workers

Training module and strategy
At the start of the "*Project Zelfmoordpreventie"* a training module called "zelfmoordpreventie bij jongeren" (i.e. "prevention of suicide in young people") was worked out within the working group concerned with young people. It was thoroughly revised and completed in 2003. This extensive training module offers information and various didactic working methods, enabling project workers to immediately start preparing conferences or trainings lasting several days. Participants can also use this module as a basis for constituting a file. Guidelines have been issued in order to form a strategy called "Prevention of suicide in young people" aimed at schools. It provides information on how to react when faced with (attempted) suicide at school. School authorities (and other interested people) receive coaching whilst drafting the strategy.

Implementation partners
In Antwerp and Limburg there is a provincial steering committee called "*zelfmoordpreventie bij jongeren"*, which draws up initiatives around this topic. Among those forming this steering committee are several of the partners involved: project workers, staff from the PMS centres, teams consisting of children and teenagers from the CGG, staff from the prevention cell of the *Bijzondere Jeugdzorg* (Special Youth Care).

Achievements
In four areas (Limburg, Antwerp, Mechelen and Turnhout) three-day training sessions are organised on the prevention of suicide in young people. This training is given by two coaches using various teaching methods (lectures, group conversations, role playing, videos…) and is meant for student supervisors, school authorities, PMS centres, the *Bijzondere Jeugdzorg*, CGG and JACs (centres providing advice to young people). In Antwerp, victim support staff and the youth squad can also take part.

The idea of working with mixed groups appears to be a good one and the participants agree on this. The demand for this kind of training remains very high, even in those regions where it has been organised for several years. A student in therapeutic pedagogy from the VUB (Vrije Universiteit Brussel) made an assessment of these three-day training sessions. Those who had taken part in this study were very pleased with both the form and the content of their training. Most of them said that the training had improved their knowledge as well as their attitudes. Since 2004, a second aim of the Limburg steering committee "*zelfmoordpreventie bij jongeren"* has been that of making a didactic video on the prevention of suicide in young people. The idea was for this video to be used in the three-day trainings, starting at the end of 2006.

In addition to these three-day trainings for mixed audiences, specific trainings were organised for schools (in the provinces of Flemish Brabant, East Flanders and Limburg). Workshops and conferences were organised in the schools (mostly within the framework of creating the "*zelfmoordpreventie bij jongeren"* strategy). There were also two-day trainings for the staff of the PMS centres.

Three project workers took part in the follow-up of an Internet forum on suicide amongst young people organised by the magazine Klasse. This site was found to have a very high number of visitors, with a great many young people apparently using it to express their ideas and thoughts on this topic. A professional follow-up is advisable. Project workers follow the messages that are posted on this forum and, when necessary, give answers and provide information on possible help.

One school called in the local project worker to supervise the performance of a play called "Spiegelschrift", the subject of which is suicide by young people. The project worker gave information on how to tackle this topic and deal with suicidal pupils in a sensible way.

Project workers are also frequently contacted by telephone by student supervisors and PMS centre staff regarding specific cases and provide help to schools that are in a crisis. Another one of their tasks is answering students' questions.

Future projects
The *"Eenheid voor Zelfmoordonderzoek"* (Suicide Research Unit), Ghent, the CPZ and the working group *Verder* ("Next") have determined together what message to give to schools on the prevention of suicide. They decided to write a joint letter explaining which actions are efficacious, which have little or no effect and which are likely to have negative results. This action was initiated in 2005 and continued in 2006. It is a first step towards providing schools with a more structured offer.
Secondary schools and the PMS centres will be contacted about a quality suicide prevention programme in schools.

D. Developing police competence

Training module

The existing training module has been adjusted to the needs of the police. The decision was made to compose a large file. This will eventually allow police staff to give training sessions themselves. The working texts too have been revised. Thanks to the exercises, the training is highly interactive and adapted to the police environment.

The training has been given to a very broad audience within the police, including not only people dealing with victims but also police officers who enter into contact with suicidal individuals. Given the fact that suicide amongst members of the police is a current issue for many forces, it is useful that also middle-rank police officers have this training. This will enable them to detect early warning signs in the police officers themselves and learn how to deal appropriately with situations such as these.

Implementation partners and regional activities

The working group "police" continues to look into the different possibilities that would allow them to reach their target group, i.e. the police, in all regions. Their means of access are provincial police academies, those dealing with victims, district councils, police stress counsellors and the police forces.

Given the fact that police academies are organised on a provincial level, the working group has contacted several of these academies. Depending on the policy used and the priorities set, several types of training have been given to the various academies.

Within the working group "police", a detection file has been set up for the continued training provided at the East-Flanders police academy (OPAC). This *good practice* may be copied by the other provinces. Meanwhile, several two-day trainings have been organised, which have been shown to be adapted to concrete reality and have been given very positive evaluations.

In the police academy of the province of East-Flanders (OPAC), the topic of "How to deal with suicide and attempted suicides" also forms part of the training of those who will deal with victims.

In the province of Limburg there is good quality co-operation with the *Provincie Limburg Opleiding en Training* (PLOT) (*The province of Limburg: Theoretical and practical Training*). In the basic training for police agents, a two-hour course module was set up and given twice together with the teacher. The permanent teacher has meanwhile integrated that subject matter. All police forces have been offered continued training in co-operation with PLOT. A one-day continued training was also organised.

The various forces themselves also receive training. This had already taken place in the past in the provinces of West-Flanders and Limburg. In Brussels, contacts have also been made.

District councils are looking into ways of working together. As regards victim support, a council has been created in each district. They include everything and everyone related to victim support: the police, officers dealing with victims, victim support services, centres for abused children, refuge homes, houses of justice, the bar, victim reception centres and the public prosecutor.

In the province of Limburg, a one-day training session was organised for those dealing with victims on the subject of those bereaved by suicide as well as a debriefing session with the collegiate support cell of the (HAZODI) (Hasselt – Zonhoven – Diepenbeek) police zone.

Finally, during the 4th *Dag van de Nabestaanden na Zelfdoding* (*Day of those bereaved by suicide*), there was a day of conferences and meetings for those bereaved by suicide, health professionals, teachers and the police, as well as a workshop on "the police/those dealing with victims and who are in contact with the bereaved". The issue of how to deal with those bereaved by suicide was approached in an interactive way. The main points were how to announce the bad news after a suicide, how to deal with the bereaved and whom to refer them to, the first reactions of grief and how to handle one's own emotions when dealing with the victims.

Future projects
Police training requires a multiple strategy. Complying with the requests from police academies and promoting continued training (as was done by the OPAC in East Flanders) in all of the provinces constitute complementary strategies. The district councils are also an important channel that may be contacted in other regions. Complying with the requests made by the police forces remains a point of special interest. In more concrete terms, with the police themselves constituting a high-risk group, the working group "police" will look into what additional offer, apart from training, can be made by the project workers, depending on the suicide prevention policy taken by the forces themselves. Contacts have been made with the federal police's stress counsellors and several ways of co-operating have been assessed. Training has been offered in the various regions in collaboration with the partners and will be embedded as much as possible in local training structures.

E. Increasing competence in the *Centra voor Geestelijke Gezondheidszorg – CGG*:

One of the objectives of the *Zelfmoordpreventieproject* of the *Centra voor Geestelijke Gezondheidszorg* is optimising the assistance provided to suicidal patients within the CGG (www.zelfmoordpreventievlaanderen.be).

Workshops
Every two years the CGG *Zelfmoordpreventieproject* organises workshops on suicide and suicidality for all CGG professionals. Such topics as the following are discussed: risk-assessment, legal implications, how to deal with the bereaved, how to cope with one's own emotions, etc.

Internal training
In several CGG teams, local project workers offered training on how to prevent suicide. Also discussed are: the problems that arise when providing outpatient care to suicidal patients, the part played by the CGG in setting up a network around the suicidal patient…

Written account
A written account on how to prevent suicide has been provided by the CGG. This account is concerned with the part played by the CGG in the co-operation concerning the suicidal patient. It also discusses the steps that need to be taken in crisis situations… For the CGG teams who deal with children and teenagers, there is a written account devoted to under-age suicidal patients and those close to them.

5.4.2 Assistance for health professionals: the EOLE project

Eole is a telephone help line for all health professionals faced with psychiatric and psychological emergencies and crises in the Brussels-Capital-Region. This help line aims to:

- assist the callers in analysing their situation;
- provide theoretical as well as practical information on mental health care;

- make it easier to access existing therapeutic resources;
- set up, together with the caller, a network of individual care for the patient;
- stay in contact in order to help set up a permanent therapeutic project in the Brussels-Capital-Region.

This means that GPs can at all times ask for advice on how to deal with mental health and refer their patients to appropriate care when necessary.

5.4.3 Assistance for schools

Various studies have shown how difficult it is for school principals and teachers to face the crises that result from a suicide or attempted suicide committed by a student or someone close to them.

After someone has committed suicide or has attempted to do so, those close to them are found to undergo a real psychological shock. Denial, guilt, withdrawal, defiance are the individual and collective reactions that create tensions among the bereaved and prevent appropriate action from being taken.

In addition, when a suicide occurs, those most vulnerable amongst the bereaved may commit an act of despair themselves. The risk of imitation is particularly high in young people with a peer or relative who has committed suicide or has attempted to do so.

Based on these observations and on the requests made to this effect by the schools, the province of Liège has put in place several means of taking action through both its *Commission Provinciale de Prévention du Suicide* (i.e. "Provincial Commission of Suicide Prevention") and the Brussels *Centre de Prévention du Suicide*.

Thus the province of Liège has decided to create a "rapid intervention team in case of suicide", which responds to requests from school authorities belonging to all systems following a suicide or attempted suicide that the class and/or pedagogical team has difficulty coping with. This team, which consists of persons with various sorts of training (doctors, psychiatrists, psychologists, nurses, criminologists) acts to ensure that the correct information, follow-up and appropriate support are provided to the school in question. It is also charged with referring individuals that may require it to the most appropriate persons or services (PMS, PSE, Centres for Mental Health Care) after discussing the matter with their partners.

These measures aim at a healthy reflection upon what constitutes the best action and reaction. Indeed, though it is not advisable that there should be a total lack of response on the part of the school authorities and the pedagogical team in cases of suicide, the initiatives taken by "well-meaning" teachers sometimes have perverse results.

After a case of death that results in certain excessive emotional reactions, it appears important to put the emphasis once again on the institutional framework in order to restore the primary function of the school and to make use of the support available in and around the school, such as that offered by the PMS Centres, the mental health care services, etc.

<u>Manual for school professionals</u>
Moreover, in addition to the team set up by the province of Liège, there is a manual entitled "*Le risque suicidaire et les adolescents – Quelques répères pour les directeurs et enseignants du secondaire face à une problématique complexe"* ("The risk of suicide and teenagers – some information for secondary school authorities and teachers faced with a complex issue"*)*, which was published in 2001. The text was prepared and drawn up by the non-profit organisation CLIPS (Centre Liègois d'Interventions Psychosociales / Clinique des comportements violants – Liège) (Liège Psychosocial Intervention Centre / Violent behaviour clinic – Liège).

This 24-page booklet was distributed amongst all schools belonging to all systems in the province of Liège, amongst PMS centres, teams promoting health care in schools and mental health services. So far, over 5 000 booklets have been distributed.

This manual not only contains some information that makes possible a better understanding of the phenomenon, it also suggests concrete ways of action for the various parties involved and refers to the health specialists.

The *Centrum ter Preventie van Zelfmoord* and the *Eenheid Zelfmoordonderzoek* have also created a general module for secondary schools. School authorities, teachers as well as students contribute to this project. The teachers' module is devised in co-operation with the *Project Zelfmoordpreventie* described above.

- School authorities: providing information and raising awareness;
- Teachers: improving their competence (ability to detect warning signs, to react appropriately, to refer to the appropriate help…). In order to do so, use is being made of e.g. the expert knowledge of the *Project Zelfmoordpreventie;*
- Students: pedagogic module (mental health and mental health care, coping, help-seeking behaviour…).

Practical guide for teachers: what to do when a student wants do a presentation on suicide?

The *Centrum ter Preventie van Zelfmoord* and other Flemish organisations involved in suicide prevention (*Project Zelfmoordpreventie, Eenheid Zelfmoordonderzoek, Werkgroep Verder*), deal with questions from students who wish to do a presentation on suicide. It is these organisations' experience that these students are not sufficiently aware of how sensitive this topic really is. More precisely, there may be high-risk students in the classroom (i.e. young students with a history of suicidal behaviour or a depression, students who have lost a close relative through suicide…) who will be put in a very difficult position if this topic is broached in an abrupt or ill-considered manner. Teachers are not always aware of the line of conduct that is required when the subject of suicide is being discussed.

Research shows how important it is:

- to present suicide in a larger context, i.e. that of mental health;
- to propose alternatives to suicide (with the emphasis on help-seeking behaviour);
- to avoid dramatising and romanticising.

These and other guidelines are explained in the practical guide, which offers help to teachers. Needless to say, the latter can contact the *Centrum ter Preventie van Zelfmoord* for any remaining questions as well as for support.

The most important guidelines are the following:

- describe the aims of the presentation;
- try to understand the student's motives;
- be your own support as well as the student's and the class's;
- pay special attention to high-risk students;
- avoid dramatising, giving details and idealising;
- view the suicide in a wide context (mental health care);
- take the time to have a discussion with the class;
- provide the addresses of important services offering assistance.

5.4.4 Improving the competence of key figures for the elderly (e.g. home nursing)

We are now living longer and longer and there are an ever-increasing number of elderly people. However, as it turns out, these elderly people do not find it easy to live long and "happy" lives. Though the percentage of deaths by suicide is relatively low amongst the over-65 year-olds, the absolute number of suicides amongst the elderly is very high. With men, the suicide rates reach a peak from the age of 75.

The reasons for these high numbers are: depression, loneliness, bad health, social isolation, loss of independence, loss of a partner or someone close… The elderly constitute a high-risk group as far as depression and suicide are concerned, but far too often, the depression is not noticed in time, one reason being that it is thought that those minor health problems in elderly people are caused by the "normal" process of growing old. Moreover, the suicide rates amongst the elderly are often lost sight of because of the concern – however justified – in society with the high number (expressed in percentages) of young people committing suicide.

The *Centrum ter Preventie van Zelfmoord* aims at using this training programme to provide information to those taking care of the elderly about how to prevent suicidal behaviour. This means increasing the alertness ("What are the signs I must pay attention to?"), open-mindedness ("What is my own attitude to suicide?") and expertise ("How should I react and whom can I refer this person to?") of these health professionals with respect to the suicidal behaviour of the elderly. This training is offered to home nursing personnel (household help and nurses) via the VIAC (a training institute).

5.4.5. Improving the competence of the 112 emergency number and help line call-takers

A small-scale survey carried out in the province of East-Flanders has shown that on average three suicidal calls are recorded in the 100-headquarters in East-Flanders every day. On "difficult" days, such as e.g. 30 December 2003, the number of such calls was as high as 7. It is therefore of vital importance that these call-takers be fully capable of dealing with suicidal individuals.

The basic training of the call-takers aims at improving their alertness, open-mindedness, and competence in handling suicidal callers. It is provided by a team of two trainers from the *Centrum ter Preventie van Zelfmoord vzw*.

Those taking part in this training are the call-takers who will be in charge of the future single emergency number 112 (already being used as the international emergency number). They will answer the call, analyse it (who, what, when?) and immediately forward the information to the computer dispatching. The dispatching service will inform the appropriate intervention service (fire brigade, police, medical assistance) but the call-takers may also do the dispatching themselves. Up to now, at the first stage, the information about the call has been passed on orally, which goes to say how important good quality communication is.

The aim of this training is to create awareness of the issue of suicide as well as the suicidal process and teach good discussion techniques so that adequate answers can be given in particular situations. The most frequent situations are:

1. a person in an acute crisis – an attempted suicide is in progress
2. a person needing a comforting conversation
3. a call in behalf of a third party
4. a *postfactum* call in behalf of a third party (after what is or is not a lethal attempted suicide).

Other telephone help lines like the *Kinder- en Jongerentelefoon* and the *Holebifoon* (for homosexuals) and primarily informative lines such as the *Druglijn* also receive calls from suicidal individuals and call upon the *Centrum ter Preventie van Zelfmoord* for training in suicide prevention.

5.5 Providing care to suicidal individuals and post-hospital follow-up – Developing networks

As was explained in section 4.6, there is a great need for setting up a post-hospital follow-up of suicidal individuals, as simply treating the physical consequences of the act does not suffice. This observation has led to several initiatives being taken, some of which will be described below.

5.5.1 The Cellule d'Intervention Psychologique of the Centre de Prévention du Suicide

The *Centre de Prévention du Suicide* has created a *Cellule d'Intervention Psychologique* (CIP) (i.e. Psychological Crisis Intervention Cell), which has two distinctive features, viz. it

- functions as an interface between hospital and therapeutic health professionals;
- provides punctual interventions in crisis situations.

Aim of this project

The aim of this cell is to ensure that suicidal individuals are given solid therapeutic counselling. On the one hand, it will aim at deciphering the intrapsychic and interpersonal aspects of the crisis and on the other, it will facilitate the expression of the emotions and difficulties that go with suicidal decompensation. It will allow suicidal individuals to deduce the meaning of the crisis they are going through from their life stories, to become aware of the repetitive patterns which they themselves and those around them are faced with and, on that basis, make changes in their personal and family lives. In doing so, the emphasis will have to be on the context in which the symptom emerged, rather than on the symptom as such.

The project is being carried out in co-operation with several Brussels hospital services. The idea is that, after an exploratory analysis, assessment and feasibility study, the project should be exported to other cities of the French Community of Belgium and be adapted to the specific needs of rural areas.

Procedure

- The hospital service, when faced with suicidal patients (who have already agreed to the procedure), forwards their personal information to the CIP.
- The CIP contacts the suicidal individuals in order to offer them assistance within 48 hours at most.
- If they agree to this, a first appointment is made.
- Following that first appointment, new meetings are organised (up to seven) so as to be able to deal with the crisis and, if necessary, to get the suicidal individuals themselves to ask for a long-term therapeutic follow-up.
- If the suicidal individuals express a wish for therapeutic follow-up, the cell refers them to a hospital institution, a mental health service or an independent therapist for treatment.
- At the end of the follow-up and potential referral, the suicidal individuals are contacted again by telephone (provided they have agreed to this) after a period of one month / three months / six months / a year, in order to maintain contact and assess their general evolution.

Some observations and considerations

The project was met with a mixed, sceptic, sometimes even hostile welcome from the hospitals, which were hardly in favour of seeing people from the outside intruding into their own territory and, what is more, dealing with such a sensitive issue to the medical profession as suicide. Providing information and explanation has, however, allowed ambiguities to be solved, making it possible to refocus the debate on the notions of partnership and complementarity, which are at the heart of the project.

Working together with the hospitals belonging to the group shows that the various parties involved benefit from it:

- it is reassuring for the hospital staff to know that the suicidal patients they allow to leave will be given specific follow-up care – in addition, the "response" they give to these suicidal individuals, through the CIP, reconnects them to the basic "repairing" function of their job;
- the awareness created by the CIP seems to have a comprehensive effect within the hospital service. More specifically, it appears to have generated a greater and better involvement of psychiatric resources;
- for the patient, the out-of-hospital setting guarantees maximal flexibility and a less charged environment.

In more concrete terms, practice has shown how important it is to contact the suicidal individuals by telephone without delay in order to make a first appointment. The later they are contacted, the higher the number of refusals. The 48-hour deadline set by the CIP therefore truly constitutes an upper limit that should not be exceeded.

At the end of the first three months, which are considered as the most dangerous, the number of new attempts is almost zero amongst the suicidal persons taken care of by the CIP. The strategy may therefore be taken to be an efficient one.

5.5.2. Pilot project in Limburg: Co-operating with general practitioners in preventing recurrent suicidal behaviour after dismissal from the hospital

This project was set up following the observation that the clearest clinical risk factor involved in suicide is a previous attempted suicide. Moreover, the risk of recurrence is at its highest during the first two/three months. Accordingly, the pilot project is being tested within the framework of a recurrence-prevention strategy. The idea is to provide the best care possible through setting up a better network between hospitals and general practitioners. This project requires active involvement from the GPs after the patient's dismissal from the hospital. They are asked to "take care of" the patient and ensure the co-ordination of care. To that end, they can receive adequate training or find support. This project, which has been financed by the Flemish authorities since 1 November 2003, involves a real desire to promote professionalism among GPs.

Aim of the project

This project aims at improving – through the GPs' intermediate help – the follow up of individuals who have attempted to commit suicide. The project will enable GPs to contact their patients as soon as possible in order to be able to ensure that they are given follow-up care.

Many individuals who have attempted to commit suicide are taken directly to general hospitals without seeing their GP first:

- 16% of those who have attempted to commit suicide are taken to the emergency service by their doctor.
- Among the 84% of those who have attempted to commit suicide and end up in the emergency service, only 11% have informed their doctor.

However, it is difficult to provide optimal psychosocial care in hospitals. This is mainly due to the high number of patients leaving hospital early. Moreover, these patients rarely heed the referral to other specialists or the treatment administered for underlying problems after having been treated in the emergency service. In this project, the GPs are asked to actively follow the patients and to encourage them to receive post-hospital follow-up care (possibly provided by the hospital).

The role of the GPs can be of crucial importance as a result of the help they can provide to their patients. However, they are not always informed about the fact that one of their patients has tried to commit suicide and, moreover, they do not always feel at ease when tackling this issue.

Procedure

A procedure is set up according to which the hospital has to contact the GP upon dismissal of these patients in order to inform them that one of their patients has attempted to commit suicide.

Suicidal patients are asked to contact their GP again during the week that follows their return home. If this is not the case, the GPs themselves contact their patients during the second week after the latter have left hospital. GPs are also offered help in the form of training and information.

Researchers closely follow how these various contacts develop. After two weeks, these patients are contacted by telephone and asked the following questions: Has there been any contact with the GP during these two weeks? If not, why not? If yes, how did they experience this contact? After six months, the research team contacts these patients again to determine the number of care contacts that have taken place, as well as their frequency. They also aim to find out whether the patients are satisfied with the help provided, whether the latter intend to consult their GP in case of a crisis, what their present psychosocial functioning is and whether there were any recurrences of suicidal behaviour. The psychosocial functioning is measured by means of the following instruments (which have been validated internationally): the General Health Questionnaire (GHQ12), the Beck Hopelessness Scale (BHS), the *Positive and Negative Affectivity Scale* (PANAS). The researchers go to the home of the person to be interviewed.

The final report was submitted to the *Vlaams Ministerie voor Gezondheid, Welzijn en het Gezin* (i.e. Flemish Department of Health, Well-Being and Family) in January 2006 and contained:

1. the results of a survey conducted in all the general hospitals in Flanders about their reportings to GPs;
2. the results of the survey into the effects;
3. the results of the assessment of the process;
4. the inventory of the critical success factors of the project.

A second strategy called "*Pilootproject Psychosociale Opvang en Evaluatie van Suïcidepogers"* (i.e. " Pilot Project Psychosocial Care and Assessment of Suicidal Individuals") is currently being tested in 6 general hospitals in the Flemish province of Limburg.

The Pilot Project "*Pilootproject Psychosociale Opvang en Evaluatie van Suïcidepogers*"

This pilot project was financed from the 1st of June 2005 to the 1st of July 2006 by the Flemish authorities *(Ministerie van Gezondheid en Welzijn)*. The psychosocial treatment and assessment include, amongst other things, an inventory of the risk factors that might trigger a recurrence in

suicidal behaviour, the need for providing care to these patients and referring them to post-hospital follow-up care once they have left the hospital. All suicidal individuals, even those who leave hospital early, must receive such care. It must even be available in hospitals where there is no specialised staff (psychiatrists, psychologists) present 24 hours a day and 7 days a week.

An instrument is being set up that aims at ensuring good quality care taking and screening, viz. the *Instrument voor Psychosociale Evalutie en Opvang (IPEO)* (i.e. the "Instrument for Psychosocial Evaluation and Care"). This instrument for psychosocial evaluation and care is being tested in six general hospitals in the province of Limburg. These six hospitals (three of which have a psychiatric ward and three do not) are working out a clinical procedure to ensure the providing of psychosocial care and to make certain that the different stages of the care process pass off without a hitch and that good quality follow-up care is organised. This project is linked to rapid reporting to the GPs, in which the latter are asked to provide follow-up care to their patients within two weeks after the latter have left hospital (integration with the preceding project). GPs receive information and an offer of training. An appendix to the hospital report provides the basic guidelines as well as a link to "GACHET", the electronic helpdesk for general practitioners.

An implementation study, which assesses this instrument and examines its effect on the patient, is linked to this project. Moreover, an assessment is made of the effect of training and the use of this instrument on the attitude and knowledge of the staff, as well as on the extent to which the latter feel it is effective. The project is carried out by the university of Ghent, the university of Hasselt, and the CGG's *Zelfmoordpreventie project*[20] .

These experiences show that there are different ways in which post-hospital follow-up care can be provided to suicidal patients and that it is of crucial importance that there should be a system set in place that ensures that this is indeed the case. Yet this system can be set up locally, taking into account local culture, usual forms of co-operation, constraints, etc. It is necessary to determine at a local level what constitutes the best working method, in order to allow the setting up of a network, consultations, and integration.

[20] The report on "recidivepreventie suïcidepogingen in samenwerking met huisartsen" can be viewed online on the following website: http://doclib.uhasselt.be/dspace/bitstream/1942/942/1/Eindrapport.pdf

5.6. Those bereaved by suicide

5.6.1. The Working Group *Verder, Nabestaanden na Zelfdoding*

The task of the working group *Verder* includes defending the interests of those bereaved by suicide by co-ordinating, organising, and supporting the initiatives that have been taken by and for them in Flanders. The aim of the working group is to raise awareness and improve the care provided for the bereaved, as well as to make it possible to talk about "mourning after a suicide" in our society, thus reducing the taboo surrounding this subject. To achieve this aim, various types of action are undertaken, not only for the bereaved, health professionals and other organisations in contact with the bereaved, but also for the general public, in order to break the taboo and make it possible to talk about mourning a suicide.

Thus, efforts are being made to involve the family and the larger circle to a greater extent, thereby increasing the involvement of the whole of society in providing care and support to those bereaved by suicide. This will lead to the latter receiving the support they need from their immediate surroundings and knowing they can talk about what has happened to them. Those bereaved by suicide risk being isolated, going through a complex mourning process, developing psychosocial problems and losing their own lives by committing suicide. The working group *Verder* also aims to show that those bereaved by suicide want and are able to play a role in politics and give advice on the prevention of suicide.

The working group *Verder, Nabestaanden na Zelfdoding* was set up in early 2000 and is a form of co-operation between "hands-on" experts (the bereaved) and health professionals from different sectors. It involves staff from the *Project Zelfmoordpreventie* (CGG), Similes, Trefpunt Zelfhulp, Tele-Onthaal, C*entrum ter Preventie van Zelfmoord (CPZ), Slachtofferhulp (CAW)* (i.e. "Victim support"), *Eenheid voor Zelfmoordonderzoek* of the university of Ghent and "hands-on" experts who coach self-help/ group discussions for those bereaved by suicide. The working group *Verder* also has close contacts with international organisations and is a member of the International Network for Suicide Survivors and the International Association for Suicide Prevention.

Thanks to the *Vlaamse Gezondheidsconferentie over zelfdoding en depressie* (2002) (Flemish Health Conference on Suicide and Depression), the working group *Verder* is currently financed by the Flemish authorities, more precisely by the *Ministerie van Welzijn, Volksgezondheid en Gezin.*

<u>An overview of the achievements:</u>

The discussion groups receive both substantive and logistical support thanks to organising of training and "intervision" sessions for those coaching these groups and the writing and distributing of a booklet entitled "*De Wegwijzer"* (the Signpost), which contains, among other things, an inventory of all the self-help and discussion groups for those bereaved by suicide.

Specific groups for teenagers and young adults have also been created. At the end of 2005, a booklet was published containing guidelines for the creation and coaching of self-help groups for those bereaved by suicide.

In each province, associations of various services involved in taking care of the bereaved have been set up as well (e.g. *Centra voor Geestelijke Gezondheidszorg* and self-help and discussion groups). The continued existence of the self-help groups has thus been ensured, and the bereaved can be referred more easily to health professionals.

The charter "*De Rechten van de Nabestaanden na Zelfdoding"* (i.e. The Rights of the Bereaved after Suicide) was written and distributed in co-operation with the bereaved. This charter mentions 10 rights of those bereaved by suicide. It provides guidelines for health professionals

and those close to the bereaved on how to deal with the latter. It contains a reply coupon enabling one to express the wish to be informed on the activities of the working group *Verder*.

Since 2002, the working group *Verder* has organised a "*Dag van de Nabestaanden na Zelfdoding*" each year, i.e. a day devoted to a conference and meetings for those bereaved by suicide as well as for health professionals, and which about 350 to 400 people attend each year. In the morning there is a plenary session (with, among other things, a witness report, a contribution by the Minister), in the afternoon there is a possibility of meeting fellow sufferers, taking part in workshops and conferences and taking a walk. Throughout the day a quiet room, a room for conversation and a cafeteria are available to the participants. In 2005 there was, for the first time, an offer for children (starting from the age of 6), which was provided in co-operation with the victim support service that works with children.

The poster campaign *"Iemand verloren door Zelfdoding"* (i.e. "Lost someone through suicide") is one of the ways in which to reach the bereaved who cannot be contacted through the usual support organisations. 10 000 posters were distributed to all Flemish GPs and pharmacists in order to refer the bereaved to the working group *Verder* and its website.

With the same end in view, an educational play was created with the title "*Uit het leven – Over leven en Zelfdoding"* (i.e. "Out of Life – About Life and Suicide"), which so far over 2 500 people have seen. There was also a radio spot, which was broadcast on Radio 1, Radio 2, StuBru, Donna, and Klara in 2005 and 2006. It triggered a tremendous amount of positive reactions and led to a record number of visitors on the website. This radio spot was made by the working group *Verder*, in co-operation with individuals bereaved by suicide (including the actor Pol Goossen) and the production house La Vita e Media. It also had the support of the Flemish Minister of Well-Being, Public Health and Family.

In fact, the website (www.werkgroepverder.be) is an essential instrument of the working group *Verder*, not only because it is used to announce future actions and spread information, but also because it allows the bereaved to contact each other ("*leg contacten"* – "*Forum*") anonymously and by e-mail, which for many people lowers the threshold for actually making use of it.

The working group also contributes to a positive and truthful representation in the media of the mourning process and of those bereaved by suicide. To this end, it has issued some guidelines and there is a "press list" of those who are willing to talk about their experience.

In 2004 and 2005, the *Media-Onderscheiding* (media prize) was awarded in the course of the "*Dag van de Nabestaanden*". This prize is meant to encourage responsible and constructive reporting on suicide and the bereaved.

Finally, the working group *Verder* is also involved in improving intermediary competence by organising conferences and trainings on the topics of suicide and those bereaved by suicide. There is a request for more attention to be paid to those health professionals who lost a patient through a suicide. It also deals with financial and legal problems (among others, those resulting from a suicide on a railway line).

*5.6.2. "*L'Autre Temps*"*

When talking about suicide, one thinks in the first place of the suffering of those who put an end to their lives, without giving much thought to that of those left behind. For the former the suffering ends with death, for the latter it goes on, taking on the proportions of a tragedy involving all aspects of their existence.

Usually, when someone has passed away, family and friends dwell upon the life of the deceased, remember their qualities and the time they spent together, talk about their last moments. If the death is the result of a suicide, the reactions are different. There is a malaise: people do not know how to react, what to say, what to do… As a result, they avoid contact with those mourning out of ignorance or fear, leaving them alone with their pain and their questions. Indeed, soon after the shock of the news, the feeling of guilt crops up, with its stream of torturing questions: "What did I do?" or "What didn't I do?", "I should have", "if only I had said…" The "whys" are abundant. Those who did not receive a letter of farewell regret this; the others are just as keen on finding an explanation that eludes them. Questions torture them without respite; today's answers are rejected tomorrow. Guilt, shame, panic, revolt, sorrow, despair, fear become constant, excessively faithful companions during endless days and sleepless nights. In order to escape the torment, many of them consider killing themselves and are even tempted to do so.

These observations have led the *Centre de Prévention du Suicide* to set up conversation groups called "Autre temps" (i.e. "The next stage"). In charge of these groups are two professionally trained bereavement counsellors. The participants all have in common that they have lost someone close through suicide. This shared experience makes it easier to break the taboos, which, in the outside world, virtually condemn one to silence. In these groups no-one judges the others, feelings can be brought into the open, questions can be asked as often as necessary. Everyone shares their pain at their own pace, using their own words to express what they are going through, what they think, what they feel. Everyone is accepted unconditionally. As these meetings take place, one grows towards one another, allowing ties to be formed both during the meetings as well as on other occasions, and making it possible to start finding the answers that are necessary for the mourning process.

- These groups are open to everyone mourning the death by suicide of someone close within a minimal period of 5 months after the event. In order to preserve the relational balance in the group, only one member per family is allowed to take part.

- The aim is to give support to the mourning process, not to provide therapy. The meetings have no pre-established topic but follow the group's own dynamic process.

- Procedure:
  - contact the *Centre de prévention du suicide* by telephone;
  - meet with each coach for an individual interview;
  - register for the group (which consists of maximally 8 and minimally 5 participants);
  - enter a closed group for a six-month period (i.e. without any new arrivals during this period);
  - take part in the fortnightly meetings.

The *Réseau d'Accompagnement du Deuil après Suicide* ("Network for bereavement support after suicide")

The *Réseau d'Accompagnement du Deuil après Suicide,* which received financial support from the Cera Foundation for its setting up, is officially in use since September 2002. It groups together the associations and organisations working in the field of mourning, as well as family planning services that have accepted to integrate this activity within the services they offer. These different partners subscribe to a founding Charter and the statutes issued by the *Centre de Prévention du Suicide*, which is also responsible for the general co-ordination of the network. They have all had specific training on the issue of suicide and offer different types of counselling in order to meet different expectations: individual meetings, open or closed discussion groups – either self-help groups or groups that are coached by professionals – for children, teenagers and adults.

This network aims at offering those mourning a suicide as wide a range as possible of support services, between which they can choose the one that best meets their needs and expectations.

The project is based on the belief that there is not one, and only one, way to go through the process of mourning and that it is therefore of primary importance to combine all possible help so that those suffering can find the best way of taking charge of their own lives once again.

This network only exists as a result and with the intent of bringing together all the possibilities offered by each of its members. It aims at being a "plus", not only for the people concerned by the different services which it functions as a link to, but also for the different partners it unites. When joining this network, an association certainly commits itself to respect a number of rules that are essential for joint work, but it does not in any way renounce its independence and its own identity. It retains its own characteristics, its organisation, and its working methods.

5.7. The Media

5.7.1 Booklets

There are booklets available that were written for journalists in the French-speaking as well as in the Flemish part of the country (*Suicide et Presse; Reflections à l'usage des médias – Zelfdoding en de pers; Aanbevelingen voor journalisten*[21], i.e. "Suicide and the Press; Recommendations for journalists"). These booklets remind the press of the potential dangers involved in the way in which they report on suicide, as well as the requirement that the privacy of those concerned be respected. They also make a series of good practice recommendations.

5.7.2 Awards

1. The CPZ awards a biennial prize to a good initiative in the prevention of suicide. In 2004 this prize went to the magazine Klasse.

2. As regards the issue of depression, the *Ligue Belge de la Depression* also issued a "Prix de l'information sur la dépression " (Award for information on depression) for the Flemish and French-speaking press in March 2006. A jury, consisting of psychiatrists, clinical psychologists, GPs, members of associations for patients suffering from depression or those close to them, representatives of the mental health institutions, is invited to give a score to the articles and files published in 2005 and sent by the journalists competing for the award.

Some of the criteria for the assessment are: "destigmatising effect", "objectivity and credibility", "clarity and understandability", "long-term interest", "newsworthiness", "title, reflection of its content". Most of the articles submitted for this award deal with the link between depression and suicide (more specifically in teenagers), and that between taking antidepressants and suicidal behaviour.

[21] http://www.wvc.vlaanderen.be/gezondheidsconferentie/zelfdoding_pers.pdf

6. RECOMMENDATIONS AND SUGGESTED ACTIONS TO PROMOTE PUBLIC HEALTH

The data and opinions in this document support the view that suicide and the depression that often precedes it are very important problems that pose a threat to public health. It is also clear that a very substantial number of health professionals, various services and organisations are concerned by these issues and can offer specific help. Practical examples show that individual therapists and highly committed organisations offer great quality service in Belgium. But there is above all a shortage of co-operation and co-ordination. Also the distribution of tasks is less than ideal.

This is the reason why our general recommendation is that the authorities should develop **a large-scale and coherent care programme** regarding the issue of depression and suicide. A health care programme is a coherent and goal-oriented unity containing a distribution of tasks, means and measures that ensure that each health professional involved can offer his/her specific expertise when required. This calls for a guideline on optimal care that groups together the necessary indicators to assess the follow-up of the quality of care, as well as an inventory of the different persons involved and their specific skills, a distribution of the tasks, including a communication strategy and a co-ordination task, a precise list of the health professionals and other organisations involved, and adequate means to support the completion of these tasks.

6.1 Mental health promotion, health education and prevention

Positive mental health promotion by means of:

- National mental health policies that should strengthen the value of mental health, recognise and try to solve the great problems affecting mental health in all layers of society: refugees, disaster victims, those marginalised from society, the mentally handicapped, very old and disabled individuals, abused women and children, as well as financially impoverished people. In order to do so, it is necessary to adapt the organisation of the Community accordingly (with regard to mass media, health services, other organisations, industry and business, legislation).

- Programmes aimed at enhancing the quality of the relationship between parents and children/teenagers and which may stimulate their emotional, social, cognitive and physical development. It is clear that schools too should be more active in playing a complete educational role that takes care that the students show a healthy social and emotional development (cf. the WHO's "Life Skills" educational curriculum).

- Special emphasis on what is likely to promote mental health at work. According to the WHO, eight domains have been identified in which this type of action can be taken, i.e. making employers more aware of mental health issues, identifying the common goals and positive aspects of the job, creating a balance between job demand and professional competence, training social competence, improving the psychosocial climate in the work place, giving advice to employees, improving the ability to work as well as strategies for early rehabilitation, improving work opportunities.

- Matched programmes for improving the quality of life of those who have reached – or are reaching – an advanced age, so as to make the ageing process a positive experience.

- Health promotion programmes that are aimed at improving people's ability to handle the transition periods they face throughout their lives, with special emphasis being put on social support, amongst other things.

- Interventions aimed at improving people's sense of coherence with regard to their roles in life, their taking part in and sharing of common values as well as strengthening their ability to deal with change, their credibility and confidence in our society, so as to make it easier for them to adjust to the rapid changes in society.

6.2 A care programme with those local actors who co-operate in a given area in order to provide specific care to the people involved.

A care programme should be conceived in a centralised, but structured way and should be set up locally. Ultimately, the quality of the care provided depends on the local co-operation between general practitioners, psychologists, psychiatrists, mental health care centres, and all those facilities involved in providing care for depression and suicide. What matters is that they should agree among themselves on how to organise the care, who provides what kind of support and what addition to this care, as well as on what specific procedures are to be set up. They should also settle on the agreements that can be made in that region about the providing care to and referring of patients as well as the handling of recurrences. In order to achieve this aim, the authorities may consider providing support to local programmes, following-up on regional data and co-ordinating local health professionals. Continued training, various forms of flexible mutual support through telephone consultations, the providing of advice, and the temporary taking-over of care: these are all new forms of local co-operation that are preferentially set up between health professionals who really co-operate in the interest of a specific patient. The authorities may ask those concerned to submit a local care plan for depression and suicide.

6.3 Setting up of and providing a solid basis to an efficient network of complementary disciplines and structures for dealing with depression and suicide.

Efficient co-operation with everyone playing a complementary role is also very important for dealing with depression and suicide. Nowadays everybody still works too much within their own field, within the framework of their own offer of care. The sectors are growing increasingly wider and diversified, often in a parallel way. The front-, second- and third-line care facilities are increasingly well structured, but within their own framework. One thinks in terms of "one's own field and own mission". At most one tries to co-ordinate and include other groups. Transversality, co-operation across sectors, consultations concerning the patient and other forms of care sharing are new notions that receive too little support from the NISII.

Measures should be taken to support the open co-operation between hospitals, centres for mental health care, GP practices and their local circles, liaison psychiatrists and ambulant psychiatrists, as well as various psychologists in the various structures. This is crucial, especially with respect to the care provided for depression and suicide. Systematic links should be established, there should be support for moments of reflection, and one should encourage consultations at crucial moments.

At present, there is too much complexity and confusion: efficiency, clarity, and transparency should play a more important role. It should be possible for a care path outlined in co-operation with or by the general practitioner to lead from the general practitioner to the specialist and the right facilities, as well as from the hospital to post-hospital follow-up care via these facilities.

These considerations amply justify the present initiative taken by the Public Health Authorities to improve the manner in which the activities of all mental health professionals are geared to one another.

6.4 Early identification of high-risk situations, including mental disorders and depression in particular

Suicide prevention requires that mental disorders be treated in an efficient manner and that environmental risk factors be kept under control. The progress made in treating depression has a positive influence on suicide prevention as a part of the care provided to these patients.

In case of treatment with drugs, patient compliance should be ensured, for the most serious problems caused by antidepressants are undertreatment and treatment failure. The primary concern of doctors, pharmacists, and other health professionals is informing their patients and drawing their attention to the fact that it is of crucial importance to use the correct dosage (e.g. by drawing their attention to the potential side effects of a treatment once it has been started and explaining to them that antidepressants need a few weeks to take effect).

Suicide prevention involves:

- Recognising high-risk individuals and situations at an early stage: identifying certain (explicit, ambiguous or implicit) warning signs, having environmental factors under control, examining the indicator for the evolution of the suicidal thoughts provide real means for preventing suicide. With a previous attempted suicide constituting the most important risk factor for a renewed attempt and with a minority of patients seeking professional help after a first attempt (according to the WHO, only one in four is admitted to hospital), it is absolutely vital that as many health professionals as possible (doctors, specialists, pharmacists, home care nurses, etc.) should receive adequate training to recognise the risks of suicide and refer the patient to the appropriate health professional.

- The progress made in treating depression: this makes it possible to help those suffering from depression to give meaning to their suffering and suicidal thoughts, to suggest that they should take part in a project that provides appropriate care in order to contain their determination to commit the lethal act.

- Searching for a means to include the family in the treatment.

6.5 Crisis interventions

It is crucial to take advantage of the moment of crisis and the moment at which the suicidal act is being carried out to make extensive use of the issues of the patient as well as those of the whole system of which he/she forms a part. As it happens, this moment sets free an energy favouring a change, and which one has to make use of to reinitiate the dialogue and communication before the usual defence mechanisms set in.

In order to prevent the emergency services from being reduced to a place in which patients are simply sorted into categories or in which only their symptoms are taken care of, it is important that psychological care should be provided even at this early stage.

Therefore three central ideas should be developed:
1. Specific training for the staff of the emergency services that enables them to have a better understanding of what the issue of suicide involves.
2. A more friendly reception of those who have attempted to commit suicide, one which makes them feel that their suffering is understood, and in which there is no judgment or moralising.
3. The immediate setting up of a psychosocial evaluation aiming, first, at understanding the reasons for the suicidal act and attempting to assess the risks of recurrence and, second, at

referring the person in question to the appropriate health professionals and guaranteeing specific long-term care.

In conclusion, the aim is to establish a real crisis intervention right from the arrival of the patient in the emergency service, its main objective being to reconnect the triggering event – too often perceived as the only cause of the act – to the course of the subject's life. The dramatic character of the event becomes clear as soon as it is linked once again to similar sufferings that the patient was unable to cope with in the past. Thus recognising the hidden issues and putting things in perspective can help these individuals to overcome, little by little, their feelings of helplessness. From then on, they can make personal, relational and family adjustments (once again).

6.6 Training

The training of those likely to be faced with the issue of depression and suicide plays a crucial role in the fight against depression and suicide. It enables the various parties involved to perceive the warning signs, to know what to do when these situations occur.

These trainings should reach a very large audience:

- general practitioners
- staff of the centres for mental health
- hospital staff
- social workers
- teachers
- police
- ambulance staff
- nursing staff/ home care nurses
- rest and nursing home staff
- prison staff
- …..

So far, various initiatives have already been taken and some of them have been assessed.

The main issue now is to define, for each occupational group, what minimal training should be acquired. On the basis of this, the question will be to decide what belongs to the basic training and should therefore be taught in all courses, and what belongs to continued training.

Finally, on the basis of what has already been done in other European countries, basic training in handling suicidal crises might be made eligible for accreditation and certification at the federal and/or Community levels.

6.7 Support for professionals

Despite being an individual matter, committing the act of suicide upsets one's relational network more or less widely, involving as it does many more people than just one's close relatives.

Any community is likely to be faced with suicidal behaviour or even death by suicide at some point.

In addition to the training one should take into account the emotional burden with which a great number of professionals have to come to grips in their work.
So as to avoid all risk of burn-out and help professionals improve the manner in which they cope with the stress that inevitably results from their being in permanent contact with depressive,

depressed and/or suicidal patients, several possibilities might be considered that might help them avoid these situations:

- taking a break (a place, space and time) so as to be able to take stock of the situation and think about the interventions before implementing them, especially when in a crisis with the persons concerned;
- a service that is available at all times to health professionals to answer their questions;
- the possibility of individual supervision;
- Moments of team supervision.

6.8. Actions aimed at close relatives

The family members of depressive patients or persons who have attempted to commit suicide should not be considered as victims but as real participants in the crisis. A suicide or an attempted suicide within a family may lead to a series of often major psychological disorders. It is a traumatising event for all those close to the person who committed suicide or attempted to do so.

All too often, the care provided in the hospital or in ambulatory care only concerns the patients themselves. No attention is paid to their families, partners or friends through lack of time or physical resources (shortage of staff, lack of adequate training…), or as a result of faulty judgment (rash judgment or victimisation).

Putting it differently, what needs doing is setting up a **therapeutic alliance** with the patients themselves as well as their families, whose skills will have to be used in bringing about a change. This means allowing the time for receiving all those involved and allowing them to speak, thus enabling them to express what the situation is making them go through.

In cases of completed suicide, it is advisable that the bereaved should be given care and follow-up care by the general practitioner for instance.

6.9 Communication and the media

The media play a crucial role in today's society by spreading a vast amount of information through a variety of channels. They have a profound influence on our attitudes, beliefs and behaviour, and play a major role in political and economic life as well as social relations. On that account, the media can also play an active role in suicide prevention.

Suicide is perhaps the most tragic way of ending one's life. Most people who consider suicide are ambivalent. They are not sure they want to die. One of the numerous factors that can drive a vulnerable individual to suicide could be the publicity given by media about suicide. The way in which a case of suicide is presented by the media can trigger others.

Apart from the risks involved in tackling such delicate matters in the media, the latter may also play a very active part in suicide prevention by spreading information within the context of a report on a suicide.

It follows that it is important to provide the recommendations made by the WHO to the media (cf. 4.8) and to ask the latter to add the following to the usual information:

- a list with all the mental health services and telephone help lines, as well as their most recent addresses and phone numbers;
- the warning signs of depressive and/or suicidal behaviour;

- the fact that depression often goes hand in hand with suicidal behaviour and that depression can be cured, in order to remove the stigma on this disease;
- the telephone numbers of specific help groups.

6.10 Epidemiological research, scientific research and evaluation

Scientific research plays an important role in understanding the phenomena of depression and suicide, thereby allowing expert knowledge to be considered when taking action.

First, there is the need for epidemiological research. How frequent is suicidal behaviour in the general population? What tendencies can be observed over time with respect to sociodemographic factors and clinical risk factors? Are there any peculiarities as regards young people?

It should be possible for all these questions and many others to be evaluated and quantified by means of tested and standardised methods at the national as well as at the regional and provincial levels. It is worth mentioning here that a first recent evaluation of the suicide rate in Belgium should be carried out soon.

A second issue that scientific research should look into are the biological, psychological and/or social causes of the phenomenon. Why is it that Belgium has a top-10 place for women and a top-13 place for men in the international statistics on suicide? How can the differences between Wallonia, Brussels, and Flanders be accounted for? Etc.

Finally, there appears to be a need to release the necessary funds to evaluate the programmes and the actions taken across the country. It seems essential to be able to test the effectiveness, efficiency, and extent to which each action meets expectations, in order to improve their quality and spread them further if they should turn out to be interesting. As a result, there is a need for adequate financial and technical means.

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8. APPENDIXES

8.1 Depression in the elderly

"Depression is an important health problem amongst the elderly. Health professionals must be aware of the fact that depressions have a different pattern of symptoms in the elderly compared to those belonging to younger age groups. Increasing their expertise can lead to early detection, diagnosis and treatment of depression in the elderly, thus improving the latter's health, enhancing their autonomy and increasing the quality of their lives.

Depression in the elderly is often different from depression in other age groups. What differs is not really the depression itself, but the fact that the elderly show a different pattern of symptoms (Van Den Boogaard et al., 1996). Therefore, the diagnostic criteria of the DSM-IV are not sufficiently valid for depressive symptoms in the elderly.

At an advanced age, the symptoms of a depressive mood are often replaced by physical complaints, like chest pain, abdominal pain, tightness of the chest, dizziness, sleep problems as well as general and changing pains. These complaints draw more attention and can lead to a detailed medical examination. In addition, it often happens that the patient also suffers from physical illnesses.

Apart from the apathy and concentration problems connected to depression, the elderly in particular often show orientation and memory problems, i.e. cognitive functioning problems. In such cases, the depression can at first sight look very much like a dementia syndrome. About 50% of the patients affected by senile dementia show depressive symptoms and 15-20% of Alzheimer patients exhibit symptoms of major depression.

Compared to other age groups, depression in the elderly more frequently exhibits such psychotic characteristics as delirious ideas, hypochondriac disorders ("my bowels are rotten"), feelings of guilt ("I am the cause of all the misery in the family") or paranoid ideas ("they'll come to take me away").

It is the loss of interest that comes first in the elderly, before the subjective experience of a depressive mood – elderly people suffering from depression show less gloom. Consequently, to arrive at a diagnosis of depression, the signs that can be observed from the outside are the ones that are particularly important, such as retreat, self-neglect, slow speech, and slow movements.

The elderly are relatively often faced with situations of loss (partners, physical abilities, memory function…). The symptoms of depression can occur during a normal mourning process. It is only when they last for too long or are too strong that one talks of depression. There is a risk that a depression is put down to the mourning process and is thus not recognised as such.

The resemblances with the characteristics of the ageing process (a slowing down of mental rhythm, more fragile cognitive functions, changes in the way in which feelings are perceived, altered sleeping patterns, etc.) may make the diagnosis impossible. Finally, the idea "that gloom forms an integral part of old age" may also prevent a depression from being detected in elderly people (or lead to therapeutic nihilism). Depression in the elderly must be distinguished from physical illness (especially from such illnesses as are characterised by tiredness and apathy), medicinal or toxic influences (due to sedative or mood-altering drugs), adaptation or anxiety disorders, psychotic disorders and dementia syndromes. As a result, the diagnostic process consists of an anamnesis, a heteroanamnesis, a clinical physical and psychiatric examination, an assessment of the cognitive functions and a blood test. Before making use of certain psychotropic drugs (like tricyclic antidepressants), it is recommended to first plan an electrocardiography. In cases of late-onset depression in particular, medical imaging (CT or NMR) can offer a substantial

contribution both in terms of diagnosis and prognosis, especially for cognitive disorders. The presence of subcortical white matter hyperintensities (NMR) is clinically associated with executive dysfunction, residual depressive symptoms, and an increased risk of recurrence (Ellison J et al., 2003)."[22] (Bouckaert, 2005).

[22] Translated from original in Dutch.

9. COMPOSITION OF THE WORKING GROUP

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