The information in this snapshot is a summary of abstracts presented at our scientific conferences from 1998 to 2010. Years mentioned in brackets refer to the year the information was presented.

EUPHA snapshot 2011-1 Suicide and suicidal behaviour

Abstracts on **suicide and suicidal behaviour** presented at our conferences:

2003	2004	2005	2006	2007	2008	2009	2010
3 abstracts	9 abstracts	8 abstracts	6 abstracts	6 abstracts	10 abstracts	8 abstracts	8 abstracts

Risk factors for suicide in Europe:

- Low school grades (2010)
- Previous convictions for juvenile delinquency (2010)
- Receipt of disability pension – own or parent's (2009)
- Maternal teenage pregnancy (2009)
- Previous suicide attempts and psychiatric conditions of family members (2008)
- Single-parent households (2008)
- psychiatric diagnosis (2008)
- Unemployment (2007)
- Alcohol, tobacco, and drugs use (2004)
- Sexual violence in childhood (2004)
- Not living in partnership (2003)

A HUMAN, SOCIAL AND ECONOMIC EMERGENCY

Suicides are today among the leading external causes of morbidity and mortality in Europe. Every year, **at least 60,000 persons commit suicide in the European Union** (2009).
Every suicide brings direct and indirect costs as police, funeral services, health care, lost productivity and intangible costs of pain, grief and premature loss of life. The average lifetime costs of each completed suicide are at least € 2 million (2009).

AN AGE-SPECIFIC BURDEN?

In Finland, most of the excess mortality in **ages 15-30** is related to suicides (2006); Suicide (by hanging) has become the **4th leading cause of mortality among children** between 10 and 14 years in the industrialized countries in 2003 (2009).
On the other hand, in many countries (e.g. in Italy), suicide rates increase with age for both genders and are highest for males, especially **among the elderly >65 years** (2006).

Suicide and migration:

Some studies suggest that the country of origin, the country of immigration and the time since immigration is associated with suicide among migrants:

- First generation Male immigrants from Greece and Russia, but not first generation male immigrants from Turkey, to Germany have been found to be influenced by the suicide rates of the host country (2003).
- A 2009 Dutch study suggests the highest suicide rates among male asylum seekers from Africa, the highest suicide attempt rates among males and females from Central, East and Southern Europe.

INVESTING IN SUICIDE PREVENTION IS POSSIBLE AND EFFECTIVE

Prevention of suicide is possible

Following the *Health in All Policies* framework, interventions in other sectors also prove effective:

- A mass rise in unemployment has been found to be associated to suicide, but the effect is reversed in the presence of **social spending in active labour market programmes** (2009);
- Simply **coordinating all of the institutions that could play a role** in influencing personal behaviour within a country has the potential of having a significant impact (2006).

COUNTRY EXPERIENCES

An interdisciplinary, long-term project for preventing suicide has been initiated in the Celje region of **Slovenia** in 2001. After a first stage focused on the operators' side and a second stage centered on the subjects at risk, the project was successful in **decreasing suicide rates of 12%** by 2005 and 2006.

The "Nuremberg Alliance Against Depression" applied an intersectoral approach in 30 regions all over **Germany** in 2001, achieving a **24% reduction in the number of suicidal acts** in only 2 years. The approach has since been encoded in the approach of the European Alliance Against Depression (EAAD).

As part of the project "Promoting Mental and Emotional Health" in **Early Adolescents**', 500 **Slovakian** adolescents underwent a teacher-led mental health promotion programme and were followed between 1999 and 2003. The intervention proved useful in the short term, but not in the long term.

A multi-level intervention program, based on the EAAD framework and named **"Optimizing Suicide Prevention Programs"** and their Implementation in Europe (OSPI) was started in 2009 in four European regions in **Germany, Portugal, Ireland and Hungary** and is currently ongoing for a duration of four years.

The intersectorial approach, already implemented in 17 European countries consists of:

1. Co-operation with general practitioners and pediatricians
2. Public Awareness Campaigns
3. Offers for high risk groups and self-help activities
4. Training sessions for multipliers