Background document for
The Thematic Conference on Prevention of Depression and Suicide
under the European Pact for Mental Health and Wellbeing

"Prevention of Depression and Suicide- Making it Happen"

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CONTENTS

Depressive disorder and suicide are pressing public health challenges. Depressive disorder is a major contributor to the European burden of disease, incurring high social and economic costs and constituting a major threat to Europe's productivity.

Depressive disorder can lead to suicide, but prevention of both depressive disorders and suicide are possible and cost-effective. Evidence-based solutions which the EU, Member States and stakeholders can adopt and implement do exist in the form of policies, practices and initiatives aimed at tackling depression and suicide.

Major depression is a main contributor to the European burden of disease

Major depressive disorder is common. In the EU, it affects 13% of Europeans at some point in their lives[1]. Estimates for the total disease burden in the WHO European Region indicate that in 2004 depression accounted for 5,6% of all DALYs in Europe[2]. Furthermore, the WHO expects the role of unipolar depression to increase, especially in high and upper middle income countries, reaching 8,5% and 6,0%, respectively, of the total burden of disease in 2030. In high income countries, such as western EU Member States, depression will be the single most important cause of the burden of illness[2]. One reason for the major contribution which depressive disorders make to the burden of disease in Europe is that they start earlier than most physical disorders.

Depressive disorder threatens Europe's productivity

Major depression leads to substantial impairment in quality of life and ability to take care of everyday responsibilities. Depressive disorder is a major cause of lost productivity in the EU. People with major depression in Europe report more than seven times more work days lost than people without any mental disorder.[3] Individuals with major depression report, on average, about 25% of lost work days, while sufferers of heart diseases or diabetes report 18% and 12%, respectively.[3] Two thirds of the individuals with depression report severe interference with normal function, a considerably higher proportion than individuals with physical chronic conditions[4].

Suicide is Europe's unseen killer

Depressive disorder can lead to suicide.[5] In 2006 about 57 000 persons in the EU completed a suicide, i.e. on average one person every 9 minutes. [6] Of every 1000 Europeans, 11 die by suicide. Suicide is a leading cause of death in young people, especially for young males.

Depression and suicide are linked to core EU policy targets

Mental health and mental well-being are fundamental to the quality of life and productivity of Europeans and core contributors to sustainable development. Depressive disorder and suicide contribute grossly to health inequity and difference in life expectancy between EU citizens. Thus actions to reduce depressive disorder and suicides are in line with EU efforts to increase social cohesion and health equity. Good mental health of the population is a prerequisite for economic growth and the establishment of a prosperous information society. Thus actions to promote mental wellbeing and prevent mental disorders are at the core of EU policies.

Depressive disorder is the public health challenge of tomorrow

The physical health of Europeans is improving. This is not evident for the mental health. A modern EU built on information and knowledge increasingly depends on the mental capital and thus the mental health of EU citizens. Thus focus of public health policy needs a shift towards mental health, in particular depression. Changes in work life, as well as globalisation and the current economic crisis create additional mental health challenges.

What is depression?
Depression is low mood, lack of interest and fatigue. Spells of low mood are normal, but depression is defined as a mood disorder when it lasts for more than two weeks and significantly affects your ability to function, study or work. Such major depression is characterised by depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. This background paper deals with depression fulfilling the above criteria of a major depressive disorder.

Major depression affects women almost twice as often as men. Data from western and southern Member States indicate that lifetime prevalence of major depression is 13% overall, 9% of adult European men and 17% of adult European women**Error! No s'ha definit l'adreça d'interès.** Being single or having a chronic illness increases the risk of having depression.[7]

Depression is highly co-morbid with other mental disorders like anxiety disorders[8] and alcohol use disorders[3]. European data indicate that mood disorders markedly reduce quality of life[9]. The impact on quality of life of a depressed person is comparable to a severe physical illness, e.g. severe stroke[10]. Global data indicate that depression causes a worse decrement in self-reported health score than angina pectoris, arthritis, asthma or diabetes[11]. Depression is a risk factor for physical ill health and people with major depression are at increased risk of death due to physical diseases.[12]

Costs for depression have doubled in ten years
In 2004, economic costs of depression were estimated to be € 250 per inhabitant, or € 118 bn in EU25 and EFTA[13]. Direct costs, i.e. health care costs, account for only a minor part of the total economic burden,[4,13,14] A majority of costs (between65-85%) are indirect and arise indirectly from loss of productivity,[13,15] i.e. sickness absence and early retirement but also from mortality due to suicide. Data from Sweden indicate that the costs for depression may have doubled from 1997 to 2005, mainly due to increase in indirect costs.[14]

Prevention of depression and suicides is possible and cost-effective
In most cases, major depression is a treatable disorder and many suicides are preventable. Depression can be prevented by policy actions targeting the causes of depression throughout the lifespan. Effective psychological intervention programmes for prevention of depression exist.[16] Suicide prevention has consistently been shown to be highly cost-effective.[17,18]

More Europeans are reporting depressive symptoms
Self-reported depressive symptoms are increasing in many Member States, e.g. school children in Finland and Sweden report more depressive symptoms than before, and depressive symptoms have increased considerably among the adult population in France[19] and Hungary in the last 20 years (Figure 1). It is difficult to know whether the increased levels of self-reported symptoms means that also prevalence of major depression has increased. EU-wide comparable data on trends in prevalence of major depression are missing.

Figure 1

Prevalence of depressive symptomatology (above 18 points according to BDI) in Hungary between 1988 and 2006
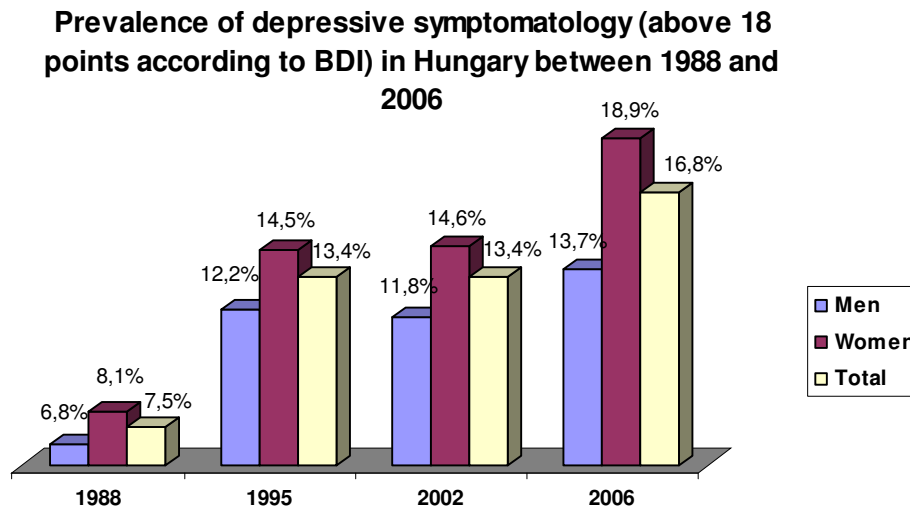
Source: Kopp MS, Skrabski A 2009. Presentation: Economic Crisis, Work, Mental Health in a Changing Society for the WHO/EU Conference: Mental Health and Suicidal Behaviour in Times of Economic Crisis: Impact and Intervention. October 2009, Stockholm.
BDI = Beck Depression Inventory

Suicide is often a consequence of mental disorders
People with mental disorders, including substance use disorders, are at risk of suicides. 90% of suicides are estimated to be associated with mental disorders, mostly with mood disorders like depression (which is associated with 60% of suicides)[20] but also with alcohol use disorders. High risk groups also include those with severe somatic illness, the socially disadvantaged, those with recent loss, especially through suicide,[21] and some migrant groups.[22,23] People with a history of suicide attempts are at especially high risk of dying by suicide.

Suicides are linked to inequalities
Suicides are also linked to social isolation, physical illness, substance abuse, family violence, and access to means of suicide[24]. More than 50 000 people die of suicide each year in the European Union, with EU suicide rates varying from 2,6 per 100 000 people in Greece to 28,4 per 100 000 people in Lithuania[25] (Figure 2). Seven of the 27 EU Member States are among the global top 15 countries in male suicide rates, and five in female suicide rates (WHO data, most recent year available as of 2007).

Figure 2

Death due to suicide and intentional self harm. Standardised death rate by 100.000 inhabitants
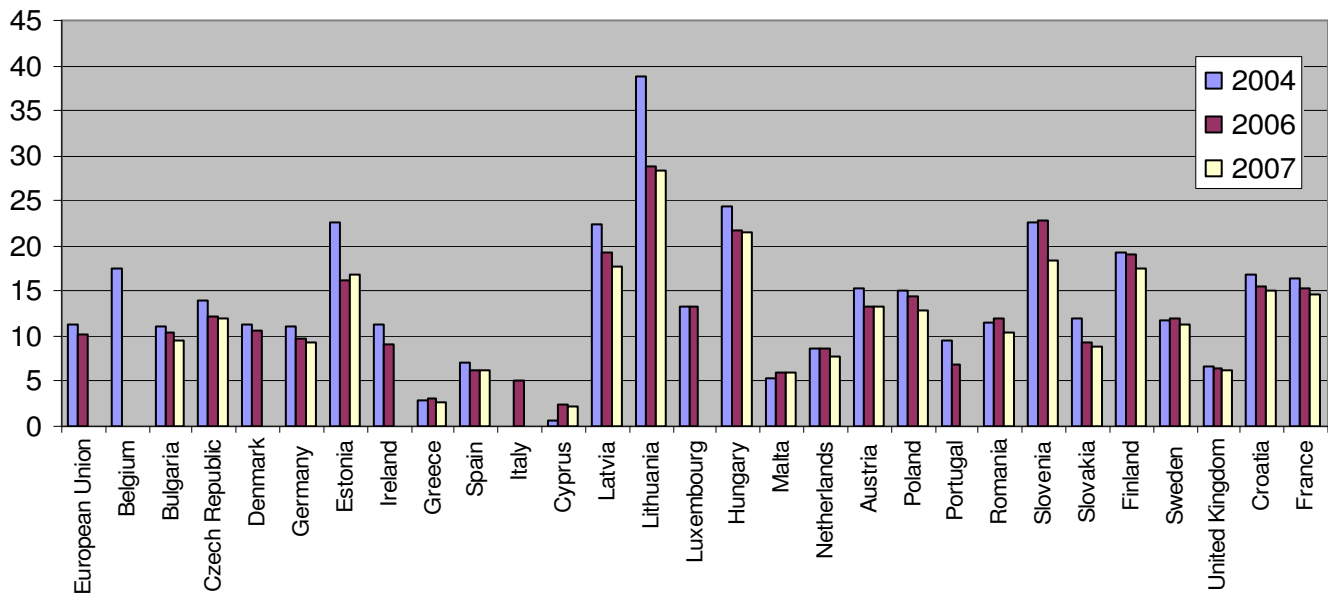
Source: EUROSTAT, data from 2004, 2006 and 2007.[26]

There are gender and age differences in suicide

Men die three to four times more often by suicide and intentional self-harm than do women in all Member States.[24] However, women attempt suicide more often than men.

A recent WHO study shows that young people are often at risk of suicide, and that suicide is the second largest cause of mortality in the 10-24 age group[27]. In addition, European data indicates that gender differences are marked in completed suicides by adolescents (see Figure 3). Of special concern are new types of extended suicides, such as school shootings.

Figure 3

Crude death rates due to suicide for 15-24 years old - per 100 000 inabitants, 2008*
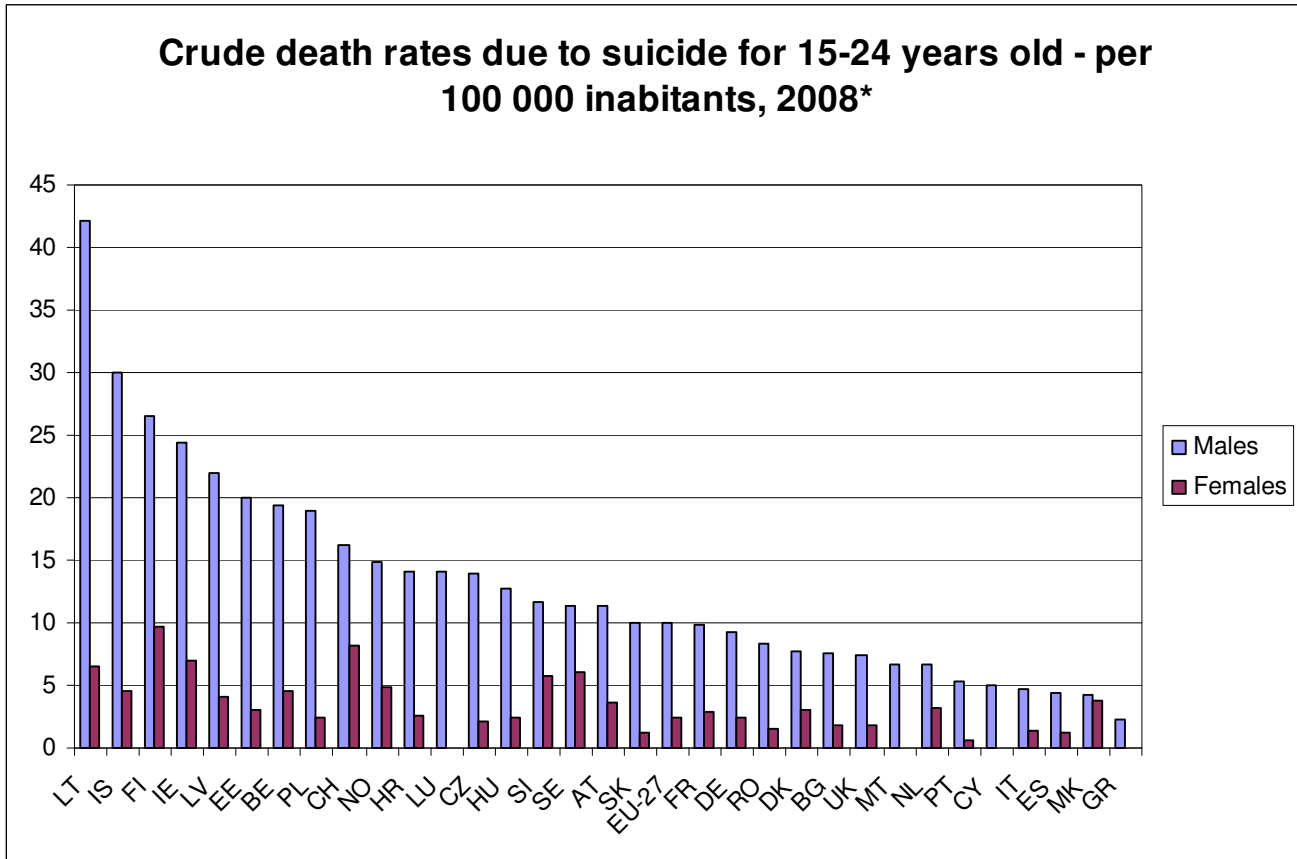
* BE: 2004; DK, IT, LU, HU, PT: 2006; BG, DE, EE, ES, FR, CT, MT, PL, RO, SI, FI, SE, UK, IS, NO, CH: 2007

Source: EUROSTAT, data from 2008.[26]

Conclusions

Based on the above facts, the time has come to address the prevention of depression and suicide at the EU level. To support the exchange of information in the EU, this paper strives to present current problems and evidence-based solutions in tackling depression and suicide in the EU, taking into account the diversity among Member States. Whilst acknowledging the need for tailored action appropriate to member states' cultures, this paper aims at universal key messages in each area of concern.

Mental health and mental well-being are fundamental to the health, quality of life, the learning success and productivity of Europeans and core contributors to economic growth, social cohesion and sustainable development, as envisaged by the Lisbon strategy. The economic crisis has a major impact on many mental health determinants. Thus action to prevent depression and suicide is now highly needed.

The mental health of the workforce has become a factor of increasing importance in economic terms, creating mental capital of nations and companies[28]. Changes in the nature of work in a knowledge-based economy require mental fitness, but also increase psychological stress.

Several long term societal trends create challenges for the prevention of depression and suicide. Globalisation and work life changes, such as increase in job insecurity and precarious work, appear to result in increased psychosocial stress.[29]

Prevention of depression and suicide is mostly within the competence of the Member States. The European Pact for Mental Health and Wellbeing,[30] adopted in 2008, provides the framework at EU-level to support Member States' mental health policies through exchange and cooperation. Key issues are identification of good practices, development of recommendations and integration of mental health issues into community policies.

Prevention of depression and suicide is one of the five priorities of the European Pact for Mental Health and Wellbeing.

BOX i: EU level actions relevant for prevention of depression and suicide

In past decade several steps have been taken in the EU relevant to the prevention of suicide and depression:

- the Council Resolutions in 1999[31] and in 2000[32] invited to promotion of mental health and requested action on health determinants.
- the Council Conclusion in 2001[33] on a Community strategy to reduce alcohol-related harm underlined the close link between alcohol use disorders, social exclusion and mental illness
- the Council Conclusion in 2001[34] on combating stress and depression-related problems invited to actions to improve knowledge on the promotion of mental health in primary care and other health services as well as in social services
- the Commission Green paper on mental health in 2005,[35] supported by a Parliament Resolution in 2006[36] pointed out that depression is one of the most serious health problems in the EU, and listed preventive actions to reduce depression and suicide.
- the EU Sustainable Development Strategy from 2006 (reviewed 2009[37]) identified improving mental health and tackling suicide risks as one of the operational objectives of the strategy in the field of public health.
- the Commission Health Strategy, 'Together for Health: A Strategic Approach for the EU 2008-2013',[38] identified prevention of suicides as a public health priority for the EU.
- the Council Resolution[39] in 2008 on the importance of closing the gaps in health and life expectancy stressed the importance of prevention activities in the field of major chronic non-communicable diseases
- the Commission 2008 Green Paper on the European Workforce for Health.[40]
- the European Parliament Resolution on Mental Health of 19 February, which communicated the Parliament's support to the European Pact for Mental Health and Well-being and proposed actions for each of its priorities[41];
- the Commission Communication "Driving European Recovery [42] in 2009 on the need of supporting people through the current economical crisis and of reducing its human cost, with a key aspect on minimising the harmful impact of the crisis on people's mental health and well-being.

Key message
Depression and suicide should be prioritised in policies and by stakeholders, from the EU-level to local level, supported by outcome targets

The problem
Depression and suicide are major public health challenges, with roots across sectors of society.

Depression is prevalent, affecting 13% of Europeans during their lifetime, with high levels of suffering for individuals and families as well as high costs due to loss of productivity and health care.

Depression reduces productivity, due to increase in sick leaves and disability pensions.

Depression and suicide are major contributors to health inequalities in EU.

Recognition of the possibilities for mental health promotion and prevention of depression and suicide within and outside of health systems, still needs to be increased in Europe.

The scarcity of strategic policy frameworks maintains this low level of recognition of the importance of depression and suicide and this is a challenge when compared with equally important physical illnesses. Similarly, the necessary commitment to prevention of depression and suicide is often difficult to ensure, leading to few long term approaches to deal with these problems.

What works
Addressing depression and suicide in strategic frameworks
Preparation and implementation of national and/or sub-national strategies and action plans for mental health, with prevention of depression and suicide as key components brings together key stakeholders and allows horizontal actions in all relevant sectors.

Intersectoral approach
Effective public health action to prevent depression and suicide requires an intersectoral policy framework at all levels. This is because amendable determinants of depression and suicide mostly lie in the domains of non-health sectors. Effective inter-sectoral work can be supported by appointing a national cross-sectoral public health committee.

Public health policy needs to include mental health
Public health policy should encompass mental health promotion, i.e. to foster resilience against depression, as well as health protection, i.e. actions to prevent depression and suicide.[43]

Setting targets
Setting targets for suicide reduction in policy action plans may help focus attention on suicide prevention. Targets need to be formulated as health inequalities targets to support suicide reduction among the most vulnerable groups or the most deprived areas. To be meaningful, targets set should be measures which avoid masking an increase of suicides in young people by a decrease in older people.

Depression targets can be formulated as rates of access to promotion or prevention programmes in schools or workplaces, reduction in sickness allowance days per employee due to depression, or reduction in number of new disability pensions due to depression. Depression targets can also be formulated as the rate of evidence based therapy received. However, this is difficult to measure and may need specific survey approaches.

Raise awareness among policy makers
Securing political commitment to fighting depression in health and non-health policies by raising awareness of the prevalence of depression and the impact of depression and suicide on well-being and productivity, ensures that prevention of depression and suicide is a key component in EU-level, national and sub-national health policies. Political commitment leads to mainstreaming of prevention of depression and suicides into relevant non-health policies, action plans and programmes.

Ensure equity and parity between mental and physical health needs
Building policies on the principle of equity and parity between mental and physical disorders lessens health inequalities

Policy and stakeholder initiatives

BOX 1. The Netherlands: Prevention of depression as a focus of public health policy
In the Netherlands, the national public health policy for 2007 – 2010[44] includes prevention of depression as one of five priority areas, along with tackling overweight, smoking, alcohol use disorders and diabetes. Access to evidence-based interventions aiming to prevent depression is a specific priority within the framework. For the implementation of this priority objective the 'Depression Prevention Partnership' has been established, led by two key players at national level, the Trimbos Institute –with a national remit in mental health promotion and research- and the Dutch Mental Healthcare Association (GGZ Nederland). Increasing awareness of mental health problems and developing e-health solutions such as web-based depression prevention courses are among the measures to improve access to mental health prevention. The programme will be evaluated.

BOX 2. England: NHS- National Health Service: New Horizons Consultation Project 2009/10
New Horizons will form a programme of action to advance the twin aims of: improving the mental health and well-being of the population and improving the quality and accessibility of services for people with poor mental health. The programme takes a life-course approach, from laying down the foundations of good mental health in childhood through to maintaining mental resilience into older age; from prevention of mental health problems, through effective treatment to recovery.
The consultation project forms an important part of the New Horizons programme. It sets out the continued high profile of mental health as a Department of Health priority and an agreed set of key values and principles for the NHS, local authorities and other government departments to guide service design and delivery. The consultation reflects on what has been learnt from the National Service Framework (NSF) and its implementation over the past 10 years.
More   information:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103333.pdf

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BOX 3. Eastern Europe: Stability Pact for health development action for south-eastern Europe (SEE)
In 2000, seven countries (Albania, Bosnia, Bulgaria, Croatia, Macedonia, Moldova, Montenegro, Romania and Serbia) entered the Stability Pact for health development action for south-eastern Europe (SEE). The pact has four components:
-- Harmonisation of mental health policies and legislation related to it – all of the countries prepared their national policies according to WHO guidelines and in accordance with the Helsinki Declaration;
-- Establishment of a common SEE model for community mental health centres;
-- Training courses for professionals for community mental health centres,
-- Establishment of an information network.
The programme has been evaluated. Its success and effectiveness can be seen in the transformation of the programme network into Regional Health Development Centres for Mental health in South-Eastern Europe, and a network of national institutions for the coordination and promotion of mental health.[45] [46]

BOX 4. National suicide prevention programmes
Finland was the first country to implement a successful comprehensive and multisectorial community-based national suicide prevention programme in 1986-1996.[47]. It resulted in the reduction of suicide mortality by 30% among men and by 17% among women within 20 years.
Following publication of the 1996 United Nations guidelines, national suicide prevention programmes have been developed in several countries (e.g. Denmark, England, Ireland, Sweden and Scotland), or are in the process of being approved (e.g. Germany). Some countries have adopted a comprehensive population approach across sectors, while others have adopted more restricted programmes approaching mainly high risk groups.
In 2002 Scotland initiated "Choose Life" as part of the Executive's National Programme for Improving Mental Health and Well-being. Choose Life is the national strategy and action to prevent suicide and provide detailed information on the epidemiology of suicide at national and local levels. Choose LIfe sits in the broader context of health improvement, public health work and wider work on social justice.[48] The programme is being continuously evaluated and a first phase evaluation report is available.[49]

BOX 5. England and Scotland suicide reduction targets
National targets for suicide prevention have been used in England and Scotland. In 1992, the English health strategy target was set as a 15% reduction in number of suicides. In 1999 the target was set to reduce the number of suicides by at least a further 20% before 2010.[50] In Scotland the target is to reduce suicides by 20% between 2002 and 2013.[18,49]

BOX 6. Sweden: Suicide Vision Zero
The Swedish government announced a 'Vision Zero' policy for suicide in 2008. The 'Vision Zero' initiative is to promote the idea that suicide is everyone's responsibility, and first-aid training to help suicidal persons should be provided for every citizen. This policy is vital in conveying a strong signal from the Swedish Government to the whole population that suicide is an important issue and must be addressed accordingly. The policy is also intended to counteract the many stigmas and taboos surrounding suicide.[51]

BOX 7. Germany: Nuremberg four-level approach programme to prevent suicide
The Nuremberg 2-year multi-level approach pilot study included: Training of general practitioners to recognise depression, public information on depression, support to high-risk persons and self-help groups, and co-operation with multipliers that is priests, teachers, police and the media. The Nuremberg study resulted in a significant reduction of attempted suicides (non-fatal self-harm), compared to both a baseline year and a control region.
Based on the concepts and materials of the Nuremberg study the European Alliance Against Depression (EAAD) started implementing four-level interventions in model regions in 17 EU countries. Based on the experiences from these models regions alliances of depression are presently expanding to many other regions in the respective countries. In Germany 56 regions have started four-level interventions under the umbrella of the German Alliance Against Depression.[52 53]
The second follow-up data of the Nuremberg Alliance Against Depression showed that intervention effects were sustainable and even increased compared to the baseline year in the follow up year.[54] This underlines the cost effectiveness of these community based interventions.
More information: www.eaad.net   www.buendnis-depression.de

BOX 8. Ireland: Annual Report on Suicide Prevention
The Health Service Executive (HSE), National Office for Suicide Prevention in Ireland has a statutory responsibility under the Health (Miscellaneous Provisions) Act 2001 to prepare an annual report on suicide prevention activities across the country. This report is laid before the Houses of the Oireachtas (Irish Parliament). The report has the effect of maintaining suicide prevention on a political agenda and provides a focus every year for media coverage.
More information: www.nosp.ie

Key message

Some major determinants of depression and suicide are modifiable by policy actions[55].

Integrate action to prevent depression and suicide into the response to the economic crisis to strengthen protective factors and to reduce risk factors.

The problem

Depression and suicide are among European health inequalities. Many vulnerable groups are more affected by depression and they die more often from suicide. Depression and suicide are linked to a range of determinants. Especially stressors in early childhood, socio-economic circumstances and work life are of importance.

Macro-level socio-economic and environmental risk factors

Major individual socio-economic risk factors for mental health problems, depression and even suicide are poverty, poor education, unemployment[56,57], high debt, social isolation and major life events. Socially excluded and deprived people are at a higher risk of developing mental health problems and especially depression.[58] Depression and suicides are linked with social exclusion and lack of social capital.

On the community level suicides are linked with socio-economic deprivation[59,60,61] and unemployment. Those who become unemployed are twice as likely to have increased depressive symptoms and be diagnosed with clinical depression as those who remain employed.[62] In Europe between 1970 and 2007, a more than 3% increase in national unemployment rate was linked to a 4.5% increase in suicides.[63]

The number of people in high debts has recently risen due to the economic crisis. Financial difficulties lead to an increased occurrence of major depression.[64] People in high debt who have been granted debt relief have been shown to have better mental health than those who have not been granted debt relief.[65]

Living and working conditions

The effects of work on mental health are complex. On the one hand, work is a source of personal satisfaction and accomplishment, interpersonal contacts and financial security. These are all prerequisites for good mental health. The workplace social capital, i.e. trusting relationships, has been shown to protect against depression.[66] On the other hand, there is evidence to indicate that a high workload, precarious work, and high emotional demand, as well as school or work place bullying and violence, are linked with depression.

Developmental risk factors

Prenatal maternal stress is a risk factor for behavioural and mental disorders, including depression. Those born small, due to foetal stressors, have an increased risk of adult depression[67].

Hostile, unstable, and unsupportive parent-child relationships can lead to depression later in life. Corporal punishment, harsh parenting and child abuse, physical, sexual and emotional, and inter-parental conflict, are associated with adverse psychological outcomes[68] and disorders in childhood[69] and adolescence.[70] Promoting a nurturing early interaction between caregivers and the child increases resilience in the face of adverse life events and promotes life-long mental health and well-being.[68] Children of parents with depression are a high risk group: six of ten will develop a mental disorder before the age of 25.[71]

Life-style risk factors

Alcohol causes depression[72]. Alcohol problems lead to a more serious course of depression, including earlier onset of the disorder, more episodes of depression and more suicidal attempts.[73] People who binge drink get depressive symptoms 2-4 times more often than people who don't.[74] A rise in per capita alcohol consumption has been linked to a post-war rise in suicide mortality in many European countries

(Denmark, France, Hungary, Norway, Sweden), but not in southern Europe.[75,76] The link seems to be more pronounced in countries where strong spirits dominate the consumption,[77,78,79] and only in some population groups, such as lower educational group.[80] In Scotland more than half of those who self-harm reported consuming alcohol in connection with self-harming, and 27% of men and 19% of the women cited alcohol as the reason for self-harming.[81] At least 10 000 suicides in the EU each year are alcohol-related.

Physical activity reduces depressive symptoms.[82]

Individual risk factors

Impact of genes on mood is not predetermined, but modified by experiences in early life. Stressors encountered early in life, increase the risk of later depression by persistently altering the expression of genes related to depression[83]. Thus quality of care early in a child's life has profound effects on mental health.

There are significant gender differences in the number of people experiencing depression and in suicide rates: depression and suicide attempts are more common among women, but suicides are more frequent among men[84]. The gender difference in major depression is linked to traditional female gender roles, and the difference narrows where gender roles are more modern.[85] People in sexual minorities can exhibit specific vulnerabilities to self harm and suicide.[86]

Chronic physical disease and functional limitations predict depression and can lead to suicide, but this effect is, however, modifiable by psychological resources such as self-esteem and mastery of life.[87]

Suicide is closely linked to having a mental disorder, especially mood disorders and substance-related disorders. About 60% of suicides are linked to mood disorders, like depression.[88]

A highly increased risk of suicide after suicide attempt can be found in people with a mental disorder. To reduce risk of attempting further suicides, people with mental disorders need aftercare, especially during the first two years after attempted suicide[89].

Bereavement after a suicide is unique and associated with prolonged grief and loneliness[90], guilt, shame[91], stigma, isolation, anger and search for motives for the suicide[92]. Consequently, the bereaved have an increased risk for suicide and non-fatal self-harm[93,94,95].

Availability of suicide means

Choice of suicide mean varies according to the country[96] and even inside one country[97], and by age[98] and gender. [96] Suicide means used also vary over time[99]. Hanging was found to be the most prevalent suicide method in 13 EU and 1 EEA country among both males (54%) and females (36%).[99] Other often used suicide methods in the EU are firearms, self-poisoning with legal and illegal drugs, drowning, jumping from a high location or in front of traffic.[98] The use of different suicide methods also depends on the availability of suicide means.

Summary table: Risk and protective factors for depression and suicide	
Protective factors	**Risk factors**
Welfare (social protection, social inclusion, social capital)	Macro-level socio-economic risk factors (poverty, poor education, deprivation)
Healthy work place and living (social capital at work, workplace health promotion, stress management)	Poor living and working conditions (unemployment, job insecurity, job stress, bullying, high debts)
Healthy prenatal and childhood environment	Developmental risk factors (prenatal nutrition, abuse, harsh upbringing, poor relationship to parents, intergenerational transmission)
Healthy life style	Life style risk factors (alcohol and/or drug use)

Individual psychological resilience (sense of mastery, self-esteem)	Individual risk factors (mental disorder, major life event, physical illness/disease, gender, migrant or minority status, access to lethal means)

What works

Social protection
The impact of unemployment on depression and suicide rates seems modifiable by social protection and active labour market programmes.[63]

Debt support and debt relief programmes
Support for people in high debt through e.g. national debt relief programmes show effect and give help to people who need it most. Free advice on financial, debt management and reviewing debt relief legislation, to reduce burden and risks of people with high debt is important.

Restrictions on access to alcohol
There is strong evidence for the effectiveness of policies that regulate the alcohol market by taxation and restricting access in reducing the harm done by alcohol. Promotion of a healthy lifestyle and avoidance of harmful drinking are cornerstones in promotion of good mental health and prevention of suicides[100].

Restricted access to lethal means
The restriction of access to common and highly lethal suicide means, such as toxic substances and firearms, is successful in reducing suicides [101,102,103]. Restriction of one suicide mean seems not to lead to a switch to another, as suicidal persons tend to have a preference for a specific method[104]. Common European measures are increasingly important because free movement of goods enables also means of suicide to move more freely from one country to another, but also because successful national initiatives to restrict access can be exchanged within EU.

Mental health promotion
Building resilience can successfully be done by support for parenting and early relationships, social emotional learning in schools or by stress management training at workplaces (see section 6)

Policy and stakeholder initiatives

BOX 9. France and UK: Warnings on the risk of alcohol during pregnancy
France and the UK implemented pictograms on bottle and can labels alerting pregnant women of the dangers of alcohol consumption during pregnancy. Available evidence shows that the impact of such health warnings is not strong in changing behaviour, but there is a lack of studies. The impact of health warning labels should be seen as a part of a mix of measures to reduce alcohol related harm[105].

BOX 10. Sweden: Debt assistance and relief policy
The Swedish Enforcement Authority actively provides information about the risks associated with borrowing and buying on hire purchase, and about debt traps. It has customer service offices over the country to provide support to over-indebted people. The primary target group for preventive action consists of young people, but other vulnerable groups in society are also targeted. Debt relief requires living five years at the minimum possible level of financial outgoings while the surpluses in the finances will be used to pay off the debts, A new Debt Relief Act will probably come into force in Sweden during 2010 which will make it easier to get debt relief and in a shorter time (three years). The situation of over-indebtedness in Sweden and the service provision have been evaluated.[65]
More   information:
http://www.kronofogden.se/omkronofogden/allmantomkronofogden/paandrasprakinotherlanguages/engelska.4.7856a2b411550b99fb7800086559.html

BOX 11. Germany: Health promotion in case of job loss

The Federal Association of the Company Health Insurance Funds (Bundesverband der Betriebskrankenkassen - BV BKK) in Essen in cooperation with University of Dortmund initiated support for long-term unemployed older workers, but also unemployed youth and other groups. When the steel works in Gelsenkirchen closed in 2004, the BKK offered a health initiative to all employees affected by the closure. Funding and staff required for this health promotion action were provided by the BKK. The focus of the programme was to deliver voluntary health promotion workshops on the production site. The concept had two main aims: first, to improve the access to and chances on the labour market for those who are unemployed; Second, to promote health amongst those in unemployment and to work with them to maintain quality of life. The project has not been rigorously evaluated but the qualitative feedback indicates a positive effect.[106]

BOX 12. Restrictions in availability of paracetamol

A commonly used analgesic, paracetamol, is lethal even in fairly small doses. In UK, where paracetamol has been the most common drug taken in overdose, legislation in 1998 reduced maximum packet size sold by outlets other than registered pharmacies. Paracetamol-associated mortality rates, hospital admissions and the severity of paracetamol overdose appear to have been decreasing since 1998[107]. Major changes in prescribing after the announcement of the withdrawal of Co-proxamol (a popular painkiller combining two active ingredients, paracetamol and dextropropoxyphene) have had a marked beneficial effect on mortality by poisoning involving this drug, with little evidence of substitution of suicide methods related to increased prescribing of other analgesics.[103] Recently, Germany also reduced the package sizes of paracetamol.

5. MAINSTREAMING MENTAL HEALTH IN HEALTH DISCIPLINES

> **Key message**
> Integration of mental health care with general health care supports prevention of depression and suicide.
> Mental health needs to be mainstreamed across medical disciplines and health professions

The problem

Prevention opportunities in health care are not used
One in five primary care patients suffer from depression.[108] In up to 80% of suicides the person had contact with a primary care physician within a year of their death. Two thirds of those who committed suicide met a primary care physician within a month of their suicide[109,110]. People with depression have more physical disorders than average for EU citizens in general[111]. Opportunities to promote parenting in the first few years of life and among families with mental health problems are often missed.

Under-recognition and under-treatment are common
Depression is common but only one in every two people with depression who visit primary care is recognised as having depression.[108] Of those recognised very few receive adequate treatment in Europe[112]. Children and young people are especially likely to have their depression go unrecognised. These findings indicate that capacity building is needed in primary care to support prevention, early recognition and treatment.

Mental health skills are lacking in primary care
Many health professionals are not adequately trained to provide proper assessment, prevention and management in the fields of depression and suicide. Additional skills in short-term and group psychotherapy are needed in primary care. Gaps remain in training programs for health professionals[113].

Mental health services are poorly integrated in the health system
The vision of primary care for mental health has not yet been uniformly implemented in Europe. Lack of political support, inadequate management, overburdened health services and, at times, stigma-related resistance from policy-makers and health workers has hampered the development of services. Integration of mental health services into primary care is most successful when mental health is incorporated into health policy and legislative frameworks and supported by senior leadership, adequate resources, and ongoing governance[114].

Lack of integration of health services means unnecessary deaths
People with mental disorders often have co-occurring physical disorders and high healthcare needs. Studies in several Member States have indicated that the mortality from natural causes is higher among people with mental disorders than among the general population.[115] Reasons include barriers in access to general healthcare, lack of responsiveness in health services, and discrimination of people with mental disorders.

What works

Depression can be prevented by targeted actions in health care
There is emerging data on effectiveness of targeted and indicated prevention by psychological interventions in primary care. A stepped care model for prevention of depression in primary care halved the number of new cases of depression among old people[116]. Psychological and/or educational interventions are effective in preventing depression of children and adolescents,[117] and effective

interventions have been developed to prevent intergenerational transmission of depression from parents to child.[118]

Health care staff capacity building supports prevention and recognition
Training of healthcare personnel in preventive actions and early recognition of depression and suicide risk in children and young people as well as adults, identification of sub-optimal parenting, and provision of support in families where parents have mental illness is essential.

Programmes aimed at education of primary care physicians (e.g. in Hungary[119], Northern Ireland[120], Slovenia[121] and Sweden[122,123]) have improved detection of depression and increased prescription rates of antidepressants, and even led to a decrease in suicides due to depression.

Healthcare personnel training positively influences staff attitudes and professional identity and skills in treating suicidal persons[124,114].Responsiveness of services to the needs of individuals with suicidal behaviours is an essential component of suicide prevention[125].

Health care staff can reduce alcohol-related mental health problems
There is extensive evidence for the impact of brief advice ("mini-intervention"), particularly in primary care settings, in reducing harmful alcohol consumption.

Integration of mental health care and general health care builds capacity
Integrating mental health services into general health care is the most viable way of closing the treatment gap and ensuring that people get the care they need. Primary care responsibility for mental health care should be supported by accessible referral systems and specialist supervision.[114]

Psychological support to bereaved after suicide
'Suicide post-vention' is support given to family members or others bereaved by suicide. The experiences of providing support are encouraging.[126]

Policy and stakeholder initiatives

BOX 13. Romania: Training of primary care staff
In Romania, in 2008 and 2009, the Twinning Project of the European Commission "Support for the development of community mental health services and the deinstitutionalization of persons with mental disorder" by Austria and the Netherlands has developed training materials for general practitioners, including aspects of risk assessment and of early diagnosis of depression. A multi-stage training methodology was used, which included both knowledge transfer and practice in the field. The perceived usefulness of the project was assessed by a short questionnaire and found to be successful according to participants.[127]

BOX 14. Hungary and Sweden: Education of general practitioners (GPs) decreased suicides
In the Gotland region, Sweden depressive suicides accounted for 42% of all suicides during the 2.5 years before the GP education of prevention and treatment of depression' programme. The programme was evaluated as effective and depressive suicides were reduced to 12% of all suicides during 2.5 years after the programme and to 16% over the 9.5 years following the programme.[122] In Hungary, in a region with a high suicide rate, a reduction in suicides from 60 per 100 000 persons prior to the intervention to 50 per 100 000 persons, in a 5-year intervention period was gained by educating GPs and their nurses in depression management[128].

BOX 15. The Netherland's Depression Initiative: integrated care
Trimbos Institute launched the Depression Initiative to develop an integrated collaborative care model for people with major depressive disorder in primary care and to evaluate its cost-effectiveness. The initiative is characterized by enhanced collaboration between health care professionals who are involved in the treatment of the depressed patient, for example, nurses, GPs and psychiatrists. It encompasses treatment for the patients according to their preferences and according to evidence-based guidelines, easy access to a psychiatrist for consultation, a web-based monitoring tracking system with a stepped care treatment algorithm, monitoring of treatment progress, and a relapse

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prevention plan. The monitoring task is delegated to a care manager. This is a practice nurse, a community psychiatric nurse or a social worker. Evaluation research has started to identify facilitating and inhibiting factors for the implementation of the model.[129]

BOX 16. UK: STORM -Training for risk assessment of suicide
The STORM project is a not-for-profit venture based within the University of Manchester. STORM offers skills-based training in risk assessment and management of suicide and self-injury. It is intended for frontline workers in health, social and criminal justice services. It focuses on developing, through rehearsal, the skills needed to assess and manage a person at risk of suicide. The STORM package is designed to be flexible and adaptable to the needs of a service and has been evaluated with positive results[130]
More information: http://www.medicine.manchester.ac.uk/storm/

BOX 17. Ireland: A primary care approach to the assessment and care of those in suicide crisis.
The Health Service Executive, National Office for Suicide Prevention funds two pilot SCAN (Suicide Crisis Assessment Nurse) Projects. The purpose of the SCAN projects is to provide a rapid response priority referral service to suicide crisis. The projects work directly with over 100 General Practitioners. Early results from the pilots show:
-        90% of patients are seen within the GP setting leading to reduced stigma, increased uptake and shared care
-        Psychiatric admission is significantly reduced with resulting savings
-        Only 35% of those assessed had mental health problems, 65% having addiction or social crisis.
-        Individual care need provided through mental health services, counselling and social care networks.

Box 18. Finland: Effective Family Project
The Effective Family project aims to provide health services with methods for supporting families and child development when a parent has mental health problems, a severe somatic illness or other factors that make it more difficult to cope with parenthood. The Effective Family working method is applicable in the general health services, wherever the parent is provided with health care. The Effective Family project has developed training packages and ways of embedding the method in practice, and has also carried out evaluation research on the issue.
More information: http://info.stakes.fi/toimivaperhe/EN/methods/methods.htm

Key message
Prevention of depression and suicides relies on work across sectors, i.e. on the principles of Health in All Policies.
Engage in partnerships with other policies and sectors.

The problem

Prevention requires inter-sectoral work
Depression and suicide are not only challenges to the health sector but are highly relevant for other sectors such as education, child and family policies, labour policies, and regional developing. Evidence indicates that sound public policies, such as those that address social protection, education, labour, urban planning, nutrition and transport, also improve mental health and reduce the risk of mental disorders.[131] Important life span settings in prevention of depression include early life, child care, schools, and work life.

Child and family policies are decisive
Foundations of adult mental health are laid in early life. Abusive or hostile parenting and neglect leads to adult depression and emotional unavailability of parents predicts adolescent suicide attempts.[132] Support for parenting by family policies, good quality day care for all, and flexible work life arrangements for parents, as well as programmes addressing parenting skills, contribute to prevention of depression and suicide.[133]

Education sector contributes with life skills
Social and emotional learning at schools significantly reduces later depression[134]. Girls who have been victims of bullying in elementary school later do more suicide attempts and suicides[135]. Evidence indicates that multi-faceted whole school approaches which target the mental wellbeing of staff as well as students reduces the risk for mental disorders and is an important component in mental health promotion across the lifespan[136].

Unemployment and work life adversities are risk factors for depression and suicide
Long-term unemployment doubles the risk of increased depressive symptoms[137]. Precarious and insecure work, irregular working times, conflicts at work with other persons, work overload or incapability to manage the work can have a negative impact on mental wellbeing[29]. The combination of a high level of job strain and high job insecurity may increase the risk of depression by fourteen times compared to those who have control over active, secure jobs[138]. Workplace interventions have been shown to promote mental health and wellbeing and to reduce the risk of depression[139].
Unemployment is linked also to suicides, especially among men and in cases of insufficient social protection[140]. Programmes for unemployed people, including peer support, job search training and preparation for setbacks, protect against depressive symptoms and depression[141].

Environmental planning can support mental health and prevent depression and suicide
Mental health can be compromised by living in deprived neighbourhoods with high unemployment, poor quality housing, limited access to services, poor quality environment and low social capital. Good urban planning creates a safe and inviting environment, which is especially important for children to enable safe enlargement of the zones for their socio-emotional developmental activities. Improved housing conditions can promote mental health and increase social and community participation[142]. Community mobilisation facilitates better mental health of its members[143].

What works

Mental health promotion in early age is effective
Provision of a safe and nurturing environment for every child by addressing physical and sexual abuse of children, access to good quality childcare for all, and by actions against school bullying is effective.

School programmes prevent later depression
Evaluation research supports that social emotional learning (SEL) and Skills for life (SFL) programmes enhance the social and emotional skills of children and youngsters, and significantly reduce or prevent behaviour and mental problems or disorders, such as violent, aggressive and antisocial behaviour, drug problems, anxiety and depressive symptoms and disorders.[133] These programmes are more effective if provided in the context of whole school approaches rather than stand alone classroom programmes.

Targeted actions for vulnerable groups prevent depression
Targeted policy measures for specific groups at risk for depression reduce depression. Such measures should include good social protection and access to job search and socio-emotional skills training for unemployed people. Debt management and psychosocial support should be available for all persons in high debt.

Work life measures promote mental health
Labour policies set "healthy working climate" as the target of every working place by capacity building of managers and staff.

Environmental planning prevents suicides
Safe environments contribute to suicide prevention. Prevention of suicide can be taken into account already in the planning process or after an environment (e.g. bridges, railways) has been identified as a suicide hot-spot.[144]

Policy and stakeholder initiatives

BOX 19. Spain: Strategic intersectoral approach in health plan
The second Andalusian Comprehensive Mental Health Plan (2008-2012) plan stresses the intersectoral approach to attend mental health needs of groups at risk of social exclusion. Assessment reports are regularly submitted to the Comprehensive Plan Follow-up Committee as well as yearly reports on all strategies and objectives of the mental health plan.[145]

BOX 20. Finland: Internal Security Programme
The Internal Security Programme from 2008, headed by the Ministry of the Interior, aims at making Finland Europe's safest country by 2015. The programme is truly cross-sectoral and emphasises social cohesion by measures to reduce social exclusion.
Actions encompass provision of job opportunities, organised free time activities for young people with the support of NGOs, improved access to mental health care for young people, measures to reduce abuse, harassment and web grooming by introducing presence of authorities in web-based virtual social networks, provision of safety training for all children to increase their awareness of sexual exploitation risks, and prevention of victimisation due to domestic or other violence or sexual abuse. Prevention of extended suicides, e.g. school shootings, has been given special attention in the implementation phase of the programme. The programme's impact will be evaluated through research.[146]

BOX 21. Effective parenting programmes

EU/Finland: The European Early Promotion (EEP) Project includes a method of working with families to promote the psychosocial well-being of children and to prevent the development of psychological and social problems, implemented widely across Europe. In Finland, the project has been developed into the nationwide programme VAVU for child health clinic staff to support early interaction between newborns and their parents.[147]

The Netherlands: VIPP Programme
The Video-feedback Intervention to promote Positive Parenting (VIPP) is an attachment-based intervention aimed at enhancing parental sensitivity. It has been found to be effective in different populations in a number of countries.[148] The programme is a short-term, behaviour-focused and attachment-based intervention and shown to be effective in enhancing parental sensitive discipline and decreasing toddler externalizing problems.[149]

EU: Triple P draws on social learning, cognitive-behavioural and developmental theory, as well as research into risk and protective factors associated with the development of social and behavioural problems in children. The project bases on a group behaviour management parenting programme available at four levels from preventive to very high risk in families with children 3-13 years. The programme has been evaluated and shows evidence for its effectiveness.

More information: http://www.triplep.net/

BOX 22. Examples of school-based intervention programmes

England: Adolescents and anti-stress courses
The Coping with Stress Course (CWS), targeted at adolescents at risk of mental disorders, is a group-based prevention programme to prevent major depression later in life. The program involves cognitive-restructuring techniques in which participants learn to identify and challenge negative or irrational thoughts. The intervention was effective when analysing major depressive episodes during a 14-month follow-up.[150]
More information: http://www.promisingpractices.net/program.asp?programid=151

Poland: Warsaw Educational Preventive Programme
The Polish Suicidological Society funded by Ministry of Health has prepared and implemented school based suicide prevention programmes in about 100 schools and centres. Psychologists, special teachers, psychiatrists and medical sociologists have prepared special lectures, an instructional movie and guidelines after receiving intensive training. The main aim of the programme was to clarify and define the goal, objectives, and responsibility of school system and families in suicide prevention, to provide important and useful information on suicide risk and protective factors, and to provide basic training for recognition of risk behaviour and early mental health screening. The formation of local referral practices for suicidal behaviour was important. A survey has been conducted to measure usefulness of and satisfaction with the training. Almost every responding participant found the programme positive or very positive.
More information: Polish Suicidological Society: www.ipin.edu.pl/towsuicyd

Malta: Mental health promotion is catered for in the national education curriculum and delivered by teachers trained in Personal Social Development. All school children between 11-15 years have at least 1 hour per week on personal social development whereby they are empowered to build the skills needed to be responsible citizens within society, integrate positively within their social peer groups, and cope with every day life situations and stress factors. Psychological services are also provided by the Ministry of Education for children needing such care[151].

Scotland: Mental health promotion is integrated in the national education curriculum and delivered by trained teachers has also be implemented in Scotland's "Curriculum for Excellence"[152] The Scottish Government will publish a Framework for Assessment which will provide guidance and support to ensure that arrangements for assessment, at all levels of the educational community, support of values, purposes and principles of Curriculum for Excellence will be given[152].

EU: SEYLE- Saving and Empowering Young Lives in Europe
SEYLE is a health promoting programme for adolescents in European schools, which started in January 2009 and will have a duration of three years. An intervention study is implemented to assess the effects of three different health promoting / suicide prevention programs among 11,000 students across 11 European countries with risk screening through questionnaires, gatekeeper programmes training of adult staff at school and a general health promotion program.
More information: http://www.seyle.org/

BOX 23. Finland: Time Out! Getting Life Back on Track
Time Out! Getting Life Back on Track Project aims to develop a psycho-social support programme for preventing the process of social exclusion among young men. The target group consists of men who are exempted from military service at the call-up for conscripts or who interrupt military or civilian service. The project developed a case management model for support interventions. Each young male at risk social exclusion is assigned a personal case manager from health or social services to provide signposting and guidance to available services. Evaluation shows that the support programme has an impact on young men's psycho-social well-being. Psychological distress decreases in the intervention group more than in the control group[153].The intervention is presently piloted also in schools.
More information: http://info.stakes.fi/aikalisa/EN/index.htm

BOX 24. Framework on work-related stress
The European social partners' "Framework Agreement on work-related stress" (2004) aims to increase awareness of work-related stress and to prevent stress. It sets out employers' and workers' responsibilities. The Agreement identifies a number of anti-stress measures, mainly in the fields of management and communication. The implementation of the agreement has been evaluated in 2008, and it was concluded that the European Agreement created a momentum to make progress.[154] In many countries (e.g. Denmark, Germany, Hungary) work-related stress and psychosocial problems at work has become a priority in occupational health and safety strategies.

BOX 25. England: Workplace toolkit
The charity Mentality produced "A toolkit for Mental Health Promotion in the workplace" which looks at practical steps for addressing mental health in the workplace.It outlines the policy framework, makes the case for investment, provides the evidence base and gives some examples of possible ways forward and practical steps to be taken.
More information: http://www.scmh.org.uk/index.aspx

BOX 26. Healthy Cities
The WHO Healthy Cities[155] programme engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning and innovative projects. It promotes comprehensive and systematic policy and planning with a special emphasis on health inequalities and urban poverty, the needs of vulnerable groups, participatory governance and the social, economic and environmental determinants of health. Each five-year phase focuses on a number of core priority themes and is launched with a political declaration and a set of strategic goals. The overarching goal of Phase V (2009–2013) is Health and health equity in all local policies. Phase V is supported by the Zagreb Political Declaration for Healthy Cities[156] in the European Region. The WHO Healthy Cities programme is part of an ongoing analysis and evaluation process.

Box 27. ASIST (Applied Suicide Intervention Skills Training)
The ASIST training has been developed by Living Works (Canada) and is delivered across the world. The training programme is designed to achieve an immediate reduction of self-harm and suicide. So far over 750,000 people have been trained worldwide, and there are over 3,500 ASIST trainers. In Europe, ASIST has been adopted and supported by governments in Scotland, Wales, Ireland, and Norway. The evidence and the benefits of ASIST training has been reviewed by independent partners like the National Suicide Prevention Lifeline (USA) and Choose Life Scotland[49], England (Ministry of Defence (MOD)) or Norway (Health and Social Affairs)[157].
More information: www.livingworks.net/AS.php

7. ACCESS TO HEALTHCARE

Key message

Prevention of depression and suicide is strengthened by addressing hurdles of access to health care. Access to adequate health care for depression and suicidality should be provided.

The problem

Most people with depression do not receive adequate treatment

Several population-based studies have shown that most people with psychiatric problems do not receive professional help. In Europe, only one in four individuals with a 12- month mood disorder reported formal service use in the previous year[158]. The problems in health care access for depression are linked to lack of awareness and deficient health literacy, stigma related to depression, and deficient capacity in primary care to identify and treat depression.

People with depression and/or suicide ideas have overlapping disadvantages

People with depression often have overlapping disadvantages, such as poverty and unemployment[159] and migrant status[160]. They are also more likely to face physical health problems and to die prematurely[161]. There is evidence that they do not receive the health care services that best responds to their needs.[115] General health policy measures to improve access to health care will benefit also people at risk of depression or suicide. Existing health services is an efficient delivery channel for prevention.

Poverty, social exclusion and inequalities in access to health care continue to be serious challenges across the European Union and for health systems in Member States[162]. The number of people affected by poverty and social exclusion across the Union has continued to grow in many Member States. In 2007 the average at-risk-of-poverty rate in the EU was 17%. Poverty and material deprivation are often compounded by inadequate access to healthcare, in particular for a range of marginalized groups such as migrants, minorities and unemployed people. Health care cost-sharing requirements are of particular concern in countries with a relatively high formal co-payment, widespread use of private health services or common use of informal "under the table" payment.

Barriers of access are linked to stigma and taboo of depression and suicide

Depression and suicide are connected to stigma, which is a widespread and well-documented major access barrier in the mental health field[163]. Evidence suggests that stigma lessens the responsiveness of the health services, and that the fear of being labelled as having a mental health problem may cause individuals to delay or avoid seeking treatment altogether if people with depression are not treated respectfully and with dignity in health care services.

Successful prevention and treatment of depression are important components in suicide prevention

People who survive intentional self-harm or suicide attempt have a considerable and long-lasting risk of further suicidal behaviour.[164] and of dying by suicide[165,166,167,168]. Easy and quick access to treatment facilities for persons in aftercare may prevent further suicide attempts.

People at risk of suicide have problems locating professional help

The most common barriers of access to services reported by suicidal people were problems in navigating in the health services, unavailability of professional help and a preference to manage the problem self.[125] The finding underlines the need to establish low threshold services to prevent suicides.

What works

Mainstreaming mental health into primary care

A health policy supporting integration of health and social services and mainstreaming of mental health services into primary care improves access. Providing even minimal psychotherapy in primary care can prevent full-blown depression[169].

Community based services
Access of care is related to mental health care structure. Community-based, well-developed and multi-faceted mental health services have been linked with lower suicide rates than hospital-based traditional services[170].

Novel ways of delivering health services
Access to preventive interventions can be improved by telephone and e-health solutions.[171]

Targeting survivors of suicide attempt
Readily available and continued psychological and medical care for persons after non-fatal suicide attempts prevents further suicides[172,173].

Targeted actions to improve access for vulnerable groups
Actions to prevent depression among vulnerable groups (e.g. Roma, unemployed, young men) reduce new cases of depression

Policy and stakeholder initiatives

BOX 28. Finland: Occupational health care for unemployed people
A project started in 2007 started to establish free and accessible occupational health care at local job centres aiming to mitigate the negative health effects of unemployment and promote re-employment. This project is ongoing and the aim is improved health care access for unemployed people. The project is funded and supported by the Finnish Ministry of Social Affairs and Health and is evaluated by the National Institute for Health and Welfare (THL).[174] [175]

BOX 29. Scotland: "Keep Well" Pilot Project
The Scottish government opting for a "healthier Scotland" and NHS Scotland initiated the "Keep Well" project aiming to improve access to health promotion. "Keep well" is a free health check for people aged 45-64 living in deprived areas. Questions about lifestyle are asked and people get follow-up advice or treatment. There is a range of support available like interpreter services if English is not your first language, and there may be support if you are deaf or hard of hearing. The Keep Well pilots will be evaluated by University of Glasgow and Edinburgh University.
More information: www.keepwellscotland.com

BOX 30. Sweden: Act Lex Maria
Mandatory reporting of any suicide occurring within or associated with the health care system to the National Board of Health and Welfare became valid 2006. The act requires that all suicides within or associated with health services, must be followed by a comprehensive, documented internal investigation with factors identifying future preventive strategies. Documentations of future strategies and precipitating events in a separate database allows for a systematic and national analysis of suicide[176].

BOX 31. Germany: Mental health counselling
In Germany, mental health counselling by psychologists affiliated to the social health insurance scheme does not require a prescription but may be accessed directly. Clients see a physician for a somatic check-up after the sessions. This regulation was introduced in1999 to avoid excess somatic-orientation leading physicians to under-recognise mental disorders and under -provide mental health services. [177]

Key message
The web and media offer opportunities for effective prevention of depression and suicides, but may also increase stigma of depression and provoke suicides in vulnerable individuals.
Provide reliable and trustworthy information; make use of new media and eHealth.

The problem

Media contributes to stigma of depression
Most people are not aware about the risk and protective factors of depression. Less than 40% of the general population correctly identifies a depression[178]. Attitudes which hinder help seeking are common.[179] Much of the mental health information provided by popular media is misleading. As a consequence of distorted media presentation people with depression are not understood and subject to stigma and discrimination.[180]

Sensationalised or idealising coverage of suicides provokes further suicides
There is significant evidence from around the world to indicate that highly sensationalised reporting of suicides, providing detailed descriptions of method can and does lead to 'copy-cat' suicides.[181] On the other hand, responsible reporting on suicides reduces copycat suicide[182,183], especially among adolescents[184].

Quality of web-based information on depression is poor
Web-based information on depression is of varying character and the general quality is poor[185]. For-profit websites contains poorer information on depression than not-for-profit websites[186].

Internet sites and peers may provoke suicide attempts
There are social networking sites and chat rooms where suicide is glamorised and detailed instructions and techniques for suicide might be given. Contributors to chat rooms may exert peer pressure to commit suicide, idolise those who have completed suicide, and facilitate suicide pacts[187]. This is particularly dangerous for young people.

Lack of access to effective web-based prevention
Effective web-based prevention and mental health promotion is possible, but often not available. Implementation efforts need to be stepped up to use the full potential of e-mental health in promoting mental health and preventing depression, taking into consideration that there are still different levels of internet access in EU[188]. From the view of prevention of depression and suicide, it is cumbersome that the groups most excluded from Internet access are the elderly, the unemployed and those with a low level of education, i.e. vulnerable groups at risk of depression and suicide. Alternative novel ways of delivering free prevention interventions, based on e.g. mobile phones, are needed.

What works

Co-operation with media
Liaising with media supports their important role in educating the public about depression and responsible coverage of suicide. Media guidelines for reporting suicides and monitoring of stigmatising media reports have been linked with reduced stigmatisation in press and reduction of suicides.[182,184] Such reporting guidelines can be based on recommendations by the WHO[189].

E-health solutions for promotion and prevention
Internet improves access to preventive services, such as web-based depression prevention courses, and may encourage health service uptake by those who fear stigma or have difficulties travelling to and from health services.[171]

Web-based communities can support mental well-being
Supportive depression communities on the web offer peer support for people at risk of depression. In related health areas, it has been evidenced that web-based peer support improves feelings of well-

being and cut costs by minimizing visits to physicians[190]. Increased adult and health professional presence on the web will support provision of balanced and correct information and may restrict peer misbehaviour. Information offered by easily accessible sites can also assist in getting the first step towards help.[187]

Policy and stakeholder initiatives

BOX 32. The Netherlands: Developing e-mental health

The Innovation Centre of Mental Health & Technology (I.COM) at the Trimbos Institute aims to promote the use of e-mental health to improve the quality and accessibility of mental health care. The I.COM programme 'Mentaal Vitaal' includes 13 projects and 6 web-based interventions, aiming to ensure that the least possible number of people suffer from depression. The Trimbos Institute conducts research for strengthening the evidence base of e-mental health intervention by conduction randomised trials and meta-analysis; conducting economic evaluations of the interventions to inform health planners about cost- effectiveness of the interventions and developing bench marks for quality assurance in e-health (norms, standards, protocols), with the aim to support the delivery of effective, safe and affordable e-health interventions.
More information: www.icom.trimbos.nl

BOX 33. Scotland: Anti-stigma Campaign
'see me', launched in 2002, is Scotland's national campaign to end the stigma and discrimination of people with mental ill-health funded by the Scottish Government. Working with the media is one of 'see me's key activities. The approach is to work in partnership with the media and create a relationship that aims to educate and inform journalists. This is happening by challenging poor/negative reporting and responding to articles, praising positive reporting, monitoring media and providing support and briefings to journalists. Activities of 'see me' are constantly evaluated.
More information: www.seemescotland.org.uk/
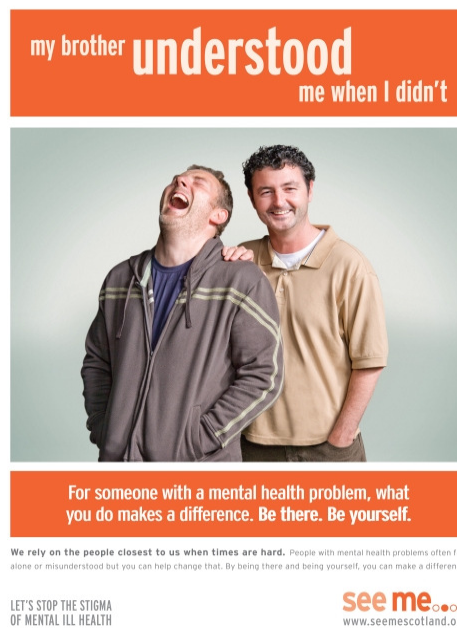
BOX 34. Greece: Media anti-stigma programme
In Greece the national anti-stigma programme informs and co-operates with the media and co-ordinates a network of volunteer "stigma busters". The programme includes a number of preparatory actions relevant to the stigma issue, including: General population survey on prevalence of mental disorders; Informative Guide of Mental Health Psychosocial Rehabilitation and Support Services in Greece; Preliminary studies on knowledge and attitudes of general public and special groups about and mental illness; Publication of educational material for patients and their families and an HORIZON Program focused on stigma experienced by families and patients.[191] A study indicates that in Greece stigmatisation in the press has been reduced[192].

BOX 35. Germany: Increasing mental health awareness by movie festivals
The German organisation "irrsinnig menschlich e.V" (insanely human) and EYZ MediaGbr inititated a movie festival (2008-2009) for young people and adults called: Ausnahme/Zustand - Verrueckt nach Leben (state of emergency- crazy for life). The main aim was to raise awareness and to break down stigma around mental disorders and to focus on mental wellbeing in children and young people. The idea was also to involve local stakeholders (e.g. schools) in different German cities. After each movie session, open discussions took place, information was disseminated and help-forums were offered. During the festival some cities had also "open days" in psychiatric hospitals or mental health awareness days. The evaluation of a similar project in 2006 has been carried out[193].
More information: www.ausnahmezustand-filmfest.de/

BOX 36. EU: SUPREME: Internet and Media-based Suicide Prevention
The National Swedish Prevention of Suicide and Mental Ill-Health (NASP) leads the project SUPREME, which is a mental health promotion programme. SUPREME comprises a multi-language, culturally adapted, highly interactive website accessible to the general public that is particularly aimed at adolescents. The programme is to enhance and improve the mental health and well-being of European adolescents. The project will start in 2010 and will have a duration of three years. Associated partners are based in Italy, England, Spain, Lithuania, Estonia and Hungary. The project is co-funded by DG SANCO.

BOX 37. Austria and Germany: Media guidelines
In Austria, media guidelines on reporting suicide have been offered since 1987 with a subsequent reduction of suicides. Guidelines state that probability of an imitation effect will increase when an article on suicide act contains sensational headlines and is romanticised, contains details of the person who completed suicide, of the suicide method and site, and/or simplifications for reasons leading to suicide. According to the guidelines probability of imitation is lower when examples of individuals who overcome psycho-social crisis are provided, alternatives for suicide are stated clearly, contact points for suicidal persons are given and warning signs listed.[182]
The implementation of the guidelines resulted in an improvement of the quality of reporting, and was associated with a decrease of national suicide rates, which was most pronounced in regions with strong media collaboration.[183] Since 2008, the media guidelines have also been offered by the World Health Organization, in a joint project with the International Association for Suicide Prevention (IASP).[194]
More information: www.suizidforschung.at

In Germany, a guideline document: "Take Care – Be Aware" for media when reporting on suicide were developed by Competence Network Depression (see Box 43) and an interdisciplinary group of journalists, psychiatrists and communication scientists in 2000.
More information: http://www.deutsche-depressionshilfe.de/stiftung/media/medienguide.pdf

BOX 38. Ireland: Mental health campaigns
The campaign Your Mental Health was set up to promote positive mental health amongst the Irish population. A page was launched on the Bebo social networking site and a TV advertisement highlighting the importance of looking after your mental health. A booklet for general distribution has also been prepared. A study of mental health and wellbeing was also undertaken to provide a baseline to evaluate the effectiveness of the campaign. More information: www.yourmentalhealth.ie
A targeted young people's mental health campaign comprising a TV/Cinema advertisement, Bebo social networking page and outdoor advertising was launched in October 2009. Information on the launch is available on www.epractice.eu

BOX 39. UK: Depression Awareness Campaign
The Defeat Depression Campaign from 1992 to 1996 aimed to educate the public about depression and its treatment, to encourage earlier treatment-seeking and to reduce the stigma of depression. It included use of radio, television and print media. National surveys carried out at the beginning, middle

and end of the campaign showed small but significant changes in the percentage of the public who believe that antidepressants are effective and who would be willing to seek professional help.
It is impossible to say whether these changes were solely due to the campaign, but the results are certainly encouraging.[195]

BOX 40. Scotland: Suicide awareness campaign: "Suicide. Don't Hide it. Talk about it"
To promote greater public awareness of suicide and how it can be prevented Choose Life encourage people who may be feeling suicidal to talk to someone they trust or phone a helpline. A suite of awareness campaign materials have been developed that will assist in communicating these objective e.g. on the yearly running suicide prevention weeks. Following the launch of the materials in 2008, research was carried out to evaluate the overall awareness and source of awareness of the campaign, the impact/effectiveness of the messages and the relative appeal/acceptability of the creative approach.
The campaign was successful in reaching the public, as research indicates that 58% of respondents remembered some form of communication through poster advertising, radio or press coverage[196].
More information: www.chooselife.net/Campaign/SuicideDonthideitTalkaboutit.asp

Key message
Mental health information systems and research need to be brought to the level of information and research in physical health to support policy on depression and suicide prevention

The problem

Mental health information systems are weak
In spite of depression being a key public health challenge in EU, most current regional, national and international health information systems are weaker in the field of mental health than in physical health[197]. Population data on mental well-being is in most countries not available, notable exceptions are Hungary, Ireland, and Scotland.

Valid population data on trends in depression and suicide attempts are lacking in Europe. Monitoring of suicide and suicide attempt methods and surveillance of suicide hot spots is not done routinely. Beyond this information on risk groups, such as migrants are lacking.

As a consequence, comparable mental health information is not available and policy makers lack the knowledge base for decision making and preventive action. Thus the integration of depression and wider mental health issues into health policy development is delayed. Even today the role of mental health is lacking in such core health policy concepts as healthy life years.

Evidence on effectiveness of preventive interventions is not well known
Effective measures for prevention of depression[198] and suicide[20] exist. Research indicates that prevention of suicides is highly cost-effective[17,18] and emerging research indicates that targeted prevention of depression can be cost-effective[169,199]. Yet preventive public health programmes to reduce incidence of depression are not widely used[200].

Prevention research is underfunded
Prevention research is often not resourced according to population needs. Prevention actions build on sound knowledge of risk and protective factors. Intervention research is needed to establish effectiveness and cost-effectiveness of prevention.

Mental health systems research
Health system level research is needed to optimise prevention and management of depression and suicide. Yet much of research efforts go into individual level studies, meaning that important system level determinants and intervention possibilities may remain undetected.

Lack of user involvement in research
The involvement of both mental health service users and potential users is critical to ensure that research reflects the appropriateness to those who have contact with services.

Political background
The European Parliament has called on the Member States, in cooperation with the Commission and Eurostat, to improve knowledge about mental health and about the relationship between mental health and the years of healthy life, through establishing mechanisms for the exchange and dissemination of information in a clear, easily accessible and comprehensible manner.[201]

What works

For health policy and planning to be based on evidence support from research and health surveillance is needed. Therefore policy needs timely population based data on epidemiology, risk factors, health services use and resources spent. Further interventions to be endorsed by policy need to be based on evidence for their effectiveness and their efficiency. Knowledge for this purpose is gathered in the following sectors:

Improving health information systems
Inclusion of mental health as a prominent component in health surveys, health and social indicator systems, as well as health and health system statistics in a transparent and understandable manner will support increased awareness on the magnitude and consequences of depression and suicide.

This can be as well achieved through structural indicators as through regularly assessed process parameters, such as through well-being and mental health scores. Structural indicators have been devised to compare and assess trends in EU and Member States and to support the "Lisbon agenda". The existence of structural indicator supports the development of any policy field. Development of a structural mental health indicator or strengthening the mental health contribution to the 'healthy life years' indicator would contribute to strengthening the political importance of mental health.

Investment in research pays off
Research on the aetiology and determinants of depression and effective prevention of depression and suicide has resulted in hugely improved opportunities for preventive actions. To support the implementation of preventive actions health systems research and cost-effectiveness studies are needed. As part of strategy development there needs to be agreed investment in national research and an understanding that such research will link into the international research community.

Synthesising evidence for policy makers
Translation of research findings into practice by evidence-based policy briefs and practice guidelines on prevention of depression and suicide, developed on the basis of systematic reviews of best available evidence, will increase awareness and understanding and foster effective policy measures. Strong links are required between research, policy and implementation.

Policy and stakeholder initiatives

BOX 41. EU: Depression and suicide information projects funded by EC Programmes

The EPREMeD Project
The EPREMED (European Policy information research for mental disorder 2005- 2008) was conducted following a complex population- based home interview survey which contained detailed data on prevalence, risk factors, burden, and service use of individuals with mental disorders in six European countries: Belgium, France, Germany, Italy, the Netherlands and Spain. The aim of EPREMED was to qualitatively and quantitatively improve the mental health policy information in Europe through a better understanding of mental health burden, determinants, and service needs.
More information: www.empremed.org

The MINDFUL Project
The MINDFUL project (see www.stakes.fi/mindful) aimed at improving population mental health monitoring in the EU by defining a common set of mental health indicators, analysing availability, evaluating and preparing of a common European database. It aimed at improving the status of mental health information by widening the scope of the mental health monitoring systems to cover not only mental disorders and mental health systems, but also positive mental health and determinants of mental health, which had been previously rather neglected. The MINDFUL project recommended a final set of 35 mental health indicators.
More information: www.stakes.fi/mindful

The MONSUE Project
MONSUE is a European multicentre study on suicidal behaviour and suicide prevention carried out within 15 EU countries and 8 countries within the European region of WHO. The objective of the research project is to delineate suicide trends and suicide risk groups as well as protective factors and effects of preventive measures. The Monsue project is ongoing monitored and evaluated.
More information: www.selvmordsforskning.dk/Web/English/Menu2/Research/MONSUE

The OSPI - Europe Project
OSPI-Europe is a collaborative research project funded by the European Commission under the Seventh Framework Programme. The goal of OSPI-Europe is to provide EU members with an evidence based prevention concept for suicidality. Further, concrete materials and instruments for running and evaluating these interventions and recommendations will be developed and disseminated for the proper implementation of the interventions.
More information: www.ospi-europe.com

BOX 42. Scotland: Systematic review on effectiveness of suicide prevention
The Scottish Government commissioned a systematic review[201] on effective suicide prevention in 2005, to guide decision-making. One goal of the review was evaluate the evidence available to inform the prevention of suicide in Scotland. The review covered quantitative as well as qualitative evidence.

BOX 43. Germany: Kompetenznetz Depression - Suizidalität - German Research Network on Depression and Suicidality
The German Research Network on Depression and Suicidality is one of currently 21 health competence networks funded by the German Federal Ministry for Education and Research. In order to address the multiple deficits with regard to diagnosis, treatment and research in the field of depressive disorders the competence network connects 15 German research centres and university hospitals as well as relevant institutions. It aims to improve research, research knowledge between research facilities and the improvement of care provision of depression and suicide. It provides help and advice for patients and their families. General information is given to the public and more specific information for experts. A web forum is available for discussions. The health competence networks have been found to be successful and effective and have received further funding from the German Federal Ministry of Education and Research.
More information: www.kompetenznetz-depression.de

Box 44. Ireland: National Suicide Research Foundation (NSRF).
The NSRF is an independent research body funded through the Health Service Executive National Office for Suicide Prevention (NOSP). The NSRF runs the national registry of self harm and undertakes commissioned work on behalf of the NOSP. The NSRF and NOSP are closely linked to ensure the transmission of research into policy and practice.
More information: www.nsrf.ie

BOX 45. England: Evidence-based practice guideline for depression
The National Institute for Clinical Excellence (NICE) guideline has published guidelines on depression, which make recommendations on the identification, treatment and management of depression[202]. Nice guidelines are a good example for the translation of research findings into practice by evidence-based policy briefs. The impact of NICE guidelines are evaluated and the ERNIE Database is a source of information on implementation and uptake of NICE guidance.
More information:
http://www.nice.org.uk/usingguidance/evaluationandreviewofniceimplementationevidenceernie/evaluation_and_review_of_nice_implementation_evidence_ernie.jsp

10. CONCLUSIONS

Action against depression is necessary, possible and pays off. Evidence-based, cost-effective actions are available.

Suicides can be prevented by diversified actions within and outside of health care. Evidence of cost-effectiveness is emerging. Suicide prevention is especially needed in the present times of rapid economic change.

Prevention of depression and suicide contributes to improving the health of populations and tackling health inequalities in Europe.

A successful fight against depression and suicide requires continued investment in mental health research and monitoring, willingness to work across sectors, and readiness to address determinants, such as child abuse and bullying, gender and health inequalities, high debts, work life problems and poor social protection. Effective instruments in the fight are responsive primary health care services, collaborative media, a health promoting educational system and healthy work places.

Above all the effective prevention of depression and suicide requires political commitment and its translation into sound strategic action frameworks.

Annex 1 – A template of action for the prevention of suicide (by Prof. Armin Schmidtke)

Thematic area	Intervention field	EU Interventions	Member states and stakeholder interventions	Examples of implementation /**good practice**	Implementation steps
Policy frame-work	Suicide policy	Recommendations for aspects/ingredients of a national suicide policy	National suicide policies	Programmes in Finland Sweden Norway German proposal Study on effectiveness of NPs: Felber (Dresden)	Mandates of National policy bodies (Parliaments, Governments, relevant NGOs)
Non health actors and agencies	- regional policies	- Norms for barriers/fences/kind and heights of barriers/fences on bridges/railings, safe railroads etc. Norms for building new psychiatric hospitals (distance from hot-spots) or Regulations for security measures for and in "old" hospitals	Identification of the main (national and local) suicide method(s) -Reducing the access to these methods Identification of suicide hot-spots - building "safe" bridges, houses, "safe" hospitals (general, psychiatric hospitals and homes for elderly,) railroads Regulations for safety in (psychiatric) clinics (windows, bath rooms, hooks, ropes, access to electricity; etc.)	Studies in UK (coal gas) Studies on hot-spots in Germany, New Zealand etc. Study on bridges in Switzerland (Swiss recommendations) Study on "railway suicide hot spots" in Germany	Recommendations for the relevant national bodies (e. g. Association of drug companies, associations of pharmacists, associations of architects, relevant institutions for construction and building of hospitals

	- consumer policies - Good Practice Examples	- Control norms for lethal means such as pesticides, gas, prescription of package size(s) of medications, repetition of prescription(s), introduction of necessity of prescription(s) of OTC medication over a certain amount Norms for car exhausts (automatic stop switches after a certain period of time of running of the engine without mowing/driving)	Development of regulations e. g. Kind of prescription (possibility of repetition(s) of prescriptions) Kind of package sizes, amount of medication Regulation for the access to lethal means		

Media/Internet	- Information and communication systems	-Implementing recommendations/(norms of "safe" reporting of suicidal behaviour in mass media, - Information and recommendations to film makers (film schools) Improvement of cooperation of poison information centres in EU (recommendation of monitoring trends in methods of suicide and suicide attempts, especially open accessible means, OTC pharmaceuticals, plants) Information about suicide in special groups at risk -Immigrants/persons with migration background -unemployed people/threatening unemployment -homelessness/persons with threatening homelessnesss -prisoners (at least on a micro-census level) Information -for associations for immigrants or people with migration background Information for web-site providers in the Internet (Webmaster(s) and providers)	UK (Samaritans) Canada Germany Example: new regulations for managers in France Examples in Germany	Recommendations for associations of press people/TV people Recommendations for the association of film makers Recommendations to employers' associations and trade unions
Health care	Health systems	Improvement of continuity of care provision, Green Card models Social funds	Nuremberg Model, European Alliance Against Depression (EAAD), Green Card Models	Implementation in the education of doctors, nurses, personal of homes for elderly

Knowledge base	Surveillance/Monitoring of: Prevalence Service use Self perceived health Self perceived socio-economic status	- Eurostat Health Interview survey	National Health and Social Reporting		
Non health actors and agencies	- Education system	Good practice examples Exchange/Guidelines/good practice how to react after suicide in schools to prohibit imitation effect	- Increasing awareness in Schools, training teachers in dealing with suicidality - Implementing support systems in schools and communities - Education of first line help providers in suicidal de-escalation techniques Paramedics Police forces Firemen	SEYLE US and Canadian school studies Crisis teams in Germany	Recommendations to institutions in the education system
Non health actors and agencies	- Labour market	- Open method of coordination in social policies	- Implementing (mental) health promoting measures at work place - reintegrating mentally ill persons into work life		
	-Social protection - Workplace interventions on Depression (measuring health, identifying risk settings, training managers) - FA Stress, FA Violence and Harassment	- Restructuring Forum - MH Pact Thematic Conference			

• Non health actors and agencies interdisciplinary	"Care" and "support" providing systems (health, social support, residential care, municipalities)	- EU- social funds, - Research - Joint actions	- Training of GPs in depression care - Improving depression care for elderly (see also framework depression) - measures to prevent loneliness - training of psychiatrists to address physical comorbidity(ies) - Measures to improve autonomy - adequate treatment of pain disorders - Improving access to social activities		
Risk factors and health determinants	Social protection, bank policies, Correction policies	EU-alcohol policy Good practice examples	- Debt-counselling, - debt relief, -Campaigns/ information of high risk groups how to avoid over-indebtedness. - local alcohol prevention policies - exempting the poor from co-payments for treatment - suicide screening in prisons and other settings with increased suicide risk		
Knowledge base	- Health services and health system research - health reporting	- EU 7th Research Framework - Eurostat Continuing collecting suicide attempt data (in representative catchment areas)	- National research funds, - Ministry financed research - independent research foundations - industry		

ANNEX 2 - Comparison between EU-Member States: Prevention of depression and suicide

The level of information regarding prevention of depression and suicide in EU Member States is unsatisfactory. Data on mental-health related mortality (e.g. suicides) and hospital-based register data are available to a reasonable extent. Comparative European data on community mental health services, promotion and prevention in mental health, and mental health expenditure is virtually non-existing, and even more so regarding depression-specific information.

Some existing European surveys include questions with relevance for depression. Such surveys are the Health Behaviour of School Children Survey (HBSC), the EU Survey of Income and Living Conditions (SILC), the EU Labour Force Survey (LFS), the European Survey on Working Conditions (ESWC) and the Survey of Health, Ageing and Retirement (SHARE).

Depression

The SILC contributes with information on determinants of depression, such as poverty, indebtedness and income (Chart 1).

Chart 1: At-risk-of poverty rate and At-risk-of-poverty threshold in the EU (%), 2007
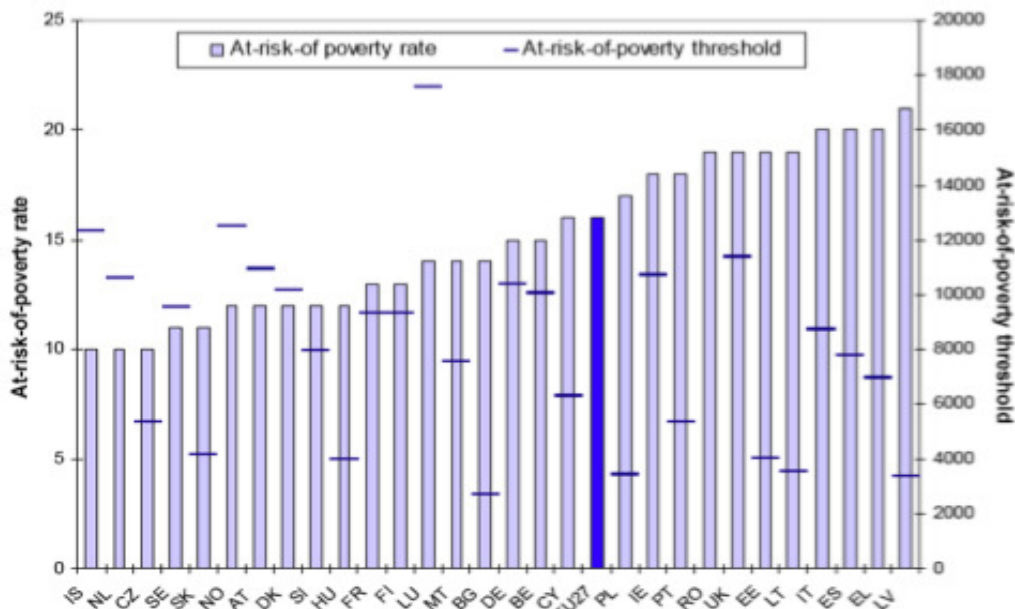
Source: SILC 2007 for all countries except Bulgaria and Romania (National household budget surveys)

SHARE contributes with data on depression prevalence among old people in selected EU countries.

Chart 2: Prevalence of depression in later life, by country and gender. Data from SHARE waves 1 and 2 (2004-2007).
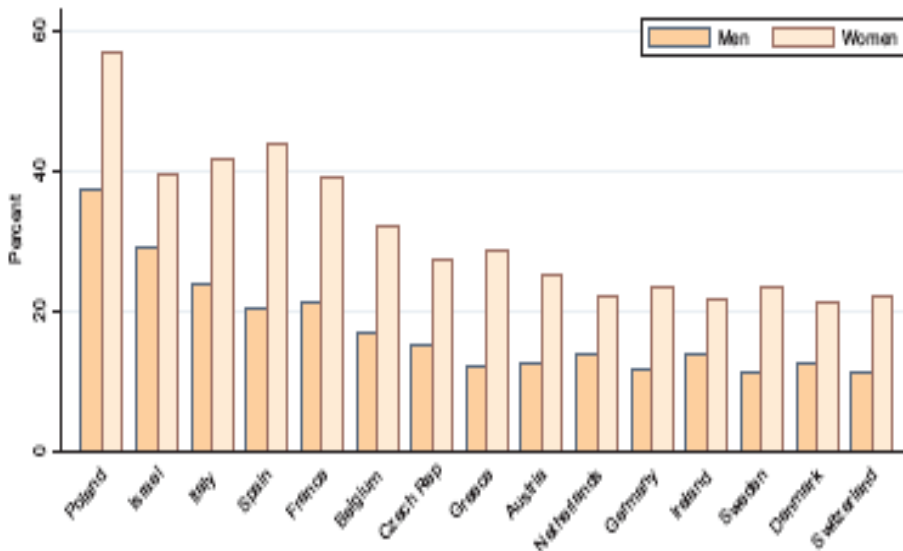
Countries: Poland, Israel, Italy. Spain, France, Belgium, Czech Republic, Greece, Austria, Netherlands, Germany, Ireland, Sweden, Denmark and Switzerland.

Source: Share Project: SHARE waves 1 and 2 (2004-2007).[203]

The Eurobarometer is an EU-wide opinion poll based on phone interviews. In 2003, the mental health of EU citizens was surveyed in the Eurobarometer, using the Mental Health Inventory 5 (MHI-5) for determining caseness. MHI-5 cases have a high probability of major depression or some other common mental disorder.

Chart 3:

Occurrence of MHI-5* cases (score 52 or less) by sex and country (%)
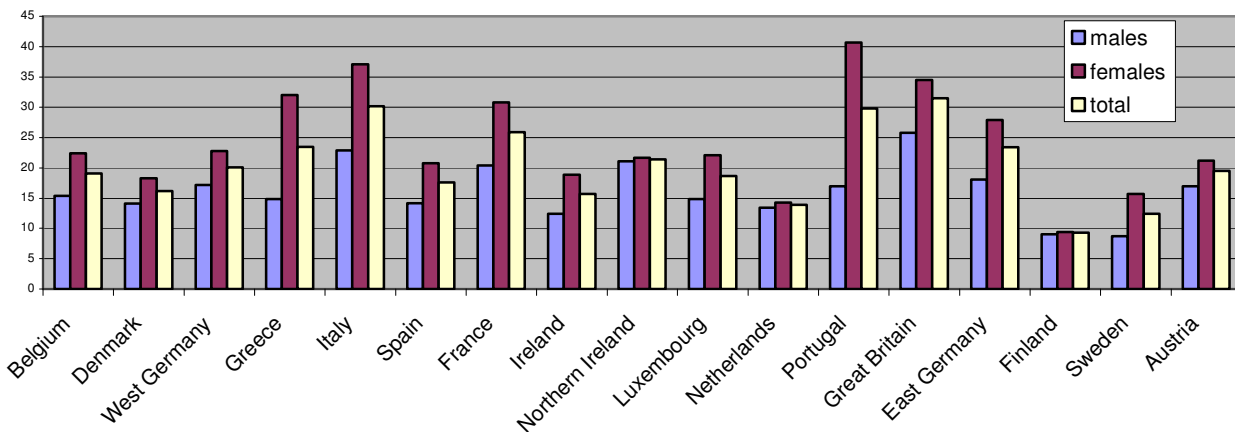
* MHI-5: The Mental Health Inventory (MHI-5) is a widely used instrument to measure quality of life [204] and general mental health using a short screening questionnaire.
Source: Eurobarometer 58.2. The mental health status of the European population. [205]

Suicide
Information of suicide prevention programmes in EU Member States have been collected by NASP (National Prevention of Suicide and Mental Ill-Health at Karolinska Institutet,Stockholm) in 2009.[206]

EU Member States with national programme for suicide prevention (11/27 Member States)

Austria, United Kingdom, Bulgaria, Sweden, France, Denmark, Finland, Germany, Netherlands, Ireland, Lithuania

Approved by parliament (3/27)

Lithuania, Netherlands, Sweden

EU Member States without national programme for suicide prevention WHO European Region (15/27 Member States)

Belgium, Cyprus, Czech Republic, Estonia, Greece, Hungary, Italy, Latvia, Luxemburg, Malta, Poland, Portugal, Romania, Slovakia, Slovenia

EU Member States without national programme but with local or regional suicide preventive programmes

Belgium, Hungary, Italy, Latvia, Poland, Portugal, Spain

Trend analysis

Suicide in EU-27 countries. Trend analysis of rates (number of suicide per 100 000 inhabitants), assuming linear trend

Countries	Data	All	
	available year	Suicide rate in first year	linear slope β - means decrease + means increase
Austria	1999-2007	34,9	-0,74
Belgium	1997-1999	37,7	-1,83
Bulgaria	1998-2002	32,1	-0,51
Cyprus	2004, 06	1,5	+1,09
Czech Republic	1997-2007	33	-0,33
Denmark	1997-2006	25,7	-0,52
Estonia	1997-2005	86,3	-2,55
Finland	1997-2007	51,1	-0,84
France	1997-2006	34,3	-0,18
Germany	1998-2006	25,5	-0,36
Greece	1998-1999	7	-0,25
Hungary	1997-2005	61,7	-1,14
Ireland	2007	21,5	
Italy	1997-2000,03,06	14,5	-0,23
Latvia	1997-2007	80,7	-2,16
Lithuania	1998-2007	103,8	-2,47
Luxembourg	1997-2005	36,5	-0,88
Malta	1997-2007	8	+0,11
Netherlands	1997-2007	16,5	-0,12
Poland	1999-2006	33,3	-0,03
Portugal	1998-2000, 02-03	10,1	+1,57
Romania	1999-2007	26,2	-0,22
Slovakia	1997-2005	27,5	-0,03
Slovenia	1997-2007	61,5	-1,16
Spain	1997-2005	15,3	-0,10
Sweden	1997-2006	23,6	-0,12
UK	1998-1999,01-07	14,5	-0,13

Source: European Detailed Mortality Database. Processed by NASP (National prevention of suicide and mental ill-health at Karolinska Institutet) Sept 2009

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Council's Centre for Suicide Research and Prevention of Mental Ill-Health. Information available at:

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