Community Suicide Prevention

“How to ease the pain and prevent suicide at the local level”

Its name is EXCLUSION: Ours, INCLUSION
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Foreword

In the “Safe Community” movement there has been an increasing urge to not only work to prevent accidents and violence but last decade also suicide attempts.

The initial contributors of this book on the community approach of preventing suicide were mostly physicians of different backgrounds working in public health/social medicine. However, as the book matured, professionals from other disciplines or just people interested in suicide prevention joined. This helped us a lot since the book was never intended specifically for medical doctors or health professionals. Rather, this has been and will remain an attempt to share with others the “Safe Communities” approach as complementary to other views on suicide prevention, and the prevention of other forms of violence and injury. The positive aspect of this paradigm is that it seeks to promote inclusion in social life i.e. a shared social life of mutual respect, inclusion, and harmony in the midst of diversity that honours human rights and exalts kindness over brutality and exclusion.

We also contacted some Safe Community and Suicide prevention program managers around the world to give us their concrete experiences. They are responsible only for their own chapters. We as editors are responsible for all other chapters and conclusions. However Jan Beskow has as editor above answering to one separate chapter also scrutinized all chapters from his view of being a world-wide known and experienced suicidologist. As you can see the three editors are presented here but the rest of the authors are introduced by their own contributions.

Bogota, Colombia and Stockholm and Gothenburg, Sweden
March 2010

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Introduction

Suicide implies a great deal of suffering, for survivors and for persons who think about taking their lives. This is also present during the process leading to suicide that is suicidal thoughts, attempts and completed suicide. In 1,600 years it has been forbidden to talk about suicide leading to underdevelopment of knowledge and a scanty language. The issue of suicide therefore evokes a lot of affections.

As it happens with other topics, it also stirs controversy, sometimes polarization, between schools of thought and disciplines. For example, there are those who hail Emile Durkheim (Photo Intr 1), the founder of Sociology, as the most classical of suicidologists, and those who disregard his contributions on grounds of what they interpret as “his baseless dismissal of mental illness as a key determinant of suicidal behaviour” (Durkheim 1897, Robertson 2006).

It is not unknown for doctors, psychiatrists, psychologists, and educationalists to miss and dismiss important information just because it comes from the social sciences, as much as it is for social scientists to question what they call a disease model of individualistic approaches and positivistic science associated with medicine and psychology. Mutual rejection makes meaningful dialog impossible.

The beneficiaries of interventions should be communities, as much as individuals

Power struggles between disciplines can make us forget who should be the beneficiary of our interventions. In the Safe Communities Movement we believe that the beneficiaries should not only be individuals but communities, and that there are no better authorities than the communities themselves. And we are also convinced that usually there is no one is more willing to help with the healing processes than those near the victims. “Ordinary” citizens and community members, be they social
workers, priests, teachers, rescue workers, the police, local leaders, parents and family, friends, or conditional experts, have a lot to say about suicide and suicide victims as they are the ones closest to a shared painful reality and more in contact with actual communities and individuals. Regardless of theoretical constructs we have much to learn from them, mostly because they are perceived by most members of communities as being their equals, and not as someone whose behaviour is highly determined by professional structures.

In general all professionals and health professionals, in particular, usually approach others by telling them what to do, i.e. moving from a relationship of sharing and teaching (which conforms to the etymology of the Latin word *doctor*, meaning teacher) to sometimes one of overbearing. This does not necessarily define health or other professions; it just speaks of an accepted conformity, a result of which professionals of different disciplines end up excluding (excluding others and excluding themselves). Those that should be accompanied and consoled are instead patronized, ignored or just not helped. To regard a person as a victim increases passivity. To regard her as an actor increases her capacity to solve difficult problems.

Traditional critics of medicine that extend from Durkheim himself at the beginning of the 20th century to Ivan Illich, Thomas Mc Keown and René Dubos (Photo Intr 2), among others, have pointed out how medicine could not claim the merit of our improved health. Instead, it might be as much a source of problems which once created is extremely difficult to overcome. That is, medicine and health services may suffocate or demean community initiatives and the powerful gluing influence of solidarity. As a result people are weakened instead of strengthened. Eventually a critic of the critics, Vicente Navarro would assert that the problems of medicine are much deeper and structural, and are a result of overriding political and economical structures (Navarro V. 1976).

Among the great critics of the medical establishment, only Dubos talks about communities! Usually critics don’t see how changes close to people have any bearing on these phenomena. These supporters of structuralism have difficulties understanding
that a social structure is not something isolated on top of people and community. Rather, it comprises people and community. Thus, changes in community/people’s action will also influence overriding social structures.

**Different approaches should not mean antagonism**

When confronted with different approaches in our book we aim to benefit from what is useful and practical from any approach. This derives partly from a posture of healthy eclecticism, and partly because in suicide prevention we have learnt not to take sides. Similarly, in medicine we do not privilege the need to have a precise diagnosis over the treatment of symptoms, or vise-versa. Sometimes severe symptoms demand immediate action and this is as much good medicine as making a precise differential diagnosis. No one could say that treating fever or shock is not an integral part of the treatment, or decide what is more important to do in an epidemic by an infectious agent: treating individuals or looking for the origin or a common source epidemic. Therefore, in suicide prevention work we propose not only treating individuals with the best resources available, but also treating society, which includes prevention and health promotion based in communities, not imposed on communities. Within our “all inclusive” approach all forms of prevention (primary, secondary and tertiary) are essential and complementary. Consoling the next of kin, then, would be part of tertiary prevention for the families and communities of victims and would also lead to the prevention of new suicides.

In other words, as much as we accept that in suicidology good individualistic approaches are essential, we also ask ourselves: are they enough? Could we go further and deeper? This means that while we treat individuals with all needed resources we do not forget the society in which they are embedded. Further, we interpret their experiences as a possible social symptom, and acknowledge the need for social diagnoses and interventions. This in turn acknowledges that, we try to keep the model resistant from becoming too individualistic, too psychologically oriented or too medically dependent, while we express our doubt concerning any model that ignores medical or individual components of human events.

**Inclusion more than exclusion**

With our effort we hope to convey the message that within any society everyone is important, that in suicide there are other people as important as doctors, health specialists, or for that matter, any professional dealing with suicide victims. But we
also want to transmit the message that doctors, health care systems, the media, the police authorities, and the political and legal institutions are as much a part of society as anybody else. Simply, to prevent suicide it is better for all concerned to work in harmony than in discord. Inclusion more than exclusion! That is our motto. And through this book we’ll hope to show that exclusion is very expensive and has negative effects not only on those who are excluded but on those who exclude. Exclusion is the root of all violence, including self-violence, and it can and does kill. Contrary to that, inclusion fosters life and hope.

**The solutions should come from the communities**

In our view there are no healthy responses to this problem outside of communities. Consequently, our interpretations and our solutions include and pass through communities. We do this through the concrete examples of colleagues who have explored suicide prevention within the Safe Communities model and other models. Case Studies on suicide prevention with a community approach are drawn from Sweden (Arjeplog), from Korea and from Japan and will show what our interpretation of community participation and community intervention have to offer. Efforts from other teams- for example from Jönköping in Sweden- will show how others that do not formally belong to the Safe Communities Movement still use community approaches successfully.

*Photo Intr 3. The Municipality of Arjeplog in the north of Sweden - working with community suicide prevention (Chapter 6). (Photo: B&M H)*
With what we have learned from actual experiences, ours and others’, we will make some recommendations on how communities might more effectively work on suicide prevention and healing.

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**Suicide is always painful and touches everyone**

Suicide, apart from hurting the victims directly, extends in waves of troubling pain through successive family circles, to those both near and in more remote relationship, to neighbourhoods, communities and to eventually affect everyone in society. This effect explains why persons in jeopardy sometimes mimic or adopt another’s “individual” pain as theirs. But we also believe that in the same manner in which the waves created by suicide spread outward like a stone thrown into a pond, solidarity from the community and community strength will coalesce in successive centripetal circles from the wider community, the inner circle, families, and eventually individuals to help them find other ways out than suicide. While it is true that suicide is painful to all, pain may hurt less and have more healing power when shared with others. Sharing starts both the healing process and impels prevention and promotion safety efforts. There are aspects of how communities work with safety promotion that are well identified and studied just as injury outcomes have been carefully measured. We wish we could say the same about suicide and suicide prevention. With the assumption that
suicide can be prevented, it’s about time we join forces and find a common approach more useful to all.

**Suicide can be prevented**

Within our view, *suicide can and should be prevented not only individually but in communities since suicide unsettles individuals and communities.* Suicide is not a private matter. Instead, the behaviour of an individual has consequences for the whole community and then higher levels. If a case has occurred, we must make sure that the best help is available to close relatives and friends of the victims as well as people in community networks. And we also must make sure that community involvement in this means taking specific steps. Otherwise this book or any effort to prevent suicides would not make sense.

We can take heart in the work that lies ahead to prevent suicide by the example provided by the pioneering social psychologist, Dr. Dan Olweus. Specifically, in late 1982 a Norwegian newspaper reported that three 10 to 14-year-old boys from the northern part of Norway had committed suicide, in all probability as a consequence of severe bullying by peers. The public outrage resulted in a nationwide campaign being launched against bully/victim problems in the primary and secondary schools throughout Norway. This work was sponsored by the Norwegian Ministry of Education and began in the autumn of 1983. Dan Olweus spearheaded an effort that has since spread worldwide and has resulted in the development of an intervention model that has led to reductions in bullying behaviours of 50% or more once the school and community-wide intervention is fully implemented (Olweus 1986/1993).
References


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Glossary of terms

Suicidal thoughts, attempts and completed suicides

**Suicidal behaviour or suicidality** is a comprehensive concept including suicidal thoughts, attempts and completed suicides.

**Suicidal process** is “a developmental process which leads
a) to suicidal ideation, self destructive behaviour, and in some cases even to suicide, and b) its consequences to survivors” (Lönnqvist 2000, WHO 2002).

**Suicidal ideation** refers to suicidal thoughts, images and plans of killing oneself, in various degrees of intensity and elaboration. It includes “the feelings of being tired of life, the belief that life is not worth living, and a desire not to wake from sleep”(Paykel 1974).

**Attempted suicide (term more used in the USA) and deliberate self harm or Para-suicide (terms more used in Europe)** are terms used to describe behaviours through which people
- inflict acute harm upon themselves
- poison themselves
- or try to do so without fatal outcome

These behaviours are linked to, but do not result in death (Kerkhof, Arensman 2000).

**Suicide.** There is no single unanimously accepted definition of suicide. “Most proposed definitions consider suicide as a fatal act of self injury, undertaken with more or less conscious self destructive intent, however vague or ambiguous”. A **suicide attempt** is a similar act with non-fatal outcome. **Suicidal thoughts** are the focus of early detection of suicide risk. Early identification increases the probability of successful interventions (WHO 2002).

One thing is “successful” suicide and another one is failed suicide.

Suicide and attempted suicides are acute events; this delimitation is a product of an operational necessity. As we shall see throughout the book, many people might be committing slow suicide through their behaviours, but this is not admitted in the operational definition of suicide, or in the statistical sense.

**Surveillance systems and epidemiological surveillance:**

**Epidemiological surveillance** is the systematic, continuous collection of data on a disease or events in such a way that they can be identified early enough to make
interventions possible in a timely and efficient manner. epidemiology and public health that should not be forgotten in suicide prevention.

**Local and central levels.** Data collection means that data are gathered and interpreted locally, so decisions are agile; but also mean that communication and coordination with the central level is permanent so as to establish common patterns in bigger areas, and to make distribution of resources more just and efficient.

**Community level.** It could be said that data collection starts at the most basic local level. This could be the community. However, in some communities this could not be realistic, since the structure needed to do epidemiological surveillance can be can be relatively complex (epidemiologists, statisticians, personnel trained in the use of computers and statistical packages). However household surveys is always a cost-efficient way to obtain information.

**Two different things: Levels of Health Care and Levels of Prevention:**

Levels of care should not be confused with levels of promotion: one thing is Primary Health Care in which the interventions are based on prevention, community work and education, and another thing is levels of prevention which can be developed independently of the level of attention, Primary Health Care included. In other words, regardless of the sophistication of the health institution, health centre, community centre, or university hospital, all can do primary, secondary, and tertiary prevention.

**Primary Prevention** has as its objective to reduce the incidence of disease (the appearance of new cases) through immunization, hygiene, education. This concept cannot be separated from that of **Health or Safety Promotion**, whose objective is to preserve the level of health of the community, to educate it so the community itself has better control over its health, and to stimulate it to practice healthier life styles.

**Primary prevention of suicide** includes activities designed to educate people on the risks of suicide and to promote better mental health and improved communication among different members of society. Other examples are environmental changes and product development that makes suicidal attempts impossible to lead to deadly consequences.

**Secondary Prevention** has as its objective the early demonstration (early diagnosis) and treatment of a disease or the risks factors.

**Secondary prevention in suicide** would be the identification and early intervention of individuals of groups with increased risk of suicidal behaviour and in general impaired
mental health. This secondary prevention of acute momentous events is not accepted by many.

**Tertiary Prevention** has as objective to reduce the complications of diseases or events and to improve the functional status of individuals and their groups through palliation and rehabilitation.

**Tertiary prevention in suicide** would be the treatment and recovery of those who attempted suicide and failed and the repair work that needs to be done with family members and communities of suicide and failed suicide victims.

**Safety**

“Safety is a state in which hazards and conditions leading to physical, psychological or material harm are controlled” (WHO 1998).

**Safety promotion**

“Safety promotion is the process applied at a local, national and international level by individuals, communities, governments and others, including enterprises and non-governmental organisations, to develop and sustain safety (WHO 1998).

**Community Safety Promotion (Safe Community)**

Community Safety Promotion and Safe Communities refer to the process applied at a local level by individuals, communities, governments and others, including enterprises and non-governmental organisations, to develop and sustain safety.

**Injury**

Injury is the unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy, or from the absence of such essentials as heat or oxygen.

**Injury Control**

Injury Control is the scientific approach to injury that includes analysis, data acquisition, identification of problem injuries in high risk groups, option analysis and implementing and evaluating countermeasures.

The three phases of injury control as defined by the National Centre for Injury Prevention and Control (USA) are prevention, acute care, and rehabilitation. This concept is not frequently used in Europe.

**Injury Prevention**

Injury Prevention refers to the efforts to forestall or prevent events that might result in injuries.
Lessons to be learnt

- Suicide is a worldwide public health problem affecting individuals and societies of all ages, sexes, races and conditions. Each year approximately one million people in the world die from suicide. This toll is higher than the total number of world deaths on average from war and homicide combined.

- Similarly, suicide attempts are a big problem. They share the same biology and probably the same external factors as suicides, even if the end result is different. It has been estimated that there are from 10-20 times as many suicide attempts as suicide deaths.

- Suicidal thoughts are the focus of early detection of suicide risk. Early identification increases the probability of successful interventions.

- It is remarkable to discover how most societies fail to see suicide as an expression of deficiencies in societal structures. This is indeed stranger nowadays when so many seem to accept that behind every diagnosis, figure, number, disease event (even symptom), and premature death, there are explanatory social associated factors.

- In the introduction to his work on suicide Durkheim dedicated his efforts to establish in effect that there was “for each social group a specific tendency to suicide not explained by either the psycho-organic constitution of individuals or by their physical milieu”; he concluded by elimination that the tendency to suicide must necessarily “depend on social causes and constitute by itself a collective phenomenon”.

- Durkheim’s great contribution to science was the concept of anomic suicide. Anomie is a state of social deregulation as a result of which people lose sight of their value and place in society.

- “Society is not the only object that attracts to itself with unequal intensity the feelings or the activity of individuals. Society is also a power that regulates them; within the form in which she exercises the regulatory function and the suicide rate there is a rapport”.
• Now (2010) when the threats of economic recession are no longer looming on the horizon, but realities, is when Durkheim’s concept of anomie becomes more relevant. Both ups and downs in economic circumstances increase the number of suicides.

• As expressed by the anomic categories, not only economic deregulation can lead to suicide. There is a remarkable relationship between separation and suicide that is not found within the organic predisposition of divorcees, but within the intrinsic nature of separation as an expression of exclusion.

• In sum, people are more at risk when excluded. Inclusion and fairness are good for everyone, but are more difficult to achieve since they mean commitment, along with a sense of belonging that is not self-centered, i.e. they involve betting on others and not only on ourselves.

• Durkheim’s work on suicide is of great importance because it is the first serious effort to establish empiricism in sociology, an empiricism that would provide a sociological explanation for a phenomenon traditionally regarded as exclusively psychological and individualistic.
References


Chapter 1.
Emile Durkheim and the concept of anomie

Suicide is a worldwide public health problem affecting individuals and societies of all ages, sexes, races and conditions. Each year approximately one million people in the world die by suicide. This toll is higher than the total number of world deaths on average from war and homicide combined (WHO 1997). The consequences are huge. “The burden of bereavement by suicide can have a profound and lasting emotional impact for family members, but also to societies”. This happens regardless of mores, religion or culture.

Similarly, suicide attempts are a big problem. They share the same biology and the probably the same external factors with suicides, even if the end result is different. “It has been estimated that there are from 10-20 times as many suicide attempts as suicide deaths”. According to some modern suicidologists, “at a personal level, all suicide attempts, regardless of the extent of injury, are indications of severe emotional distress, unhappiness and/or mental illness”. The fact is that suicide and suicide attempts have serious emotional consequences for families and friends, and society in general. Self-destruction is a wider concept, including both direct self-destruction, that is suicide attempts and completed suicide, but also indirect self-destruction, giving immediate satisfaction but injuries in the long run, such as smoking and alcoholism.

It is remarkable though to discover how most societies fail to see suicide as an expression of deficiencies in societal structures. This is indeed stranger nowadays when so many seem to accept that behind every diagnosis, figures, numbers, disease events (even symptoms), and premature deaths, there are explanatory social associated factors. Well-to-do societies boast about high life expectancies and low infant mortality rates, and strive to be recognised as world leaders among countries in the welfare race. However, the same societies that attribute such progress to social interventions often leave suicide rates to be explained by individual deficiencies, or at the most as a consequence of environmental factors such as the lack of light.

Few of you would remember a Prime Minister or any important government official standing up and declaring that they are prepared to intervene to ease the pain of the victims or their families as a matter of national importance proportional to the suffering created by suicides in the society. Similarly, despite its frequency and its consequences, we do not understand suicide or suicide attempts; at least we do not understand it as much as we claim to understand non-intentional events, accidents and maybe even violence.
Difficulties in conceptualizing suicide and finding universal definitions

Deciding what is and what is not suicide has for long proved elusive. It has been even more difficult to decide on the ultimate motives behind suicides. At the end of the XIX century Durkheim expressed it this way: “because suicide is a common topic of conversation in most cultures it cannot be concluded that its meaning is known by everyone and thus it would be superfluous to define it. Nevertheless the term is ambiguous and could lead to grave confusions”.

Durkheim attempted successive definitions of suicide. In the first formulation proposed, he called suicide “every death resulting by the mediation of or immediately from a positive or negative act by the victim himself”. But then Durkheim himself saw that this definition was incomplete since it did not distinguish between the madman that throws himself out of the window (hallucination) from some one who is not hallucinating and knows what he/she is doing.

In his second formulation, Durkheim (1897/1997) proposed to define Suicide as:
Any death resulting directly or indirectly from an action positive or negative carried out by the victim himself/ herself, with the purpose of achieving this result. He recognized, though, that it is always difficult to know what the real intention of the suicidal person was. Attempted suicide is when the attempter decided to carry out the act but decided to stop or was stopped before he/she could die.

Both suicide and attempted suicide imply an act of volition, including making a conscious plan for suicide. Consequently it cannot happen in animals, just in human beings.

More recently The Centers for Disease Control and Prevention, agencies within the Department of Health and Human Service in the USA, define suicide as: “death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted and that the decedent intended to kill him/herself” Such definition is also adopted by forensic examiners and coroners (the professionals who investigate causes of death).

The World Health Organization defines suicide as “a suicidal act with a fatal outcome”, and a suicidal act as “self injury with varying degrees of lethal intent”. In turn, the WHO’s definitions build substantially on Edwin Shneidman’s account in his book “Definition of Suicide” (Shneidman 1985).

Sweden’s National Board of Heath and Welfare’s description of suicide in a Swedish context has the heading “Intentional self-destructive act”, under which are reported not only suicidal acts that have given rise to a fatality, but also suicidal attempts that have led to in-patient care (National Board of Health 2006). In Sweden’s National Encyclopedia’s word list, suicide is described as an “intentional self-destructive act that leads to death” (Nationalencyklopedin 2006).
Two complementary models

Different approaches need not be mutually exclusive. In order to end up making our proposals of Safe Communities clear, and how we integrate within the wider field with the work developed by others, we will first expose in this chapter a summary of Durkheim’s main contribution from the XIX century and beginning of the XX (a predominantly sociological approach). In a later chapter, the contributions of several teams who use the Safe Communities approach to suicide (and other forms of injury) prevention will be related followed by brief descriptions of the work developed with the same purpose by contemporary Swedes, namely those teams led by Professor Danuta Wasserman and Professor Jan Beskow and other Scandinavian experts representing predominately individualistic approaches that, nevertheless, do not exclude sociological approaches. We will try to show how contemporary approaches, as much as ours, fit within a matrix created for prevention of all types of injuries developed by the Safe Communities model while pointing out how much work is still needed to achieve a comprehensive model of intervention for the prevention of suicide.

Émile Durkheim and the concept of ANOMIE

Mental disease or social causes

Durkheim (1897) thought that suicide was a phenomenon related to, or consecutive to, a great number of causes. After examining in detail all possible associations he concluded that there are realities for which our psychological explanations are not enough. He decided to focus on the social factors associated with suicide more than its characterization within a given disease category.

Social causes in different groups

In the introduction of his work on suicide Durkheim dedicated his efforts to establish in effect that there was “for each social group a specific tendency to suicide not explained by either the psycho-organic constitution of individuals or by their physical milieu”; he concluded by elimination that the tendency to suicide must necessarily “depend on social causes and constitute by itself a collective phenomenon”. He decided then to observe collective tendencies of suicides, by observing what could only be observable through biggest possible number of individual suicides, outside of those showing mental alienation.
Types of social suicide

Durkheim proposed four types of suicide, based on the degrees of imbalance of two social forces: social integration (egoististical suicide, and altruistic suicide), and moral regulation (anomic and finally the fatalistic suicide. The latter was only shortly mentioned by Durkheim. The regular system is then so suffocating that no independent individuals can develop, only slaves. We shall comment on the first three.

**Egotistic suicide resulted from too little social integration.** Those “individuals who were not sufficiently bound to social groups (and therefore well-defined values, traditions, norms, and goals) were left with little social support or guidance, and therefore tended to commit suicide more than others”. As an example Durkheim discovered that “unmarried people, particularly males, who, with less to bind and connect them to stable social norms and goals, committed suicide at higher rates than married people”.

The second type, **Altruistic suicide**, was a result of too much integration. It occurred at the opposite end of the integration scale from egoistic suicide. Self sacrifice was the defining trait, where “individuals were so integrated into social groups that they lost sight of their individuality and became willing to sacrifice themselves to the group’s interests, even if that sacrifice was their own life”. The most common cases of altruistic suicide occurred among members of the military. For them suicide occurs not because it is their right, but because it is what they consider to be their duty. If egoism is the state where one finds himself when one lives a personal life and does not obey anyone else but oneself, altruism, the opposite, means that one does not belong to oneself, i.e. the axis of behaviour is outside oneself.

However, one of the central concepts to us and therefore the one on which we concentrate is the concept of anomie and anomic suicide.

**Anomic suicide**

*Anomie* is a state of social deregulation as a result of which people lose sight of their value and place in society, leading to moral dissolution.

“Society is not the only object that attracts to itself with unequal intensity the feelings or the activity of individuals. Society is also a power that regulates them; within the form in which she exercises the regulatory function and the suicide rate there is a rapport”.

Now (in 2010) when the threats of economic recession are no longer looming in the horizon, but realities, is when Durkheim’s concept of anomie becomes more relevant.

**Types of anomie**

- **Acute economic anomie**: describes the “sporadic decreases in the ability of traditional institutions (such as religion, guilds, pre-industrial social systems, etc.) to regulate and fulfill social needs”.

- **Chronic economic anomie**: long term diminution of social regulation. Durkheim identified this type with the industrial revolution of the XIX century, which eroded traditional social regulators and often failed to replace them. Industrial goals of wealth and property were insufficient in providing happiness, as was demonstrated by higher suicide rates among the wealthy than among the poor.

- **Acute domestic anomie**: sudden changes on the micro social level resulted in an inability to adapt and therefore higher suicide rates. Widowhood and divorce are examples of this type of anomie.

- **Chronic domestic anomie**: referred to the way marriage as an institution regulated the sexual and behavioral means-needs balance among men and women. Marriage provided different regulations for each, however. Bachelors tended to commit suicide at higher rates than married men because of a lack of regulation and established goals and expectations. “On the other hand, marriage has traditionally served to over regulate the lives of women by further restricting their already limited opportunities and goals. Unmarried women, therefore, do not experience chronic domestic anomie nearly as often as do unmarried men”.

**The importance of financial aspects**

“It is known that economical crisis have an aggravating influence on the penchant for suicide”. During Vienna’s financial crisis of 1873 there was a sharp increase in suicides. Something similar occurred during the Paris Stock Exchange crack in the winter of 1882” (Durkheim 1897). Why do these financial crises have so much influence? Is it that because by weakening public fortune they increase misery? Is it because life becomes more difficult? Seductive by its simplicity, the theory is nevertheless contradicted by facts. If voluntarily deaths increased as a result of life becoming too
hard, too rough, then suicide rates should also clearly get lower when help/assistance become greater. Otherwise, the poor of the world would commit suicide more than they usually do.

Both ups and downs of economical circumstances increase the number of suicides. With the ascension of Victor Manuel to power Italy became very rich, and salaries and incomes increased. Yet, Italy experienced at that time an exceptional increase in suicides. Something similar occurred in Prussia. Universal Expositions, the most famous being the Paris exposition at the turn of the century meant wealth and success. And yet during them, suicide numbers increased. Opposite phenomena were observed in Ireland during the time of the potato famine where poverty was so dire, life so difficult and yet suicide was low. The financial development in Ireland supported by the European Union on the contrary lead to an increase in the suicide rate. Therefore, if a financial crisis produces an increase in suicides, it is not because it makes people poorer, since the same happens when prosperity arrives, but because there is a perturbation of the collective order, a change of the status quo through which human beings lose their points of reference.

During every great threat there is a rupture of the equilibrium of the social order, or during any rearrangement within the social body, men kill themselves more easily. Why? “Because men are not only dependent on physical needs. There are other needs that need to be fulfilled, the first one of which is recognition”. There are within the moral conscience of societies an unexpressed sentiment of how much they belong to a group and how much they are worth. Social discipline cannot be useful if it is not considered just by the people submitted to it. When this is only maintained by habit or by force, peace and harmony subsist only in appearance. The state of deregulation or anomie
is reinforced by the fact that passions are less regulated - undisciplined in moments when they are most needed.”

Today, religions have in many countries lost the power of regulation they used to have. Industry and progress have become the only and the whole object for many societies. The new generations do not play by anybody else’s rules. There is deregulation, anomie in all aspects of life. As expressed by the anomic categories, not only economical deregulation can lead to suicide. There is a remarkable relationship between divorce and suicide that is not found within the organic predisposition of divorcees, but within the intrinsic nature of divorce as an expression of exclusion. It appears to be in that realm where it is necessary to search for a cause.

Research experiences after Durkheim

Emile Durkheim’s work has had an enormous influence on later sociological theories, which has developed and tested his hypothesis. Ilkka Mäkinen, 2009, has described this later development. Generally the Durkheimian theory is a grand structural theory, explaining the relation between society and suicide in general and especially how more or less a stable structure causes suicide. Generally he does not formulate specific hypothesis for specific situations or functions but rather let his data illustrates his thesis.

This large-scale character of Durkheims work has been further developed in different directions, such as the increasing complexity of society (Halbvacs 1978/1930), disorganization (Cavan 1928), and role states and role conflicts (Gibbs, Martin 1964). Other researchers are more interested in subgroups as the integration power of religion and family life and the influence of alcohol. In South Africa and US there has been an inverse relation between manslaughter and suicide. In Russia

Figure 1.3. A starving boy and girl in Cork hoping to find a potato 1847.
and the Baltic states on the contrary the anomic state induced by the introduction of capitalism both manslaughter and suicide increased (Värnik 1997).

Douglas 1967 suggested a bridge between a societal and individual perspective. Through intensive observation, description, and analysis of individual cases it should be possible to identify both individual roles and shared social meanings. The modern tendency to qualitative studies leads to more detailed information about for instance the suicidal process, giving new hypothesis to test. The interaction between society and individual is to-day understood as much more complex than previously. Some results are presented in a later chapter.

“Durkheim’s work on suicide is of great importance because it is his first serious effort to establish empiricism in sociology, an empiricism that would provide a sociological explanation for a phenomenon traditionally regarded as exclusively psychological and individualistic. Durkheim felt that his empirical study of suicide had discovered the structural forces that caused anomie and egoism, and these forces were natural results of the decline of mechanical solidarity and the slow rise of organic solidarity due to the division of labor and industrialism. Also of importance was Durkheim’s discovery that these forces affected all social classes” (Durkheim 1897).

People are more at risk when excluded. Inclusion and fairness are good for everyone, but are more difficult to achieve since they mean commitment, along with a sense of belonging that is not self-centered, i.e., they involve betting on others and not only on ourselves.

If we as professionals interested in the social aspects of suffering, independently of our specialties, claim to know who are the main victims of exclusion in today’s world, and which social, political and economical models could be held responsible, surely we should at least ask ourselves if it is our concern as health professionals or public health workers, and to what extent should we become seriously interested in economy and politics; or on the contrary, if knowing and perceiving what we do, are we going to remain comfortable and ignore what is around us because if is not our field? Or if are we going to participate actively in the construction of new societies?

Surely we need to study social networks and the influence of isolation on the state of health and well being. In a similar manner to that in the brain or for that matter in the body, nothing in society happens in isolation. The brain and the physic functions are not organs so different or isolated from others that one cannot be affected without the others being affected. Societies are not isolated from each other, nor are the individuals independent from them.
We write this with the belief that in the same way that suicide has been said to be contagious so could be the healing process and the prevention process. The fabric of society as whole (a unit) needs to be continuously repaired if broken, and this should be done not only through individual interventions but also with social solutions.

In a later chapter we shall discuss complex contemporary models used for the understanding of the actions taken for suicide prevention within the framework of the Safe Communities movement and by others.

Photo 1.1. Economic crisis of our time. The great credit crisis has cost the world’s largest banks billions since it started in August 2007. UBS, the biggest casualty in Europe, admitted in early July that it faced further writedowns - estimated by analysts at $7.5bn (£3.8bn). It has already written off more than £18bn from its exposure to the US mortgage market. The losses cost chairman Marcel Ospel his job.
Lessons to be learnt

- In the introduction of his work on suicide Durkheim dedicated his efforts to establish in effect that there was “for each social group a specific tendency to suicide not explained by either the psycho-organic constitution of individuals or by their physical milieu”; he concluded by elimination that the tendency to suicide must necessarily “depend on social causes and constitute by itself a collective phenomenon”.

- Durkheim’s great contribution to science was the concept of anomic suicide. Anomie is a state of social deregulation as a result of which people lose sight of their value and place in society.

- “Society is not the only object that attracts to itself with unequal intensity the feelings or the activity of individuals. Society is also a power that regulates them; within the form in which she exercises the regulatory function and the suicide rate there is a rapport”.

- Now (2010) when the threats of economic recession are no longer looming in the horizon, but realities, is when Durkheim’s concept of anomie becomes more relevant.

- Both ups and downs of economical circumstances increase the number of suicides. As expressed by the anomic categories, not only economical deregulation can lead to suicide. There is a remarkable relationship between separation and suicide that is not found within the organic predisposition of divorcees, but within the intrinsic nature of separation as an expression of exclusion.

- In summary people are more at risk when excluded. Inclusion and fairness are good for everyone, but are more difficult to achieve since they mean commitment, along with a sense of belonging that is not self-centered, i.e., they involve betting on others and not only on ourselves.

- Durkheim's work on suicide is of great importance because it is his first serious effort to establish empiricism in sociology, an empiricism that would provide a sociological explanation for a phenomenon traditionally regarded as exclusively psychological and individualistic.
References


Chapter 2.  
The meaning of suicidality

By Jan Beskow

The challenge for Safe Communities in suicide prevention is to create security (knowledge and structures) so that normal and helpful suicidality neither intentionally nor non-intentionally result in death or other forms of injury. The visionary goal should be a community without suicide.

Introduction

Suicidality is thinking and planning suicide, making attempts at suicide, and finally killing oneself. Suicidality is usually understood through a “psychiatric model” of symptoms of mental disorder, especially depression. But it is also understood as a longitudinal process from the first genuine personal suicidal thought (“I can commit suicide!”) through to the ultimate suicidal act. Thus, the suicidal process has been perceived as separate from mental disorder.

Over the last decade, researchers inspired by cognitive therapy have been interested in how we can understand the suicidal process in greater detail. During its later phases, near the suicidal act, the person’s control of the situation may decrease or even get lost altogether. This has raised the question of whether some suicides might be perceived as non-intentional acts, as accidents.

The consequences of this new knowledge for suicide prevention are still not well understood. Here are some points about where we are today.

- **Thinking of suicide is a normal process.** Everyone does it now and then.
- **Thinking of suicide is helpful.** If your consciousness is totally occupied with hurt, anxiety and depression up to the state of paralysis, thinking of suicide can make it possible to take a next step. And look around the corner; something happens and life once again seems valuable and possible to live!
- **Thinking of suicide is a message.** It may be like the howling of a fire alarm: “You certainly have real problems! Solve them now; otherwise your life may be at risk!” During our evolution we have developed this warning system. Suicidality is communication with a clear survival value (Beskow 2005). That is the meaning of suicidality.
• *Thinking of suicide is dangerous.* But if the problems are not solved, suicidal thoughts may deepen, and a method, place and time may be decided. Such plans may be susceptible even to small triggers, and can explode in a life-threatening suicidal act. Thus, be aware: Do not think too much about suicide!

• *Suicidality has symptoms.* In psychiatric care, suicidal thoughts and attempts, and completed suicides, are looked upon as symptoms of mental disorder. That is understandable. The psychiatrist’s job is to identify and treat such disorders, thereby making an important contribution to suicide prevention. Suicidal patients, however, do not identify themselves as mentally ill. Consequently, they seek psychiatric care late, often the day before the planned suicide. It is deplorable, because then they are difficult to help. Thus, psychiatrists often miss the early stages of the process, the time that is good for suicide prevention.

The first message of this chapter is that suicidality is a process in its own right and that prevention must start early in the process.

Loneliness. Painful problems over a long period give feelings of loneliness. “No one loves me, and I don’t love anyone, I’m of no use – just a burden. I don’t belong to the human community any more.” Cultural values, such as individuality and the concept that life is your own property, exaggerate this experience of being isolated. When you
do not belong to anyone or anything, you feel non-existent, dead. Then, it is better really to be dead, and at the same time be spared intolerable pain.

_Suicide prevention as inclusion._ Suicidal feelings are exclusion; the task of suicide prevention is inclusion. The core of suicide prevention is to welcome the suicidal person back into the human community as a respected and valuable person, and to do it over and over again. Do not exclude, but integrate! That is the key statement in this book on community suicide prevention.

**The second message** of this chapter is that the challenge of suicide prevention is to re-integrate the suicidal person into the community.

_Loss of control._ Close to death, filled with anxiety, depression and mental pain, the suicidal person’s mind is not clear any more. The precision in his or her evaluations and acts are diminished. The risk of committing suicide by mistake increases.

_Accident?_ Is it then possible to understand at least some suicides as accidents? Is it possible to bridge the gap between the concepts of accident and suicide?

**The third message** in this chapter is that this does seem possible.

Let us discuss the third message first, go on to consider what happens during a suicidal process, and then close the chapter with some consequences for prevention.

**Bridging the gap between accident and suicide**

When the Safe Communities movement started in 1975, it focused on the prevention of accidents. In the 1990s, the leading communities in the movement opened the way for including violence prevention. In recent years, suicide prevention has also been included. Are there similarities and differences between accidents, acts of violence and suicides? In other words, can analysis of Safe Communities open up a basis for common strategies?

_The concept of injury._ This concept focuses on the effects of processes, which may damage humans or property. These effects may be due to accident, violence or suicide. All these latter concepts comprise both the event that caused the injury and the process leading to this event.

- Accident refers to _unintentional_ events, which may cause injuries to both humans and property.
- Violence refers to _intentional acts_ (events), which may cause injuries to both other humans and property.
• Suicide refers to *intentional* acts and events, which may cause injuries to the actor and – more indirectly – to property, e.g. when shooting, blasting or burning oneself to death.

The process leading to accident or suicide may show a rapid escalation of the threatening situation, resulting in a loss of control.

**The problem of intention**

At first glance, accidents and suicides may seem to be totally different. An accident suddenly happens, often by chance. Suicide is by definition intended. A will to die is in fact a cardinal criterion in definitions of suicide. The concept of intention, however, is more complicated than it first appears.

In the 1930s, Erwin Stengel (1964/1979) regarded attempted and completed suicide as different entities. He also noted that persons who attempted suicide did not always want to die. The problem was solved by broadening the definition of suicide, placing less stress on absolute intention. Suicide was seen as “a fatal act of self injury, undertaken with more or less conscious self-destructive intent, however vague or ambiguous”. This opens up the possibility that some suicides may be non-intended.

A suicide attempt was defined as a similar act with a non-fatal outcome. Now we know that many persons attempting suicide, especially through cutting or poisoning, really do not want to die at all.

**Sudden events.** When performing a community diagnosis in Arjeplog (Chapter 6), the working group noted that suicides often occurred unexpectedly. This is in accordance with many clinical observations. Among elderly people who commit suicide, most of them die at the first attempt. In attempted suicides, Deisenhammer et al. (2009) found that nearly half of patients referred for medical care after a suicide attempt reported that the time from the first current thought of suicide to the actual attempt was 10 minutes or less. Thus, many suicidal acts occur rapidly. This puts in question the concept of intention, and also the concept of a distinct border between suicide and accident. One path to understanding may be to shift the focus from the act to the process behind the act. Another is to understand risk situations as ones that impose highly increased demands on individuals.

**Risky decisions**

**Example 1. The driver.** Early in the morning, after a good evening, but with a bit too much alcohol, a man saw through his window that the roads were slippery from the snow that had fallen during the night. Irritated, he remembered that he had forgotten
to get his bad brakes fixed. However, he had to get to work. In that moment, he made three important decisions, namely to drive his car despite not being quite well himself, despite slippery roads, and despite bad brakes. Each increased the risk of an accident. Certainly he did not want to die.

Half an hour later, on a sharp curve, the driver met a heavily loaded lorry coming at him at high speed. The feeling of threat started intensive cognitive activity in the frontal part of his brain. (Cognitive comes from cognition, a collective word for our mental images of the surrounding world, thoughts, memories, and action plans. Cognitive activity is the ever ongoing activity that helps us to solve the small and big problems that are a natural part of life. The focus in cognitive and behavioural therapy, CBT, is on solving problems through developing cognitive functions.)

The driver saw the lorry, and tried to estimate the distance to it and the time he had to avoid an accident. Many questions needed immediate answers. How slippery was the road just there? Dare he use his bad brakes? What about the right ditch? Could he drive near to it or perhaps drive his car off the road? The time for action rapidly diminished as he approached the lorry. Despite using his total cognitive capacity, he did not succeed. A few minutes later, he and one of his passengers were dead, two others were seriously injured.

**Example 2. The loser.** He was a somewhat peculiar, lonely 20 year-old man, convinced that he would never be able to attract a girl. However, he succeeded and was happy. Three months later the girl broke up with him. It was a catastrophe, but as a man he did not talk about it. He developed a slight depression, but did not seek any help. As usual, he met his friends every Friday afternoon for a few bottles of beer. Thus, he too made three important decisions. Each of these increased the risk of a suicidal death. Certainly, he did not want to die.

Under the influence of the beer, the young man got even more depressed and started to talk about suicide. Sitting in his car for two hours, two of his friends tried to talk him into a state of calm, and to promise not to take his life that night. However, they did not take contact with anyone in his family. A week later the same happened again. The third Friday, when standing at the bottom of the stairway to the subway, there was a minor row. One boy hit him in the chest, half as a joke, half sincerely. He then ran away to his car, took a rope he had there, and vanished into the woods nearby. After a few minutes, his friends ran after him, but arrived too late. He had already hanged himself. Certainly he had thought about suicide previously, but the definite intention to die was present only for these few minutes.
Neither of these two men really wanted to die. However, both of them made at least three decisions that increased the risk. In these respects, the backgrounds to the accident and the suicide were similar.

**Risky situations**

Both these men met, for them, unknown and extremely demanding situations, which not only challenged but also exceeded their cognitive problem-solving capacity. They had a cognitive insufficiency relative to the extremely high demands. A risky situation can be understood as one that challenges the limits to what a person can do. Demands may exceed what can be achieved. The mechanisms are illustrated in Figure 2.1.

![Figure 2.1. The demand–achievement model.](image)

The lower line illustrates demands, the upper one achievements (Waller 1980, Beskow 1983). Usually the gap is large, and the problem-solving capacity high enough. With a rapid increase in demands, the person tries to increase achievements – sometimes with success, but in this case not.

**Cognitive insufficiency**

As Ernst Mach (cited by Reason 1990, p. 1.) noted as early as in 1905: “Knowledge and error flow from the same mental sources, only success can tell the one from the other”. Thus, both accidents and suicides can be understood as cognitive insufficiencies in extremely demanding situations.

The phenomena leading to an injury may be described at three levels:
• *Cognitive insufficiency* in an extremely demanding situation, i.e. a collapse of the problem solving process.

• *Destructive or dysfunctional processes* leading to an accident (non-intended), violence (intended towards another person) or suicidal act (intended towards oneself); some violence and some suicidal acts, however, may be caused by loss of control and thus be more or less non-intended.

• *Injuries of different types* are caused by these three processes.

In accidents, the mental representations that are the focus of the cognitive problem-solving process are predominantly physical forces. In violence and suicidal acts, they are predominantly emotional forces created within the area of human conflicts.

**Conclusion.** Thus, it is possible to understand accidents, acts of violence and suicides as involving three processes, all rooted in cognitive insufficiency in extremely demanding situations. Violence and suicidal acts may have varying degrees of intention.

But what about the psychological processes leading to a suicidal act? In fact, new research supports the idea that some suicidal acts may be perceived as accidents.

**Models used to understand suicidality**

Generally two models control our way of perceiving suicidality – the psychiatric and the psychological.

**The psychiatric model.** The most common model in clinical work is the mental disorder model, which treats suicidal thoughts and acts as symptoms of a psychiatric disorder. This model is useful in the identification of risk factors and for treatment. Treatment of psychiatric disorders certainly decreases the risk of suicide.

However, the psychiatric model is a model for mental disorder, not for the suicidal process. Williams (2006) has shown that, in recurring depressions, variation in depressive symptoms is great. But there are two exceptions: concentration (p<.05) and suicidal thoughts (p<.001). It is not surprising that a person thinking of taking his life has difficulties in concentration, leading to a reduced cognitive capacity. The even stronger persistence of suicidal thoughts comes from their cognitive nature. They are part of cognitive problem-solving processes, and therefore easier to remember than vaguer symptoms with their origins in emotions and the body.

**The psychological model.** By contrast with the mental disorder model, the psychological or suicidal model focuses on the development of suicidal thoughts
through peaks of increasing suicidal involvement, leading to attempted suicide and sometimes completed suicide. Research based on this model has increased our understanding of suicidal behaviour in many ways. Only limited expressions of the process are observable from the outside. Since the intensity of suicidal thoughts and suicide risk vary a great deal, relatives and mental health personnel need to be prepared for sudden suicidal crises. To do that it is important to catch suicidal messages: direct verbal – “If you leave me I will commit suicide”, indirect verbal – “Farewell, I assume we will not meet for a long time”, direct behaviour – “May I borrow your gun?”, and indirect behaviour suggesting the end of life – e.g. giving presents, arranging for a funeral, etc.

The suicidal process

![Suicidal process diagram](image)

Figure 2.2. The suicidal process showing the development from the first suicidal idea, through a long period of suicidal thoughts of varying intensity, sometimes ending up with a completed suicide.

**New research findings on the suicidal process**

Over the last decades, many researchers inspired by cognitive theories have tried to describe the suicidal process in greater detail. In their studies of the cognitive problem-solving capacity of suicidal persons, they have made many observations that increase our understanding of how some suicides might be accidents (Ellis 2006, 2008, Wenzel 2009).

*Normality.* First, thinking of suicide is a *normal* reaction. Almost everyone sometimes thinks of suicide. Threatening situations evoke anxiety, which is a reaction
in nucleus amygdale that activates the cognitive areas in the frontal lobes. The lobes work intensively to decrease anxiety by solving the problems. If successful, this leads to a decrease in the anxiety level. But sometimes they cannot see how it can be done; there is no way out. This is a very scary situation, painful and difficult to endure. Suddenly, the frontal lobes detect a way out of the pain: Suicide! The feeling of being captured or paralyzed then dissolves, making it possible to take the next step. And there – around the corner – new experiences await. The suicide can be postponed to an uncertain future.

*Problem solving.* Thus, suicidal thoughts have an *informative value:* They function as an alarm clock. They point out for the person that he/she has urgent problems to solve. They also have an *adaptive value.* They point to a possible rescue from the intolerable pain. This brings new hope, the anxiety level decreases, and new energy is elicited to attack the problems. This has a clear *survival value.* – Research interventions intended to reduce recurring suicide attempts have been successful only when the researchers relate to the suicidal patients in a new way. In practice, they adopt an outreach approach, and support them in situations of insufficient cognitive and social skills. The suicidal person must be an active part of the problem-solving process (Michel 2002).

**Suicidal thoughts may become dangerous.** However, the increase in activity level can also result in chaos. Since many persons thinking of suicide also have difficulties in concentration and problem-solving, Williams (2005) claims that they may develop negative spirals, augmenting the threat, increasing the anxiety, decreasing the problem-solving capacity, and so on.

*Photo 2.3. The suicidal situation is often described as a trap or a prison. The suicide may then appear as the only way out. In the Cage the depressed song bird is symbolized by a dying rose, loosing all her beautiful flower leaves, longing for freedom. (Photo: CG)*
The suicidal thoughts can then deteriorate into psychopathology. When the frontal lobes cannot solve the problem, the suicidal person is preoccupied with suicidal thoughts, worrying about the future and/or ruminating over what has happened. The brain can be exhausted, and react with depression, a dangerous disorder that increases the risk of suicide.

**Acute suicidal episodes.** Suicidal thoughts can develop into complex mental structures, called *suicidal modes*. Such latent suicidal modes may be *triggered* by very subtle stimuli, exploding into transient self-limiting episodes (Beck 1996, Rudd 2000). Physiological reactions to a perceived threat include autonomic arousal, and motor and sensory activation, oriented towards fight–flight–freeze reactions. Multiple factors converge, temporarily increasing suicide risk. Thus, suicidal persons may lose control in life-threatening situations, influenced by both longstanding latent factors and factors present only in the acute suicidal episode.

Even though suicidal thoughts have survival values, they do not always succeed in their life-saving function. We cannot always rely on our suicidal cognitions, but react with a suicidal act, which may be conceived of as a *cognitive error in the threatening situation*. If such failure occurs, it is the task of researchers and clinicians to try to investigate why. Studies of non-functioning open up a new world. As demonstrated immediately below, a large number of rapidly interacting factors are active during these delimited acute suicidal episodes, when there is a high risk of suicide.

**Microanalyses of suicidal episodes**

Owing to the relative low incidence of suicide, the value of statistical research is limited. Instead, the researcher has to use other scientific methods. Just as in accident analysis (Hollnagel 2004), we also have to move from *causes* to *understanding*, i.e. from defining a few influential factors to describing the intimate interaction of many large and small factors.

This involves a movement from asking *Why did this happen?* to asking *How did it happen?* Such research strategies have for long been studied in cognitive accident prevention research, often with the help of commissions of inquiry. The concept of cognitive insufficiency is reflected in the names of some well-known methods, successfully applied in process industries and in air traffic, such as the Cognitive Reliability and Error Analysis Method (CREAM) (Hollnagel 1998). The question is: “Can we rely upon our cognitions even in demanding situations? If not, we need a method for analyzing why.” A similar method, adapted for the analysis of road accidents, was introduced by Ljung (2007), the Driver’s Reliability and Error Analysis...
Method (DREAM). The analysis includes the determination and measurement of factors or failures related to man (driver), the machine (car), and the environment (roads, ditches etc).

The SCREAM project. A research group in Gothenburg, led by the author, now uses roughly the same micro-analytic approach in order to explore what happens in acute suicidal episodes. It is called the Suicidal Cognitions and Reliability Error Analysis Method (SCREAM). “Can we rely on suicidal cognitions as warnings that lead to problem-solving? If not, we have to search for the failure.” In a pilot study, Beskow et al. (2009) examined four suicidal episodes in a depressed and suicidal woman. As is shown in their provisional report, it is possible to differentiate between latent longstanding and acute situational conditions, and also between factors related to the woman herself, and also her interactions with other persons, and different suicide methods. These factors were also related to her coping strategies on a preliminary life-saving scale. The approach actually generated more valuable information than we had expected.

Different degrees of loss of control

- There was a huge gap between the subject’s normal, especially professional, high level of behaviour and her grave cognitive insufficiency during threatening episodes.
- The perceived intensity in the threat gave rise to different degrees of cognitive insufficiency.
- The suicidal involvement in the acute episodes often started with a rapid increase in arousal, subjectively acknowledged as increasing anxiety.
- This arousal resulted in higher levels of suicidal involvement and an increase in subjectively estimated suicidal risk up to a stage of dissociation when the patient almost automatically performed a suicide attempt. Orbach (2006) has pointed out that dissociation means detachment from the body, which is perceived more as an object and therefore easier to damage.
- During the episodes a great variety of coping strategies were available and used.
- After the acute episode the suicidal risk did not vanish entirely. To the contrary, it was possible to discern different levels of baseline suicidal risk: no suicidal thoughts at all; vague suicidal thoughts with small impact; and compulsive suicidal thoughts, reducing the mental energy available for other life problems.
The duration of the episodes was from a few hours up to two and a half days, thus generally longer than for accidents. Distinct criteria for the beginning and end of an episode have to be worked out.

Conclusions
Preliminary data from the scientific study of acute suicidal episodes show a rich variation in increased demands and coping strategies, opening up the possibility to train patients in coping with their suicidal thoughts.

The data also support the view that at least some suicidal acts are due to a total loss of control through cognitive insufficiency in special situations. In these respects, they are similar to accidents. Support for these suicidal persons must come from within their immediate surroundings. Thus, most of this work must be performed at community level.

Consequences for suicide prevention
Generally, our control of life is restricted. In very special, extremely demanding situations it is so restricted that the risk of death is imminent. Cognitive insufficiencies in these situations, combined with a lot of chance factors, may then result in an accident, violence or a suicidal act. Thus, the well-known schema for understanding accidents, Haddon’s matrix, can be used for all these three processes.

Haddon’s Matrix
Haddon (1974) briefly describes the process up to an accident, the accident itself and its consequences, the injury, and then combines parts of the process with different forms of prevention, treatment and rehabilitation. His matrix is equally relevant to suicide prevention, suggesting interventions at the pre-suicidal phase, against ongoing suicidal behaviour, and during the post-suicidal phase. Or better: before, during, and after the acute suicidal episode.
Individual Means of suicidal prevention Environment behaviour

Pre-suicidal factors
- Age
- Gender
- Personality
- Mental disorder
- Substance abuse
- Inherited factors
- Physical illness
- Accessibility of:
  - drugs
  - firearms
  - pesticides
  - jumping sites
- Personal relationships
- Community support
- Media influences

Suicidal behaviour
- Substance intoxication
- Inter-personal rejection
- Suicidal intent
- Lethality of method
- Proximity to others
- Likelihood of discovery/prevention

Post-suicidal factors
- Help-seeking
- General health
- Compliance with treatment
- Effectiveness of acute and follow-up treatment
- Availability of treatment
- Social and personal support network

| Table 2:1. Haddon’s Matrix for factors influencing suicidal behaviour and its outcome (Goldney 2008). |
|---|---|---|
| **Pre-suicidal factors** | **Individual** | **Means of suicidal prevention** | **Environment behaviour** |
|  |  |  |  |
|  |  | Accessibility of: |  |
|  |  |  | Personal relationships |
|  |  |  | Community support |
|  |  |  | Media influences |
| **Suicidal behaviour** |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Post-suicidal factors** |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

This new knowledge about suicidal processes, and especially acute suicidal episodes, makes it possible to define useful suicide prevention interventions a bit more precisely. Some actions are described here, first in an overview, then through examples. Further examples are given in Chapter 10. I concentrate on direct suicidal interventions, leaving important indirect interventions, such as bridging the gap between social classes and measures against substance abuse aside for the moment.

**Overview of some suicide prevention measures**

**Pre-suicidal.** It is essential to build an infrastructure for suicide prevention, defining the responsibilities of different actors from the government, central authorities, municipalities, and welfare organizations. This includes:

- Collaboration with the media in order to promote good and responsible reports about suicide and suicide prevention.
- Training in life skills in schools and organizing a general public mental health campaign over a lengthy period in order to train everyone in good mental health practices, and also to embrace mental life-saving as a supplement to physical life-saving.
- Plans for restriction of available suicidal methods.
• Plans for crisis action, especially for crises that may increase the risk of further suicidal acts; examples of such plans are forms/rituals for grieving after a suicide or suicide attempt, e.g. in schools, working life and among survivors, and also for coping optimally with suicidal clusters.

• Developing mental healthcare for the understanding, analysis and treatment of early suicidal thoughts, and working with coaches and outreach activities to reduce dropout from treatment programs.

• Research projects for the microanalysis of suicidal events ending in death or near death.

**Suicidal:** Observing, meeting and treating people with acute suicidal episodes, and also chronic suicidality.

**Post-suicidal:** Lower thresholds for help-seeking behaviour.

• Developing methods for suicide diagnosis, prevention and follow-up in general health care.

• Developing intensive departments for suicidal persons, e.g. with psychological laboratories for identifying and coping with suicidal thoughts.

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**Examples of suicide prevention interventions in Safe Communities**

In what follows, examples of interventions at a community level are presented. The focus is on the early stages of the suicidal process. Some of them are divided into three phases: before, during, and after the acute suicidal episode.

**Public mental health**

Everyone is supposed to know how to save a drowning person, and how to do mouth-to-mouth resuscitation, i.e. *physical life-saving*. But few know how to encounter a person filled with mental pain and close to suicide, *mental life-saving*.

In an acute suicidal episode, the expert is usually far away. First aid is given by a layman. Accordingly, everyone needs to know the principles. The goal is to be able to react rationally when meeting a person in an acute suicidal episode and afterwards. Training may be achieved through lectures (usually two full days), and through films, brochures, the media, etc. The first objective is to overcome the suicide taboo, which is the irrational horror of speaking about death and suicide.
Goals of training in mental life-saving

People think of suicide, now and then, everywhere. Sometimes, they get captured by their thoughts. Then, it may be dangerous, and they need help. The first step is to overcome the horror of talking about suicide, the suicide taboo, and get training in mental life-saving. After that they should:

• be able to talk about existential questions, about life, death and suicide, and talk about them without irrational fear;
• have basic knowledge about anxiety, depression, violation and suicidality;
• know how to talk to people about these matters; and,
• know to whom they can refer to if they cannot cope with the situation themselves.

These goals have been formulated by Suicide Prevention in the West organized by the West-Swedish Network for Suicide Prevention, WNS, a lobby organization for suicide prevention in the regions of Halland and Västra Götaland in western Sweden, of which the author is a leader.

The media

Suicidal ideas are contagious, especially among youth. To speak and write about suicide must be done with responsibility. The WHO’s rules for professionals are a helpful guide for everyone.

Norway, a country that has worked with suicide prevention for more than ten years, has developed close collaboration between its suicide prevention agency and Norway’s journalists’ organization (see www.selvmord.no). The aspects below are taken from their experiences.

1. Before the suicidal episode. The WHO’s rules have been re-formulated and adapted to circumstances in Norway. Through articles, brochures and books, in conferences and seminars, these rules are debated, and understanding is made deeper.

2. During the suicidal episode. Reporting about individual, and especially about clusters of suicidal acts, deserves special caution. Discussions between professionals and journalists are necessary. Recommendations for hot lines and other forms of support have to be published.

3. After the suicidal episode. There is joint monitoring of how the rules are followed. A special prize focuses on journalistic achievements within the field, while reporting errors are criticized.
Summary of guidelines for the media in suicide prevention (WHO 2000)

*What to do:*
- Work closely with health authorities in presenting the facts.
- Refer to suicide as a completed suicide, not a successful one.
- Present only relevant data, on inside pages.
- Highlight alternatives to suicide.
- Provide information on help lines and community resources.
- Publicize risk indicators and warning signs.

*What not to do:*
- Don’t publish photographs or suicide notes.
- Don’t report specific details of the method used.
- Don’t provide simplistic reasons.
- Don’t glorify or sensationalize suicide.
- Don’t use religious or cultural stereotypes.
- Don’t apportion blame.

**Elderly people**

**Outreach activities.** The tendency to isolate elderly people from society must be counteracted. A good example of prevention before an acute episode is the Tele-Help/Tele-Check service, established in the Veneto region of Italy (de Leo et al. 1995). Users can send alarm signals when in danger, but are also contacted by telephone twice a week. They may also contact the centre at any time and for any reason. Follow-up after ten years (N=20,000) shows a statistically significant fall in the number of suicides compared with the expected number. Text messages by mobile telephone (Beskow 2009) and the use of computers in homes connected to a service station are new technical aids that can be used.

**Increased competence** in suicidal care for elderly people is an important intermediate goal. Suicide Prevention in the West, together with the survivors’ organization in Sweden, has developed study material, which includes two films. A hint of its general principle – to help personnel speak openly and without fear about issues of life and death with elderly people – is illustrated in the box below.
Example. Hedwig doesn’t want to live any more
When Maria from home services arrives at Hedwig’s (95), the old woman is lying in her bed, with her back towards the room, saying nothing. After some coaxing, Hedwig mutters in a low voice tainted by aggression: “I don’t want to live any more!” Maria gets scared, but succeeds in avoiding a standard response like “Don’t think that way. There are still good moments ahead. Let’s have a cup of coffee!” Instead, Maria starts pondering over what Hedwig actually said and then asks: “Please Hedwig, tell me more. What are you thinking about?”

“Don’t want to live” may mean that Hedwig has reached and accepted a final stage of life, and that death is near. More probably, however, it means that Hedwig is depressed. Then, she needs diagnosis and treatment. Hedwig may also be preoccupied with a normal mourning process, since her son died recently. Or she may feel violated and angry over an insult, and thinks of suicide as a good escape from an unacceptable situation. Whatever it might be, Maria needs to differentiate between normal dying, anxiety, depression, feeling of violation, and suicidality. When Maria talks respectfully with Hedwig, and with interest, she invites her to re-enter the human community. The first suicide prevention step is decisive to suicide prevention.

Mental healthcare including substance abuse
Psychiatric or psychosocial treatment? A suicide rate of 5-10 per 100,000 can be ascribed to hereditary factors, expressed, for example, in impaired transportation of serotonin. This rate is probably roughly the same in all cultures (Goldney 2008). The focus of suicide prevention in countries with relatively low suicide rates may therefore lie on increasing the quality of individual care, e.g. through early detection and treatment of people at risk, but always with due consideration of individual psychosocial circumstances.

Higher suicide rates indicate a greater impact of psychosocial factors. The focus must then be on strengthening community solidarity by combating economic and social gaps between population groups, counteracting social problems, such as indebtedness and the abuse of drugs, and restricting the availability of suicide methods. Even then, of course, individuals have to be treated.

Suicide prevention in psychiatric care. Psychiatry is an essential part of suicide prevention, particularly in countries with a low suicide frequency.
1. Before the suicidal episode

- **Increase the general standard of care.** Suicidality is a problem area with about the same death rate and complexity as heart disorder. Suicide Prevention in the West has therefore formulated a reasonable standard: “*The care of suicidal persons should have the same quality regarding personnel and technology as heart intensive-care wards*”. The huge differences in suicide ward quality are totally unacceptable.

- **Increase the competence** of health personnel in suicide prevention. Health personnel are often still caught in the suicidal taboo. Often, they can speak about suicidal thoughts as symptoms, but not as suicide as a real option for a patient in a stagnating and hurtful problem-solving process. Greater stress on problem-solving helps early detection, when suicide prevention may still be useful. Remember: It is always the patient who decides between life and death. Consequently, patients need detailed knowledge about their own suicidality.

- **Work with a low threshold** for taking contacts when needed. That this is an important principle is shown in research projects that have succeeded in lowering the relapse frequency following suicide attempt (Brown et al. 2002/2005, Wang 2009).

- **Make cognitive psychotherapy (CBT) available.** Why? Because: a) CBT has a strict scientific base; b) it is goal-directed, solving one problem first, the others next (not all at the same time); it always chooses the most dangerous problem first, i.e. the threat to life; c) it is effective, requiring a minimum of sessions; and, d) it is well structured, keeping the anxiety of the client at a manageable level.

- **Create psychological laboratories** for eliciting, analyzing and training, to cope with acute suicidal episodes.

2. During the suicidal episode

- **Evaluate the suicide risk.** There are a lot of schemas for this, which may be useful even if their predictive value is restricted. The patient has to involve the therapist in the problem-solving process. As “two researchers”, they attack the patient’s suicidality as a problem, engaging both of them. The patient contributes her unique knowledge about herself and her suicidal thoughts, the therapist her experiences, theories and techniques in order to strengthen the patient’s coping capacity.
3. After the suicidal episode

- *Undertake a microanalysis of the episode* and pinpoint the still only partly understood message that the patient has tried to communicate to herself through the act. Let the result be a platform for further analysis of the patient’s life problems.
Lessons to be learnt

- Recent research has modified and differentiated our understanding of the suicidal process. It is now possible to see the connection between suicides, acts of violence and accidents, since all three are based on cognitive insufficiency in unusual and extreme situations.

- Suicidal thoughts have normal functions with adaptive and survival values, but can deteriorate into pathologic suicidality and increase the risk of suicide.

- Also, in the presence of suicidal modes, small everyday triggers can elicit suicidal acts, which can then be conceived of as accidents. Then, prevention can use principles from accident prevention, such as Haddon’s matrix.

- In acute suicidal episodes, the risk of suicide can increase rapidly. The person may lose his or her control of the situation, and is dependent on rescue by other persons. Public mental health information must prepare everyone to provide such help – mental life-saving.

- After the episode, the suicidal risk may be reduced to different levels of baseline suicidal risk, with different implications for prevention.

- Both general social and individual interventions are necessary. Biological/genetic anomalies may be responsible for only a small part of suicidal acts. In countries with low suicide rates, the individual treatment perspective may therefore prevail; by contrast, in countries with high figures, the social preventive perspective should be predominant.

- The tasks of suicide prevention in the future are not only to identify and treat mental disorders or to identify and provide support with difficult psychosocial problems, but also to identify the suicidal process in the individual as a problem in its own right and to help the suicidal person to understand and cope with it.

- A specific challenge is to cope with short acute suicidal episodes, mental accidents, when the person is overwhelmed by his/her suicidal emotions and in need of support from other people.

- The challenge for Safe Communities in Suicide Prevention is to create safety (knowledge and structures) so that normal and helpful suicidality
neither intentionally nor non-intentionally results in death or other forms of injury. The visionary goal should be a community without suicides.

- The first principle is, however, to support better mental health. The examples of good interventions given in chapters 2 and 10, as in many of the other chapters in this book, may be used for the development of Safe Communities. Most of these imply prevention and intervention at a community level, leading to better integration of the suicidal person into the community. The concept of Safe Communities is therefore especially well suited to meet the challenges ahead.
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Chapter 3.
Epidemiological issues related to suicide and self inflicted injuries

By Lars-Gunnar Hörte

In the previous chapter Jan Beskow discussed the meaning of suicidality and clarified some of the biological, medical and psychological aspects related to suicide and possible suicide prevention interventions. Nevertheless a question remains: is that enough to develop prevention programs based on communities?

To develop effective interventions and assign adequate budgets there is also a need to become aware of the dimension of the problem of suicidality in every place, region and circumstances. For that we need to use statistic and epidemiological tools, knowing that owing to the relative low incidence of suicide the value of statistical data is limited and the researcher has to use other scientific methods.

Suicide is a reality that can be expressed statistically

The statistical realities of suicide are frequently presented in academic and political forums. But they are often expressed differently without always realizing that data mean different things for different audiences.

According to statistics from the World Health Organization, suicides are the 10th leading cause of mortality in the world. They are just as common as road traffic deaths (Murray, Lopez 1996), and a leading cause of death among the young, an age group in which rates have been increasing to such a point that they are currently the group at highest risk in one third of all countries, high income and low income countries alike. The situation is worsening among youth: 2002 was the fifth consecutive year where there were more than 30,000 suicide deaths.

Every year, almost one million people die from suicide; a “global” mortality rate of 16 per 100,000, or one death every 40 seconds.

For every suicide there are at least 20 suicide attempts. Self-inflicted injuries represented 1.8 percent of the global burden of disease in 1998 and are expected to
increase to 2.4 percent in 2020. In the last 45 years, suicide rates have increased by 60 percent in some countries and, worldwide, suicide ranks among the three leading causes of death among those aged 15-44 years.

Suicide also has regional and national variations; the rate in Japan, 25 per 100,000, greatly exceeds that of the UK (7.4 per 100,000) and that of the US or Germany, 12 and 15.8, respectively (Ministry of Health and Welfare 2000).

Among countries reporting suicide to the World Health Organization, the highest rates are recorded in the Eastern European countries; and, among them, Belarus (41.5 per 100,000), Lithuania (51.6 per 100,000), Estonia 37.9 and the Russian Federation have higher rates than others within the same region. In contrast, low rates are found in Latin America, e.g. in Colombia, where violence and homicide rates are high.

Does that mean, as interpreted by some, that when homicide rates are high suicide rates tend to be low? Do they really have different tendencies?

What is clear is that one has to be careful in the way data are interpreted. On the one hand, countries like Sweden and Finland have had data on suicide rates since the 18th century. In one way this reflects how much they have advanced in collecting and interpreting data; in another way, it must be recognised that the criteria for recording and quality of statistics vary from country to country. If solutions are to be found one must resist the temptation of accepting easy explanations and attribute changes too quickly to new social and economic realities.

Numbers apart, suicide is not given the same attention or the same level of resources as that given to traffic accidents, for example.

**Suicide is a social reality worldwide, but also reflects local social circumstances for which we need specific locally based social solutions**

Many authors venture explanations of the social phenomena accompanying suicide. This is independent of whether they are part of the lay or the scientific press. According to some, the suicide rate in middle aged men (40-54 years), observed in Japan to five times higher than in women, can be explained because of the association between suicide, unemployment, and economic recession (Takei et al.2000, Desapriya 2002).

In contrast to the above interpretation of the Japanese reality we could discuss the Irish reality where suicide rates among males of all ages, but particularly among the young, have been steadily going up since the economy of the country improved after joining the European Union (Mittendorfer et al.2004). In a similar manner, we could study the Russian suicides. In fact, when Gorbachev introduced Perestroika, suicide rates decreased in Russia; the phenomenon was originally attributed to a better
economy and the suicide-preventive efforts brought about by Gorbachev’s reforms. Unfortunately, the good results did not last.

Since 1990 there has been an increase in the suicide rate and overall mortality in Russia, which has been attributed to an increase in alcohol consumption (Värnik 1997).

This phenomenon of reduced suicide numbers being associated with restricted access and reduced alcohol consumption, and the opposite of increased numbers of suicide being associated with increased alcohol access and consumption has been discussed in the literature (Wasserman et al. 1998, Leon et al. 1997).

The knowledge accumulated so far should be enough to justify diminished alcohol accessibility to alcoholics and other population groups together with other social interventions (Skog 1991, Wasserman 1992).

After reading the literature, one can be certain that certain long-held popular mythical statements should be avoided: “The Swedes commit suicide more than others. They are wealthy and bored with life”, “The Japanese glorify suicide, so do Koreans”. “Catholics kill themselves more than do Protestants”. Such stereotypical portrayals of suicide not only suggest that suicide does not hurt, but also they are largely misleading, confuse thought, and do harm. Suicide always hurts. Above all, suicide is a public health problem that must be treated as preventable, as are other injuries, and therefore given resources and commitment commensurate with other important health issues.

“In a ranking of 34 European countries from highest to lowest according to their suicide rate, Sweden lies in 21st place. Suicide rates in Europe vary considerably between countries and regions, between urban and rural areas, and by gender and age, all of which underscores the importance of social and cultural factors” (WHO 2002).

Costs

There are substantial costs associated with lives lost to suicide. These arise from the loss of economic potential, from the often devastating effects of symptoms of bereavement through suicide, from the medical and mental health costs associated with suicide attempts, and from the burden of family care for those who have made suicide attempts.

*Internationally, the annual cost of suicidal behaviour is enormous* (Yang et al. 2007).
Family and community impact

The families of those who make suicide attempts are often especially anxious and concerned about the risk of further suicidal behaviour, and about their responsibilities in trying to prevent further attempts. In the same way, societies where suicide has been identified as a problem are anxious to discover effective interventions to avoid suicide.

It has been accepted that “suicide always has a major impact on the survivors”. Suicide is a threatening event not only among close family members, but also in the surrounding population, including treatment personnel and the people at the victim’s workplace or school. The major challenges after suicide in addition to the normal mourning process, are dealing with the shame and guilt feelings, and the crisis of survivors. Sharing of the traumatic experience and social support should be arranged immediately and continued, if necessary, at least for the first 6 months after the suicide and with the help of mental health professionals” (Jouko, Lönnqvist 2000).

Why the inconsistencies and differences in the numbers

Differences in numbers may be due to the way suicide is perceived, but also to the ways definitions are interpreted and the way numbers are reported, collected and interpreted. The quality of data varies so much that comparisons may – up to a point – be a futile exercise.

Perhaps the need for social inclusion and related interventions is most graphically illustrated in figure 3.1 that tracks the rate of suicide by geographical area in the US. The colour red is used below to reflect the highest suicide rates, i.e. from 30 to 40 plus suicides per 100,000 from the period 1988-1992. This map makes it clear that the highest rates of suicide are found in the most sparsely settled, mountainous, isolated regions, e.g. Nevada, Wyoming, Montana, and the Big Bend region of the Texas panhandle, all in the American West.

Description of some of the difficulties in gathering and interpreting data

With some much information available coming from many different quarters, it is obvious that if those data are to be compared there is a need to have a unified methodology for gathering data about suicide and suicide attempts, and also on the way of measuring effects from the interventions. Traditionally the WHO has been the leader in this field, and as such their experts have identified some of the technical difficulties.
Difficulties in gathering and interpreting data

With some much information available coming from many different quarters, it is obvious that if those data are to be compared there is a need to have a unified methodology for gathering data about suicide and suicide attempts, and also on the way of measuring effects from the interventions. Traditionally the WHO has been the leader in this field, and as such their experts have identified some of the technical difficulties.

Mortality

Accurate and timely data on deaths and causes of death with medical certification are essential for any medical condition. The WHO collects information on causes of death from its Member States annually. But for more than a fourth of the world’s population – largely in Africa, South-East Asia and the Middle East – the WHO has no recent data available. These are the regions where much of the burden of disease falls. Altogether, 115 Member States have some form of death registration known to the WHO. They include China and India, which also have sample vital registration systems.
An assessment of the quality of cause-of-death information by the WHO suggests that ideal civil registration systems operate in only 29 of 115 countries that report such statistics to the WHO. These systems represent less than 13% of the world population. In the remaining countries, mortality statistics suffer from incomplete registration of births and deaths, and incorrect reporting of causes of death and ages. These include suicide.

The suicide problem is something that is talked about in most countries. Comparisons are made with other countries, but few know what the statistics stand for. Let us look at them for a moment.

- “Suicide is defined as a death arising from an act inflicted upon oneself with the intent to kill oneself” (Rosenberg et al. 1988).
- 86% of all suicides occurred in low and middle income countries.

**Coding**

In 1948 the WHO published the International Statistical Classification of Diseases and Related Health Problems (ICD), a book with rules and codes for different diseases and causes of death. This code list was to be updated every 10 years. The latest version available today is the tenth revision (ICD-10).

Not all countries have adopted this updated version, and many still use ICD 9.

At the beginning suicide was coded as E970 to E979 (ICD7), according to the method used by the victim. When ICD-8 was implemented (1965) WHO Board decided that the new numbers were E950 to E959 there should be a new way of classifying a case where it was uncertain whether it was a suicide or an accident inflicted by someone else or by the victim him/herself. It was pointed out that, in some cases, an apparent suicide could even be due to a disease. The code numbers were E980–E989. In cases under these codes, little was known whether or not there was intent to commit suicide. For example, it can be very difficult to establish whether a person has taken too much of a drug by accident or with an intent to kill himself. The same problem can be seen with drowning, at least in cases where nobody has witnessed the act.

Another problem to consider when comparing statistics from different countries is the autopsy rate. Again, it is very difficult to find the right external cause if the coroner/forensic specialist cannot perform an autopsy. The autopsy rate varies between countries.

In 1992 the 10th revision of ICD was published by the WHO. The code numbers were changed from X60 to X84 and Y10 to Y34 respectively.
All of these factors lead to confusion in the field and make it subject to potentially major errors.

**Who decides whether there is a suicide or not?**

In most countries a death certificate is usually signed by a doctor. The forms are made according to the International Form of Medical Certification of Cause of Death that the WHO has published. The doctors have to decide whether a case is a suicide or “unclear” death, and give that information on the certificate.

How is one to estimate the number of suicides? In most publications, only the cases coded as suicide are counted and published. The problem is how to deal with the uncertain cases. In Sweden the number of uncertain cases is about 20% of the total number of deaths. From various studies, we know that approximately 75% of these may be suicide. The rest are probably something else.

Is it fair to sum suicides and unclear cases? It is at least worth thinking about.

There are many other problems to take into account. For example, doctors have different opinions on whether or not a case is a suicide or not. There are a few reports published that show that there can be legitimate differences. Another issue to consider is that religion can affect a doctor’s willingness to report a death as suicide.

On the one hand, there is the problem of false positives. There could be cases registered as suicide that are probably not. One example is poisonings. In a report from Sweden on suicides where people had been taking a special kind of drug (Dextropropoxifen) the authors discussed whether the diagnoses were suicide or not. The authors argued that they were not suicides, but the result of taking the drug and drinking alcohol at the same time. If they are right, the statistics are wrong.

On the other hand, there are some accidents reported as traffic accidents that rightfully should be listed as suicide.

**How to calculate the number of suicides**

Is it correct to sum the numbers of suicides and unclear cases? Maybe. But you have always to take into account the problems we have listed above.

Figure 3.2. Suicide mortality rates in WHO regions by age group and sex. The data cited in this book were taken from the year 2000 (WHO 2000).

Figure 3.2 shows that worldwide the highest suicide rates are found among males in the European Region and among both sexes in the Western Pacific.

Over 50% of the global mortality due to suicide occurs among young persons aged between 15 and 44.

Males in the low and middle income countries of Europe have a suicide rate that is almost twice as high as those among men in the other regional groupings. Similarly, women in China have a suicide rate that is approximately twice that of women in other parts of the world.

Suicide burden and Disability Adjusted Life Years (DALYs), are shown in Figure 3.3.

The Western Pacific Region (WPR) accounts for 38% of the total number of DALY’s lost globally to suicide. Are all these cases true suicides? What about the uncertain cases?
Difficulties involved in interpreting statistics

Statistics are powerful tools. Without them we could not envisage the world. But they also have their limitations:

- On the one hand, they are difficult and expensive to obtain, and require training and investment.
- On the other hand, to comparable statistics have to be of similar quality. There is a real problem with the quality of data in many parts of the world.
- They also must mean the same; people have to discuss what the meanings are of the concepts they employ.
- In certain quarters, mainly academic and governmental, there is an overdependence on statistical interpretations to the point of paralysis. For some, a lack of statistical information and analysis, understood within narrow mind frames, is enough to invalidate experiences of tremendous local importance. Within our community approach just because the numbers do not add is not enough to invalidate the meaning of some achievements.
Community perception counts for a lot! Therefore, anything you do to strengthen communities around any problem or situation often has more value than do the cold numbers themselves. In other words, community interventions, whether they can be measured or not in statistical terms, may have a healing power that makes them worthwhile.

- With suicide prevention we have the same problems that we find with any form of prevention: that success is measured by a lack of events. In other words, success is measured by non-events, and people find it difficult to invest or give importance to things that do not happen. They tend to believe that they are immune to the problem.

- Suicide is still a rare event in small populations. That means that it is likely that many years would be needed to detect whether the efforts made in communities, resulting in significant decreases in numbers, could be attributed to the interventions.

- Should the statistics of rare events invalidate the efforts and the integrative work of the community as well as the gluing effect and the importance of such interventions in the healing process? In our approach, the quality of life and construction of community are important goals in themselves. That is also what this book is all about.

- Modern statistical methods. There are modern statistical methods to deal with small numbers, and they should be used when dealing with situations where it is not possible to obtain large numbers. But there are also qualitative methods, and those adopted in the social sciences, when used in conjunction with quantitative ones, can do much to strengthen the overall evaluative process.

Suicide is difficult conceptually and technically

As mentioned by Jan Beskow due to the nature of suicide, in many cases and circumstances, it might be very difficult to define with precision whether a person has committed suicide or not.

Are suicides only those dramatic, acute cases where victims, for example, shoot themselves or hang themselves or take a highly poisonous substance with acute effects? Or, should we also include – as well as what is included in the definition – behaviours like those of patients suffering anorexia nervosa, or those who neglect themselves, or those who indulge in risky behaviours that shorten life? Are deaths that occur after
drinking alcohol and driving at high speeds suicides? Who can tell whether many of those who disappear in the sea are not victims of drowning but suicides?

Perhaps communities can help to widen the narrow view that health professionals and criminologists have of suicide. This book aspires to open the minds of many by showing them different approaches to dealing with suicide.

In this book, though, we will accept the definition given by the WHO and international bodies where “suicide is considered as a fatal act of self-injury (self-harm) undertaken with more or less conscious self-destructive intent, however vague and ambiguous” (Jouko et al. 2002).

References


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Chapter 4.  
The community approach and the need to develop safety promotion

Community

Definitions and interpretations of communities range from the scepticism expressed by Noam Chomsky that “community is PR bullshit designed in the 1930s by the corporations as means of social control” to the complex ones proposed by sociologists and other social scientists.

Like most constructs in the social sciences, communities can be identified but are not easily defined; they may come in many forms, sizes and may be situated in different locations, no two of which are alike. More importantly, a community is not just the people who are in it (Photo 4.1.). It is something that is beyond its very components, its residents or community members.

Photo 4.1. A community is not just the people who are in it. A group of men in a canoe- in Kerala, India. (Photo:LS)

Communities are defined not just by what they do, but for what they do based on shared expectations, values, beliefs and meanings between individuals. And
Community interventions are distinguished by a shift in focus away from individual responsibility towards multifaceted community-wide interventions designed to ensure that everyone in the community is involved (Ekman 1999).

Within the Safe Community approach, communities necessarily include the political, administrative and power structures. They change like “living organisms” do, but like them they have identifiable patterns that need to be understood to understand and make viable any political system and all subsystems that make part of them.

**What is community for us?**

In this book community means: a real, concrete group of people that make part of a concrete societal structure, and therefore we acknowledge state, political, and power structures as essential components of communities. This inclusion means active participation, social and not only personal responsibility, outside the clan and family; it means a sense of belonging to a wider group.

We see many actions without community participation and as long as there is exclusion, incomplete solution and high possibilities of failure, frustration and resentment will prevail. On the contrary, community participation is a source of strength that leads to a better quality of solutions like inclusion.
Solidarity self imposed limits.
So far efforts to prevent suicide seem not to have taken communities into consideration.

Some basic principles
To understand the meaning of community it is necessary to bear in mind certain principles.

- Communities are more important than societal structures.
- Nevertheless, communities are not in the air. They are part of specific societies and therefore subjected to their structures, their dynamics, and their rules.
- States and state structures are important components of any community and cannot be ignored.
- However, these structures cannot become more important than the communities that they are supposed to serve.
- It is very easy to perpetuate and defend structures for their own sake. The only way to avoid this is through strong communities.

Communities may mean different things to different people:
In Sweden and in other European countries all communities are approached similarly (Photo 4.3.). Educated and privileged people do not routinely resent being part of a given community. Authorities and experts are included in the concept of community. On the other hand, in places like Latin America, traditionally the privileged do not like to be referred to by this name or perceived as being part of communities. They are members of clubs or interest groups that consider themselves as self sufficient, which by definition exclude others. The rich might encourage the creation of communities, or manage them, but rich people are not usually part of communities. While there are internationally recognized Safe Communities in Latin America, a community is a term most commonly applied to the poor or to religious communities, i.e. considered as, sociological jargon.

Nevertheless, communities do exist, and we believe that outside a community it is not possible to find appropriate solutions for injury prevention and safety promotion.
For the concept of communities to be useful in suicide prevention means

- To acknowledge the existence of communities as real live structures.
- To acknowledge that everyone is part of a community or many communities.
- To accept that communities have rules.
- To accept that rules are created for survival and better coexistence.
- To acknowledge that when societies disorganize themselves individuals are most at risk because they tend to be excluded.

The ultimate objective of the Safe Communities movement is to prevent injuries and promote safety. Within this concept we include suicide prevention and promotion of strong and organized communities that could impact suicide prevention and advance integrated treatment for suicide attempters and the families of suicide victims.
Safety and safety promotion

**Safety promotion** is the process applied at a local, national and international level by individuals, communities, governments and others, including enterprises and non-governmental organisations, to develop and sustain safety. This process includes all efforts agreed upon to modify structures, environment (physical, social, technological, political, economical and organisational), as well as attitudes and behaviours related to safety (WHO 1998).

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**Photo 4.4.** “Safety promotion process includes all efforts agreed upon to modify structures, environment...”. (Photo: GS)

The following are concepts that we need to grasp in order to understand the role of Safety in Communities in suicide prevention.

**Safety**

1. Safety is a fundamental human right.

2. Safety is a state in which hazards and conditions leading to physical, psychological or material harm are controlled in order to preserve the health and well-being of individuals and the community. It is an essential resource for everyday life that an individual and a community need in order to fulfil their aspirations.

3. There are two components to safety: one is objective and assessed by behavioural and environmental objective parameters and the other is subjective and appreciated according to the feeling of safety (or insecurity) of the population (WHO 1998).
Both dimensions can influence each other either positively or negatively (Forde 1993). Indeed, improvement of the objective dimension can sometimes diminish the subjective dimension (e.g. the presence of numerous armed policemen in a given area to fight crime could generate a feeling of panic among some citizens). On the other hand, improving the feeling of safety can lead to a deterioration of the objective dimension (e.g. acquiring a firearm to feel better protected from attacks increases the risk of having a household injury). This dynamic between the objective and subjective dimensions of safety is sometimes even used to prevent some problems by inducing a feeling of insecurity in order to encourage safer behaviours that will benefit all (e.g. reducing the width of roads to slow traffic speed in school zones. In suicide we must not only consider the so called objective dimension.

4. Safety is a prerequisite to the maintenance and improvement of the well-being and health of the population. It is the result of a dynamic balance that is established between the different components within a specific setting.

5. Attaining an optimum level of safety requires individuals, communities, governments and others to create and maintain the four following conditions: 1) a climate of social cohesion and peace as well as equity in protecting human rights and freedoms at a family, local, national or international level; 2) the prevention and control of injuries and other consequences or harms caused by accidents violence and suicide; 3) the respect of values as well as the physical, material and psychological integrity of individuals ; and 4) the provision of effective preventive, control and rehabilitation measures to ensure the presence of the three previous conditions.

**Safety promotion**

6. Safety promotion is the process applied at a local, national and international level by individuals, communities, governments and others, including enterprises and non governmental organisations, to develop and sustain safety. This process includes all efforts agreed upon to modify the environment and structures as well as the attitudes and behaviours related to safety. It is based on a multisectorial approach and includes community enabling activities.

7. At least two types of processes can be used to promote safety in a community: the *problem-oriented* process and the *setting-oriented* process (WHO 1998). The two processes, though quite distinct, are both complementary and essential. The problem-oriented process is the search of specific solutions to problems considered one at a time. The setting oriented process consists
above all in the assessment of the safety problems of a specific setting in a
global perspective and in the identification of an integrated set of solutions
aimed at improving the safety level of the population.

8. The mobilisation of a community towards safety improvement requires the
presence of many critical factors, the most important being the following:
- the existence of a multisectorial committee responsible for safety
  promotion;
- the implementation of a programme covering all ages, environments and
  situations;
- the active involvement of the local community network;
- priorities for action based on what the community feels is most
  important;
- the capacity to assess the importance and causes of main safety issues and
  problems;
- a special concern for high risk groups and environments;
- a program planned on a long term rather than a short term basis; and
- use of a wide range of techniques to mobilise the population, its
  representatives and decision makers.

These eight statements provide a global and positive point of view in regards to safety
and safety promotion. It is useful to better understand and integrate the efforts made in
a community to improve its safety. It should also favour mobilisation of the population
and multisectorial partnerships aiming toward common safety goals, and thus should
favour the effectiveness and efficiency of interventions.

Main reasons to develop a safety promotion framework

Safety is a basic human need

Safety is an ever present concern within the population. Most individuals seek safety
by all means. Therefore safety improvement as an explicit goal can be a powerful
mobilising force. It is thus important to develop an enabling approach to facilitate the
achievement of this goal.

Many safety issues are related to each other in many aspects

Many safety issues share common risk factors. For example, firearms, medication,
drugs and alcohol are all related to suicide, violence, criminality and non intentional
injuries. Interventions that take into account these risks and problems globally are liable to be more effective and efficient.

Many of the recipes against suicide address just the accessibility of means and preach restriction. It is necessary to restrict access but this alone is insufficient and simple.

**Safety means more than the absence of violent events or injuries**

Safety is based in more conditions than just the absence of violent events or injuries. Furthermore, safety includes a subjective dimension that is important to take into account. This dimension is influenced by individual and collective experience which will act upon the feeling of safety of the community. This observation explains to a certain extent why, for example, in some communities the feeling of safety diminishes while the magnitude of safety problems as injury, violence or crime remains the same.

**Safety enhancement is a specific mandate for several agencies**

Whoever works in safety improvement activities knows the indispensable contribution of a set of sectors such as health, public safety, transport, justice, sports and recreation, housing, etc., when the time comes for creating and implementing interventions. These sectors generally have among their mandates the enhancement of the population’s safety. That is why a framework on the concepts of safety and safety promotion can be a helpful tool for them.

**There is no common understanding of “safety”**

Much confusion exists concerning the concept of safety. For some, this concept refers only to the prevention of crime and violence; for others it refers more to a feeling of being out of danger than to an objective state, or it refers to the satisfaction of basic needs (food, shelter, clothing, etc.). These interpretations do not always include injury prevention, *much less suicide prevention*. In fact, the concept of “safety” is quite difficult to understand in all its dimensions (physical, social, psychological, etc.), and therefore difficult to promote.

Having a common understanding of safety should favour better cooperation between the variety of disciplines and sectors concerned, and consequently reduce the state of isolation the interventions are in. Also, it should stimulate the development of initiatives that can reduce the occurrence of a given problem, and improve the
safety of the population in a comprehensive perspective. This can only help to create a positive vision of safety as a value worth promoting in our communities.

In some settings and circumstances the use of the term Safety may have problematic results because of its political undertones. In a recent presentation of the Safe Communities model in Bogotá, there was strong resistance from some quarters to the use of the word “Safety” (mainly by some of the groups most interested in working on the concept of safe communities within the city), because the word and the concept of safety are part and parcel of the “Democratic Safety Program” (Programa de Seguridad Democrática) promoted by the national government to fight left wing guerrillas and other opposition groups.

A safety promotion framework can be a good junction point between concerned actors from a variety of sectors of society

Many approaches are used in the field of safety promotion and injury prevention. These approaches attract different followers, often based on their occupation, sector and country of origin. Each group uses a specific vocabulary and may have very different ways of understanding reality, as well as of designing interventions and putting them
into place. For example, in order to prevent violence in a neighbourhood, the police department might use repressive measures, the urban planning department will favour environmental measures to avoid opportunities for assaults and the recreational department will put forward a program to foster activities for youths. As for the actors from other sectors, they could favour programs aimed at preventing violence by implementing measures focused on early childhood. Yet, all are working toward the same goal. However, the absence of a common thread among these models of intervention results in misunderstanding among various groups and makes it difficult to understand each group’s actions in light of the realm of possible interventions (Else 1978); (Hayes 1996). When safety proponents work in isolation, the achievement of shared goals may be compromised. A common framework for these players can therefore represent a useful common thread among the various models used. It also favours collaboration between proponents and a better co-ordination of their interventions. The mobilisation of all partners involved in safety will then be facilitated.

A consensus has been reached as to the following elements:

1. Safety as a human right.
2. Safety as a prerequisite to well-being and health.
3. Principles to respect in a definition of safety.
4. Subjective and objective dimensions of safety.
5. Main conditions necessary to attain safety.
7. Safety promotion general process.

The following framework is based on these consensuses.

**Conditions of Safety**

To improve the safety of the population, it is necessary to consider the two dimensions previously mentioned for the following reasons:

- While much of what the population perceives as a problem is well-founded, it may not be demonstrable with objective parameters (Hayes 1996).
- Safety promotion programs need to be adapted to each community, to its real-life as well as to its subjective judgements about situations affecting it (Forde 1993, Svanström 1993).
The dynamic between objective and subjective dimensions can better be taken into account while assessing the problems and planning the interventions.

The objective and subjective dimensions of safety can differ dramatically because of the numerous stereotypes in society. Since people have a tendency to behave according to a certain number of stereotypes, it is important to take them into account. For example, any type of marginal behaviour can represent a risk for some because of the stereotype generated from the difference. In this case, it is important to distinguish the reality from the feeling of a population in order to protect the rights of certain marginal individuals (Augoyard 1990).

Safety is a prerequisite to the maintenance and improvement of the well-being and health of the population

According to Maslow’s Needs Theory, safety is a primary fundamental need of human beings, as are physiological needs (Maslow 1968). Consequently, safety can be viewed as a prerequisite for maintaining and improving the health and welfare of a population. The health and welfare of a population is determined mainly by environmental conditions or exhibited behaviours. The effect of behavioural and environmental determinants on health and well-being is often a function of the level of safety attained.

Photo 4.6. “Safety is a prerequisite to the maintenance and improvement of the wellbeing and health of the population.” (Photo: GS)
Four basic conditions for safety

Attaining an optimum level of safety requires individuals, communities, governments and others to create and maintain the following conditions, regardless of the setting:

1. A climate of social cohesion and peace as well as of equity in protecting human rights and freedoms at a family, local, national or international level;
2. The prevention and control of injuries and other consequences or harms caused by accidents;
3. The respect of the values and the physical, material and psychological integrity of individuals; and
4. The provision of effective preventive, control and rehabilitation measures to ensure the presence of the three previous conditions.

Safety concerns everybody. The whole community, including individuals, stakeholders, agencies and community groups must be mobilised to enhance the safety of the population. These basic conditions for safety must be present in all settings. A setting is considered a system having one or more finalities. Each setting is made up of many components (individuals, social, cultural, material, economical and technical elements, etc.) each of which fulfils a specific function. These components influence each other according to rules that are not always well known. A family, workplace, school, neighbourhood, town or a country can be regarded as a setting.

The climate of social cohesion and peace as well as of equity in protecting human rights and freedoms, at a family, local, national or international level, refers to a fair society protecting the harmony between groups or communities of different races, sexes, ages, religions, countries, etc., without impeding the rights and freedoms of individuals. This condition must lead to non-violent co-existence of these different groups or communities. It must also shelter the population from wars or any other form of organised violence. Finally, it must lead to lowering poverty and inequities both of which cause a great deal of safety problems at an international, national and local and family level.

Social cohesion means inclusion. The opposite is patronization, which is not inclusion but the creation of the rules and an atmosphere that makes it possible for some to always be winners while others remain losers and victims. This reflection applies not only to local levels but can also be applied to international relationships. In their book Berger and Mohan (Berger 1966) find that expressions such as high
income and low income countries can be more useful to describe differences in the
global distribution of wealth and also point out how these differences are reflected on
the nature and extent of injuries.

The prevention and control of injuries and others consequences or harms
cased by accidents means the presence of environments and behaviours that prevent
the occurrence of bodily lesions or other harm such as stress, social adaptation problems,
post traumatic shock, resulting from a sudden transfer of energy (mechanical, thermal,
electrical, chemical or radiant) or from sudden deprivation of any vital element (e.g.
drowning, strangulation, freezing).

The respect of the values and physical, material and psychological integrity of
the individuals refers to the harmonious and non-violent co-existence of individuals
within a life setting. This state allows each individual to live without the fear of being
personally attacked, either psychologically (harassment, hateful remarks, bullying
etc.) or physically (assault, rape, etc.), and to be able to enjoy his or her belongings
without fear of having them stolen or vandalised. Unlike the first condition (a climate
of social cohesion, peace and equity), which refers to interactions between groups,
the present condition, refers to interactions between individuals. It must be noted that
suicide is considered a self-inflicted aggression resulting in part from a dysfunctional
co-existence between an individual and his setting.

The provision of effective preventive, control and rehabilitation measures to
ensure the presence of the three previous conditions refers to resources (material,
human and financial) to programs and to services put forward in a community. These
means are aimed at ensuring the presence of the first three conditions, minimising the
harm caused by an unfortunate event and facilitating the rehabilitation of individuals
or communities affected.

These conditions are not exhaustive. Indeed other conditions could have been
added depending on the scope of the field to be included (e.g. provision of healthy
food, of work and income, etc.). However the conditions retained for this framework
delineate the field by targeting the problems of most concern in this document, that
is, violence, suicide and non intentional injury. This field generally squares with the
mandate of many organisations having a mission to ensure the safety of the population
(e.g.: public security, municipalities, justice, transport, labour, etc.). These conditions
are important and relevant for different sizes of settings such as a family, a school, a
workplace, a neighbourhood, a city, a nation, etc.
Lessons to be learnt

Communities
Like most constructs in the social sciences, communities can be identified but are not easily defined; they may come in many forms, sizes and may be situated in different locations, no two of which are alike. More importantly, a community is not just the people who are in it. It is something that is beyond its very components, its residents or community members.

Communities are defined not just by what they do, but for what they do based on shared expectations, values, beliefs and meanings between individuals. And community interventions are distinguished by a shift in focus away from individual responsibility towards multifaceted community-wide interventions designed to ensure that everyone in the community is involved.

Within the Safe Community approach, communities necessarily include the political, administrative and power structures. They change like “living organisms” do, but like them they have identifiable patterns that need to be understood to understand and make viable any political system and all subsystems that make part of them.

Communities are more important than societal structures. Nevertheless, communities are not in the air. They are part of specific societies and therefore subjected to their structures, their dynamics, and their rules. State structures are important components of any community and cannot be ignored.

The ultimate objective of the Safe Communities movement is to prevent injuries and promote safety. Within this concept we include suicide prevention and promotion of strong and organized communities that could impact suicide prevention and advance integrated treatment for suicide attempters and the families of suicide victims.

Safety
The following are concepts that we need to grasp in order to understand the role of Safety in Communities in suicide prevention:

1. Safety is a fundamental human right.
2. Safety is a state in which hazards and conditions leading to physical, psychological or material harm are controlled in order to preserve the health and well-being of individuals and the community.
3. There are two components to safety: one is objective and assessed by behavioural and environmental objective parameters and the other is subjective and appreciated according to the feeling of safety (or insecurity) of the population. Both dimensions can influence each other either positively or negatively.

4. Safety is a prerequisite to the maintenance and improvement of the well-being and health of the population. It is the result of a dynamic balance that is established between the different components within a specific setting.

5. Attaining an optimum level of safety requires individuals, communities, governments and others to create and maintain a climate of social cohesion and peace as well as equity in protecting human rights and freedoms at a family, local, national or international level.

**Safety Promotion**

6. Safety promotion is the process used at a local, national and international level by individuals, communities, governments and others.

7. The mobilisation of a community towards safety improvement requires the presence of many critical factors, the most important being the following:
   - the existence of an multisectorial committee responsible for safety promotion;
   - the implementation of a programme covering all ages, environments and situations;
   - the active involvement of the local community network;
   - priorities for action based on what the community feels is most important;
   - the capacity to assess the importance and causes of main safety issues and problems;
   - a special concern for high risk groups and environments;
   - a program planned on a long term rather than a short term basis; and
   - use of a wide range of techniques to mobilise the population, its representatives and decision makers.
Conditions of safety

Many safety issues share common risk factors. For example, firearms, medication, drugs and alcohol are all related to suicide, violence, criminality and non intentional injuries. Interventions that take into account these risks and problems globally are liable to be more effective and efficient.

Safety is based in more conditions than just the absence of violent events or injuries. Furthermore, safety includes a subjective dimension that is important to take into account.

Whoever works in safety improvement activities knows the indispensable contribution of a set of sectors such as health, public safety, transport, justice, sports and recreation, housing, etc., when the time comes for creating and implementing interventions.

Safety concerns everybody. The whole community, including individuals, stakeholders, agencies and community groups must be mobilised to enhance the safety of the population. The climate of social cohesion and peace as well as of equity in protecting human rights and freedoms, at a family, local, national or international level, refers to a fair society protecting the harmony between groups or communities of different races, sexes, ages, religions, countries, etc., without impeding the rights and freedoms of individuals.

Social cohesion means inclusion. The opposite is patronization, which is not inclusion but the creation of the rules and an atmosphere that makes it possible for some to always be winners while others remain losers and victims.

The respect of the values and physical, material and psychological integrity of the individuals refers to the harmonious and non-violent co-existence of individuals within a life setting. This state allows each individual to live without the fear of being personally attacked, either psychologically (harassment, hateful remarks, bullying etc.) or physically (assault, rape, etc.), and to be able to enjoy his or her belongings without fear of having them stolen or vandalised.
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Chapter 5.
The “Safe Communities” Model in Suicide Prevention

The “Safe Communities” movement was developed by a number of communities around the world in order to enhance safety, but its formal consequences were developed by the WHO Collaborating Centre on Community Safety Promotion at the Karolinska Institutet of Sweden under the auspices of World Health Organization. This movement aims at supporting communities in their safety enhancement activities.

At first it was involved in safety promotion through unintentional injury prevention activities and is now developing many projects with a special focus on violence or suicide.

Currently, more than one hundred and seventy communities are officially designated a “Safe Community”. To be part of the movement a community must put forward a program fulfilling different explicit principles and criteria. These are based on the theoretical and practical knowledge concerning safety promotion and community mobilisation. The effectiveness of such programs has been demonstrated on several occasions (Schelp 1987, Svanström1998).

The basic principles of programs are the following:

- Safe Community Programmes must be based on all relevant organisations in the community and closely associated with all related sectors of activity – Community Organisation. The structure used to promote safety will vary from community to community and from country to country.

- Safe Community Programmes must be based on sufficient epidemiological and other data (surveillance) to document the size and nature of safety problems, including accidents, injuries, violence, and suicide as applied to all environments, including home, transport, workplace and leisure.

- A priority for action and decision making must also be based on what the community feels is most important. Solutions should be made by the community and suggestions from outside should only be adopted if they are seen as appropriate by the community. A prerequisite for achieving this is involvement of individuals as well as communities in the process of promoting safety.
A wide range of techniques and methods must be used. These include for example mass media interventions, presentation of local data, the publication of other types of information and advice, education of professional groups as well as members of community organisations, supervision through safety rounds and checklists, environmental control and product development.

Those principles lead to a certain number of criteria to fulfil for a community to be a member of the Safe Community movement.

These are in a free text version:

- The existence of a multi sectorial based structure responsible for safety promotion.
- The involvement of the local community network.
- A programme covering all ages, environments and situations.
- A programme showing a concern for high-risk groups and high-risk environments and aiming particularly at ensuring safety for vulnerable groups.
- A programme where those that are responsible are able to document the frequency and the causes of injuries.
- The community must also undertake to:
  a. Utilise appropriate indicators to evaluate processes and the effects of change.
  b. Analyse the community’s organisations and their possibility of participation in the programme.
  c. Involve the health and well-being organisations in both surveillance and the safety promotion programme.
  d. Be prepared to involve all levels in the community in solving the safety problems.
  e. Disseminate experiences both nationally and internationally.
  f. Be prepared to contribute to a strong network of “Safe Communities”.
Community suicide prevention within the frame work of “Safe Communities”

Safety is a much wider concept than absence of injury, in the same way that health is much wider than absence of disease.

Community suicide prevention and interventions to ease the pain of suicide within a community are wider concepts than just suicide prevention as traditionally interpreted by the health and psychological establishments. More so, mental health promotion and promotion of safe, healthy communities where people do not commit suicide or if they do or attempt and fail, societal responses go beyond of what has been traditionally offered by health institutions.

Suicide, suicide attempts, as is the case with unintentional injuries, violence and crime, are better tackled within the prevention and health promotion perspective through the planning and implementation of safety enhancement interventions in a community.

Safe Communities is a specific structured model to work in communities with the purpose of preventing injuries and violence, and promoting safety. In this particular case the model has to do with what we do to prevent suicide and promote safety in relation to suicide and suicide attempts. But it also means interventions to strengthen communities that have been affected by suicides.

The fundamental idea behind developing a Safe Community is to address all kinds of safety issues and prevent injuries in all areas, encompassing all ages, environments and situations, and involving both non-governmental and governmental community sectors. This includes suicides and suicide attempts, and also dealing with the suffering created by them in a way that communities, when those events occur, may strengthen themselves.

When introducing Safe Communities we must avoid building just another structure” that attacks or integrates with the establishments when convenient. In other words, Safe Communities is not and should not be another form of ideology.

However, part of what Safe Communities movement does is to get involved in politics and political analysis.

Difficulties faced in preventing injuries and suicide and promoting safety

The tasks of the society, including those of the States, have become more complex, and the size of politics larger and more heterogeneous than the institutional forms of
liberal democracy developed in the nineteenth century. Representative democracy, along with its techno-bureaucratic administration, seems increasingly ill-suited for the novel problems we face.

The Neoliberal model, although now seemingly taking on water and floundering, is still a model highly prevalent and serves as a point of reference for most nations in the world.

Injury prevention, suicide prevention included, is still struggling to lean on those institutional forms.

*Safe Communities* at its best addresses a specific area of public problems best solved through a process of reasoned deliberation that relies on the bottom-up involvement of ordinary citizens to generate a fairer, more equitable outcome. The general principles underlying such *empowered deliberative democracy* are focused on specific, tangible problems.

- Develop solutions through deliberation;
- Involve both ordinary people affected by the problems and officials;
- The public decision authority is significantly developed to empower local units; those are in turn linked to coordinate the distribution of resources;
- This empowered deliberation is accomplished primarily through the transformation of State institutions rather than through voluntary work developed in the civil society.

We should focus on how the safe community approach gives expression and substance to the principles and ethos of injury and suicide prevention. “How do the two converge to support promotion, and can the *community safety network* be considered a social movement within the larger injury prevention sector?”

**Meaning of injury and suicide for the health professions**

Professionals, especially medical professionals, prefer to focus on injury as the door that opens the way to defining and understanding the problem. Injury is what should be prevented – mostly physical damage- but with death included. For the health establishment, society should become aware of this and cooperate to prevent those injuries, provided it is done within their framework. Health workers are more and more bothered that society does not always adopt those priorities. In other words, health professionals resent not being the ones who decide what is convenient or relevant to communities, and resent their interpretation of the facts not being accepted.
It is not the society who has to understand what the doctors say but it is the other way around. First of all, good doctors go to their people and listen to what they say.

**Meaning of injury and suicide within the framework of Safe Communities**

When Communities do join the Safe Community movement, the medical community starts reconsidering the priorities. They often come to realize that they and their ways of prioritizing can be justified only to the degree that they are part of communities wider than their own professions. It is, we have learnt, evident that the more involved community sectors and voluntary organisations become, the broader will be the concepts and realities embraced.

**Thirty years of experience in Safe Community development**

*Safe Community, as a formal concept,* is closely associated with the World Health Organization, and can be traced back to the First World Conference on Accident and Injury Prevention (Manifesto for Safe Communities 1989) and the establishment of a WHO Collaborating Centre (on Community Safety Promotion) at the Karolinska Institutet in Stockholm, *Sweden*. Ever since, the Centre has served as an engine, within a worldwide network, to spread the idea that safety can be promoted at a very basic level, and that injuries- suicide included- can be prevented.
The concept of Safe Community is a formal concept closely associated with the World Health Organization, and not an unspecific concept that can be liberally applied to any community interested in safety issues.

Local Injury Prevention and/ or Community Safety Promotion?

The first programs were all initially designed to identify areas of non-intentional injuries through hospital and primary care based injury surveillance. These activities, even if they were specifically oriented towards injury causation, became over time more general in their nature. Injury surveillance results as a starting point for safety promotion activities were crucial in the Falköping trial but were less important in other programs. Activities involved different local government sectors, as well as non-governmental organizations, formed into task force groups. These inter-sectorial groups subsequently developed their own grounds for priorities. Still they were focusing on accidents (non-intentional injuries). But towards the end of 1980’s violence and crime prevention (intentional injuries) came more into focus. Prevention of suicide attempts (self-inflicted injuries) has later been included in the work of some communities.

Only after prevention efforts were developed for other forms of injuries did we become aware that suicide could also be better prevented from and within the communities.

Injury Prevention and Safety Promotion – a Concern for the World Health Organization

The World Health Organization has long since launched a Global Program on Injury Prevention. This program has shown an interest in specific sectors that reflect a high toll on human life, e.g. traffic, where World Health Day 2004 focused on this area. Another approach is that some specific type of injury is brought into the focus of the World Community, such as violence. In the 2002 “World Report on Violence and Health” it was stated that each year over 1.6 million lives are lost due to violence.

The local and community levels continue to be central for prevention efforts. This goes back to the tradition of the WHO to expect that inter-sectorial work, local community action and community participation can make great contributions to World Safety. The Manifesto for Safe Communities became the first of many policy documents for not only the emphasis on injury and accident prevention but also for the Safe Community Movement:
“Safety – A Universal Concern and Responsibility for All”

Equity

‘All human beings have an equal right to health and safety’ - this principle of social policy is the fundamental premise of the World Health Organization’s Health for All Strategy and for the WHO Global Program on Accident Prevention and Injury Control. “Safety for all can be achieved by reducing injury hazards and by reducing the differences in accidents and injury rates among socio-economic groups.”

Photo 5.2. “All human beings have an equal right to health and safety”. (Photo: LS)

National and international participation

“As part of its national health plan, each government should formulate a national policy and a plan of action to create and sustain safe communities. All national health authorities urgently need to develop national safety goals and plans to achieve these goals. We believe that good plans depend on the cooperation and participation of many sectors.” “Countries should cooperate with each other to ensure the development of safe communities. Information about the experiences of safe communities in one country benefits other countries.”
**Recommendation for Action**

- Formulate Public Policy for Safety
- Create Supportive Environments: “We recommend that local, national and international bodies establish and strengthen networks of researchers, training personnel, and program managers for accident and injury prevention.”
- Strengthen Community Action: “Care must be taken, however, to ensure that a community program is designed by community members, responds to community needs and uses community resources.”
- Broaden Public Services: “A Safe Community involves not only the health and safety sector, but also many other sectors, including agriculture, industry, education, housing, sports and leisure, public works, and communications. These sectors must co-ordinate their efforts to achieve optimum results.”

“The health sector and safety professionals have a crucial role in collecting and disseminating information on injured people, injury patterns, the causes of injuries, and the most hazardous situations.” “Health personnel can participate in local community health education and safety promotion efforts.”

**The WHO Collaborating Centre on Community Safety Promotion**

At the same time as the establishment of the Manifesto the first agreement between the WHO Head Office in Geneva and the Karolinska Institutet was signed and The WHO Collaborating Centre on Community Safety Promotion was established. The main responsibility for that Centre is to develop a world-wide network of Safe Communities and to fulfil the policy principles established in the Stockholm Manifesto for Safe Communities (www.phs.ki.se/csp).

*Photo 5.3. WHO Collaborating Centre on Community Safety Promotion.*

Chair
Leif Svanström

Co-ordinator
Moa Sundström

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In essence, what are the details of the lessons learnt so far?

1. Prioritise – but use many techniques and methods

Priorities for action and decision-making must be based on what the community feels are most important. The community should reach solutions, and suggestions from outside should only be adopted if the community sees them as appropriate. A prerequisite for achieving this is the involvement of individuals as well as community organizations in the process of promoting safety.

Many techniques and methods must be used, including media interventions, presentation of local data, the publication of other types of information and advice, education of professional groups (as well as members of community organisations); supervision through safety rounds and check lists, environmental control, and product development. These principles (derived from the experiences of a number of Safe Community programmes and from many travelling seminars) have led to the establishment of six specific criteria for designation as a “Safe Community:

“Safe Communities have:

1. An infrastructure based on partnership and collaborations, governed by a cross-sectional group that is responsible for safety promotion in their community;
2. Long-term, sustainable programs covering both genders and all ages, environments, and situations;
3. Programs that target high-risk groups and environments, and programs that promote safety for vulnerable groups;
4. Programs that document the frequency and causes of injuries;
5. Evaluation measures to assess their programs, processes and the effects of change;
6. Ongoing participation in national and international Safe Communities networks.”

2. The idea behind Safe Community programmes

The fundamental idea behind a Safe Community is to address all kinds of safety issues and prevent injuries in all areas, encompassing all ages, environments and situations, and involving both non-governmental and governmental community sectors. The theoretical framework for the programmes is based on general health-promotion concepts, including community organisation and a participatory strategy for community involvement. Data from local hospital emergency departments provide a good basis for intervention and sometimes outcome evaluation.
3. Improve cooperation first
Based on a seminar held in Linköping, Sweden, conclusions about Safe Communities in industrialized countries were drawn (Klang 1992). Providing safety for citizens is, in many industrialized countries, a public undertaking – one that is expressed in national legislation and the distribution of roles. This is something to which careful attention should be paid when designing forms of inter-sectorial cooperation. If responsibility is clear and divided between actors, the first task is to improve cooperation on the basis of roles that have already been allocated. Otherwise, there is a great risk that those expected to carry out a task will feel that responsibility has been taken away from them, making them passive rather than active. They may also become negative toward the whole project.

One uncertainty related to likelihood of success in inter-sectorial work is that the responsibilities of the various sectors involved are not clearly expressed. Unexpected results may provide scope for ideas that may never otherwise have had a chance in a stricter organisation. Because often there is no fixed priority for safety-promotion and injury-prevention measures in many organisations, there is an opportunity for a stream of new ideas to be created. And this may pave the way for new participation, and more and hopefully better activities.

3. Try to use existing structures as a foundation
Adopting the Safe Community model intrinsically involves proceeding from the organizations and structures that exist in a community. But there are no general solutions that can be copied directly. If there are good examples, however, these can be used as prototypes. For this reason, evaluation of actions that have been taken is important. It provides general knowledge about which measures are effective. Evaluation can also have other aims, e.g. to justify a programme or improve its design.

Within any programme, it is important to highlight different types of accidents and situations where injuries are incurred. Injury registration plays an important role in this, as do other statistics and information available to the community. Injury-prevention activities can be initiated on the basis of data from other districts, but when work has been in progress for a time, local injury information will be required.

4. A Guideline for Safe Communities
A Guideline for Safe Communities was formulated out of experiences from WHO travelling seminars in Sweden and Thailand. It reads as follows: “Community interventions to reduce accidents and injuries occur alongside a number of other initiatives with the same goal. They are important because they add a new dimension
to the fight against a growing toll of injury in both developed and developing nations. They will not replace other initiatives but will complement them, creating a new way of tackling the ever-changing pattern of accidents and injuries. Dealing with problems which have proved insoluble using traditional top-down approaches focuses on utilizing the strengths of the people to bring about necessary changes in awareness, behaviour and environment” (Moller 1989).

Based on the experiences of Linköping in Sweden and Wang Khoi in Thailand, five basic areas have been developed to provide a basis for developing a Safe Community project. (Figures 5.1-5.5).

Figure 5.1 Organisation needs for Safe Community work.

1. Community injury control must be based on all relevant organizations in the community (according to their strengths).
2. A community injury-control programme must be closely associated with all relevant sectors of activity, especially the primary health-care sector.
3. The structure used to promote a Safe Community programme will vary from community to community and country to country, but will make the best use of effective decision-making processes already in place and supplement ineffective decision-making mechanisms.
4. The community will take part in solving problems and provide some resources if it recognizes the benefits as relevant.

Figure 5.2 Epidemiology and information to reach target groups and areas

1. Community injury prevention must be based on sufficient epidemiological and other data to document the size and nature of the accident/injury problem in all environments, including home, travel, workplace and leisure.
2. The community should be made aware of possibilities for injury prevention and control, and the nature of problems in the local area. This may be achieved by using the media and any other traditional forms of information-sharing.
3. Information sharing should be appropriate and relevant, and presented simply with an emphasis on local factors.
4. Information about how to prevent and control injuries should be widely sought and adapted to local conditions.
Figure 5.3 Intervention – participation, targets and foundations

1. In general, the community will participate in interventions which are in its own interest.
2. As far as possible, interventions should be acceptable and beneficial to the largest number of people.
3. In the short term, solutions should be applicable to existing social, economic and political processes through research and education.
4. Interventions should be based on an inter-sectorial approach.
5. Targets must be set, and baseline measures and data collection appropriate to evaluating the process and outcome of the intervention that has been put in place.

Figure 5.4 Priority list for decision-making

1. Priorities for action should be based on what the community feels are most important.
2. Community decisions must be made from an awareness of the problems it faces and possible solutions (including knowledge that many are inexpensive).
3. Community involvement should start at programme outset. The community should not have decisions thrust upon it.
4. Intervention should aim for early measurable success to act as a stimulus for the community to take further action.
5. As far as possible, the community should make suggestions about solutions. Solutions from other places should not be imposed, but adopted only if they are seen as appropriate by the community.
6. Relevant knowledge about possible solutions should be presented simply and clearly to the community.

Figure 5.5 Technologies and methods

1. Increasing awareness is necessary at both the governmental and community level. A wide range of techniques, including the media, presentation of local data, programmes in schools and personal visits to key decision-makers, are necessary.
2. Data collection about accidents and injuries should be kept simple. They should also be sufficient to show the pattern of events leading to injury, and to identify hazardous places, risk groups and dangerous products. The scale of data collection must be kept within the resources and technology immediately available. Specifically, in suicide prevention work this may likely present a challenge because of the difficulties in conceptualizing suicide expressed at the beginning of the book.
3. The community must be supported by a community-development process, so as to operate freely in identifying hazards and finding locally acceptable solutions. Advice should be available to act as a catalyst and provide technical information.

4. A wide range of methods for identifying hazards must be used – including safety rounds, check lists, research findings from other places, and by encouraging people to report dangerous situations. Recipients of this information will vary from project to project.

5. Resources should be obtained by using community participation and labour, not just monetary contributions. In some countries it may be possible to obtain funding from public sources and the sponsorship of private companies. The use of matched funding from government to supplement local funds will act as an incentive. Wherever possible the community will decide on means of income generation for sustaining injury-prevention programmes.

6. Communities have a responsibility to influence government policies and the practices of private companies in matters affecting the safety of people. And the people have an important role in persuading policy-makers and managers to become more committed to injury prevention. Governments have a responsibility to make legislation and develop decision-making processes that complement people’s efforts to achieve a Safe Community.

7. Methods that change the environment to ensure the removal of hazards or the automatic protection of individuals are vital if the greatest reduction in injury is to be achieved. They are often simple and inexpensive. Projects should aim at inventing new technologies that offer cheap automatic protection, e.g. ways of separating vehicle and pedestrian traffic, protection of electrical circuits by instantaneous cut-offs, and the installation of safeguards to cover moving parts of machines.

8. Use of personal safety equipment, such as protective clothing, helmets, eye protection and spray masks, should be promoted by the community. It must be ensured, however, that equipment of sufficient quality to be capable of providing adequate protection is chosen.

Injuries – including Suicide Prevention and Safety Promotion – do they converge or diverge?

So far it is difficult to say based on the worldwide experience whether suicide prevention and safety promotion will converge or antagonize. In countries and communities where professionals have a strong influence there seems to be a strong emphasis on trying to make the communities focus on injury prevention. In other circumstances where citizen involvement is stronger a more comprehensive view on safety seems to be developing. Safe Communities involve almost all kinds of safety promotion, including working with fear of violence and accidents. Even awareness of the need to address the fear of natural disasters, war and terrorism seem to have increased within the movement. It seems, however, that the mere fact that injury
prevention specialists do not always agree with the priorities – if they participate in the democratic processes of the community – often leads them to restrict their focus. It seems, however, that Safe community programs give room for experts, local governments and non-governmental organization. The process involves representative democratic governmental approaches as well as participatory democratic individual and organizational non-governmental engagement.

“Safe Communities”- are they an experiment in “Empowered Deliberative Democracy”?

Fung and Wright claim in a paper that “As tasks of the State have become more complex and the size of politics larger and more heterogeneous, the institutional forms of liberal democracy developed in the nineteenth century -- representative democracy plus techno-bureaucratic administration – seem increasingly ill-suited for the novel problems we face in the twenty-first century.” (Fung 1999).”Perhaps this erosion of democratic vitality is an inevitable result of complexity and size.” “But perhaps the problem has more to do with the specific design of our institutions than with the tasks they face as such”. Based on an exploration of five societal reforms in the USA, Brazil and India, the above mentioned authors make an analysis of institutional redesigns. The example closest to the safe community development is *The Participatory Budget* of Porto Alegre, Brazil. In this case, residents are enabled to participate in forging the city budget and use public monies previously diverted to patronage payoffs to pave their roads and electrify their neighbourhoods. A Safe Community program has also been developed in Porto Alegre. All these reforms described “aspire to deepen the ways in which ordinary people can effectively participate in and influence policies which directly impact on their lives”. The same authors call this class of reform *empowered deliberative democracy*- a concept better described by J Cohen (Cohen 1996). These five experiments are democratic in the sense that they rely upon the participation and capacities of ordinary people.
Principles of Empowered Deliberative Democracy

The general principles underlying empowered deliberative democracy are described by Fung & Wright (1999) in the following six design elements:

- they all focus on specific, tangible problems;
- they develop solutions through deliberation;
- the deliberations involve both the ordinary people affected by the problems and officials close to them;
- public decision authority is significantly devolved to empower local units;
- the empowered local units are in turn linked together to coordinate the distribution of resources between them and generate inter-unit learning; and
- This empowered deliberation is accomplished primarily through the transformation of state institutions rather than in voluntariness in civil society, secondary associations, or the market.

Such experiments could be described as addressing a specific area of public problems that are solved through a process of reasoned deliberation that relies upon bottom-up involvement of ordinary citizens and also generate fairer, equitable outcomes.

Injury prevention work could theoretically contain this reform but mostly it doesn’t – it still struggles to lean on the traditional “representative democracy including technobureaucratic administration”. Safe Communities at its best addresses a specific area of public problems and those are solved through a process of reasoned deliberation relying upon bottom-up involvement of ordinary citizens and thus also generate a fairer, equitable outcome.

Manifesto for Safe Communities

In 1989 the First World Conference on Accident and Injury Prevention took place in Stockholm, Sweden. The central theme permeating the event was “Safety as a Universal Concern and Responsibility for All.” 500 delegates from 50 countries (Image 5.1) met to discuss the immense injury and accident problem and the need for action.

The Stockholm conference was held in response to the urgent need for promoting injury and accident prevention and to mitigate their consequences on the health of the people.
The following conclusions were drawn:

- Injury is the number one cause of death among children and young adults.
- Injuries disproportionately affect socially and economically disadvantaged groups.
- Despite the size of the injury problem, most nations do not yet recognise injury prevention as a priority goal.
- Community level programs for accident and injury prevention—“Safe Communities” programs—are the key to reducing and preventing injuries. *In both developing and developed countries, wherever the community has participated prevention programs have led to safer communities.*
- Governments should strengthen any existing community action program and coordinate the work of health and safety agencies, social and economic authorities, professional and voluntary organizations, private industry, and the news media.

First World Conference on Accident and Injury Prevention
Themes covered:
- Involving people and community.
- Strategies for accident and injury prevention on the local, regional, national levels.

Definition of terms:
We use the terms “accidents” and “injury” because of consensual agreements on meaning despite speaking many different languages and each country having its own historical and cultural contexts.

*An accident* is an event that results or would result in injury. This would apply indeed to suicide.

The word *accident* does not mean in any way that they are random and therefore uncontrollable. This would belong to the world of magic. On the contrary, we believe that the determinants of these events can be studied and understood, and that this new understanding can be used to prevent accidents.

We emphasise that accident and injury prevention includes even those events that could but do not always lead to injuries. In addition, the term injury here includes not solely biological and physical injuries but also the adverse psychological and *social consequences and therefore community consequences.*
Besides preventing injuries, accident and injury prevention programs include strategies to improve the care of acutely injured persons and to conduct rehabilitation programs. Behavioural determinants can be eliminated or reduced, as much as the environmental and biological ones.

The Manifesto for Safe Communities

General statements
Safety - A Universal Concern and Responsibility for All.

Equity
All human beings have an equal right to health and safety. Safety for all can be achieved by reducing injury hazards, and by reducing the differences in accidents and injury rates among socio-economic groups. Inequality in the safety status of an individual in developing and developed countries is of concern to all countries. In suicide, it could be added, that doctors and health systems still need to learn to see themselves as being a part of communities - on equal footing, serving them, suffering with them, forgetting about professional detachment, becoming more humane and more committed, and learning to work professionally with others. The way it is done today is an obstacle to integration; there are still many forbidden territories, and many closed groups.

The results of this in the field of suicide prevention is that few have specific programmes, that problems and strategies to solve them are

Image 5.1. 500 delegates from almost 50 countries worked to produce "The Manifesto for Safe Communities “ during the First World Conference on Accident and Injury Prevention in Stockholm 1989. This is still a lead for everyone in the International Safe Community Movement. (http://www.phs.ki.se/csp/pdf/Manifesto.pdf)
just given lip service and, as a result, we are far from making this real. Theoretical constructs have too often served only to fill forms.

**Community Participation**

Some communities in developing and developed countries have begun community actions which have led to Safe Communities. We believe, therefore, that research and demonstration projects for injury prevention and control must include community level programs. These demonstrations projects will reveal how best to achieve Safe Communities.

To develop Safe Communities, local situations, unique resources and the important cultural and socio-economic determinants of injury must be understood and taken into account. People have the right, and some could say the duty, to participate in planning and implementing their community safety program.

*Community interventions* are distinguished by a shift in focus away from individual responsibility towards multifaceted community-wide interventions designed to ensure that everyone in the community is involved (Ekman 1999). It is not in reality possible to get everyone involved, but still enough to create a strong force in making an intervention successful.

From a theoretical viewpoint, safety interventions are founded in the community-development tradition. In the 1950’s community development was described as a process, a method, a programme, and a social movement (Sanders 1952). *Community development* is also described as “a social process by which human beings can become more competent to live with and gain some control over local aspects of a frustrating and changing world” (Bracht,Kingsbury 1990). The concept of community is defined as including “groups of people who share some common interest or function, such as welfare, agriculture, education or religion. These interests do not include everyone in the local community, but those individuals and groups who in this case have a particular interest or function in common”.

The difference between the terms is that community development is more individual, involving face to face action, whereas community organization is city-wide and agency-based.
Recommendations for action

- Formulate public policy for safety;
- Create supportive environments;
- **Strengthen community action**;
- Broaden public services (not only health and safety, but many others, including agriculture, industry, education, housing, sports and leisure, public works, and communications).

Safe Communities and suicide prevention:

*When the website of Safe Communities Programs on Community Suicide Prevention was consulted (www.phs.ki.se/csp) we obtained a variety of entries.*

**In general the entries have certain points in common:**

- Within the communities certified as “Safe Communities” there is no established pattern of description of the actions taken to prevent suicide or how to deal with mourning when this happens.
- Some activities are more structured than others.
- Up to a point actions for suicide prevention reflect the variety of sizes, geographical, cultural and social circumstances of the communities.
- For some communities that included suicide as their concern this might appear more a way to fill a gap or to comply with supposed or real expectations.
- Despite of what their websites say or fail to reveal, some communities may have community focused actions for suicide prevention and safety promotion on issues related to suicide without being aware of it.

**It is easier said than done**

Interventions that look well on paper, but are not well understood by the people and are not perceived by them to be working are rendered useless. We are confronted with the dilemma of pressuring communities to structuralize their activities according to patterns that might not be of their choice.
Complex contemporary models

In an effort to integrate contemporary models of interventions for suicide prevention we will use a matrix already used within the safe communities model for the understanding the prevention of all types of injuries.

Levels of safety promotion in suicide prevention

Any work in the health field has as a final objective the prevention of disease and injury in human beings. But in the same way that human beings are divided, in order to understand them better, into nuclear particles, subatomic articles, and then progressively into atoms, molecules, and organs it is clear that they can be considered also part of wider structures and levels of organization. Independently, while these are essentially theoretical constructs developed in an effort to understand the whole reality, the fact remains that men are not isolated individuals and can only be understood in relation to each other (Ekman 1999). They are social, community creatures nested in complex levels that go from families, to groups, organizations, communities, nations, regions and the world.

We will use this model to understand the work developed in suicide prevention. Such a model uses a familiar matrix in which the lines are the levels, and the columns are the sectors.

The five levels of prevention work initially identified (Svanström 1987) were:

1. Individual oriented;
2. Group oriented;
3. Organization oriented;
4. Community oriented;

And the sectors most commonly mentioned are:

1. Education sector;
2. Transport sector;
3. Work sector;
4. Health sector;
5. Leisure activities sector;

However, we could make fit into this matrix any sector identified by assigning a number in the columns.
The levels

**International level**

The WHO has been working increasingly with injury prevention and safety promotion over decades. When the WHO established its 8th General Program for the period 1990-95 the number of countries with adequate policies and programmes were few and still are. With the programme the WHO wanted to move from the gathering of facts to the taking of action in injury prevention and safety promotion. The focus of the program should be on activities at the local community level.

*Safe Communities*, originally a Swedish concept in practice but formulated by the WHO, was formally introduced in 1989. A Safe Community is meant to be a local community- often a municipality – where there is an active injury prevention programme covering all ages, environments and situations, and also where networks of public authorities, health services and voluntary organizations, enterprises and interested individuals work together. We will expand on this concept later.
National level
Work at this level can be influenced by legislation or performed through agreement between federations of companies or organizations (Svanström 1987).

Population level
At this level work is performed in a defined geographical area, e.g. the community. Thus, work is directed at activating local groups/organizations on the basis of knowledge about the health of the population and local preconditions. Activities can be performed regionally, as well as locally, in a country, municipality, neighbourhoods, what we usually call a community. For example health planners/educators or health centres school health services collaborate and build networks by gathering data and organizing courses/conferences. Voluntary organizations cooperating with a municipality or county council may be mobilized in an injury prevention programme.

Community level
Community interventions are distinguished by a shift in focus away from individual responsibility towards multifaceted community-wide interventions designed to ensure that everyone in the community is involved (Ekman 1999).

Organizational level
As biological and social human beings we are dependent on membership with groups in order to satisfy our most basic needs for protection, production, defence, education, protest, emotional warmth and self consciousness. Important group affiliations are the families in which we were born and the ones we create as adults, the groups we play with as children, school groups, and teenage groups. We participate in many groups where we work, train or study, and in voluntary associations. Schools and workplaces are evident examples of well-developed organizational structures, while volunteer organizations can be less structured.

Individual level
The contradiction between the individual and collective interests is one of the main bones of contention in societal development. The individual-oriented view on democracy and the society-oriented collective view on democracy are often seen as opposites. This contradiction is also seen in interventions with suicidal people. But both collective and individual views are essential and complementary.
At the individual level the targets of interventions are individuals, and work includes individual advice and support. This can be given generally, or to some high risk individuals through personal contacts by health and other professionals of different backgrounds: social workers, mental health counsellors, psychiatrists, psychologists. Work at this level includes advice and support. It would be called treatments, consults, individual therapies and counselling.

The need to act at all levels and not only at the individual level

Although there is the tendency to believe that all actions must end in actions taken at the individual level, and it is true that all actions should end affecting individuals’ behaviours, this does not mean that we do not need to act at different levels with different strategies and within different sectors. Thus it becomes obvious that many of our interventions in suicide prevention leave out other levels.

Through examples from selected publications that summarize their approach to suicide prevention, we’ll see how in the following chapter that contemporary teams from Sweden incorporate other levels of prevention and associate them with individual interventions. Also from the review that follows, we shall see how much ground is still left uncovered without anyone specifically assuming this duty.
Lessons to be learnt

The Safe Communities Movement
The "Safe Communities" movement was developed by a number of communities around the world in order to enhance safety, but its formal consequences were developed by the WHO Collaborating Centre on Community Safety Promotion at the Karolinska Institutet of Sweden under the auspices of World Health Organization. This movement aims at supporting communities in their safety enhancement activities.

The basic principles of programs are the following:

- Safe Community Programmes must be based on all relevant organisations in the community and closely associated with all related sectors of activity – Community Organisation. The structure used to promote safety will vary from community to community and from country to country.

- Safe Community Programmes must be based on sufficient epidemiological and other data (surveillance) to document the size and nature of safety problems, including accidents, injuries, violence, and suicide as applied to all environments, including home, transport, workplace and leisure.

- A priority for action and decision making must also be based on what the community feels is most important. Solutions should be made by the community and suggestions from outside should only be adopted if they are seen as appropriate by the community. A prerequisite for achieving this is involvement of individuals as well as communities in the process of promoting safety.

- A wide range of techniques and methods must be used. These include for example mass media interventions, presentation of local data, the publication of other types of information and advice, education of professional groups as well as members of community organisations, supervision through safety rounds and checklists, environmental control and product development.

Those principles lead to a certain number of criteria to fulfil for a community to be a member of the Safe Community movement.
Community suicide prevention within the frame work of “Safe Communities”

Same way that health is much wider than absence of disease. Community suicide prevention and interventions to ease the pain of suicide within a community are wider concepts than just suicide prevention as traditionally interpreted by the health and psychological establishments. More so, mental health promotion and promotion of safe, healthy communities where people do not commit suicide or if they do or attempt and fail, societal responses go beyond of what has been traditionally offered by health institutions.

Safe Communities is a specific structured model to work in communities with the purpose of preventing injuries and violence, and promoting safety. In this particular case the model has to do with what we do to prevent suicide and promote safety in relation to suicide and suicide attempts. But it also means interventions to strengthen communities that have been affected by suicides.

The fundamental idea behind developing a Safe Community is to address all kinds of safety issues and prevent injuries in all areas, encompassing all ages, environments and situations, and involving both non-governmental and governmental community sectors. This includes suicides and suicide attempts, and also dealing with the suffering created by them in a way that communities, when those events occur, may strengthen themselves.

Difficulties faced in preventing injuries and suicide and promoting safety

The tasks of the society, including those of the States, have become more complex, and the size of politics larger and more heterogeneous than the institutional forms of liberal democracy developed in the nineteenth century. Representative democracy, along with its techno-bureaucratic administration, seems increasingly ill-suited for the novel problems we face.

The Neoliberal model, although now seemingly taking on water and floundering, is still a model highly prevalent and serves as a point of reference for most nations in the world.

Injury prevention, suicide prevention included, is still struggling to lean on those institutional forms.
Safe Communities at its best addresses a specific area of public problems best solved through a process of reasoned deliberation that relies on the bottom-up involvement of ordinary citizens to generate a fairer, more equitable outcome. The general principles underlying such empowered deliberative democracy are focused on specific, tangible problems.

- Develop solutions through deliberation;
- Involve both ordinary people affected by the problems and officials;
- The public decision authority is significantly developed to empower local units; those are in turn linked to coordinate the distribution of resources;
- This empowered deliberation is accomplished primarily through the transformation of State institutions rather than through voluntary work developed in the civil society.

**Thirty years of experience in Safe Community development**

The concept of Safe Community is a formal concept closely associated with the World Health Organization, and not an unspecific concept that can be liberally applied to any community interested in safety issues.

Priorities for action and decision-making must be based on what the community feels are most important. The community should reach solutions, and suggestions from outside should only be adopted if the community sees them as appropriate. A prerequisite for achieving this is the involvement of individuals as well as community organizations in the process of promoting safety.

Many techniques and methods must be used, including media interventions, presentation of local data, the publication of other types of information and advice, education of professional groups (as well as members of community organisations); supervision through safety rounds and check lists, environmental control, and product development.
The idea behind Safe Community programmes

The fundamental idea behind a Safe Community is to address all kinds of safety issues and prevent injuries in all areas, encompassing all ages, environments and situations, and involving both non-governmental and governmental community sectors. The theoretical framework for the programmes is based on general health-promotion concepts, including community organisation and a participatory strategy for community involvement. Data from local hospital emergency departments provide a good basis for intervention and sometimes outcome evaluation.

We basically see “Safe Communities”- some kind of “experiment” in “Empowered Deliberative Democracy”.

The general principles underlying empowered deliberative democracy are:

- they all focus on specific, tangible problems;
- they develop solutions through deliberation;
- the deliberations involve both the ordinary people affected by the problems and officials close to them;
- public decision authority is significantly devolved to empower local units;
- the empowered local units are in turn linked together to coordinate the distribution of resources between them and generate inter-unit learning; and
- This empowered deliberation is accomplished primarily through the transformation of state institutions rather than in voluntariness in civil society, secondary associations, or the market."Deliberative Democracy”?"
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Chapter 6.
Specific example I:
Arjeplog, Sweden – an example of a true community approach with the Health Centre as initiator

By Bo Henricson

The geography

Sweden is among the most developed countries in the world economically, politically and socially. This prosperity was achieved mainly during the 20th century.

Arjeplog Municipality (Arjeplogs kommun) is situated in Norrbotten County in Northern Sweden. In area it is Sweden’s fourth largest, but the fourth least populated with 3,650 inhabitants, distributed in an area of 12,804 Km². It is located by the shores of Lake Hornavan, the county’s deepest lake and one of its largest. The municipality is popular because of the scenery of the lake but also because of its untouched nature.

Despite the beautiful landscape with many forests and lakes (8,000 lakes and streams), the national parks, clean water and clear air, its popularity as winter resort, testing area for all car manufacturers in the world and in general high standards of living, physical isolation is a reality for many. Winters are very cold and dark, and distances between towns and houses are big. Communication is not a luxury but a necessity, and inclusion may mean life or exclusion death.

Deaths, especially suicides, can be a devastating experience for all community members. This might be a shared phenomenon with other places; the difference though
is that here in Arjeplog no suicide goes unnoticed, i.e. every case is known and counts socially as much as statistically.

There are other aspects of life in Arjeplog that should be analyzed: Alcohol consumption- a factor universally associated with increased suicidal behaviour- is high; lack of job opportunities meant migration into the urban areas and changes in the demography, the result of which the proportion of women 1984 was lower than that of men and it was not easy to form new families.

Since it is known that the single most important demographic and social aspect for an adult man to remain healthy is to marry and to remain married, and some women have better health outcomes when they divorce, it is necessary to ask ourselves to which point this influences suicidal behaviours. Also we need to clarify if the lowering of cases could be due to the fact that potential suicides are not happening now in the Arjeplog area but are instead occurring in the new place.

The Arjeplog experience in suicide

In 1994 we had several very tragic suicides in our community. The description of cases that follow does not necessarily correspond to the suicides that occurred during that year. Rather, I will try to picture some, as I see it, typical suicides.

**Case 1: Man 80 years**

Social life: Retired lumber worker, living in a primitive settlement in a rural area together with his male friend. They had been living together for several years and everything had been working well.

During the last years his friend had become progressively senile and things were very bad. One afternoon, the social workers, after contacting the family, transported this man’s friend to the nursing home.

Diseases: Mostly healthy, no psychiatric history.

Description of his Suicide: The day after his friend was admitted to the nursing home, he killed himself with a gun. No farewell letter was found.

**Discussion:**

As I understood, he was aware that he was going to live alone, something that in his reasoning he would not be able to manage. Had we been more observant, perhaps we could’ve understood that if we separated him from his companion of many years the old man would have a crisis with which he could not cope. Separation as a result of illness or old age might be good for some people but not for others.
Case 2: Husband and wife 70 years

Social life: This couple had a good life together. Before the husband suffered a stroke both had experienced minor ailments but not severe diseases. There were no identified social or psychiatric problems.

Diseases: Six months before their death the husband had a stroke and experienced difficulties in talking, eating and walking. However with good physiotherapy he was recovering very well. He was at home with his wife by his side helping him. Probably he would’ve needed some help for the rest of his life.

Suicide by exhaust: One day the couple failed to contact their daughter who found a farewell letter in their house. After an intensive search we found them sitting in their car with the exhaust tube inside it. Both were dead.

Discussion:
Once more this is a case of an elderly person who could not stand his handicap. This suicide may have been the result of a love pact; he brought his wife into death. At the time of their death not much consideration had been given by anyone to the psychological problems created by a severe disease. The signs were of a depression but this was considered “normal” after this stroke. Where were the social services?
Case 3: Woman 80 years

Social life: This is the case of a widow, who after severe arthrosis became institutionalized at the nursing home. Before her illness she was known to be a headstrong lady, with an extensive social life and many friends. Appearances meant a lot to her.

Other diseases: Due to increasing arthrosis, (worn out joints) she became progressively handicapped to the point of not being able to manage the household; she could not walk and had continuous, severe pain. At last, after some pressure from her relatives she was admitted to a nursing home as she did not want to go to the old people’s home. (Among the elderly in Sweden, old people homes were considered a place for the very poor, a situation that could be held as a truth maybe 50 years ago but is not true today. Nevertheless, it was more socially acceptable to be at the nursing home).

Suicide: 3 days after admittance the old lady hung herself with the wire from the bed’s radio.

Discussion:
Social disgrace and a bleak future were too much for this proud lady to bear. The signs of despair were there, but nobody noticed them.

Case 4: Man 72 years

Social Life: Divorced taxi driver. Before he became sick he was always happy, content to live with whatever life brought him, and had a lot of good friends.

Diseases: He was known to have a slight hypertension, but on the whole he was healthy. A year before his suicide he had been diagnosed with Alzheimer’s disease. He deteriorated very fast and within a year he was absent most of the time. Discussion was started on whether or not he should be admitted to a home for people with dementia. In between he had short periods with clear-sightedness.

Suicide: In one of these lucid periods he committed suicide with a necktie around his bedpost.

Discussion:
The above mentioned suicides can be related to loss of physical and/or social functions. Most old people who I have met and who have committed suicide were in good mental health and in their opinion had clear reasons for the suicide. They reasoned that they could (if one will accept this) end their lives as there was no future for them as “free” human beings in their communities.

When you get old, it means a lot even to be able to live a “normal” life.
Case 5: Man 50 years

Social life: Married with three boys; apparently he had a good marriage and an acceptable economy.

Diseases: High blood pressure and a prolonged history of alcohol abuse. Initially this abuse was not obviously noticed by the community, as the close relations tried to keep it within the family, afraid of social shame. However, as the alcohol abuse became more apparent, the issue became a subject of open discussions among family, friends and the community, of which he was a very well known member. He never asked for help to stop his abuse, nor did his family. He became more depressed.

Suicide: One day he left a farewell note and took his car to an isolated place, put the exhaust tube inside the car and killed himself through CO poisoning.

Discussion:
This could be the story of one of the silent abusers. The social disgrace was too much for him to bear. Very often we see that alcohol abusers believe that nobody knows about their problem, even when it is common knowledge. It becomes as a shock to realize that their problem is known and talked about in the community. Can abuse be handled in a more collective way so it doesn’t become a problem just for the individual?

Case 6: Woman 37 years

Social life: She was a highly esteemed beautiful woman who came from a good family, and was married with three children. She used to work in her father’s supermarket. From the outside the family looked like a very happy one, with good economy.

Disease: None, no psychiatric disease.

Suicide: Found hanging under the roof of the family’s villa. In a farewell note she declared that she thought she was an alcoholic and for that reason she could not raise or take care of her children. The social disgrace and shame were too much.

Discussion:
Again this is a history of alcohol abuse and social isolation. Nobody could understand this. There were no warning signs before the suicide according to the husband. However, he too was abusing alcohol.

Case 7: Young man 22 years and his father

Social life: The young man was the second of a family with two boys and a protracted history of violence and alcohol abuse. His father was a notorious alcoholic. His mother had grown up in a family very much like his own. It was accepted that the mother died
earlier due to a stroke, but on second thoughts her death could have been caused by violence. Our victim this time lived in a cold house, in a state of bad repair, situated in the bush. At a younger age he was known to have been bullied in the school.

Diseases: None. At school he was always silent and shy, and his school marks were very bad.

Suicide: Was found in a lorry where he had shot himself with a slaughter pistol. When his father heard about this, he hanged himself.

Discussion:
Nobody will know what this young man’s thoughts were. What we can learn from this case is that children growing up in problematic families have fewer resources to cope with crisis. This is the reason for our long-term preventive work where we are trying to reduce bullying and trying to focus on families with special problems and needs. Should we try better outreach for school and social service-community work instead of social individual work, or should we try actually both?

Case 8: Woman 34 years

Social life: Married with two girls. As a child, other members of her original family consumed alcohol frequently, and this pattern repeated itself in her own marriage. She could be described as a very shy person and not very communicative.

Diseases: None. No severe psychiatric disease had been identified

Suicide: During a party in her home, after drinking large quantities of alcohol, she went to the bathroom, lied down in the bathtub and hanged herself from the water tap. No farewell letter was found.

Discussion:
Was this a suicide precipitated by alcohol consumption? There are other aspects that could be related to the outcome: We are not certain, but we have serious reasons to believe that she was victim of incest when she was a child. Rumour says she used to be locked up in her room by her father and was not allowed to go out. This history together with the alcohol abuse in her new family could have created the conditions for her to desire to commit suicide. The signs were probably there, but nobody was aware of them.

Case 9: Man 40 years

Social life: He was the youngest child in his family and had always been spoiled. Although he had been trained as a barber, he stopped working as such due to low back pain. He was married to one of the girls from a prominent local family and they had three children. He tried his luck at several different jobs. Due to his expensive life
style he was always looking for quick money. Although he was suspected of stealing and wrongful bookkeeping, he tried to keep his position in the community.

Diseases: Apart from his spinal complaints he had no other problems. He did not have psychiatric problems.

Suicide: He shot himself leaving a farewell letter.

Discussion:
Due to suspicion of wrongful bookkeeping the police had started an investigation. This meant loss of social status, something unbearable to him.

Case 10: Woman 29 years

Social life: This is the case of my sister, the youngest of three children, who had been educated at University, and had worked abroad for several years time during which she started abusing alcohol. She then came home and got a good job close to the parents, met a young TV repairman and got married. She continued abusing alcohol, although never at work. She was over-protected by our mother, who was very considerate.

Diseases: Several admittances to psychiatric hospital due to neurosis and pseudo-suicide attempts. After buying a house and a dog the marriage became stable and she stopped drinking. After a couple of years her husband found a new girlfriend and wanted a divorce.

Suicide: She became very depressed but did not show it. She visited us and was acting very happy. Two weeks later she hung herself and my father found her.

Discussion:
After the suicide we saw the signs! Nobody kept pace with what was really happening with her; nobody could imagine her taking her own life. This is what I mostly hear from relatives who have lost a close family member and friend. She not only took her life, but she “killed” a beloved daughter and sister, a wonderful friend and a person who could have been a resource and a support for many years. I will never forgive her!

Further comments about these cases of suicide:

There are several points of reflection about these specific cases of suicide within my community:

- As you will notice there were no diagnoses of severe psychiatric disorders apart from alcohol abuse and a single Alzheimer's disease among the cases described (not at least in the sense that psychiatric disorders are formally understood by health professionals). According to my experience, the overall
numbers (not the rates) of psychiatric patients committing suicide are and will remain low when compared with the crude numbers of suicide committed by common people like you and me. If this is the same in most communities as I suspect it is, it means that if we are to tackle the problem efficiently the emphasis must lie on community interventions. Surely we must work together with the psychiatric services and not leave the responsibility of dealing with suicide prevention and management of attempted victims only to them.

- On the other hand we should ask ourselves if we ordinary members of community and general practitioners are missing diagnostic cues. Cues that could help us to make better psychiatric diagnosis and that could help us to prevent suicide. Is it possible to coordinate our work better with the psychiatric services and professionals? To do what? Is it desirable? Would this mean putting the communities into a state of dependence on just a group of professionals? Can they deliver what is needed without disempowering communities?

- After discussions with relatives of suicide victims, I am also convinced that there are always warning signs, often unnoticed, mostly because people cannot imagine that their friends or relatives are capable of even contemplating these thoughts. What we should ask ourselves is if these signs really exist, why they are not seen?

- In most of the nearly 70 suicides I have been in contact with the victim’s thoughts ran around in circles and at the end they did not see any exit from the self-made hell they lived in- they killed themselves. Very often alcohol is involved in the suicides, either due to abuse or to increase the will to commit it. Both are recurrent unhealthy thoughts and behavioural patterns, but also alcoholism can be helped by proper techniques and methods available in different psychiatric services.

- I have known for several years all of the people described, either privately or as patients at the health centre. I believe that my knowledge of the people, professionally as well as privately, is rather good. Very few professionals could claim such knowledge of the victims they write about. So, being a community- oriented man, the question that I and others asked ourselves was what we can do as community to prevent suicide and to ease the pain associated with it.
Description of the actions taken in Arjeplog to prevent suicide

The psychosocial health group

The cases described above were all cases that occurred during 1975-1994. However the preoccupation has always existed in our community and in our country regarding suicide and the problem had been discussed in the eighties.

The Arjeplog project: Comprehensive health promotion in a community

Since then the public opinion was that something should be done because we had one of the highest suicide rates in Sweden. We therefore started the group for psychosocial health to discuss and implement action against suicides. Very soon it became evident, that to prevent suicides, we had to work with all aspects of the social life, not only depression and depressed people, but also maternity, childhood, family life, the physical and social environment, unemployment and many other things related to our daily life. It is well known that children being treated badly, i.e. domestic violence, domestic alcohol abuse, psycho-social problems in the family, bullying or being overly protected by their parents (curling children), are the adults in the danger zone for violence, accidents or suicide.
Arjeplog, Sweden, an example of community participation

The municipality of Arjeplog, Sweden, is an example of extensive and successful community participation of health and safety promotion. At the health care centre, personnel from diverse departments meet on a regular basis to discuss patients’ needs and exchange knowledge on medical and social matters. Care groups exist in order to enable specialists to discuss and meet community needs: a psychiatric group, a rehabilitation group, a home care group, a child and family care group, etc.

The municipality’s resources include an old person’s home which runs a day centre, a nursery, adult evening colleges, sports clubs, and associations such as Alcoholics Anonymous. All these resources serve as centres for the health and safety promotion movement. Preventing ill health among the elderly and encouraging frequent informal visits to the health centre has resulted in the need for hospital beds remaining steadily low despite an increase in the number of elderly people in the municipality. Preventive work in the form of health education has taken place in schools and through study circles specially formed by health education leaders. Public lectures have been well received and met with requests for further talks.

Visits to the outpatient clinic have dropped by about a quarter. Arjeplog has one of the lowest number of people on the sick list in Sweden and the duration of diseases is lower than average. People are generally aware of what a healthy lifestyle involves and often take measures to prevent ill health. A Health Council has been formed and is about to initiate future health work through work groups set up to meet health problems.

Photo 6.5. (Photo: B&MH)
identified collectively. The council is responsible for collecting information and has launched a quarterly journal to which different organizations in the municipality may contribute with items concerning health.

How are things organized in Arjeplog around suicide prevention?

Forza Arjeplog

A working group “Forza Arjeplog” was created with the purpose of preventing suicide in our community.

Members of the working group
“Forza Arjeplog” includes social workers, doctors, school personnel, politicians, and church and youth organisations. The issue that interests our group is the issue of Psychosocial Health and Suicide Prevention and we have also activities directed to young people, conduct social surveys, and work on divorce prevention and teach moral and ethics at school.

Education first

One of the first things to be implemented in Arjeplog was an education program for people engaged in suicide prevention. The educational activities for the group were held in Arvidsjaur; also, several people started study circles about the issue in Arjeplog. It is difficult to measure the results of these activities in statistical terms, as the community is so small that we cannot rely on statistics, but we have had only three suicides in the last eight years. However, we believe that this is a work for the future more than for today, as we can see that for some people suicide is an option and their interpretation of life and death are founded in childhood and are very difficult to change now.

Preventing alcoholism and alcohol precipitated risky behaviours

One group highly represented in suicide statistics in the years 1984-94 were single males aged between 20 and 45. As many women left Arjeplog due to lack of acceptable employment, the ratio female/male in this group was 100/254 in 1984. Many men were therefore living a highly unorganized life with too much alcohol, snowmobile driving, hunting and fishing, and very afraid of getting involved in a steady relationship. Often they woke up to find themselves lonely without any future or expectations and
confronted by their reality of severe alcohol abuse. We believe that this is one of the reasons for suicide and have been focusing in our work on that aspect.

**Our work includes:**

1. *Courses and study circles in suicide prevention* to increase public awareness of suicidal behaviour. As mentioned above, several interested people including professionals and lay people were involved in study circles where suicide prevention was the issue. Many of the people joining the circles were people who had been very close to a suicide.

   The issues treated included how to see the signs of depression or other signs like coping badly with crisis. They were then supposed to contact the individual and try to steer him or her to professional help. This was started 1993 and kept going on for a couple of years. Several serious suicide attempts have been stopped by the locals and no one has committed suicide afterwards!

   Photo 6.6. (Photo: B&MH)

2. *Creating a group for taking care of people in crisis, called “Fellow human beings on call”*. The group consists of health care staff, priest and other devoted people. This group have had a few phone calls from people in suicidal crisis but is also called together when severe accidents occur, or disease hits. For example when an accident occurs where several people are involved, families, friends or helping spectators meet in groups to discuss what happened and to debrief.
3. The municipality parliament has approved a youth political program to make it better and safer to be young in Arjeplog, 1995, recently revised. In this they stress the need for the youth to get a place to meet and be active.

4. Regular education for the pub and hotel owners and their “bouncers”. This includes discussions on what is acceptable and what is not. They have created a network where people who do not behave in the pub will be excluded for a certain time from all public houses. This is working very well, and we have seen a huge improvement in behaviour at pubs, public restaurants and dances.

5. Discussions with the different sports organizations about the municipality’s demand of rules for their work. The economic contribution from the municipality will depend on whether or not they abide by the rules especially in relation to behaviour and alcohol. Our experience is that several alcoholics started their dependence on alcohol around sporting events. It is quite common that sports people and supporters go together on buses to the matches, sometimes held between 200 and 1000 km away and there is ample time to feel bored and start drinking alcohol.

6. Lectures. Lecturers are invited to give lectures for adolescents, parents and public in general. We have had several lecturers talking first to the children at school, in the afternoon to professionals from the social office, school office and the health centre, and in the evening to interested public. Some of the lecturers come from far away in Sweden and it is costly to bring them to Arjeplog. Thus we try to share the expenses with different organisations so that we can afford to bring them here. The lectures have been about behaviour in the community, your own strength, what happens after a severe accident and moral end ethics plus some theatre performances and films.

7. Meeting facilities for the young people Meeting places have been created for young people of different ages. There are now several meeting places for the children and adolescents with specially trained adult leaders. These premises are completely alcohol and drug free and a lot of activities are going on.

8. A project against bullying. The key words are pupil’s democracy, conflict resolution, collaboration with different organizations, visible teachers, pupil’s safety person, involving parents, boy/girl groups after school and implications from teachers, parents, social workers and pupils. It’s about morals and ethics where parents and children are involved in creating a safe psycho-social
environment at school, how you treat each other verbally and physically. Even shop lifting is discussed.

9. **A plan for improving the behaviour of some of the most badly behaved males** was launched in 1995. The goal was to engage these young males in collecting money, studying English and taking a certificate on diving so that after a year they could go to the Great Barrier Reef to dive. Initially some were interested, but then initial enthusiasm dwindled. However in the spring 96, two of the most “rowdy” youngsters went to Australia to dive. Since then, none of these have been in conflict with the law.

10. **A plan for keeping women in Arjeplog and enticing women to move to Arjeplog** was launched in 1991. This is about high quality jobs, more culture and more activities for women. A female network has existed for the past 14 years; this is working very strongly as a resource organization for the different political decisions being made. Several jobs in the area of data handling have been created, where a lot of women are working. For example, The National Car Registry is partly placed in Arjeplog and several hotels have been built for the international car companies where women have plenty of working opportunities. A very active art association has existed for the last 14 years and a riding facility for young girls is active. Furthermore, the local parliament has decided that due to the importance of keeping women in Arjeplog, they give priority to female activities as the men normally fend themselves with outdoor interests like hunting, fishing and snowmobile driving. The result is now that we have a increasing female population and the Male/female ratio has gone up to 1/1 from 254/100 for the singles within the age group 20-45 during 1991 to today).

11. **Project Save the Family - Improve your Health.** As a result of more than 50% of the marriages in Sweden ending up in divorce, we have a lot of social problems. Divorced men have a 20% higher mortality rate than married men, often caused by suicide and accidents. Thus we have started a project called: Save the Family - Improve your Health. This project aims at improving the health of a family as a unit. Among the issues examined are: Expectations of each other when people move-in together, contributing to the family’s strength, conflict resolution models and education about the every day life of the family, as many young people only have their models of family life from a diversity of TV-series. This project targets with special interest families having their first child. They are invited to eight meetings with the district nurse who
acts as a facilitator for the discussions between the family members. At each
group you try to get together not only first-time parents but also parents with
several children who are accustomed to being parents and can pass along
some parental skills. This very often results in a life long friendship between
the families with support to each other. This group has been working for the
last 35 years and is part of the daily work at the health centre.

12. Project Dream Team. The church is today involved in a programme called
“dream team”. The project works with certain classes in the school discussing
“my inner feelings and my picture of myself”, moral postures and behaviour
towards others: other classes, or schoolmates; ethics and language in the
school. They start when the children are around 10 years old and continue
until the age of 16. It is immensely popular and the children want to enrol in
it every year, but due to lack of resources the church can only hold the course
every second year for each class.

The Family Project

The stability of the family is the most important health factor for children and adults.
The instability of the family is one of the most important factors associated with ill
health. In our effort to strive for a better health for all we have listed different activities
aimed at the improvement of psycho-social health in our community.

Psychosocial

- Project against bullying;
- Project against Shop lifting;
- Restricted admittance to dance;
- Drug and alcohol political program;
- Language and behaviour in school.

Drug and Alcohol Abuse

- Lectures;
- Role playing (several plays with audience about work mates with alcohol
problems);
- Newspaper Articles.
Psychosocial Prevention

- Family-project;
- Youth Activity House;
- "Psychosocial Consultations" (Trying to discuss family life at the health centre);
- Alcohol Program;
- Reducing Tranquilizers (avoiding routine prescriptions since many years ago)
- Women’s Health.

Results (2009)

An informal evaluation of our project done in the year 2009 showed some encouraging results:

- Better behaviour in restaurants;
- Extensive support of families;
- Snowmobile Accidents highly reduced;
- Parents out on the town. (Parents walking around when there is concerts and dances for the youngsters);
- Few tranquilizers used by the people of Arjeplog;
- School working group against bullying managed by the pupils;
- Political decisions considering psycho-social issues;
- Man/Woman Ratio 1/1;
- Reduction of more than 75% in suicide rates in the period 1994 – 2003. These rates are still lowering in 2009. Rates are around 9/100 000 during the period 1994-2009; while for 1984 – 1993 they were 35/100 000 per year;
- Safety awareness among politicians;
Lessons to be learnt

Arjeplog model as an example of Health and Safety Promotion, Primary Health Care, Primary Prevention, Community Intervention and Specific Actions of and successful interventions within the philosophy of Safe Communities Movements in specific settings:

These are the lessons from Arjeplog

- Suicide was perceived as a problem by the community.
- Suicides and suicide prevention activities have big effects in communities regardless of numbers.
- Before the interventions Arjeplog shared with other communities the belief that suicide was a fact to live with, and therefore little could be done.
- However, action was demanded and therefore action was taken: model of communities interventions and participation.
- Results were obtained.
- Whether you can attribute lowering in actual numbers to the interventions can be debated. Nevertheless, the fact that the community has been strengthened as a result of the actions designed to prevent suicide is an important achievement.

More comments The ARJEPLOG Model for suicide prevention

Its importance lies in serving:

As a model of intervention for suicide prevention in small isolated communities independent of the numbers. Of little importance in practical sense is to know that Sweden and Arjeplog within Sweden have had high suicide rates. Every suicide case counts.

As an example of experiences that could be promoted in ascending levels from individuals to families, to communities, to regions and then to the rest of the world. In other words, Arjeplog could serve as an example that it is possible to go in a different way of Dubos’ proposal: think globally and act locally.

As an example of how the Safe Communities model could help to find solutions for treatment of specific problems and health topics within a community.

As a model of integrated actions between primary health care institutions and community actions. Integration of excluded people. The integrated approach.

Its importance within the world-wide concept. What happened in Arjeplog will be shared by the rest of the world.
Photo 6.7. Autumn in Arjeplog. (Photo: B&MH)

Reference

Chapter 7.
Specific example II: Aomori Prefecture, Japan

By Yoshihide Sorimachi and Lars-Gunnar Hörte

Suicide prevention and the Safe Communities movement in Japan: the importance of central government and socioeconomic interventions

Introduction
Suicide has been recognized as one of the most serious social problems in Japan for many years. Despite this, it is not until recently that Japan as a nation has implemented suicide prevention policies.

However, owing to the considerable efforts of many, including the families of suicide victims, the national and some local governments introduced suicide prevention measures as a public policy. Concretely, Japan established the first law for counteracting suicide in the world, and local governments initiated suicide prevention programs in various ways. Some rural prefectures in Japan have been successful in suicide prevention as a component of community safety promotion.

In this chapter, we describe the following developments in Japan:

1. Characteristics of suicide in Japan;
2. The 1st (basic) law on suicide countermeasures;
3. The Safe Communities movement;
4. Suicide prevention as community safety promotion in a rural prefecture of Japan, Aomori Prefecture;
5. Other suicide prevention programs.
Characteristics of suicide in Japan

Figure 7.1 shows the age distributions of suicide rates for males and females. The suicide rate for males has two peaks, one for middle-aged men, and the other for those 85 years old or older, whereas the rate for females increases more or less steadily with age.

![Figure 7.1. Suicide rates for males and females in Japan by age group (2006).](image)

![Figure 7.2. Trends in the suicide rate in Japan by gender (1965-2007).](image)
There has been a marked increase in the suicide rate in Japan over the last four decades (Figure 7.2). A first peak occurred in 1983, and a second in 1998, both of which were more evident for men than for women. For men in 1997, the rate was 26.0 per 100,000 population, whereas in 1998 it was 36.5, an increase of 40% in just one year; while, for females, the increase was 24%. Over the following ten years (up to 2007), the rate remained almost constant.

“Rest and mental health” has been adopted as one of the high-priority issues in Healthy Japan 21, the country’s national health promotion campaign for the 21st century. The Department of Health, Welfare and Labour of the national government and some local governments initiated programs for suicide prevention, mainly based on a medical approach.

![Relationship between suicide and unemployment rates for males in Japan (1965-2007)](image_url)

*Figure 7.3. Relationship between the suicide and unemployment rates for males in Japan (1965-2007).*

In Japan, during this period, there has been strong recognition of increasing unemployment related to the economic crisis and, at the same time, concern over the increase in the suicide rate. The correlation coefficient between the suicide and unemployment rates for males in Japan (1965-2007) is +0.954 (see Figure 7.3).
Figure 7.4 shows trends in the alleged reasons for suicide in Japan, as interpreted by the National Police Agency. Poor health is the most common reason for suicide, followed by economic concern, which is growing. 32% of the alleged reasons for suicide were economy-based, and 16% of the people involved turned out to have multiple debts. Percentages for all the other reasons are low and constant (National Police Agency, 2007).

Another study (Watanabe R et al. 2006) shows the following:

a) For many years, unemployment has been affecting the segments of the Japanese population that shows increasing suicide rates. The relationship between unemployment and suicide is statistically significant.

b) The main factors explaining the sudden surge in suicide among 35-64 year-old males since 1997 seem to be increasing unemployment and poor economic circumstances.

c) The rate of suicide increase among self-employed persons was strongly affected by the monetary crisis of 1997-1998.

**The 1st (basic) law on suicide countermeasures**

Towards the end of the 20th century, care for bereaved families was gradually developed by non-governmental organizations (NGOs) in some urban areas of Japan, but with almost no governmental support. In 2001, Mr. Yasuyuki Shimizu (2006),
a journalist at the Japan Broadcasting Association (NHK), broadcast televised interviews with orphans whose parents had committed suicide. He was shocked to find that Japan lacked adequate national programs to support bereaved families, and also had insufficient public policies for suicide prevention. Accordingly, he established an NGO called Lifelink to support bereaved families and close friends and to prevent suicides in Japan. To achieve this, he resigned from his job. Lifelink (Kan S 2006) has become the hub of the network of NGOs supporting bereaved families and/or preventing suicides throughout Japan.

At the same time, Lifelink discussed the issue with national ministries whose remit included the issue of suicide, such as the Department of Health, Welfare and Labour, the Cabinet Office, and the National Police Agency. It also got in touch with some state politicians in order to introduce suicide countermeasures as public policies in collaboration with other NGOs throughout Japan. The media have been supportive of this effort. The NGOs insisted on establishing a law on suicide countermeasures, and collected more than 100,000 signatures of people, and also the support of 23 other organizations, who hoped for the law to be established. The first bill on suicide countermeasures was submitted to the Diet (the national parliament) by politicians of both the government and the opposition parties. This new act, the Basic Law on Suicide Countermeasures (Law No. 85 of 2006) (Akita J 2006), was approved by the Diet in June 2006, and came into force in October 2006.

The following are the basic premises of the Basic Law on Suicide Countermeasures:

• Suicide is not an individual but a social problem. Behind suicide, there are various social factors, which is why it should be counteracted by social efforts.

• Since suicide involves various complex factors, suicide countermeasures must be implemented not only by adopting a mental health approach but also by comprehensive social efforts.

• Suicide countermeasures must include prevention, crisis management, and post intervention in situations involving both those who commit suicide and suicide attempters.

• It is necessary to create inter-sectoral collaboration between the national government, local governments, medical institutions, business owners, schools, and the non-governmental organizations that work towards suicide prevention or provide support for bereaved families.
Nine basic policies in the 1st Law on Suicide Countermeasures

1. Promotion of surveys and research on suicide;
2. Promotion of public awareness of suicide prevention;
3. Promotion of human resources for suicide countermeasures;
4. Development of a framework for mental health promotion;
5. Development of a framework for provision of medical treatment;
6. Development of a framework for suicide prevention;
7. Support for survivors of suicide attempts;
8. Support for relatives of suicide victims;
9. Support for the activities of non-governmental organizations.

Also, every prefecture is obliged to create an association for suicide countermeasures with inter-sectoral collaboration, including NGOs.

The Safe Communities movement

The concept of Safe Community was not introduced in Japan until 2002. Since then, advocacy of Safe Communities has grown, but it was not until the beginning of 2005 that the concept of safety promotion was activated.

In March 2005, the government of Kyoto Prefecture adopted the concept of Safe Community as its plan of action for residential safety, making it the first Japanese local government to do so. In October 2005, the Safe Community initiative was launched by public health professionals in Towada Municipality, within Aomori Prefecture, with the purpose of achieving the status of a Safe Community. In October 2005, the third Asian Regional Congress on Safe Communities was held in Taipei, Taiwan, where delegates from Japan held a meeting and decided to establish a national network for safety promotion research and the Safe Communities movement.

In February 2006, Dr. Bo Henricson from Arjeplog, Sweden and the Karolinska Institutet visited the Kameoka Municipality of Kyoto Prefecture to supervise its safety programs. In July 2006, the Mayor of Kameoka declared his intention to pursue designation as the first Safe Community in Japan.

In September 2007, the Japanese Society of Safety Promotion was established and held its first annual conference in Kyoto City. (Professor Leif Svanström from Karolinska Institutet in Sweden and Professor Joon Pil Cho from Ajou University in Korea were the keynote speakers.) In March 2008, Kameoka Municipality was formally designated as a member of the international Safe Communities network, making it the 1st municipality in Japan to achieve such status. More municipalities in Japan have declared their intention to become members of the network. The Towada Municipality of Aomori Prefecture was designated as a network member on August 2009. Atsugi Municipality, in Kanagawa Prefecture, is on the waiting list of candidates to become a Safe Community.
For Towada Municipality, realizing its ambition to become a Safe Community has entailed an emphasis on suicide prevention as community safety promotion.

Suicide prevention as community safety promotion in a rural prefecture of Japan, Aomori Prefecture

Photo 7.1 and 7.2. Aomori Prefecture is in many senses a rural area with developed Farming. (Photo:LS)
Aomori Prefecture is located at the northernmost tip of the main island of Japan (Figure 7.5). In 2007, its population was approximately 1.4 million, of whom 23% were over 65 years of age. Mean personal income was the second lowest in Japan, and the unemployment rate was the second highest. Life expectancies for males and females were the lowest in all prefectures in Japan.

In Aomori Prefecture, the suicide rate for males in 2005 was 59.6 per 100,000, the highest in Japan.

Figure 7.5. Geography of Japan and Aomori Prefecture.

In Aomori Prefecture, the suicide rate for males in 2005 was 59.6 per 100,000, the highest in Japan.

Figure 7.6. The structure of suicide prevention programs in Aomori Prefecture.
Figure 7.6 provides a schematic presentation of how the structure of suicide prevention programs in Aomori Prefecture developed. First of all, public health centres in the prefecture analyzed basic epidemiological data on suicides for every Municipality, and identified Municipalities with high suicide rates. They recommended that such municipalities should develop suicide prevention programs. The mental health centre of the prefecture provides technical assistance to the Municipalities, e.g. by producing material for mental health workshops and for the training of municipal district nurses (mostly primary prevention).

Before the suicide prevention programs were implemented in Aomori Prefecture, talking about suicide seemed to be something like a taboo. There were many prejudices about suicide and barriers to suicide prevention. It is said that some leaders of municipalities insisted that talking about suicide might increase the suicide rate. So, mental health education began with the slogan, “Let’s improve our mental health!”, avoiding talking too much about suicide prevention. As a consequence, most of the local mayors accepted it.

**Surveys.** Suicide prevention programs in many Municipalities in Aomori Prefecture had some processes in common. As a first step, household surveys of the mental health status of residents were performed, not with the intention of screening for depressed persons, but for community diagnosis. The Centre for Epidemiologic Studies Depression Scale (CES-D)(Radloff 1977) and the Measurement of Social Support Elderly (MOSS-E)(Sakihara et al. 2000) were adopted as the depression and social support scales. Statistically, analysis of variance (ANOVA) was used in two ways to analyze the responses: both risk factors for depression and salutogenic factor (Eriksson et al. 2008) were explored in the analysis.

The community survey in Rokunohe Municipality in 2004 is a good example of the ones conducted in Aomori Prefecture (Takizawa T et al. 2006, Watanabe et al. 2004). Health volunteers administered self-report questionnaires to all the households of the targeted residents.

The CES-D scores (measuring levels of depression) for both males and females in Rokunohe Municipality were higher than those in Japan as a whole. As for suicidal thoughts, 10% of males and 13% of females stated that they thought about committing suicide when they felt depressed (Watanabe 2004).

To the question, “What is the problem that bothers you most frequently?”, the most frequent response was “economic problems”. This occurred in 31% of cases. 52% of respondents with suicidal thoughts said that they had serious economic problems, while 32% of unemployed respondents reported having suicidal thoughts (Watanabe 2004).
Six salutogenic factors for good mental health
(from the community survey in Rokonohe Municipality in 2004)

1. Having many hobbies;
2. Good communication with family, friends, and neighbours;
3. Good or well controlled physical condition;
4. Healthy economic situation;
5. Good sleep and enough rest;
6. Flexible personality.

Dissemination of results. As a second step in community suicide prevention, the results of the community surveys were disseminated in various ways. Pamphlets with the results, giving knowledge about depression, were distributed to every household in the Municipalities.

Plays and/or picture-card shows were performed in many local community centres in the municipalities, giving a brief description of the surveys and discussing what depression means to the residents. The residents could enjoy the presentations and acquire some essential knowledge on depression and how to manage mental health.

These plays and/or picture-card shows were also good media through which to advocate suicide prevention in the communities, since they had the following messages: “We can get a community to prevent suicide by social integration or solidarity”, “To commit suicide is not an act of courage, and it is avoidable”, and “Talking about what you are thinking makes your life happier”.

Help for people with mental problems. Since, according to the surveys, many people with mental problems did not know where to look for help, a so-called mental health caring nurse system was established in Rokunohe Municipality in 2004 (Watanabe 2004). It was set up by a network based on the prefectural mental health centre, with the participation of general practitioners, psychiatrists working in hospitals, and the prefectural and municipal public health centres. Mental health caring nurses were recruited from non-psychiatric clinics, from the municipal hospital and from elderly support centres and they were trained and registered. People who want brief counselling can now obtain it free if they visit the places where the nurses are working.
Suicide prevention programs in Towada Municipality as part of the Safe Communities movement

The suicide rate for both sexes in Towada, Aomori Prefecture in 2002 was 51.8 per 100,000 population, which was much higher than that for all of Japan (23.8). The suicide rate for males in Towada in 2002 was 81.3, whereas for females it was 24.8. Hence, suicide prevention programs in Towada City were initiated in 2003.
They were an emphasis on primary prevention, with the slogan “We can create a community to prevent suicide through the integration of its citizen”.

The following programs were carried out. To advocate suicide prevention, municipal newsletters were sent to every household in Towada. Mental health education for citizens, mainly focusing on the primary prevention of depression by district nurses, has been performed frequently. Volunteers advocating suicide prevention have been fostered. Some members of this group increase awareness of the importance of preventing depression and/or suicide by telling a story illustrated by picture cards.

*Picture 7.5. Mental health education for citizens by district nurses. (Photo:LS)*

*Picture 7.6. Storytelling involving the community members. (Photo:LS)*
Another group of volunteers listens carefully to what the elderly talk about. Mental health counselling services have been strengthened and publicized.

By 2004, similar programs had been implemented in 13 municipalities in Aomori Prefecture.

Figure 7.7 shows that the suicide rate in Towada City, for both genders, increased dramatically from 2001 to 2003, and that it was much higher than either the national average or that of Aomori Prefecture. The programs for suicide prevention in Towada City started in 2003. Between 2003 and 2006, the suicide rate in Towada rapidly decreased. Now, it has fallen to about the same level as the rate in Aomori Prefecture, but it is still higher than the national average.

![Figure 7.7. Trends in suicide rates for both genders in Towada City, Aomori Prefecture and throughout Japan (the arrow indicates the year when the suicide prevention programs started.)](image)

**Some further remarks**

Public health countermeasures, emphasizing a population-based approach to raise public awareness of depression and suicide prevention aimed at local residents, have the effects of increasing mental health literacy and of raising the potential to reduce suicides. Further, promoting a sense of purpose in life among senior citizens and creating a community network have the potential to reduce suicides, since they lessen the sense of isolation and enhance social capital, such as residents’ mutual trust and reciprocity (Goldney et al. 2001) Motohashi Y. and colleagues (2005/2007) recently
reported on a successful decrease in suicide rates in rural towns in Akita Prefecture (which neighbours Aomori Prefecture) following community-based intervention.

Surveying for community diagnosis is the key to community suicide prevention programs in many municipalities in Aomori Prefecture. In order to evaluate the effectiveness of the programs, appropriate epidemiological and also qualitative (e.g. focus group interviews) studies are necessary.

Other suicide prevention programs

**Coping with multiple debts.** In Amami Municipality, Kagoshima Prefecture, anyone suffering from multiple debts (consumer loans) can visit the Division of Citizen Life to be advised on how to solve their problems, (The Cabinet Office 2007). What are the lessons to be learnt? The personnel there listen to their clients very carefully and introduce them to lawyers who can advise them on how to solve their debt-related problems. In addition, the personnel often contact other divisions if it is necessary for the client to get other kinds of support. The purpose of their activities is not only to solve debt-related problems legally, but also to help the client rebuild his or her daily life. So far, personnel have been getting many phone calls from people who have suicidal thoughts and/or suicide attempters, not only in Amami Municipality but also elsewhere in Japan. Such programs for supporting people with multiple debts are being steadily adopted by other local governments in Japan.

**Psychiatric treatment for suicide attempters in emergency hospitals.** In the hospital of the Yokohama City University School of Medicine, all suicide attempters brought to the emergency room can receive psychiatric treatment and necessary social work-related help, provided by a team of psychiatrists, social workers, psychologists, etc. (Nakagawa et al. 2009). About 15% of patients brought to the emergency room are severely injured suicide attempters, who have the highest risk of suicide. The hospital evaluated the effectiveness of this form of crisis management for preventing suicide; only 4.3% of the severely injured suicide attempters who had received help in this form attempted suicide again within 300 days of discharge (Nakagawa et al. 2009).

**Support for relatives of suicide victims.** In Iwate Prefecture, bereaved relatives of suicide victims now receive pamphlets that are distributed to them by policemen or medical doctors after death scene investigations. Since August 2005, the Mental Health and Welfare Centre of Iwate Prefecture have held meetings for relatives (The Cabinet Office 2007). Later, people who had participated in the meetings themselves launched a volunteer peer support group.
Many municipalities in Japan have adopted health or safety promotion approaches as suicide prevention measures. However, most of them do not realize that they have done so. From now on, we have to advocate suicide prevention as part of community safety promotion, and link suicide prevention and the Safe Communities movement.

**Concluding remarks**

Suicide prevention programs as public policies in Japan started with the establishment of the Basic Law of Suicide Countermeasures, which included various measures to counteract suicides, involving not only medical treatment for depressed people, but also raising peoples’ mental health literacy, strengthening cohesion within communities, supporting people with multiple debts, and supporting bereaved kin and family members, etc. In other words, suicide prevention policies in Japan encompass various approaches: a medical approach, a socioeconomic approach, a safety promotion approach, etc. It can be said that a new era of suicide countermeasures, suicide prevention, and support for the bereaved and survivors in Japan has started. Nevertheless, the establishment of strategies to combat suicide among youths and people living in urban areas remains an important challenge.

*Photo 7.7. Aomori Prefecture in Japan- a beautiful part of the country. (Photo:LS)*
Photo 7.8. Lake Towada. (Photo:LS)
Lessons to be learnt

in Japan the relation between unemployment and suicide is very clear. The reasons for this are threefold: First, the extent of the problem is so large that it is impossible to ignore; second unemployment means lack of income, which in some other countries is covered by social insurance, but not in Japan; and, third, unemployment can entail social and family catastrophe leading to exclusion, which endangers sense of belonging to society.

So what are the lessons to be learnt?

For the nation:
Investigate epidemiologically the phenomenon of suicide and establish its determinants. All available studies from Japan show a very close relationship between economic deterioration followed by unemployment and an increase in the suicide rate. Take action accordingly.

Recognize suicide as a societal and public health problem, not only at local level, but as a general social problem that requires structural action at central governmental level.

Realize that it is necessary to establish inter-sectoral collaboration between the national government and local governments, medical institutions, business owners, schools, and non-governmental organizations to work on suicide prevention and support for families of the victims.

For the community and their organizations
“We can make a community to prevent suicide by integration of its citizen”.

Suicide is not solely an individual problem but a social problem and should be prevented by social efforts. Every prefecture in Japan is now by law obliged to set up an association for suicide countermeasures with inter-sectoral collaboration, including NGOs. Countermeasures must be implemented not only through a mental health approach but also through comprehensive social efforts, including prevention, crisis management and post interventions for those who commit suicide and suicide attempters and their families and friends. According to the Japanese experiences, the key to community suicide prevention lies in surveys for community diagnosis.
If a community conducts a study on the situation, what is most important is to disseminate its results back to the citizens involved.

**On the individual, group and family levels**

Suicide is an example of how individuals at the inner-most level are affected by things happening outside themselves. These seem to lead to the individual excluding him/herself from others. Close kin react to the situation at a very personal and mental health level; they might shut themselves off, leading to further exclusion. But, bearing this in mind, the Japanese example shows that there are circumstances that will promote inclusion and health:

1. Having many hobbies
2. Having good communication with family, friends, and neighbours
3. Good or well controlled physical condition
4. Healthy economical situation
5. Good sleep and enough rest
6. Flexible personality

How can this be done in practice? You can learn from some of the community programs described in this chapter.
References


Chapter 8.
Specific example III:
The role of hospital and emergency department for suicide prevention in South Korea

By Joon Pil Cho

Picture 8.1. The map of S Korea with Suwon, the provincial capital of Gyenggi-do in South Korea, is a city of 1,086,904 inhabitants (2008). It is situated 30 kilometres south of Seoul, and is one of the most populous of Seoul’s satellite cities.

Photo 8.1. Suwon is a cultural and tourist city in which tradition and modernity co-exist, and where a World Cultural Heritage (Hwaseong) centre is located. Suwon is also an industrial and economic city where high value-added industries like IT, BT and NT are developing harmoniously. (Photo:JPC)
Hwaseong, the wall surrounding the centre of Suwon, was built in the late 18th century by King Jeongjo of the Joseon Dynasty to honour and house the remains of his father Prince Sado. He had been murdered by being locked alive inside a rice chest by his own father, King Yeongjo after failing to obey his command to commit suicide. King Jeongjo’s fortress and palace Haenggung, was designated by UNESCO as a World Heritage site in 1997. The Suwoncheon, the main stream in Suwon, flows through the centre of the fortress.

The Ajou University School of Medicine

The Ajou School of Medicine celebrated its 20th anniversary in 2008. The school emphasizes medical research to produce world-class medical doctors in the global era, training its students to take leading roles in various medical fields. The school is making every effort to develop as a top-notch medical school that produces medical professionals in the Biotechnology and pharmaceutical industries, medical administrators and medical journalists, and also medical doctors and scientists.

The suicide problem in South Korea

Epidemiology

According to published reports of OECD social Indicators (2009), South Korea has the third highest suicide rate with 24.7 deaths of 100,000 persons among the member states of the Organization for Economic Cooperation and Development (OECD),
being surpassed only by Hungary with 22.6 and Japan with 20.3 (Table 8.1). South Korea ranked first with regard to female suicides among the 30 member states, with an average rate more than double the OECD average (OECD 2009, Yonhap News 2006). Deaths from suicide are only part of the problem. Suicide attempters who do not kill themselves are often seriously injured, need medical care, and can become a burden to their families emotionally, mentally, and economically.

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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>9.20</td>
<td>9.40</td>
<td>9.80</td>
<td>9.10</td>
<td>9.70</td>
<td>10.60</td>
<td>10.50</td>
<td>11.80</td>
<td>14.10</td>
<td>14.10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>18.64</td>
<td>15.09</td>
<td>13.50</td>
<td>14.18</td>
<td>17.28</td>
<td>21.50</td>
<td>21.95</td>
<td>22.52</td>
<td>19.33</td>
<td>22.04</td>
</tr>
</tbody>
</table>

Table 8.1. Suicide rate per 100,000 inhabitants in S Korea during 1988-2007.

From 1988 to 1997, the suicide rate increased slowly, but there was a sharp increase in 1998 (Figure 8.1). The suicide rate then declined until 2000, only to increase again from 2001 to 2003. Since 2003, the rate has been steady at about 19-22 per 100,000 population, although there was an abrupt drop in 2006. Over the 20 years, the overall suicide rate increased from a low of 9.20 per 100,000 populations in 1998 to a high of 22.04 in 2007. For youth suicide, the increase looks like global inflation in recent years.
In America, the suicide rate for ages 5-24 increased dramatically from 1950 to the early
to mid 1990s.

Suicide was the eighth leading cause of death in South Korea in 1997, but it became
the fourth leading cause of death for all Koreans after neoplasm, cerebral vascular
disease, and cardiovascular disease in 2008 (The Korean National Statistics Office
2009). In that year, 5.0% of all deaths were from suicide. The ranking of suicide among
all deaths is much higher than in America, where suicide is the eleventh leading cause
of death (National Centre for Injury Prevention and Control).

![Figure 8.2. Major causes of death per 100,000 populations in South Korea. Data Source:

Figure 8.2 shows an increasing trend in suicide over the last decade. Suicide is the
leading cause of death for the age group between 10 and 30 years of age. The suicide
rate is higher in males than in females, and the rates increase with age. Poisoning
is the most common method for suicide attempts and for actual suicides. Compared
with other countries, there is a difference in South Korea with regard to method. In
America, the top three methods used in suicides were firearms (51%), suffocation
(23%), and poisoning (18%) (4).

Ajou University Hospital (Photo 8.2) has developed a surveillance system for
suicide attempts, based on information from its emergency department (Photo 8.3 and
8.4). The main objective of the surveillance system is to develop intervention programs
for suicide prevention. This is a difficult task because, although the dead may leave
clues, they cannot give information about the causes, risk factors, or circumstances
involved in their deaths.
Emergency-department-based surveillance of self-inflicted injuries

Prior to data analysis, a data-collection system based on the emergency room was built up in 2003. It is called the National Emergency Department Information System (NEDIS). NEDIS is a near real-time system, which encompasses information about every patient who visits the emergency room. During the next year, the system was
established in 16 regional emergency centres and operated in 45 local emergency centres. It was extended to 96 special and local emergency centres in 2006, and now, in 2009, 125 emergency centres are in operation.

Doctors, who diagnose and treat patients (Photo 8.5), input their information into a computer and transmit it to the National Emergency Medical Centre. In every case related to injury, additional questions are asked, including about activity during harm, whether related to alcohol or not, injury development area, injury-inducing causes, and so on. These data are also input and checked by doctors and coordinators in each hospital affiliated to the South Korea Centre for Disease Control and Prevention (KCDC).

There is also a dedicated surveillance system, called the In-depth Injury Surveillance System. Lists are created on the basis of major causes of injury. This national system started in 2006 for injury prevention, including suicide. Eight emergency centres, each representing their region, have participated in the system, which has categories such as suicides, cases of poisoning, head and cervical-spine injuries, road-traffic injuries, falls/slips, and injuries to preschool and other children.
The total number of patients (Photo 8.6) seen at the Emergency Department in Ajou University Hospital during the period January 1st to December 31st 2008 was 84,001, of which 634 patients visited one emergency centre concerned with self-inflicted injuries, including 25 suicide death (Figure 8.3).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15 years old</td>
<td>7</td>
<td>1.1</td>
</tr>
<tr>
<td>15-24</td>
<td>78</td>
<td>12.3</td>
</tr>
<tr>
<td>25-34</td>
<td>143</td>
<td>22.6</td>
</tr>
<tr>
<td>35-44</td>
<td>171</td>
<td>27.0</td>
</tr>
<tr>
<td>45-54</td>
<td>123</td>
<td>19.4</td>
</tr>
<tr>
<td>55-64</td>
<td>48</td>
<td>7.6</td>
</tr>
<tr>
<td>65-74</td>
<td>42</td>
<td>6.6</td>
</tr>
<tr>
<td>75-84</td>
<td>19</td>
<td>3.0</td>
</tr>
<tr>
<td>85-</td>
<td>3</td>
<td>0.5</td>
</tr>
</tbody>
</table>

*Figure 8.3. Numbers and proportions of patients with self-inflicted injuries at the Emergency Department in Ajou University Hospital by age group. Data Source: National In-depth Interview Survey for Injury 2008, South Korea.*

As shown in Figure 8.4, about 1.5 times more women than men report attempting suicide, which is in line with the international situation (Psychiatry and Clinical Neurosciences 2005). However, severity and fatality were much higher in men than in women. 30% of men and 19% of women required admission to an intensive care unit (Figure 8.5). 7.3% of men and 2.5% of women were dead before arrival or immediately after arriving at the emergency room. 18.8% of all patients with a self-inflicted injury refused further evaluation and medical care or an interview with a psychiatrist. More than twice as many women as men (25.3% vs. 9.6%) refused this type of care. Approximately 5.3% needed an emergency operation.
At 63%, poisoning is the most common method of attempted suicide (Figure 8.6.a&b). Prescribed or non-prescribed medicine accounted for 53% of the total number of poisonings, followed by agricultural chemicals (33%), toxic chemical substances (10.6%), and gas (3.9%). In descending frequency order, the other methods of suicide were cut/stabbing, blunt objects, and hanging.
Method of attempting suicide

Figure 8.6a. Proportions of patients with suicide attempt admitted to the Emergency Department in Ajou University Hospital by method used. Data Source: National In-depth Interview Survey for Injury 2008, South Korea.

<table>
<thead>
<tr>
<th>Method</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>63%</td>
</tr>
<tr>
<td>Medicine</td>
<td>(52.5%)</td>
</tr>
<tr>
<td>Agricultural chemicals</td>
<td>(32.8%)</td>
</tr>
<tr>
<td>Toxic substances</td>
<td>(10.6%)</td>
</tr>
<tr>
<td>Gas</td>
<td>(3.9%)</td>
</tr>
<tr>
<td>Others</td>
<td>(0.2%)</td>
</tr>
<tr>
<td>Cut/Stabbing</td>
<td>17%</td>
</tr>
<tr>
<td>Hanging</td>
<td>5%</td>
</tr>
<tr>
<td>Blunt objects</td>
<td>6%</td>
</tr>
<tr>
<td>Fall</td>
<td>3%</td>
</tr>
<tr>
<td>Others (traffic crush, burning oneself…)</td>
<td>6%</td>
</tr>
</tbody>
</table>

While poisoning by medicine, including prescription and over-the-counter drugs, was most common among youth and the middle-aged, poisoning by agricultural chemicals was most common among older people (Figure 8.7). Hanging was a common method among persons seventy years of age or older.

Figure 8.6b. Methods of suicide attempts admitted to the Emergency Department in Ajou University Hospital with types of poisoning specified. Data Source: National In-depth Interview Survey for Injury 2008, South Korea.
<table>
<thead>
<tr>
<th>Age group</th>
<th>Method of attempting suicide First</th>
<th>Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td>10s and 20s</td>
<td>Poisoning - Medicine</td>
<td>Cut/Stabbing</td>
<td>Poisoning - Toxic substance</td>
</tr>
<tr>
<td>30s</td>
<td>Poisoning - Medicine</td>
<td>Poisoning - Agricultural chemicals</td>
<td>Cut/Stabbing</td>
</tr>
<tr>
<td>40s</td>
<td>Poisoning - Medicine</td>
<td>Poisoning - Agricultural chemicals</td>
<td>Poisoning - Toxic substance</td>
</tr>
<tr>
<td>50s and 60s</td>
<td>Poisoning - Agricultural chemicals</td>
<td>Poisoning - Medicine</td>
<td>Poisoning - Toxic substance</td>
</tr>
<tr>
<td>70s or more</td>
<td>Poisoning - Agricultural chemicals</td>
<td>Poisoning - Medicine</td>
<td>Hanging</td>
</tr>
</tbody>
</table>

Figure 8.7. Methods of suicide attempts admitted to the Emergency Department in Ajou University Hospital by age group. Data Source: National In-depth Interview Survey for Injury 2008, South Korea.

In the younger age groups, conflict with parents or friends was the major reason for attempting suicide (Figure 8.8). For the age groups from 20 to 60, the main reason was a difficult relationship with spouse or partner. Health problems were the primary reason among people 70 years of age or older. A high correspondence between alcohol consumption and suicide incidence was observed. About 71% of self-inflicted injuries were related to alcohol. 38% of those who attempted suicide were afflicted by mood disorders, which demonstrate a strong association between suicide and mental illness (Kim SY et al. 1999, Park & Wi 1999).

<table>
<thead>
<tr>
<th>Age</th>
<th>Risk factor First</th>
<th>Risk factor Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td>10s</td>
<td>Conflict with parents</td>
<td>Conflict with friends</td>
<td>Others</td>
</tr>
<tr>
<td>20s</td>
<td>Conflict with lover</td>
<td>Conflict with parents</td>
<td>Depression</td>
</tr>
<tr>
<td>30s and 40s</td>
<td>Conflict with spouse</td>
<td>Depression</td>
<td>Occupation-related problem</td>
</tr>
<tr>
<td>50s</td>
<td>Conflict with spouse</td>
<td>Depression</td>
<td>Conflict with other families</td>
</tr>
<tr>
<td>60s</td>
<td>Conflict with spouse</td>
<td>Conflict with children</td>
<td>Depression</td>
</tr>
<tr>
<td>70s or more</td>
<td>Health problem</td>
<td>Unknown</td>
<td>Depression</td>
</tr>
</tbody>
</table>

Figure 8.8. Risk factors of patients attempting suicide admitted to the Emergency Department in Ajou University Hospital by age group. Data Source: National In-depth Interview Survey for Injury 2008, South Korea.

16.7% of the patients had made a previous suicide attempt. The average medical cost of self-inflicted injuries was approximately US $1,282, ranging between a minimum of US $ 43 and a maximum of US $ 27,190. Source:  Report of Suicide Prevention

Figure 8.9 shows that the home was the most common place to attempt suicide (79%). The second most common place was a facility for leisure activities, followed by a group residence, business area, and road.

![Place to attempt suicide](image)

Figure 8.9. Proportions of patients with a suicide attempt admitted to the Emergency Department in Ajou University Hospital by place. Data Source: National In-depth Interview Survey for Injury 2008, South Korea.

Suicide prevention interventions in South Korea

National level

The Korean Association for Suicide Prevention and the Ministry of Health, Welfare and Family Affairs are at the cutting edge of prevention and intervention. They focus on reducing misconceptions about and prejudices against suicide, and attempt to prevent previous suicide attempters from trying again through public relations and enlightenment campaigns.

On World Suicide Prevention Day 2005, organized by the International Association for Suicide Prevention and the World Health Organization, political, religious, medical, and educational leaders in South Korea presented “7 major declarations of defending the life”, stating the responsibilities of nations, communities and individuals.

1. Life should be respected above all.
2. Threatening of life cannot be allowed for any reason.
3. Suicide should not be glorified or justified for any reason.
4. Life should not be a means for solving problems.

5. Everybody is obligated to save the life of one’s own as well as that of another.

6. Individuals and society must join in proactive suicide prevention.

7. The government should promote policies to realize a life-respecting society as first priority.

In July 2004, the Ministry of Health, Welfare and Family Affairs, the Korean Association for Suicide Prevention and the Korean Journalist Association released guidelines regarding the responsible news reporting of suicide in South Korea.

An adolescent suicide prevention program was developed, which is characterized as a psycho-educational program designed to enhance understanding of adolescent suicide, and to teach ways of making reasonable decisions.

A 24-hour, charge-free telephone-crisis intervention service is run by Life Line Korea for anyone in suicidal crisis, and is also available on the Internet. Life Line Korea is a member of Life Line International, which was set up in Sydney in 1963. It runs services for life counseling, legal advice, and medical consultation. As a continuing education organization, it also runs regular training courses for professional counselors, called Awareness, Intervention, and Referral Training.

**Community level**

**Hospital-based suicide prevention: a comprehensive approach within the community**

At the Emergency Department in the Ajou University Hospital, where the author has been Chief Emergency Physician for 15 years, three to five people on average are admitted each week due to a suicide attempt (Photo 8.7). For those whose attempts failed, the same services are offered as elsewhere in the world – mainly consultation with the Department of Psychiatry, which in turn tends to admit the “patient” for a few days, and then return him or her to the same socioeconomic environment where the suicide attempt had taken place.

In the Ajou University Hospital, a decision was made to break this vicious circle through collaborative efforts from relevant sectors. A Suwon Suicide Prevention Centre was established in 2000. At the beginning, its main focus was on public awareness, such as education for school children (mostly in middle school) and publications, including brochures and monthly newsletters. Additionally, the Centre provided crisis counseling by trained volunteers 24 hours a day for telephone callers. Recently,
Life Line, a non-governmental organization, took over telephone crisis counseling nationwide.

Most of the suicide attempters visiting the emergency department in a hospital are discharged to the same social/economic environment where the attempt was made after receiving some medical treatment. The medical care includes psychiatric evaluation and treatment, although in a hospital the nature of the care should depend on the method involved and the severity of the suicide attempt. Medical care alone is not enough to support suicide attempters. In order to prevent re-attempts, we have to break the vicious cycle and provide support with various resources from diverse sectors within the community.

In 2006, the Emergency Department of Ajou University Hospital submitted a proposal to the Korean Centre for Disease Control (CDC) – “A comprehensive approach for preventing suicide re-attempts within a community based on the Emergency Department”. The Korean CDC approved a small budget for one year only (2006), which was just enough to pay for a social worker (Picture 8.8).
The aims of the project were:

- to assess the psychosocial/economic environment of suicide attempts and to identify risk factors through in-depth psychological interviews; and,

- to develop a comprehensive intervention program within a community to prevent suicide re-attempts through emergency-department actions. The targets are suicide attempters visiting the Emergency Department in Ajou University Hospital.

The emergency physician is the first health professional to take care of a suicide attempter who enters an emergency department. At the Emergency Department, emergency medical care, psychological-crisis intervention, psychiatric evaluation and treatment, and psychosocial and economic-environment assessment are provided case-by-case.

The hospital social worker at the Emergency Department coordinated the project. The social worker interviews suicide attempters following clinical evaluation and treatment. The role of the social worker is diverse:

- Counsel attempters and their families.
- Get informed consent for further contact.
• Get a promise not to try suicide again, with a signature from the attempter – a so-called “I promise” – including contact information for when the attempter gets into a similar situation.

• Provide contact information on community resources, including non-governmental organizations, such as a local suicide prevention centre or life line, to help attempters to solve underlying problems and modify their social environment.

Figure 8.10. A proposal for a comprehensive approach to preventing suicide re-attempts within a community, based on the Emergency Department in Ajou University Hospital.

In this project, about 20 people, from among approximately 120 attempters, were enrolled for 6 months. Most of the suicide attempters did not want to be enrolled for the service. The main reason for avoidance was a concern that they might get involved further in complicated suicide-related situations, and they were worried that the information that they had attempted suicide might be made public. Quite simply, they just wanted to go home straight after medical care at the Emergency Department. Sometimes, they even refused psychiatric consultation.

After six months of the project, the Korean CDC decided the project was not successful, and suspended funding for it. Their argument was that attendance by
patients was lower than expected. It was just not cost-efficient, and it was proposed that alternative financing could be provided by insurance companies.

To prevent suicides, emergency departments are in a privileged situation with regard to identifying persons who constitute high-risk groups, such as the homeless, alcoholics, drug addicts, dropouts, etc. Social workers in the emergency departments know where to find these people – in bars, in tents, and so on. As in other countries, you will find the homeless in masses in Japan.

**Conclusion**

Suicide is a major cause of mortality and morbidity throughout the world. However, many experts agree that prevalence figures based on health records reflect only a small portion of the societal burden. Many more people are hospitalized due to non-fatal suicide attempts than are fatally injured, and an even greater number are treated in ambulatory care or emergency departments.

There is a need for longitudinal cohort studies, which may be able to identify the dynamic interaction between risk and protective factors (at individual, family, peer, community, and social levels), since they all influence suicidal behavior.

According to the WHO Safe Community concept, we must develop comprehensive strategies that have the potential to yield the greatest reduction in suicide through partnership and collaboration, governed by an intersectoral group that is responsible for suicide prevention in its community. This group encompasses a suicide prevention centre, a mental health centre, health professionals, hospitals and clinics, non-governmental organizations for charity or social welfare, local government, a public health centre, educational bodies, religious bodies, etc. The programs must be long-term and sustainable, covering both genders, and all ages, environments, and situations. They must address high-risk groups and environments.

To make suicide programs evidence-based, identification of the current situation and measuring the effects of the programs are required. Detailed information on suicide attempts and related risk factors can allow us to develop suicide-prevention programs relevant to a community. A surveillance system based on the emergency departments of hospitals is one of the most effective ways of identifying suicide problems within a community.

As is the case with other community programs, evaluation and sharing experiences are also important for the further improvement of community-based suicide prevention.
Lessons to be learnt

1. Epidemiology makes sense when the data collected indicate a problem for society. Societies react, but what about other countries? Data surveillance is central to providing efficient interpretation and action.

2. Suicide attempters who do not kill themselves are often seriously injured and need medical care, and can become a burden to their families – emotionally, mentally, and economically. Thus, it is important for hospitals and others to develop surveillance systems for suicide attempts based on data from emergency departments.

3. Interventions should be tailored according to data on age groups, gender and causes of the event. Specific patterns of means of suicide differ; then, we must be more specific in our preventive efforts.

4. The facts that about 1.5 times more women than men report attempting suicide, but that in general more men succeed, may change over time due to changing social roles. This requires further analysis.

5. Relationships are central to triggering acts of suicide; we need deeper understanding of the processes involved in order to find appropriate, tailored actions.

6. Nation states can do a lot to counteract suicide. Providing knowledge is one action, providing resources another. But it is also important to establish intersectoral collaboration with religious and other groups.

7. The Safe Community model provides an excellent start for action at local level. The most prominent lesson from South Korea is that the role of hospitals must be developed, even for primary prevention. Societies must provide resources for testing different models with long-term funding, and also accept the possibility of failure. Short-term funding might discourage hospitals from taking further action.

8. At micro-organizational level, there are many models and experiences to benefit from; counseling is one, meetings for different groups another, and providing help for managing daily life yet another.

9. To prevent suicides, emergency departments are in a privileged situation with regard to identifying persons who constitute high-risk groups, such as the homeless, alcoholics, drug addicts, dropouts, etc. Social workers in the emergency departments know where to find these people – in bars, in tents, and so on. As in other countries, you will find the homeless in masses in Japan. The emergency room can serve the community because it belongs to the community.
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Chapter 9.
Specific example IV: Jönköping in Sweden; a model for collaboration between community services to enable a more efficient response to suicide threats

By Tomas Wibble, Göran Melin and Annika Petersson with a contribution by Jan Beskow

Photo 9.1. Jönköping Municipality – one of about 300 municipalities in Sweden. (Photo: GS)

Jönköping is a city in Småland in southern Sweden with 84,423 inhabitants (2005). It is the 9th most populous city in Sweden, the seat of Jönköping Municipality, with a population of 122,194 (2006), and also the seat of Jönköping County, with a population of 331,539 (2006).

Jönköping accommodates a district court and a court of appeal, and also the Swedish National Courts Administration.

Geographically, the city is situated at the southern end of Sweden’s second largest lake, Vättern. With the sandy beach that runs through it, Jönköping is considered a very
beautiful place. The original city of Jönköping has grown together with Huskvarna and Norrahammar to form a joined-up urban area since 1971, wholly in the same municipality.

Jönköping is an old trading centre. “Jön” derives from the Junebäcken creek, which was situated in the western part of the city, and “Köping” is an old word for trading centre or market place. The city’s favored position was due to its location on the crossroads between the route following the rivers Nissan and Lagan, and the route joining the provinces of Östergötland and Västergötland. This was a natural geographical phenomenon due to the location of the city at the southern end of Lake Vättern, which divided the two counties.

However, the geographical position of the city also left it vulnerable to foreign attacks, mainly from the Danes, coming from the south along the river roads; at that time, the provinces of what is today southern Sweden – Skåne, Halland and Blekinge – belonged to Denmark. The city was plundered and burnt several times, until it was fortified in the 16th and 17th centuries.

Jönköping is known for its match industry (1845-1970). Even today it is an important Swedish logistics centre, housing many companies’ central warehouses (e.g. IKEA, Electrolux and Husqvarna).
The present

Urban Jönköping today includes the eastern industrial town of Huskvarna, with which it has grown together.

A major fair and exhibition centre, Elmia, is also located in Jönköping, with fairs including Elmia Wood, the world’s largest forestry fair. Elmia’s fairs are also the biggest of their kind in Europe for subcontractors, trucks, caravans and railways. Since 2002, Elmia has also been the location of the world’s largest LAN party, Dream Hack.

The region has some 9,800 registered companies, most of which are small and medium-sized manufacturing enterprises. But there are also a large number of international groups and companies, such as IKEA, Electrolux, SAAB, VSM Group, Fläkt Woods, Stora Enso Packaging, Kinnarps, Smurfit Munksjö, ROL and ITAB, which are based in Jönköping.

Jönköping University, which has over 11,000 students, is organized as a foundation comprising four independent schools: the Jönköping International Business School, the School of Engineering, the School of Education and Communication, and the School of Health Sciences, all centrally located on a city campus adjacent to the Jönköping Science Park.

Jönköping is the provincial capital and the administrative centre for the whole region. Central agencies are also based here, among them the Swedish Board of Agriculture and the Board of Forestry.

Jönköping offers a wide variety of cultural venues, theatres, museums (among them the unique Match Museum), cinemas, a modern concert hall, art galleries and a range of cultural events and happenings. Leisure and sports facilities are available to suit every taste: four golf courses, a racket sports centre, ice rinks, and indoor adventure baths, sandy beaches in the city centre, and nature trails and paths within easy distance.

Knowledge growth in relations

In the county of Jönköping there are three health and welfare areas, with three psychiatric clinics and 32 care centres. Suicide prevention has developed organically since 1997 through close relations between different actors. This illustrates the usefulness of knowing people and their way of thinking at the level above and below your own. At different levels you need different types of knowledge.
Population and group level

The wish to promote suicide prevention has emerged out of the hurt of people who have lost a family member from suicide. After they have passed the first hurting stage of sorrow, “Why?”, they go on to the second stage of anger, “Never more! Suicide must be prevented!”, and offer inspiration and ideas to other people. In Jönköping, suicide-prevention roles have been filled by:

- Persons from the local organization of the National Association for Suicide Prevention and Support to Significant Others (SPES).
- Persons from the local organization of the NSPH, an organization for patients and their relatives working for more adequate mental care in close collaboration with the leaders of psychiatric clinics.
- Many people from churches.
- People from eight local rotary clubs, who wanted to support suicide prevention in connection with an anniversary within the rotary organization.

Community level

- Collaboration between the local rescue service and police, SOS Alarm, and psychiatric and social services in creating routines for interventions in suicidal threat situations.
- Involvement of primary care in both suicide prevention teams and the use of care programs.

County level

- *The County Board for Strategic Development of Co-Operation between the County and the Communities* concerning psychiatry and substance abuse. The board consists of the three heads of the psychiatric departments, participants from the 13 municipalities, and two delegates from the NSPH. It has supported the development of suicide prevention teams in all three health and welfare areas since 1997. These teams cover the development of suicide prevention, organize a network, and arranges conferences within the county and in collaboration with neighbouring counties. Primarily, their task is to increase quality of care for suicidal people.

- *The Research and Development Unit (FoU)*, which – in close collaboration with the SPES and the NSPH – has supported the development of the care
programs for depression and suicidal propensity, separately, that later have been implemented in psychiatry and primary care. It is essential to have different care programs. Suicidal propensity is predominantly a cognitive problem-solving process, whereas depression is an affective disorder. Further, suicide occurs at every point in a depressive process. To understand the interaction between suicide and depression, they have to be treated separately. The primary messages were: “Dare to ask!”; “Document your suicide risk evaluation!” and “Co-operate with the patient’s relatives”.

- The County’s Public Health Department arranged a certified training course in suicide prevention for personnel in high schools, based on a film produced for schools, “Love is the best kick!” This project has been evaluated in a report from the University of Linköping.

**National level**

The government has stimulated suicide prevention in the following ways:

- Stressed the importance of suicide prevention through adopting a “Zero Vision” for suicide, just as previously for fatal accident on the roads.

- Formulated a National Program for Suicide Prevention comprising nine points. The program includes both indirect suicide prevention measures, such as better living circumstances for less privileged groups, lower alcohol consumption, and support for non-governmental organizations (the SPES and the NSPH), and also direct suicide prevention measures, such as restricting availability of suicide methods, commissions of inquiries after completed suicides (first for suicides in or immediately after medical care but later also for other suicides), information dissemination, promotion of competence among ward personnel, and better medical, psychological and psychosocial treatment.

The Central Research Institute (NASP) has contributed by

- Creating and disseminating scientific knowledge about suicide and suicide prevention.

- Organizing six networks, working all over the county, lobbying for the development of suicide prevention.

- Offering training possibilities for the film “Love is the best kick”. (courses and evaluations).

- Creating and disseminating scientific knowledge about suicide and suicide prevention.
Thus, suicide prevention work in Jönköping has followed four lines:

- Initiating and developing suicide prevention teams.
- Development and implementation of care programs.
- Education and training in high schools.
- Creating routines for interventions in acute suicidal threat situations (described below).

Further, the feeling of a common responsibility and of being together has been enhanced through the annual celebration of International Suicide Prevention Day on the 10th of September. This celebration is an initiative from the WHO and the International Association for Suicide Prevention.

Threats of suicide – collaboration between police, healthcare, SOS Alarm and community rescue services
An example from Jönköping County

Responsibility issues

Swedish legislation on compulsory psychiatric care (Act 1991:1128 § 47) empowers the police, if there is reasonable ground to suppose that someone suffers from a serious psychological disorder and is a hazard to his or her own life, or is otherwise in need of immediate help, to take that person into temporary care until health personnel can provide help. Serious psychological disorders include severe cases of depression.
with suicidal thoughts. Such compulsory care can therefore be applied in order, for example, to prevent suicide. It is this section of the Act that gives the police authorities the greatest legal opportunity to influence the situation, which means in practice that it is reasonable for the police to take the initiative in creating the preconditions for collaboration.

Assessment of which circumstances surrounding suicide attempts can lead to the intervention of rescue services is important, since it gives a basis for when municipal rescue agencies may, or have reason to, initiate a rescue. At the same time, it provides a foundation for assessing when the municipality in question is under an obligation to embark upon a rescue. Not least for the second reason, it is important not to overstretch the concept of a rescue service and the applicability of Swedish legislation on protection of accidents (Act 2003:778, the LSO) to these situations.

With regard to jumping from considerable heights and the like, however, the requirements of the concept of accident should be met, or – alternatively – those of impending danger of accident. Here, naturally, there is also scope for various types of actions that are proximate to the rescue services’ regular tasks and capacities.

Photo 9.5. Since 1989 there has been collaborative management between the rescue services, the social services, healthcare, including the hospital church, and the police with regard to psychological and social supportive efforts. (Photo: KT)

In Jönköping County, the following resources must be automatically alerted by SOS Alarm in cases of emergency calls (on tel. 112) that indicate a threat of suicide:
rescue services from the nearest rescue force, an ambulance from healthcare, and the appropriate psychiatric-emergency reception/clinic.

Swedish administrative law (Act 1986:223 § 6) states that every authority in Sweden must provide assistance to other authorities within the frame of its own operations.

Since 1989 there has been collaborative management between the rescue services, the social services, healthcare, including the hospital church, and the police with regard to psychological and social supportive efforts. Accordingly, it was natural to use this network to clarify the issue of responsibility and forms of cooperation. The results of this work have been implemented throughout Jönköping County within the frame of rescue-services collaboration (called Räddsam F).

Pursuant to § 11 of the Police Act (1984:387), a police officer, while awaiting a decision of the police authority, may take into custody a person that the police authority, by virtue of a special provision, is empowered to decide that someone shall be detained in this manner. Provisions of this kind are contained in § 47 of the Swedish Act on compulsory psychiatric care (cited above).

The police must act when they can help the general public in a suitable manner. This applies to situations where no other societal body has the task of providing assistance. In acute situations, the police can intervene (Police Act, § 2 para. 4).

A police officer, to the extent that other means are insufficient and in light of defensible circumstances, may employ violence to implement a service action (the Police Act, § 10 para. 3).

There is also an opportunity to call a medical doctor to the scene in order to make an assessment of whether a person shall be required to undergo a medical examination. If the person does not go voluntarily, health personnel can request help from the police. On other occasions, it may be that the police need to contact healthcare professionals for a medical assessment.

Pursuant to Swedish law on the social services (Act 2001:453), the services shall be informed by other authorities if they need to intervene for the protection of a minor. By a minor is meant a person who has not reached the age of 18.

The complicated pattern of responsibilities in this type of event in many cases means that the rescue services, at the same time as taking concrete action, must assess the questions of a normative nature that may arise. Do the provisions of Swedish law on protection against accidents apply (Act 2003:778, the LSO)?

The first restriction derives from Chapter 1 § 4 of the Act, namely that the relevant legislation does not apply to health and medical care. This entails that it can never be an issue for the rescue services if the suicide or attempted-suicide situation is a
medical matter, such as in the case of poisoning or the like. As stated above, it is important not to over-stretch the concept of a rescue service and the applicability of Swedish legislation on protection against accidents (Act 2003:778, the LSO) to these situations.

With regard to jumping from considerable heights and the like, however, the requirements of the concept of accident should be met, or – alternatively – those of impending danger of accident. Here, naturally, there is also scope for various types of actions that are proximate to the rescue services’ regular tasks and capacities. The four criteria specified in Chapter 1 § 2 third paragraph of the Act should often be met in these situations. That is, there is a need for speedy intervention; the weight of the threatened interest – human life – is very high; the cost of the intervention will almost always be subordinate to the risk to human life; and, there is no other private or public organization that could intervene with relevant equipment (such as fall cushions, vehicles with ladders, life-saving facilities, etc.). Each case must be assessed individually.

There is a difference between a situation where people only represent a danger to themselves and those where they constitute a danger to others, e.g. where weapons are involved or where the arrest of suspected criminals is concerned. As mentioned above, only the police may use violence in the exercise of their duties. The rescue services should work to be perceived by the public as a humanitarian organization, and pay regard to this when requesting help from the police.

In sum, our interpretation of issues of responsibility is as follows:

- The basis of the relationship between healthcare, the police and the rescue services in case of threat of suicide is that, purely in legal terms, each runs its operations individually, which are then parallel to each other.
- The police are the body that in practice has the capacity to create the preconditions for collaboration to be brought about. Their initiative may consist in creating a shared leadership site and acting as “chair” when a common direction is worked out.
- The police are responsible for transferring the person to a healthcare institution for assessment of whether a certificate that that person is in need of institutional psychiatric care should be issued.
- Accordingly, it is not possible to initiate or implement a rescue in all cases of suicide alarm regardless of cause; rather, an assessment must be made in each individual case, taking account of the limitations that prevail.
• Parts of an event can meet the criteria for intervention by the rescue services, which means that actions with the aid of the services and its facilities may need to be taken.

• The rescue services should have leadership capacity on site, with the capability of making ongoing assessments of a normative nature concerning what the services should contribute.

• Social services must always be notified immediately if the case concerns a minor, i.e. a person under 18 years of age.

• Healthcare is responsible for assessment of whether a certificate that a person is in need of institutional psychiatric care is issued, which may mean that the person would be placed in compulsory care following a suicide attempt.

• Such an institutional-care assessment can only be made after a private examination, and that in practice can only be performed in a calm place given this type of event.

• Ambulance staff may be involved in transporting the person to a care institution.

Pursuant to Sweden’s Penal Code (Chapter 24 § 4), if an emergency arises, rescue-services personnel may employ some forms of violence to save life, e.g. take a grip on a person or lift him or her away from a dangerous position.

**Alarm routines in cases of suspected suicide**

**Signals**

The following are common examples of signals given by people close to suicide. The person:

• has left a suicide note;
• threatens to jump from a high building or precipice;
• has made entry to an electric relay installation;
• hangs around lakes or water courses;
• is on the way to a lake, railway track or height;
• frequents areas with or next to rail tracks.
Collaboration

At the location of an event, a joint leadership site must be established. The right and responsibility to decide in this situation is in Sweden allocated to the police, since this agency is the only one with the right to use violence. Normally, emergency vehicles will not call upon unrestricted passage, using sirens, since this can create uncertainty in the mind of a person threatening to jump. All units on their way to the site shall go to a turning point determined by the police, from which resources can be forwarded. If there is a need for radio communication, the national fire channel or the police’s own channel can be used by police, ambulances and rescue services within Jönköping County.

Actions

The joint routines of the police, rescue services and ambulance service in cases of suicide attempt in Jönköping County are based on the following:

- The basis of the relationship between healthcare, the police and the rescue services in case of threat of suicide is that, purely in legal terms, each runs its operations individually, which are then parallel to each other.
- The police are the body that in practice has the capacity to create the preconditions for collaboration to be brought about. Their initiative may consist in creating a shared leadership site and acting as “chair” when a common direction is worked out.
- Quiet movement to and arrival at the scene.
- Stopping all road and rail traffic that might constitute a danger.
- Fencing off the area to reduce the risk of damage to the environment, injuries to people, etc.
- Evacuate the area.
- Create a calm atmosphere.
- Analyze the threat; is a firearm involved?
- Reduce the consequences if the person jumps; consider fall cushions, life-saving equipment, and emergency medical care.
- Freeze the situation.
- Establish contact with the person, and negotiate to persuade him or her not to jump.
- Take the person into care.
The actions taken by Jönköping County’s rescue services are based on the experiences of the rescue services in Stockholm and Gothenburg.

**Considerations**

- Who is to “negotiate” with the person threatening to take his or her life? The police have access to professional negotiators. In some situations, the psychiatric emergency unit can advise on another suitable person.
- How is the issue of contact between the police and the negotiator to be resolved? This can be arranged using radio, mobile telephones, or personal attendants.
- Which doctor shall be sought if there is a need to call one to the scene? District doctors (general practitioners) are on duty 24 hours a day, and can be summoned to take a position on whether a certificate that a person requires institutional psychiatric care should be issued.
- Make immediate contact with the social services, as required by Swedish law, if the case concerns a minor (a person younger than 18).

**Negotiations**

What is actually meant by the word “negotiation”? Negotiation is a tactical method employed by the police to resolve a crisis situation in a favourable manner. It is an established method, where attempts are made to avoid escalation and violence in hazardous situations.

The role of the negotiator involves building a relationship and refraining from finding solutions too quickly. The aims and overall objective of negotiation are to save life and minimize injuries to everyone involved in a dangerous situation. In cases of suicide attempt, the person in question can be regarded as having taken himself hostage, which is the most common negotiating situation for the police.

The first task is to establish communication and contact with the counter-party to persuade him or her to refrain from any act of violence. With time, a relationship and trust can develop, which may aid the counter-party in finding constructive solutions in a charged solution, and persuade him to change his behavior. The following is a step-wise model where changed behaviour is the final step (and goal):
Stepwise negotiation model

Establish communication. How?
- Active listening
- Summarizing techniques

Establish relationship. How?
- Understand the counter-party
- Show empathy

Establish trust. How?
- Respect for the counter-party’s perspective
- Treat the counter-party with dignity

Exert influence. How?
- Introduce problem solution
- Jointly seek a solution

Changed behaviour outcome:
- Non-violent solutions
- Come out/down voluntarily
- Release the hostage, etc.

One step at a time. It is important not to jump over any of the steps!

The role of community environment planning

It is important to take account of the risk of suicide even in the planning of the physical environment. Group dwellings for people with mental disorders should, if possible, not be located near electric-distribution plants or next to railway tracks. Certain locations can sometimes become common as places for suicide. An inventory should be made of such locations, and if possible they should be equipped with physical protection in the forms of railings or surveillance devices.

In an attempt to reduce the risk of graffiti being placed on stationary trains, the Swedish Rail Administration has installed surveillance cameras in a track area in the Skåne region of southern Sweden, which are monitored by SOS Alarm. If people are detected moving around in the area, rail management can be contacted and guards sent
to the site. An unexpected positive effect of the system in Skåne is that, over a short period of time, the lives of four people close to suicide have been saved.

The conclusion we can draw is that there is a great advantage in several organizations being alarmed and called to the location. Often, someone among the personnel on site can make good contact with the person in question; if things do not work with a police officer, then they may work with a member of the rescue or ambulance services. The improved alarm routines have led, above all, to greater utilization of the rescue services than before, but they are also likely to have meant that the police and ambulance services are better able to act in time.

Access to trained negotiators is essential in long-drawn-out events, and is enabled by collaboration between the police authorities. It is, however, important that anyone who may first arrive at the scene of a threatened-suicide event has basic knowledge in how the encounter should be handled. These aspects must therefore be included in public mental health education.

Action plans. The suggestions above has been the point of departure for an Action plan for suicide prevention for the community of Jönköping. This will be treated by the municipal executive board at the end of May 2010. The Jönköping model is now spread all over the country.
Lessons to be learnt

Since 1989 there has been collaborative management between the rescue services, the social services, healthcare, including the hospital church, and the police with regard to psychological and social supportive efforts in the community of Jönköping. This example shows how improvement of already existing services can be achieved by clarifying the statutory opportunities. It acknowledges the importance of working together and collaboration between different authorities and community organizations.

The police form the body that in practice has the capacity to create the preconditions for collaboration to be brought about. Their initiative may consist in creating a shared leadership site and acting as “chair” when a common direction is worked out.

Assessment of which circumstances surrounding suicide attempts can lead to the intervention of rescue services is important, since it gives a basis for when municipal rescue agencies may, or have reason to, initiate a rescue. Swedish legislation on compulsory psychiatric care empowers the police to take a person into temporary care until health personnel can provide help. Serious psychological disorders include severe cases of depression with suicidal thoughts.

There is a need for speedy intervention; the weight of the threatened interest – human life – is very high; the cost of the intervention will almost always be subordinate to the risk to human life; and, there is no other private or public organization that could intervene with relevant equipment (such as fall cushions, vehicles with ladders, life-saving facilities, etc.). Each case must be assessed individually.

Negotiation is a tactical method employed by the police to resolve a crisis situation in a favorable manner. It is an established method, where attempts are made to avoid escalation and violence in hazardous situations.

It is important to take account of the risk of suicide even in the planning of the physical environment. As an example, group dwellings for people with mental disorders should, if possible, not be located near electric-distribution plants or next to railway tracks.
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Chapter 10.

Love is the best kick
Suicide prevention among youth in Sweden: national, regional, and, community efforts

By Jan Beskow

During 2004, 151 young persons in the age range 10-34 took their own life. Of these, 113 were boys/men, and 38 girls/women (see Table 10.1). In general, suicide is more common among the middle-aged and the elderly than among the young, and about twice as common among men. The opposite however is the case with suicide attempts. In anonymous questionnaires, 3-6 percent of teenagers answered that they have attempted to take their life at some time (Olsson 1998, Ivarsson 1998). The frequency among girls is twice as high as among boys. Thinking about suicide is very common at these ages, but usually the process stops there.

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<th>Boys/men</th>
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Youth are a vulnerable target group

For many reasons young people are a special target group for suicide prevention:

- Young people are the future of the community; they need hope and enthusiasm, but also the strength and capacity to cope with destructive tendencies.

- Suicidal acts performed by young people are more embarrassing than those performed by adults; they also evoke strong wishes to combat suicidal destructivity.

- Young people are more susceptible to contagious suicidality than any other age group; there is a need for carefulness in communicating about suicidality.

- Young people are eager to use the Internet, with all its positive but also dangerous sides.
In this chapter, we present some Swedish experiences of suicide prevention work among young people.

**Contagious suicidality**

Humans are born to imitate. Imitation is the basis for gestures, language and culture. Thus, it is not unique to suicidality. For example, information about arson spread in the media leads to more fire-raising. Young people lack experience and are therefore more susceptible to imitation than any other age groups. The endemic spread of self-cutting, clusters of suicidal acts and suicidal pacts, including individuals or groups, are well-known examples.

Suicidal ideas may be inspired by the suicide of a hero, such as a pop star or a beloved actor or actress, which is then spread in a romantic tradition via the media. It may also be caused by insensitive forms of suicide prevention interventions in schools, which treat suicide as quite unique and, by nature, not really understandable. In a similar way, insensitive lessons about drugs may increase, not decrease, substance use. Suicidal thoughts may also be spread via the Internet. Especially in Japan, different
forms of suicidal pacts and group suicides have been reported. They also occur in religious organizations, when they are under strong pressure, and see no other way out of their dilemmas.

**Cluster suicidality**

Suicidal thoughts may be contagious among youth. Clusters, i.e. delimited epidemics, may appear. A suicide by a school mate, a film or pop star, and also an impression from the Internet may increase involvement in suicidal thinking in a group of young people. Death pacts and series of suicide attempts and suicides may develop. Communities need to be prepared.

*Photo 10.2. educate and train school pupils in general mental health and life skills, which should also include coping with difficulties, such as conflicts, crises, mental disorders, violence, bullying and suicidality. Young school pupils in Bhutan. (Photo:LS)*
The example of Herrljunga

One early morning in June in 1997, a 14-year-old girl hanged herself under a bridge over the road to Herrljunga, a small municipality in Sweden. At that time, the inhabitants had just finished their annual carnival.

The death of the young girl was the subject of great concern. A memorial sermon was arranged in the church, and later a big funeral was attended by most youth in the municipality. A few months later, a public music festival was organized. Money was collected for a memorial foundation in support of work among youth. As well as individual and family reasons, there were also problems in municipal youth care, which was dysfunctional with regard to identifying and meeting the needs of youngsters.

During the autumn, the pupils in the school started talking more and more about life and death, which created a depressive atmosphere. Some of them met at the girl’s grave, leaving flowers and messages: “We will follow you!”. Within six months, six pupils had been admitted to psychiatric care, two of them after attempting suicide.

Around Christmas, anxiety in the municipality increased even more: “What would happen at the next carnival?” As a psychiatrist interested in suicide prevention, I and two representatives of child psychiatry were invited to discuss the problems with school staff, parents, social agencies, the police, and two pupils at the school.

How to cope with cluster suicidality

1. Before the cluster

- Realize that dysfunctional youth care may partly be responsible for both individual suicides and suicidal clusters.

- Every municipality therefore needs to have a plan in order to meet suicidal clusters in a rational way. Elaborate an action plan with at least the elements listed below.

- Consider common basic values and means, e.g. the importance of suicide prevention, increased competence, and how to cope with integrity problems, as when a pupil said to a school mate: “I want to commit suicide – but do not tell anybody about it.”

- Create an infrastructure permitting early detection, rapid action and monitoring during a relevant period of time.
2. During the cluster

- Develop positive potential in the cluster, creating close bonds between people, training them in talking about important questions concerning life and death, and providing practical training in mental health.

- Interviews with affected young people, leading to individual and collective suicide prevention plans. Remember that not only the persons involved but also persons at some distance from the actual events may experience serious reactions.

- Police officers and other adults may investigate pro-suicidal Internet sites and contacts. On the net, young people can get rapid information about a diversity of suicidal methods, which decreases the planning period from what was perhaps months or years to days or hours. Some net contacts have a personal interest in stimulating young people to commit suicide.

- Collective actions, such as lectures and group discussions complemented by opportunities for individual meetings with priests or welfare offices. Planning of optimal memorial occasions, and also time for mourning (not too short, not too long).

- Monitor pupils especially at risk and perform interventions where necessary.

- Memorial arrangements after suicidal deaths may be performed in an optimal way in order to support the grieving process and diminish the risk of further suicides. Getting back to normal life should, however, be achieved as rapidly as possible, making use of normal stabilizing structures to counteract widespread depressive feelings.

3. After the cluster

- Analyze what happened and why. Usually, a cluster is a symptom of insufficiency, not only in a family or working group but also in a community. What is the message from suicidal people to the community? What are the lessons to be learnt? What further prevention is necessary?
National efforts

National program

The first Swedish national program was formulated in 1995. By contrast with our neighbouring countries, the Swedish government at that time lacked interest in accepting and implementing the program. One step forward, however, was the creation of six regional networks across the country promoting suicide prevention, including through biennial suicide prevention conferences.

The second national program was created in 2008, with decisive support from the government (see box below). The government also accepted a Zero Vision for suicide, as previously had been applied to traffic accidents. This was a fundamentally important message.

<table>
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<tr>
<th>National Suicide Prevention Program in Sweden (2008)</th>
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<tr>
<td>1. To promote better life opportunities in order to support the groups that are most in need;</td>
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<td>2. To minimize alcohol consumption in target and high-risk groups;</td>
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<td>3. To reduce the availability of means to commit suicide;</td>
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<td>4. To educate gatekeepers about effective management of persons at suicide risk;</td>
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<td>5. To support medical, psychological and psychosocial services in preventing suicide;</td>
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<td>6. To disseminate knowledge about evidence-based methods for reducing suicide;</td>
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<td>7. To raise the competence of healthcare personnel;</td>
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<td>8. To systematically analyze within the frame of the National Board for Health and Welfare, all suicides which occur in the healthcare system during care and 28 days after discharge from the hospital, so-called ‘Lex Maria’ regulation;</td>
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<td>9. To support voluntary organizations.</td>
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As may be seen, the program includes indirect suicide prevention measures (points 1, 2 and 9) as well as direct suicide prevention measures, the latter both to increase medical care quality (points 5, 6 and 7) and to prevent suicide from an accident perspective (points 3, 4 and 8). Source: Wasserman (2009).
The national research and education service

Research about suicide and suicide prevention has been strong in Sweden. There is a broad consensus among researchers that suicide must be prevented, not only biologically but also by psychosocial and psychological means.

The National Prevention of Suicide and Mental Ill-Health at the Karolinska Institute and Stockholm County Council’s Centre for Suicide Research and Prevention of Mental Ill-Health, called NASP, was created in 1994 and re-organized in 2004 following a decision of the Swedish Parliament (Wasserman 2009). Under the leadership of Professor Danuta Wasserman NASP is a centre of expertise and knowledge that works for a reduction in the number of suicides and suicide attempts on the basis of both international and national standards for suicide prevention. NASP’s principal activities can be divided into four areas:

- Research into and the development of suicide-prevention methods.
- Information and the compilation of knowledge.
- Epidemiologic surveillance, i.e. monitoring of trends in suicide mortality.
- Education and training.

Youth programs

Over the years, NASP has worked with two suicide prevention programs for youth: “Love is the best kick”, and “Life skills – preventive mental-health care”.

Love is the best kick is based on a documentary film in which two girls and two boys report on how they cope with their lives, their crises, suicidal thoughts, and suicide attempts. The film is complemented by written material, separately for the instructors and the pupils. The basic question is: “What can the school do if a young human does not want to go on with life?”

The title: “Love is the best kick”, was formulated by a substance abusing boy in the film, who broke with his abuse after falling
in love. The sentence may stand as a symbol for all the integrative work performed by the Safe Communities movement.

On the basis of the film, educational courses have been conducted for school nurses, educational welfare officers and teachers, who have later shown the film to pupils in the training of upper-secondary (high) school pupils and parents, and led discussions founded on its content.

*Life skills – preventive mental-health care* is a model based on presentations, practical exercises and role plays. The target group is pupils in secondary and upper-secondary (high) school, whom are trained in ordinary school work. Primarily, however, training courses, lasting two days, are conducted for school nurses, educational welfare officers, and interested teachers.

The courses are based on educational material aimed at treating stress, crisis, depression and suicidal thoughts. A further aim is to prevent destructive conflicts and bullying through peer support and, where necessary, support from the school’s own resources or referral to external experts. The method has been evaluated in collaboration with the NASP, and amended on the basis of the evaluation findings.

The TRUST program in Dade County, Miami, USA – an inspiring example

The author of this chapter has worked with suicide prevention for over four decades. For 35 years, the continuing lack of response was frustrating, even boring. But in the autumn of 2004 a journalist, Alfred Skogberg, made a TV program about suicide prevention. After that, families who had lost a celebrity member, such as an Olympic champion, a pop idol or a film actress, told about their experiences in the media in order to strengthen suicide prevention. At last, the government became interested.
Now, it is rewarding and stimulating to work with suicide prevention, as never before.

A big part of Skogberg’s TV program was a description of a successful school program, TRUST, implemented in Dade County in Miami, USA. Since it has inspired our work in West Sweden, I want to present it here.

The TRUST program was initiated during a period of high suicide frequency among persons under the age of 20. Suicide prevention, however, is only part of the TRUST program. A driving force is understanding of the great negative impact of mental disorganization on educational achievement. This focus is mirrored on TRUST’s home-page: “Division of Student Services – the heart of the education” (2009).

The goal is to reduce barriers to student achievement and prepare them for the transition from school to adult life. School welfare officers continuously train the pupils in life skills throughout their schooling. Together, they find ways to solve everyday problems in schools and families. Further, all personnel are trained in identifying signs of mental insufficiency. These prompt immediate interventions, e.g. discussions in groups with pupils experiencing the same type of problem. Where necessary, external agencies are consulted.

**Results.** During the program’s first 20 years, the suicide rate has fallen from 8 to 0.5 per 100,000. Some years, there are no suicides at all. This is apart from all the other beneficial effects.

### Regional efforts

**The West Sweden Network for Suicide Prevention (WNS).** This is one of the six networks for suicide prevention in Sweden. It was founded by the author and Ingvor Blom, president of the Western section of the National Association for Suicide Prevention and Support to Significant Others (SPES). WNS is an association of about 250 professionals and laymen, complemented by about the same number of members of the regional section of SPES, all interested in promoting suicide prevention. It runs a resource service, managed by Ingvor Blom, with brochures, books, films and other materials. As well as lobbying, the network has produced a lot of information material and performed a large number of information projects. Some of them will be presented here.

**World Suicide Prevention Day,** initiated by the International Association for Suicide Prevention (IASP 2009) and the WHO, has for six years been a unifying occasion in the community. It is arranged by WNS in cooperation with different
churches, over the three last years at a cathedral in Gothenburg Diocese. It starts with a lecture, seminar, and/or exhibition and ends with a solemn sermon, including the lighting of about 250 candles in memory of each victim of suicidal death in the region during the previous year.

**Lectures about depression and sleep disturbances.** Depression and sleep disturbances are important risk factors for suicide. Over ten years, the Resource Centre therefore has given lectures about depression (five occasions of two lectures each) and about sleeping problems (three occasions of two lectures each). The target was the general public, especially people with depression and sleeping problems of their own, and their relatives. Personnel from medical care also visited the schools. Later, they started their own schools. After ten years, this pioneering work was then included in regular primary care within the city of Gothenburg.

**Mental life-saving.** This is a 16-page brochure in Swedish called *Mental Life-saving. A first lesson in suicide prevention for those of you who consider suicide.* General information about suicide prevention is common. This pioneering work, however, combines knowledge from cognitive behavioural therapy (CBT) and suicide prevention, and is directly intended for use by the suicidal person himself/herself. The brochure, which has been very well received, was also the basis for a lecture tour to six cities during the spring of 2008.

**Net temptations.** Apart from all its positive effects, there is also a specific risk to young people from the Internet. In a few seconds, young people can get all information they need about different methods for killing themselves. The time for preparation of a suicide will then be reduced from what were years or months to days or hours, thus diminishing the available time for intervention. Young people can also be pushed towards suicide by people with psychological interests of their own in the matter.

WNS therefore has also collected information and held lectures about the Internet as a new area for suicide prevention. We need more research and analysis. We also need interventions from municipalities that encourage police officers and other adults to be visible and intervene on the net.

**Overhead material.** This is provided in a binder containing 120 overhead pictures about suicide prevention, which is available to people who want to give information about suicide prevention.

**When Heaven is Near,** a suicide prevention project among elderly people, and also the *SCREAM* project, a research project that micro-analyzes short suicidal episodes, are both described in Chapter 2.
The Future – a regional centre for suicide prevention. As well as their central research, and education institutes, both Norway and Denmark have established five regional centres, each working with action research and practical suicide prevention. *We hope that WNS will develop into the first Swedish regional centre.* This means going from a network of professionals and lay people to a network that also includes regional authorities and municipalities, supplying them with information about new research and methods within suicide prevention. This would be a much more powerful way of implementing suicide prevention than is now available. We then also need to increase the number of personnel; currently, only two persons now work at the Resource Centre. Continuing support from the city of Gothenburg is encouraging. We also enjoy good moral and economic support from the local newspaper, Göteborgs-Posten.

**Life competence for young people**

During the years 2002 to 2007, the Resource Centre carried through an education program in many schools and municipalities in the Västra Götaland region. Economically, the projects were supported by the regional Public Health Committee. When they changed their rules to support only short-term projects, the program had to be ended.

The project comprised two day-long courses, based on guidelines from the WHO (2000) and the film *Love is the best kick.* In 2007, the final three municipalities to participate, Åmål, Dals-Ed and Vara, were evaluated through questionnaires to and interviews with key persons in the community. They were summarized in a report in Swedish: *Måste någon dö för att vi ska fatta?!* (In English: “Must someone die before we understand?”).

**Results.** The report from the program showed that:

- Interest in suicide prevention often starts with a suicide, or a series of suicides, among youth. These elicit strong feelings of powerlessness, but also a willingness to learn how to cope with suicidality. It is strategically important to catch up with this burning interest.

- The courses were strongly coloured by the participants’ actual experiences of suicide. They therefore had to be adapted to meet the participants’ worries and the problems of being pushed.

- The participants experienced the issue of suicide prevention as very important. They had broad expectations, mirroring the great needs for education and training.
• The courses contributed to intense developmental work in the municipalities. As a previously marginalized problem, there was, however, a tendency for interest to wane after some time. A good infrastructure, anchored in politics, agencies and managers, treatment plans and recurring training opportunities, is necessary for creating lasting suicide prevention.

**Local efforts**

**Prevention of depression and suicide in Kungälv, Sweden**

The Kungälv experiences are based on a report (Axelsson 2007) done by Working Group Depression- and Suicideprevention within the Public Health Work and the Public Health Council. It is referred her after permission from Development Leader Inger Aronsson, Kungälv Municipality.

**Kungälv**

Kungälv is a city (pop. 20,500) in Bohuslän on the Swedish west coast and the seat of Kungälv Municipality and Västra Götaland County. Kungälv is roughly translated as “King River”, and is named after the two rivers that flow in the vicinity, Göta Älv and Nodre Älv (Photo 10.3). However, Kungälv has never been the home of any royalty, either Norwegian or Swedish. The city was founded in 1612, when the former settlement at Kungahälla moved to Bohus Fortress (Photo 10.4).

Concerning industry, Swedish Match has built a new factory close to Kungälv. The new plant, which is to produce moist stuff (Swedish “snus”) and represents one...
of the largest industrial investments in western Sweden in recent years, is scheduled to provide work for about 120 persons. Today, some 900,000 Swedes use moist snuff. More than half of them are former smokers, which has been a major contributory factor in making Sweden the first country to achieve the WHO’s target of a proportion of smokers lower than 20% of the adult population.

*Photo 10.3. Kungälv is named after the two rivers that flow in the vicinity, Göta Älv and Nodre Älv. (Photo: JL)*

*Photo 10.4. The city was founded in 1612, when the former settlement at Kungahälla moved to Bohus Fortress. (Photo: LN)*
The Falk project

Between 1995 and 2006, collaborative public-health activities were pursued between the Social Insurance Agency, Employment Services, the Municipality, and the Health and Medical Service (Region 4), called “Falk”. The activities were undertaken in work groups, and within the confines of injury-prevention work. The Work Group for the Prevention of Depression and Suicide, designed to increase knowledge of mental ill-health, was formed in 2001. In 2007, the project was replaced by the Public Health Council, representing collaboration between the Municipality and two regional authorities, the Health and Medical Care Committee (Region 4) and the Public Health Committee.

After receiving signals from School Health Services concerning the mental ill-health of young people, the Work Group in Falk determined to run the “Life skills – preventive mental-health care” program (described above). The first course was held over two days in the autumn of 2003, and was targeted at school nurses, educational welfare officers, teachers, and other staff in secondary and upper-secondary (high) schools in Kungälv. The training was then implemented on two further occasions, in 2004 and 2005, when personnel from recreational (free-time) and social services also took part. Following the basic training, the Work Group has arranged four one-day meetings for follow-up and feedback. In total, 62 persons working with young people in Kungälv Municipality have taken part in the education in preventive mental-health care.

Evaluation

- In general the results were very positive: 80 percent were satisfied with the education, 70 % with the follow-up; 67% had got new tools in their work, and 69% had used the new knowledge in their professional practice.
- Most of the participants felt that public mental health, including prevention of depression and suicide, is very important. It was valuable that the education had put these questions on the agenda.
- To engage people from different parts of the municipality, work that leads to an increased knowledge and understanding of one another is essential. The education has started a model for networking, exchange of experiences, and spread of knowledge in the municipality.
- The participants wanted more discussion about working methods and what to do in crisis situations.

Thus, working with suicide prevention has the capacity to engage people and start positive processes within and outside the field of suicide prevention itself.
Lessons to be learnt

General aspects. Young people are the future of the community. They need hope and enthusiasm, but also the strength and capacity to cope with destructive tendencies. Suicidal acts performed by young people are also more embarrassing than those performed by adults. They evoke strong wishes to combat suicidal destructivity, which are strategically important to catch up with, and take as a point of departure for developing suicide prevention routines. Evoke therefore the interest of the community in the mental health of youth, understanding that all development rests on good mental health. Be aware that dysfunctional youth care may partly be responsibility for suicide and suicidal clusters in a municipality.

Do not forget that young people are more susceptible to contagious suicidality than any other age group. Observe the special risks of the Internet! It is therefore necessary to see youth suicide prevention as a special problem area in need of special competencies and special types of prevention and intervention. The main rule is to focus on mental health and the development of life skills.

The key to working among youth is to strengthen their feelings of being valuable members of their school and community, and to give them trust in meeting adult life – just as their parents and teachers, and public mental health workers, live life with trust and enjoyment. To get a kick out of love is the best reason for living.

All this must be complemented by active outreach activities to identify and support pupils actually at risk.

Details

1. Before a suicidal episode
   - Develop a common understanding and common moral values among politicians, administrators, teachers and pupils and other persons involved concerning the school and school work.
   - Elaborate plans for how to recognize, study, monitor, intervene and draw lessons in relation to clusters of suicidality. Every municipality needs to have a plan to meet suicidal clusters in a rational manner.
   - Develop a sensitive way of transferring trustful feelings about the joy of life and of communicating about destructivity and suicide.
• Train pupils continuously in life skills, and also in managing destructive conflicts, bullying, crises, anxiety, depression and suicidal thoughts.

• Elaborate plans for interventions against bullying. The core of suicide is the feeling of not belonging. The aim of bullying is precisely to create that feeling.

• Observe and discuss the values and risks of the Internet. Train professionals to understand, use and intervene on the net.

• Elaborate plans for interventions in crisis situations, such as attempted suicide or suicide by a pupil, in a pupil’s family, or by a film or pop star. Memorial arrangements after suicidal deaths should be made in an optimal way in order to support the grieving process and diminish the risk of destructive thinking. Getting back to normal life should be achieved as rapidly as possible, making use of normal stabilizing structures to counteract irrational depressive feelings.

2. During the suicidal episode
   • Intervene in crisis situations. Investigate the risk of a suicide growing into a suicidal cluster. Intervene to prevent any such development.
   • Use the situation for deeper discussions about existential problems and to create deeper feelings of solidarity at school.

3. After the suicidal episode
   • Cope with the emotional impact of suicidal acts and attempts, and completed suicides.
   • Use the situation as a departure for broader suicide prevention measures in the community.
   • Go further with the education and training of school pupils in general mental health and life skills, including coping with difficulties, such as conflicts, crises, mental disorders, violence, bullying, Internet problems, and suicidality.
References


Chapter 11.
Reflections

This book is in an attempt to tie together history, safe community experiences, case findings and general experiences of suicide prevention from very different communities in the world, all of which are working together. Whatever particular experiences are described here, they have certain communalities:

- Professional approaches are not enough because they fall short in scope and might not be acceptable to the individuals most concerned.
- Program makers do not know for certain that they have definite answers for everyone. But, what they do seems to work, and if it does not, they seem to be satisfied because in their perception they are at least trying.

Experiences differ, and one would expect that they will keep on changing as mirrors of geography, culture and customs (Photo 11.1). Another reflection is that societies and circumstances are always changing. In face of this, we should ask ourselves if we should transfer local experiences and their solutions to other communities, in ways similar to how organs are transplanted. Probably, we cannot transplant them. It depends on diagnosis and compatibility, but also on local analysis of what other experiences can do in specific places.

In the case of the Safe Communities movement as a whole, we are always examining these experiences to see what we can learn from them, so we, in turn, can share them with other communities elsewhere.

Now, you will see that some challenging needs will be ever present:

- The need for integration and yet respect for individuality.
- The need to use all the resources available, technical and human, to serve those who need them most.
- The need to retain programs and experiences as identifiable entities, and yet integrate them into other parts of society.
- The need to understand the complexity of the issues, and consequently the need to develop specific tools for permanent assessment, without ever losing sight of particular circumstances.
All of this brings us necessarily to some final reflections on the content of this book

1. **Is suicide and suicide prevention controversial?**

   The answer will probably vary according to whom you ask. We in Safe Communities thrive on being more practical than theoretical. For this reason, we do not want to be controversial. Rather we leave these controversies to be settled by theoreticians of different disciplines.

   Also, our community practitioners, as opposed to other professionals not working in communities, want to work in the environment, not only with the victims of exclusion. With this action we expect to include them.

   Mental health professionals tend to classify an effort to help the victims but inevitably they end up creating power structures under their control.

   When we ask ourselves who suffers most – the individual or society we are not merely asking a rhetorical question. For us, individual suffering is as well a painful symptom of the deep wounds that affect the societies. Therefore, even if we appear to be solving the problems of individuals, often their pain remains unbearable, which reflects the failure of the isolated medical model? Predominantly pharmacological answers are at best partial solutions.
2. **Inclusion rather than exclusion instead of a “pill for every ill”**

We are aware that some of our statements are essentially experience-based. Still we remain convinced of the importance of exclusion as a generator of pain, disease and death, and also that the best way to fight it is not by isolating or labelling individuals, or by providing them with treatments. Instead, we should *include* them, by helping to find for them a place in society where they have reasons to live, a sense of belonging and dignity. All this might be difficult, but it is the only thing that justifies our efforts. Even if we do not accept that any isolated model is enough, we do acknowledge the best parts of what the medical model has to offer – not only the best medicine, but also the best empathy. We accept the role of medical doctors as members of society, but on equal terms.

3. **Exclusion is at the root of violence**

This applies not only to suicide but to all forms of violence, including accidents, in so far as victims are selected mainly from among people who are excluded. Modern societies tend to treat victims of accidents very efficiently, providing rescue services, ambulances, well-equipped emergency wards and technologies, but without ever attempting to get to the root of the problem. Paradoxically, the more we seem to advance our technologies, the worse the problems of suicides and accidents seem to become. And also the less satisfied societies and the individuals seem to be with our answers.

There is another question related to this. Why does suicide diminish in societies with high homicide rates? This remains to be clarified, but we should take the time to reflect! We do know that suicide is more common in societies that we perceive as more inclusive, and vice-versa. Homicides are more common in societies that exclude. We can venture some initial speculations, e.g. that inclusion is not complete. Welfare societies are ones where basic needs are satisfied, and for that one has to be grateful, but something essential are missing. As a result, anger is directed at oneself, because we do not dare to direct anger at the others who belong to a “generous” society. Violence against others is what happens in societies that exclude its members more openly.

Community models seem to work better in welfare states and societies. Why? Because welfare societies respond at a national level through the provision of services, but it is only communities that provide answers at a more intimate and meaningful level. In Durkheim’s state of anomie, the solution never comes from individual approaches.
4. **Suicide is a statistical reality!**

Scientists, not knowledgeable in the field may tend to attribute differences that do exist in reality to statistical errors or classification problems. They ignore, for example, that the high incidence of suicide in eastern and central European countries is not an artefact, but a reflection of the disintegration of these societies.

Some of these previously organized societies, like it or not, have become anomic states, leaving masses of people excluded. Similar things might happen due to recent changes with regard to religions. Countries with fast expanding economies leave huge parts of society excluded from the benefits of other more wealthy parts.

5. **Community might be a difficult concept for academic discussion**

But community is not a difficult concept to grasp for people who belong to one. For them, communities are living organisms. This ever changing reality might in itself be the reason for the ease with which any community can become a generator of anomie, which excludes both individuals and whole groups (Photo 11.2).

*Photo 11.2 Animals, human beings are living organisms that always change, always react to the environment. Dark and cold winter conditions in the Northern hemisphere. (Photo: LS)*

It is true that international organizations, like the United Nations, including the World Health Organization and the International Safe Communities movement, proclaim that *every individual has a right to safety*. Nevertheless, many individuals do not dare to claim their right to be included within the safety issues that affect their lives,
or they might not know about this right. The reason is that they do not have a real voice, and societies must express that voice, or risk becoming paternalistic or just instrumental. The Safe Communities movement deliberately does not prescribe what individuals should do, but rather gives a framework for deliberation and the promotion of integration among families and groups.

To serve this purpose, the key aspects of a community suicide prevention program are:

- Intersectorality;
- Sustainability;
- Information on progress (surveillance);
- Flexibility and replicability with regard to every changing need;
- Willingness to include;
- Adopt as its own all available technologies.

In theory “large communities”, such as national states, should fulfil the same criteria, but for the simple reason of distance, and also historical reasons involved in the establishment of states, they will always be limited in their provision of the tools needed by individuals and local communities. Communities are good to the extent that they are able to provide inclusion.

*Photo 11.3. “Every individual counts – actually has the right to be included – whether he or she suffers from exclusion or not.” (Photo: CM)*
Lessons to be learnt from local programs

- *Every individual counts* – actually has the right to be included – whether he or she suffers from exclusion or not (Photo 11.3).

- *No community can act independently of the state*. That would be unrealistic! The Japanese example is a good illustration of dynamics between a local community and the state. A state that does not influence local communities and individuals is an irrelevant state. But there are also limits to what local communities can achieve when the state cannot meet the needs of the local community. However, local communities, in the arena of suicide prevention, can and should provide solutions and opportunities for those in jeopardy as a result of economic crisis. The Korean example shows the important role of hospital wards for potential suicide victims, in the same way that the Swedish example shows the importance of health centres. Thirty-five years of experiences in developing Safe Communities provide a model of considerable value in such communities.

- In a local community, every organization must identify its role in a community suicide prevention program. The schools are good examples, but there are also rescue services, health centres, psychiatric units, nursing associations, voluntary organizations, and so on. What is important is that they operate harmoniously, without sacrificing their particular identities and experiences. Then, they can come up with ideas to help solve an ever growing problem.

- Ultimately, for the International Safe Communities movement to take on community suicide prevention is a tremendous challenge. We hope that this book has presented interesting approaches to the work, but has also provided reasons for showing humility in pursuing it.
Over the last decades, there has been a move towards trusting the local community on matters of health and safety. This concerns not only work to prevent accidents and violence but also to the prevention of suicide attempts. This has put pressure on people involved in the community to produce an introductory book on the subject.

This book is an attempt to share with others the “Safe Communities” approach as a complement to other views on suicide prevention, and to the prevention of other forms of violence and injury. The great merit of the “Safe Communities” paradigm is that it seeks to promote inclusion in social life, but does not at all exclude any other approach. Accordingly, as well as works of the three main editors, we have included contributions from community and suicide prevention program managers from around the world.

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2nd Revised Edition