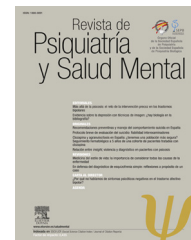


# Revista de Psiquiatría y Salud Mental

[www.elsevier.es/saludmental](http://www.elsevier.es/saludmental)



## EDITORIAL

### Suicide prevention in Spain: An uncovered clinical need<sup>☆</sup>

### Prevención del suicidio en España: una necesidad clínica no resuelta

Pilar A. Sáiz\*, Julio Bobes

*Área de Psiquiatría, Facultad de Medicina, Universidad de Oviedo; Centro de Investigación Biomédica en Red área de Salud Mental (CIBERSAM); Instituto Universitario de Neurociencias del Principado de Asturias, INEUROPA; Servicio de Salud del Principado de Asturias, SESPA, Asturias, Spain*

Suicide constitutes one of the most important problems in global public health.<sup>1</sup> That is why several studies have been published in the last 2 years among other considerations, in which a possible association is established between different economic crisis indicators and the varying suicide rates from countries of very different latitudes.<sup>2-5</sup> There have been mixed results. The most consistent data supporting such an association came from developed countries in the Anglo-Saxon world.<sup>6,7</sup> In contrast, in Spain the data were discrepant. There are studies that postulated an association between economic crisis and an increase in the number of suicides<sup>4,5</sup> and others that contradicted this affirmation.<sup>8</sup> The reasons for such discrepancies are not clear. Some authors suggest that socio-cultural aspects could explain the apparent resilience to the crisis seen in our population,<sup>8</sup> while others mention the different crisis indicators in the studies<sup>2</sup> or the different statistical approaches used as the possible cause of these discrepancies. The analysis performed by our group, using the annual unemployment rate as our crisis indicator, showed no association between this indicator and the number of suicides. However, when annual variation in the unemployment rate (which could be a more specific indicator of the number of people who lost their job during a certain period) was compared with annual variation

in the suicide rate, an association was indeed found. It was estimated that each 10% annual increase in unemployment was associated with a 1.25% increase in the number of suicides during the period before the crisis (1998-2007). The increase was similar (1.22%) after the start of the crisis (2008-2012).

Independent of the information previously mentioned, it should be emphasised that in Spain, the data provided by the National Statistical Institute (*INE* in Spanish) have placed suicide as the primary unnatural cause of death since 2008, overtaking death by traffic accident. This situation has remained unchanged through 2012, when the latest official data were released.<sup>9</sup> Furthermore, the discrepancy existing between data provided by the *INE* and the Legal Medicine Institute made us consider that there is a clear tendency to underreport the number of suicide deaths in Spain.<sup>10</sup>

The transcendence of the afore-mentioned information contrasts with some aspects to be highlighted in this editorial. First of all, the scientific community and professional circles in our country are sensitive to the problem, as demonstrated by the growing number of publications on "suicide" and "suicidal behaviour" in relevant journals in which Spanish authors contributed substantially. There was also the recent publication of preventative recommendations promoted by the Spanish Society of Psychiatry (*SEP* in Spanish) and Spanish Society of Biological Psychiatry (*SEPB*),<sup>11</sup> as well as the "Clinical Practice Guidelines for Prevention and Treatment of Suicidal Behaviour," sponsored by the Ministry of Health, Social Policy and Equality and the Galician Health Technology Assessment Agency.<sup>12</sup> However, this sensitivity does not seem to have penetrated other levels, with examples of these below.

<sup>☆</sup> Please cite this article as: Sáiz PA, Bobes J. Prevención del Suicidio en España: una necesidad clínica no resuelta. Rev Psiquiatr Salud Ment (Barc.). 2014;7:1-4.

\* Corresponding author.

E-mail address: [frank@uniovi.es](mailto:frank@uniovi.es) (P.A. Sáiz).

Firstly, assessment as well as corresponding verification of suicide risk, either in case histories or clinical reports, is handled poorly in our country.<sup>13</sup> Aspects as important as the existence of a personal history of suicidal tendencies are frequently omitted, despite this being one of the risk factors that most clearly predicts the possibility of a completed suicide in the future.<sup>14</sup> In addition, the use of psychometric scales to help in the risk assessment of suicidal behaviour has still not been incorporated routinely in daily clinical practices.<sup>15</sup> Likewise, despite the fact that there are numerous scales to facilitate assessment of different factors related to suicidal behaviour, practically none of these have been adapted and validated for use in Spain. Consequently, mere translations of these scales are used, whose validity could be considered questionable. This position seems to be in the process of rectification, making it worthwhile to note that Spanish authors have: formed a brief, comprehensive protocol for evaluating suicidal behaviour<sup>16</sup>; created new instruments for assessing suicide risk starting with the more discriminate items from scientifically validated scales for use in evaluation of suicide risk<sup>17</sup>; and validated instruments that assess the entire range of suicidal and/or self-harming behaviours.<sup>18</sup> Likewise, Spaniards have recently validated the Columbia Suicide Severity Rating Scale (C-SSRS), the only instrument endorsed by the neuropharmacological division of the Food and Drug Administration (FDA) for prospective assessment of suicide risk in clinical trials.<sup>19</sup>

Secondly, it is important to note the practically total absence of national preventative programmes in our country, despite the fact that one of the objectives of the National Health System's Strategy in Mental Health, within Strategic Line 1, includes suicide prevention by carrying out and evaluating specific actions to lower suicide and depression rates.<sup>20</sup> In fact, there is currently no national plan of prevention as such in Spain and, to date, only a few local initiatives have been developed; these are often framed within specific European projects,<sup>21–36</sup> generally of a limited duration and geographic extension and directed towards populations with specific characteristics. This puts our country far below the level of other countries of similar development. Despite all these, the fact that there is more and more evidence supporting the theory that certain preventative strategies can be useful in reducing the suicide rate; specifically, these include restricting access to suicidal methods, training mental health professionals and training primary care professionals.<sup>37</sup>

Thirdly, we would like to refer specific interventions in at-risk populations, with special emphasis on individuals who have made previous suicide attempts. Suicidal behaviour is a very complex phenomenon, making a specific treatment for it difficult to produce. Consequently, when the most appropriate therapeutic approach for an at-risk population is raised, the following fact is mentioned: in approximately 90% of suicide cases, there is an underlying psychiatric disorder. This makes psychopharmacological treatment of the base pathology the most adequate. Furthermore, there is only 1 drug to date whose potential anti-suicidal properties have been recognised by a health agency, the FDA in this case: clozapine,<sup>38</sup> a second-line therapeutic drug. In addition, the anti-suicidal potential of lithium has been demonstrated in meta-analyses on both unipolar and bipolar depression.<sup>39</sup> However, we are again talking about a

drug that cannot be used indiscriminately in all at-risk patients, due to its side effects and tolerability. In the case of antidepressants, the situation has become even more controversial, with limitations from health agencies such as the FDA and European Medicines Agency (EMA) on its use in children and adolescents, due to the possible increase in suicide risk. These agencies recommend fluoxetine for these age groups. There is evidence that the possible effect increasing suicide risk attributed to antidepressants could be age-dependent. Thus, antidepressants could have a certain facilitating effect in people aged less than 25 years, whereas there would be a neutral effect in groups 25–65 years old and a clearly protecting effect in people older than 65 years.<sup>40</sup> However, endorsements showing beneficial effects of antidepressants highly outweigh the potential increase in suicide risk for these drugs. In any case, appropriate monitoring of possible adverse effects associated with their use is necessary, above all in younger patient groups.<sup>41</sup> Be that as it may, the information previously mentioned reveals a lack of knowledge about the anti-suicidal potential of most drugs with which we typically work; clinical trials with an appropriate design to test this effect are consequently needed.

Lastly, returning to the issue of psychopharmacological approach to basic psychiatric pathology, and still totally in agreement with that affirmation, we want to point out that we often forget there is proven evidence of the preventative utility of non-pharmacological interventions designed to increase clinical follow-up and adherence to post-attempt outpatient treatment. It is important to indicate that these interventions are not aimed at specific disorders or population groups, but rather they are of a more universal character and are thus more easily generalised. Some examples are: the use of "crisis cards",<sup>42</sup> intensive contact through the mail<sup>43</sup> or case management.<sup>44</sup>

In summary, now that traffic accident death rates are going down, it is necessary (within the overall process of preventing death by unnatural causes) for the professionals to facilitate the application of all kinds of preventative programmes and the promotion of greater investigative and clinical attention for at-risk groups.

## References

1. World Health Organization. Public health action for the prevention of suicide. A framework. Geneva: World Health Organization; 2012.
2. Blasco-Fontecilla H, Perez-Rodriguez MM, Garcia-Nieto R, Fernandez-Navarro P, Galfalvy H, de Leon J, et al. Worldwide impact of economic cycles on suicide trends over 3 decades: differences according to level of development. A mixed effect model study. *BMJ Open*. 2012;14:2.
3. Chang SS, Stuckler D, Yip P, Gunnell D. Impact of 2008 global economic crisis on suicide: time trend study in 54 countries. *BMJ*. 2013;347:f5239.
4. Karanikolos M, Mladovsky P, Cylus J, Thomson S, Basu S, Stuckler D, et al. Financial crisis, austerity, and health in Europe. *Lancet*. 2013;381:1323–31.
5. Lopez Bernal JA, Gasparrini A, Artundo CM, McKee M. The effect of the late 2000s financial crisis on suicides in Spain: an interrupted time-series analysis. *Eur J Public Health*. 2013;23:732–6.
6. Barr B, Taylor-Robinson D, Scott-Samuel A, McKee M, Stuckler D. Suicides associated with the 2008–10 economic recession in England: time trend analysis. *BMJ*. 2012;345:e5142.

7. Reeves A, Stuckler D, McKee M, Gunnell D, Chang SS, Basu S. Increase in state suicide rates in the USA during economic recession. *Lancet*. 2012;380:1813–4.
8. Ayuso-Mateos JL, Pita-Barros P, Gusmão R. Financial crisis, austerity, and health in Europe. *Lancet*. 2013;382:391–2.
9. Instituto Nacional de Estadística. Available from: <http://www.ine.es/jaxi/menu.do?type=pcaxis&path=/t15/p417/a2012/&file=pcaxis> [accessed 04.02.14].
10. Giner L, Guija JA. Número de suicidios en España: diferencias entre los datos del Instituto Nacional de Estadística y los aportados por los Institutos de Medicina Legal. *Rev Psiquiatr Salud Ment*. 2014. <http://dx.doi.org/10.1016/j.rpsm.2014.01.002>.
11. Ayuso-Mateos JL, Baca-García E, Bobes J, Giner J, Giner L, Pérez V, et al. Recomendaciones preventivas y manejo del comportamiento suicida en España. *Rev Psiquiatr Salud Ment*. 2012;5:8–23.
12. Grupo de trabajo de la Guía de Práctica Clínica de Prevención y Tratamiento de la Conducta Suicida. Guía de Práctica Clínica de calidad para el Sistema Nacional de Salud del Ministerio de Sanidad, Política Social e Igualdad. Agencia de Evaluación de Tecnologías Sanitarias de Galicia (Avalia-t). Guías de Práctica Clínica en el SNS: Avalia-t 2010/02; 2012.
13. Miret M, Nuevo R, Morant C, Sainz-Cortón E, Jiménez-Arriero MA, López-Ibor JJ, et al. Calidad de los informes médicos sobre personas que han intentado suicidarse. *Rev Psiquiatr Salud Ment*. 2010;3:13–8.
14. Oquendo MA, Baca-García E, Mann JJ, Giner J. Issues for DSM-V: suicidal behaviour as a separate diagnosis on a separate axis. *Am J Psychiatry*. 2008;165:1383–4.
15. Bech P, Awatary S. Measurement of suicidal behaviour with psychometric scales. In: Wasserman D, Wasserman C, editors. *Oxford textbook of suicidology and suicide prevention*. Oxford: Oxford University Press; 2009. p. 305–11.
16. García-Nieto R, Parra Uribe I, Palao D, López-Castromán J, Sáiz PA, García-Portilla MP, et al. Protocolo de evaluación de suicidio: fiabilidad interexaminadores. *Rev Psiquiatr Salud Ment*. 2012;5:24–36.
17. Blasco-Fontecilla H, Delgado-Gomez D, Ruiz-Hernandez D, Aguado D, Baca-García E, López-Castromán J. Combining scales to assess suicide risk. *J Psychiatr Res*. 2012;46:1272–7.
18. García-Nieto R, Blasco-Fontecilla H, Paz Yepes M, Baca-García E. Translation and validation of the “Self-injurious thoughts and behaviors interview” in a Spanish population with suicidal behaviour. *Rev Psiquiatr Salud Ment*. 2013;6:101–8.
19. Meyer RE, Salzman C, Youngstrom EA, Clayton PJ, Goodwin FK, Mann JJ, et al. Suicidality and risk of suicide – definition, drug safety concerns, and a necessary target for drug development: a brief report. *J Clin Psychiatry*. 2010;71:1040–6.
20. Ministerio de Sanidad y Consumo. Estrategia de salud mental del Sistema Nacional de Salud. Madrid: Ministerio de Sanidad y Consumo; 2007.
21. Casey PR, Dunn G, Kelly BD, Birkbeck G, Dalgard OS, Lehtinen V, et al. Factors associated with suicidal ideation in the general population: five-centre analysis from the ODIN study. *Br J Psychiatry*. 2006;189:410–5.
22. Casey P, Dunn G, Kelly BD, Lehtinen V, Dalgard OS, Dowrick C, et al. The prevalence of suicidal ideation in the general population: results from the Outcome of Depression International Network (ODIN) study. *Soc Psychiatry Psychiatr Epidemiol*. 2008;43:299–304.
23. Hegerl U, Wittmann M, Arensman E, van Audenhove C, Bouleau JH, van der Feltz-Cornelis C, et al. The ‘European Alliance Against Depression (EAAD)’: a multifaceted, community-based J Biol Psychiatry. 2008;9:51–8.
24. Bruffaerts R, Demyttenaere K, Borges G, Haro JM, Chiu WT, Hwang I, et al. Childhood adversities as risk factors for onset and persistence of suicidal behaviour. *Br J Psychiatry*. 2010;197:20–7.
25. Scott KM, Hwang I, Chiu WT, Kessler RC, Sampson NA, Angermeyer M, et al. Chronic physical conditions and their association with first onset of suicidal behavior in the world mental health surveys. *Psychosom Med*. 2010;72:712–9.
26. Wasserman D, Carlom V, Wasserman C, Apter A, Balazs J, Bobes J, et al. Saving and empowering young lives in Europe (SEYLE): a randomized controlled trial. *BMC Public Health*. 2010;10:192.
27. Kovess-Masfety V, Boyd A, Haro JM, Bruffaerts R, Villagut G, Lépine JP, et al. High and low suicidality in Europe: a fine-grained comparison of France and Spain within the ESEMeD surveys. *J Affect Disord*. 2011;133:247–56.
28. Jiménez-Treviño L, Saiz PA, Corcoran P, García-Portilla MP, Buron P, Garrido M, et al. The incidence of hospital-treated attempted suicide in Oviedo (Spain). *Crisis*. 2012;33:46–53.
29. Balázs J, Adoklési M, Keresztény A, Apter A, Avigal S, Bobes J, et al. Adolescents subthreshold-depression and anxiety: psychopathology, functional impairment and increased suicide risk. *J Child Psychol Psychiatry*. 2013;54:670–6.
30. Carli V, Wasserman C, Wasserman D, Sarchiapone M, Apter A, Balazs J, et al. The saving and empowering young lives in Europe (SEYLE) randomized controlled trial (RCT): methodological issues and participant characteristics. *BMC Public Health*. 2013;13:479.
31. Bursztein Lipsicas C, Mäkinen IH, Wasserman D, Apter A, Bobes J, Kerkhof A, et al. Immigration and recommended care after a suicide attempt in Europe: equity or bias? *Eur J Public Health*. 2014;24:63–5.
32. Brunner R, Kaess M, Parzer P, Fischer G, Carli V, Hoven C, et al. Life-time prevalence and psychosocial correlates of adolescent direct self-injurious behavior: a comparative study of findings in 11 European countries. *J Child Psychol Psychiatry*. 2014 [in press].
33. Carli V, Hoven CW, Wasserman C, Chiesa F, Guffanti G, Sarchiapone M, et al. A newly identified group of adolescents at “invisible” risk for psychopathology and suicidal behaviour: findings from the SEYLE study. *World Psychiatry*. 2014;13:78–86.
34. Jiménez-Treviño L, Sáiz PA, Corcoran P, Burón F, García-Portilla MP, China ER, et al. Factors associated with hospitalization alter suicide spectrum behaviors: results from a multicentre study in Spain. *Arch Suicide Res*. 2014 [in press].
35. Kaess M, Brunner R, Parzer P, Carli V, Apter A, Balazs J, et al. Risk-behavior screening for identifying adolescents with mental health problems in Europe. *Eur Child Adolesc Psychiatry*. 2014 [in press].
36. Sarchiapone M, Mandelli L, Iosue M, Apter A, Balazs J, Bobes J, et al. Hours of sleep among adolescents and its association with anxiety, emotional problems and suicidal ideation. *Sleep Med*. 2014 [in press].
37. Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, et al. Suicide prevention strategies: a systematic review. *JAMA*. 2005;294:2064–74.
38. Meltzer HY, Alphs L, Green AI, Altamura AC, Anand R, Bertoldi A, et al. Clozapine treatment for suicidality in schizophrenia: International Suicide Prevention Trial (InterSePT). *Arch Gen Psychiatry*. 2003;60:82–91.
39. Baldessarini RJ, Tondo L, Davis P, Pompili M, Goodwin FK, Hennen J. Decreased risk of suicides and attempts during long-term lithium treatment: a meta-analytic review. *Bipolar Disord*. 2006;8:625–39.
40. Stone M, Laughren T, Jones ML, Levenson M, Holland PC, Hughes A, et al. Risk of suicidality in clinical trials of antidepressants in adults: analysis of proprietary data submitted to US Food and Drug Administration. *BMJ*. 2009;339:b2880.
41. Wasserman D, Rihmer Z, Rujescu D, Sarchiapone M, Sokolowski M, Titelman D, et al. The European Psychiatric Association (EPA)

- guidance on suicide treatment and prevention. *Eur Psychiatry*. 2012;27:129–41.
42. Vaiva G, Walter M, al Arab AS, Courtet P, Bellivier F, Demarty AL, et al. ALGOS: the development of a randomized controlled trial testing a case management *algorithm* designed to reduce suicide risk among suicide attempters. *BMC Psychiatry*. 2013;11:1.
43. Carter GL, Clover K, Whyte IM, Dawson AH, D'Este C. Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *BMJ*. 2005;331:805.
44. Sáiz PA, Rodríguez-Revuelta J, González-Blanco L, Burón P, al-Halabí S, Garrido M, et al. Protocolo de estudio de un programa para la prevención de la recurrencia del comportamiento suicida basado en el manejo de casos (PSyMAC). *Rev Psiquiatr Salud Ment*. 2014, <http://dx.doi.org/10.1016/j.rpsm.2014.01.001>.