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A NEW NATIONAL SUICIDE PREVENTION PROGRAMME IN FINLAND

ABSTRACT

Suicide prevention requires enhancing the efficiency of current activities and the introduction of new approaches. Therefore, a new suicide prevention programme has been put into action, starting this year. Its key message is the following: 1) the attitudes of those encountering persons who have attempted suicide must be transformed to ensure that no one who has attempted suicide is blamed or perceived as only seeking attention; 2) the availability of suicide methods and equipment for suicide must be reduced; 3) low-threshold crisis services must be available everywhere in Finland, and information must be provided on these to ensure that every resident knows where to find the services in their area and how to reach them; 4) access to treatment will be facilitated and accelerated by prioritising the treatment of a person at suicide risk, as well as by paying attention and providing support to the loved ones of those who died by suicide, since early support for individuals with a difficult life situation and during crises can prevent problems from getting worse and may also prevent suicides; 5) the severity of suicide risk among intoxicated people or those with substance abuse or addiction issues is assessed similarly as with anyone else at suicide risk; 6) competence in the media in communicating about suicides may promote suicide prevention, as positive suicide attempt survivor stories may help people find help in a difficult situation, and 7) there is a need for topical statistical data on different age group and risk groups related to suicides, suicide attempts, access to treatment, quality of care and early support.

KEY WORDS: MENTAL HEALTH, PROGRAMME, PUBLIC HEALTH, STRATEGY, SUICIDE PREVENTION

INTRODUCTION

Statistics on deaths from suicide have been compiled in Finland since the year of 1751 (1). This is the longest uninterrupted time series record in the world. In Finland, suicide rates have dropped by half since the year of 1990. This turn to the better occurred during the national suicide prevention project which was planned and conducted for the years of 1986 to 1996 (2, 3). During the project, it was detected that the majority of those who had died from suicide (88%) had a diagnosable disease (4). The most common of these were depressive disorders (59%), a physical illness necessitating clinical attention (46%), a substance abuse disorder (43%) and personality disorders (31%).

CURRENT SITUATION

The positive trajectory should not be expected to hold and continue unless measures are taken to prevent suicides (5, 6). Suicide mortality can be expected to gradually increase due to a gradual growth in the number of the population, since thereby more people are exposed to and live under the influence of risk factors for suicide. It may be subject to a more sudden spike, if the measures currently used to prevent suicides lose their effectiveness. The most recent data showed that 810 persons died by suicide and that the suicide mortality rate was 14.6 per 100,000 inhabitants in the year of 2018. On average, the age of persons who died from suicide was 50 among women and 48 among men. 99 individuals under 25 years of age and 203 people over 65 years of age died by suicide. The next (for the year of 2019) release of the official statistics for causes of death will be provided by Statistics Finland on 14 December 2020.

Suicide mortality is presented as the age-standardized number of people who have died from suicide per 100,000 inhabitants. The age standardization is carried out by Statistics Finland and based on the direct age standardization using the age distribution of the Eurostat European Standard Population ESP2012. Of note, the age-standardized mortality rates are only comparable when calculated using the same standard population, and the direct comparison between different countries is not meaningful, because the contents of cause of death investigations in different countries may differ greatly.

In Finland, suicide mortality rates have been characterized by major regional differences among both men and women (7). This is apparent in the potential years of life lost (PYLL) due to deaths from suicide. The PYLL index, which is calculated for deaths from suicide, presents the number of potential years of life lost due to suicides that have occurred before the age of 80 among the population per 100,000 inhabitants. The selection of the maximum age limit is based on the average life expectancy among Finns which currently is around 80 years.

A high PYLL index means that the number of potential years of life lost due to suicides before the age of 80 is high in a given region, or that deaths among young people are more common in the region. This has been taken into account in the National Action Plan for Safety Promotion among Children and Youth (*thl.fi/lastenturvallisuusohjelma*), which presents ten measures for preventing suicides in an effort to clearly reduce suicide mortality among young people by the year of 2025 (8). A separate plan has also been prepared for preventing suicides among the indigenous Sámi people (9).

REASONS FOR THE NEED FOR THIS NEW PROGRAMME

There is significant inequality in suicide mortality. Suicides contribute to around 10 per cent of the different life expectancies of different socioeconomic groups in Finland. In addition to mental health disorders, multifaceted social and economic problems and health issues underlie these rates. It is also common that the same individual is affected by more than one mental health disorder at the same time, such as a substance abuse disorder or anxiety disorder in addition to depressive disorder. This makes mental health disorders among the main causes exposing people to suicide.

The statistical data and follow-up data on the potential years of life lost are easily available in the Welfare Compass of the national Finnish Institute for Health and Welfare THL (www.terveytemme.fi/avainindikaattorit/index.html). The suicide mortality rates are given per region and age group in the Sotkanet database (sotkanet.fi/sotkanet/fi/haku). However, this information may not reach social welfare and primary healthcare professionals. There is also a delay in publishing these statistical data. As a result, we need data that are as up to date as possible on not only the age distribution and regional distribution of suicides, but also on the used suicide methods for targeting suicide prevention measures better than currently.

The measures reducing inequality in mental health and promoting mental health included in mental health policies are also likely to prevent suicides. The following section

presents proposals for measures aiming to prevent suicides. The implementation and effectiveness of the measures included in each topic area is followed based on data which is separately compiled into indicators. This information has been included in the national mental health strategy for the years of 2020 to 2030 as provided by the Ministry of Social Affairs and Health this year (10).

PROPOSALS FOR REACHING THE GOALS OF THE PROGRAMME

INFLUENCING ATTITUDES

It is necessary to encourage societal discussion on suicide ideation and suicides in order to ensure that those at risk are provided with appropriate help and equal services. At the same time, the aim is to support a sense of community and a feeling of mutual responsibility among people. Every person can help a person at suicide risk in a compassionate way without placing blame. This requires discussing the negative attitudes related to mental health disorders as well as intoxication or substance abuse and addiction issues, as a considerable share of those who have died from suicide have suffered from a mental health disorder, substance abuse issue, or both. In addition to healthcare professionals, other employees playing a key role in this context include youth workers, coaches, school psychologists, social workers, reception centre and parish staff, guards, police officers, debt counsellors, enforcement authorities, paramedics, rescue workers, prison guards, journalists, supervisors, etc.

Measure 1: Providing the general public with regular information about ways to promote mental health and prevent suicides.

Measure 2: Continuing the cooperation with the internal security programme of the Ministry of the Interior for providing training to different professionals working at the interface of emergencies.

AFFECTING SUICIDE METHODS

It has been possible to prevent deaths by affecting suicide methods. As a result, it is important to examine the prevalence of the different methods and their availability. For example, pharmacy agreements can be used to impose restrictions on the misuse of prescribed medications.

Measure 3: Considering suicide risk in work, related to traffic safety.

Measure 4: Considering suicide risk in environmental design, related to buildings, bridges, train tracks and other transport routes.

Measure 5: Considering suicide risk in interior design solutions, particularly in hospitals, child protection institutions, reception centres and penal institutions.

Measure 6: Developing regulation concerning the availability and storage of toxic substances.

Measure 7: Developing the regulation pertaining to the availability, storage at home and prescribing practices of medications; paying particular attention to substance abuse issues as a risk factor.

Measure 8: Developing regulation concerning the availability and storage of firearms.

PROVISION OF EARLY SUPPORT

Better support must be provided to people facing a lot of experience of financial, social and human marginalisation and depletion of resources. The best way to reach many people belonging to suicide risk groups is in face-to-face encounters.

Measure 9: Expanding suicide helpline activities to also cover language groups other than that of Finnish, as well as supporting and updating the competence of helpline workers.

Measure 10: Establishing a 24-hour online chat support service and requiring agents in charge of social media platforms to refer their clients at suicide risk to this service.

Measure 11: Strengthening low-threshold mental health and substance abuse services in primary healthcare and other local services, such as educational institutions.

SUPPORTING RISK GROUPS

Suicide risk is highest for those who have expressed their suicidal thoughts or attempted suicide. The need for treatment of other risk groups must be assessed. They must also be ensured an opportunity for peer support, which also means case management related to appropriate peer support. Suicide risk must be assessed for intoxicated people or those with substance abuse or addiction issues similarly as

any other client, to investigate their situation and needs for further measures.

Measure 12: Actively providing support to those at a major suicide risk and the family members and other loved ones of people who have died from suicide.

Measure 13: Developing culturally sensitive prevention programmes and crisis work that take the client's language and culture into account with representatives of indigenous population, LGBTQI individuals and other minority groups, victims of violence and others in crisis situations, persons whose asylum application has been refused, prisoners, persons subject to enforcement measures and living in poverty, persons with disabilities, and those suffering from chronic pain and long-term illnesses affecting their quality of life, substance abuse issues or gambling problems.

Measure 14: Training opinion leaders for the purpose of strengthening mental health and preventing suicides in settings such as schools and the Finnish Defence Forces.

Measure 15: Increasing the use of suicide prevention methods that have been proven effective in youth work.

Measure 16: Developing outreach work online to contact persons belonging to risk groups in order to encourage them to seek help.

Measure 17: Using the methods of mental health promotion to strengthen mental health skills in work communities in trouble and subject to sudden changes, for instance, in connection with a bankruptcy or cutting down of operations.

Measure 18: Making arrangements in the services for older people for accessible environments for preventing loneliness and new kinds of residential living supporting a better sense of community, as well as online-based and telephone-based support to supplement face-to-face contacts.

DEVELOPMENT OF CARE

In the context of organizing care, it will be ensured that the availability of evidence-based care is sufficient, and that clients can access these in a timely manner. The competence of nursing staff will be enhanced to ensure that the professionals have high-quality competence and shared, evidence-based models for addressing and assessing suicide risk as well as preventing suicides, and that they are provided with sufficient support, for instance, in the form of consultations and work guidance. Paramedics and those working at emergency appointments play a key role in this context. General practitioners and occupational health physicians also play a major role in identifying persons at risk of suicide.

Measure 19: Continuing the cooperation with the Ministry of Social Affairs and Health in organizing training on the means to prevent suicides for the professionals working in social welfare and healthcare services.

Measure 20: Further improving the efficiency of evidence-based care methods and particularly the use of new electronic approaches in treating patients at suicide risk. To establish operating approaches in healthcare that follow the Current Care Guidelines for preventing suicides and treating people who have attempted suicides.

Measure 21: Enhancing collaboration between different care providers to ensure that the care of a patient at suicide risk is seamlessly continued as the care provides changes.

Measure 22: Providing those at immediate suicide risk with an urgent consultation based on psychiatric expertise to assess the person's need for treatment and draw up a follow-up plan, including a safety plan if necessary. When the person in question is a child or a young person, parents and siblings as well as close friends need to be taken into account, and vice versa, when the person in question is a parent, children and their support need to be taken into account.

Measure 23: Strengthening cooperation between experts by experience, organizations, early support and other parts of the care system.

Measure 24: Ensuring that the high-quality and compassionate care culture is provided with the support of the management system.

INCREASING MEDIA COMPETENCE

The activities of the media have also been found to negatively or positively affect deaths from suicide. As a result, recommendations have been prepared in collaboration with professionals in media on how deaths from suicide should be reported to the general public both at a general level and, especially, at the level of individuals.

Measure 25: With professionals in the media industry, planning and organizing training on reporting news about suicides and the content of the provided information.

Measure 26: Imposing an obligation for supervisory measures on those in charge of social media platforms. The obligation will include a duty for identifying content encouraging its recipient(s) to commit suicide, messages depicting suicide ideation and involve creating a steering system for those at risk of suicide.

STRENGTHENING KNOWLEDGE BASE AND RESEARCH

To target the preventive measures better than currently requires the most recent data available on the age and regional distribution of suicides as well as that on the suicide methods. We also need research on the causes that led a person to end up at suicide risk and the effectiveness of the measures used to prevent suicide to find new ways to prevent suicides.

Measure 27: Preparing an implementation plan for suicide prevention for each government term by the Ministry of Social Affairs and Health, and using this to commit all major stakeholders representing the different administrative branches in the activities.

Measure 28: To include the suicide prevention programme in the well-being and health promotion plans of municipalities or regions (such as a mental health and substance abuse plan).

Measure 29: Providing funding to research on new, digital solutions for suicide prevention.

Measure 30: To extend the approaches of accident investigation to suicides, and to include therein the so-called psychological autopsy method, initially covering those by young people and later all suicides that have occurred during treatment or within a month since discharge from treatment.

Measure 31: Launching a national suicide register by the Finnish Institute for Health and Welfare (Terveyden ja hyvinvoinnin laitos THL) for the purpose of monitoring and assessing the quality of suicide prevention, and enabling research on suicides.

Measure 32: Bringing together national, multidisciplinary competence in suicide research to strengthen it and improve its effectiveness.

Measure 33: Allocating the responsibility for the coordination, monitoring and assessment of the national suicide prevention programme as well as the necessary resources to a specific agent appropriate from the perspective of these activities as a whole.

Measure 34: To implement the coordination, monitoring and evaluation of organization-based early support and help, for instance, at the Suicide Prevention Centre of the Finnish Association for Mental Health (MIELI Suomen Mielenterveys ry).

Measure 35: Establishing the operating conditions and activities of the non-governmental organizations engaging in suicide prevention work and other well-being promotion efforts with the support of the Funding Centre for Social Welfare and Health Organisations (Sosiaali- ja terveysjärjestöjen avustuskeskus STEA, see https://www.stea.fi/) and municipalities or regions.

Measure 36: Preparing presentations for national research financiers to launch an interdisciplinary suicide research programme.

THE MONITORING OF THE SUICIDE PREVENTION PROGRAMME AND PROPOSALS FOR INDICATORS

A significant part of the operational programme for suicide prevention consists of a comprehensive network of practical service units which is in close contact with the network coordinating the activities at the national level. As this enables the constant interweaving of the goals and implementation of the programme, it ensures that the goals remain active and that information and data are collected systematically and in a timely manner.

Proposal 1: Using the information system of forensic medicine for real-time monitoring of the number of deaths from suicide and the used methods among different population groups and different regions of Finland.

Proposal 2: Using the Care Register for Health Care for monitoring the number of suicide attempts and the used methods among different population groups and different regions of Finland.

Proposal 3: Using the quality registers of healthcare to monitor the number of patients discharged from a hospital per disorder group starting to use outpatient services within 7 days since discharge.

CONCLUSION

The positive trajectory which started after the year of 1990 and coincided with the previous national suicide prevention programme cannot be expected to hold and continue unless measures are taken to prevent suicides actively. Suicide prevention requires enhancing the efficiency of current activities and the introduction of new approaches. Therefore, a new national suicide prevention programme has been put into action, starting this year.

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