SUICIDES IN LATVIA – SITUATION, PERSPECTIVES AND SOLUTIONS

Situation Report

Riga 2009

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Foreword

The suicide rate is considered an important public health problem and also an indicator of socio-demographic situation of a country. Socio-economic aspects, health problems, the use of addictive substances, the formation of personality, religious views and other factors affect the number of suicides. Despite suicide causes, the loss of any human being is an enormous tragedy for his or her family, friends and the public at large.

Over the past years the suicide rate in Latvia has decreased, however, it is still high. The current situation and economic downturn in the country are worrying factors which make professionals review positive future forecasts in the field of suicides and plan preventive measures in due time.

The Report tries to assess the current situation by taking into account the different aspects of suicide as a phenomenon. It also analyzes the situation development and outlines the key problems and possible solutions. Specialists from other fields were involved in the development of this Report thus providing an opportunity to deal with the problem not only from the viewpoint of the health sphere.

Hopefully, the assessment and recommendations provided in the Report will help to plan and implement further practical activities in order to prevent people – the most precious value of Latvia – from an extreme and ineffective problem-solving by committing suicide.

Uldis Līkops

Director of the Public Health Agency of Latvia

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Introduction

The number of suicides is one of the indicators describing mental health of people living in a specific country and region, pointing to risk groups, risk factors and situations. Unfortunately, the suicide rate in Latvia is still high on the European Union (EU) and world scale. Bearing in mind the fact that a suicide is a result caused by many problems, including the availability and quality of medical service, public attitude and drawbacks of the mental health care system, the authors of the Report will try to examine the problem in a complex fashion by assessing the theoretical grounds, experience and best practices of other countries, focusing on the situation in Latvia and on its peculiarities.

Definitions

Suicidal behaviour is a process that starts with suicidal thoughts leading to an attempted and a completed suicide.

Suicide is the act of killing oneself deliberately and performed by the person concerned in the full knowledge or expectation of its fatal outcome.

An attempted suicide is an action representing different types, motives and severity in order to die.

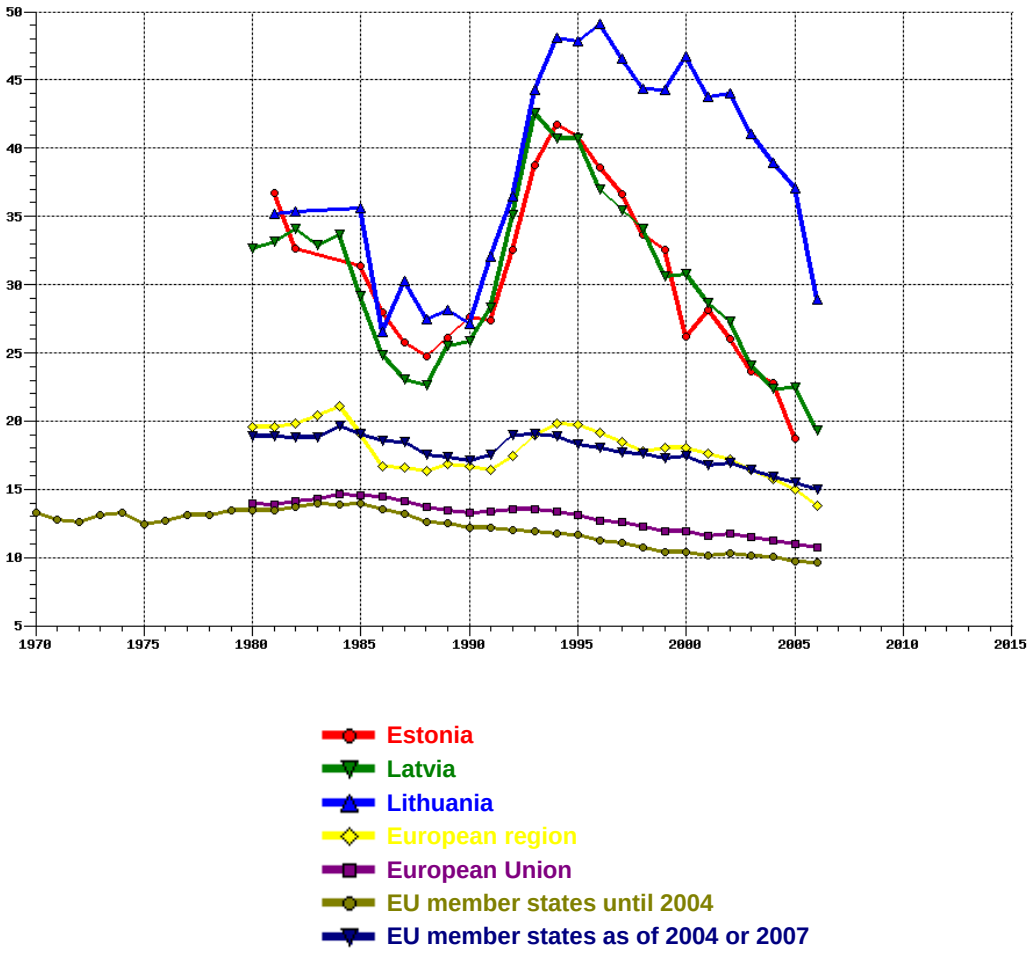
Parasuicide - an act with a non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause a self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired, via the actual or expected physical consequences[1].

Suicides, like mental illnesses, are considered a biological, social and psychological phenomenon[2].

Topicality of suicide problems in Europe and worldwide

Currently, suicide is not considered a person's individual problem only. It is a major public health problem as it affects people of different professions, social strata, age and sex. Suicide has a negative impact on society since it affects the able-bodied population and causes damages to families and a country's economy. In 1998, suicide was a second major cause of death among external causes of death after traffic accidents in 53 countries of the European region. But, for instance, in China it represented the main cause of death. Self-harm, including suicide, constitutes 1.3 percent[3] of all disability-adjusted life years. In 2006, approximately 59,000 people committed suicide (45,000 men and 14,000 women) in the 27 EU member states. Thus in 2006, more people died due to suicide than in traffic accidents[4] in the EU. In 2006, the number of people, who died as a result of suicide, 10 times exceeded the number of people who died of HIV/AIDS[5].

Graph 1 Number of suicides per 100,000 inhabitants between 1970–2006 (WHO data base Health for All (HFA), July 2008)



When analyzing the Latvian situation in the context of other countries, quite similar dynamics of suicide rates should be noted in the new EU member states, which joined the EU after 2004[6]. In the neighbouring countries of Latvia – Lithuania and Estonia[7] – the suicide rate also increased in the 1990s. The situation development and common positive tendencies in the three countries have been similar as of 1993. This could be caused by the impact of the socio-economic situation on the suicide rates as the Baltic countries are connected geopolitically and their history of development is also similar.

Suicide epidemiology in the world

This chapter focuses on circumstances influencing suicide rates in the world as the Report provides an opportunity to compare Latvia's situation with European and world tendencies, as well as to evaluate Latvia's peculiarities and specific problems.

Men commit suicide three times more often than women, and the most frequently used suicide methods are shooting, hanging, jumping from height, the use of psychoactive substances and medicine. Middle-aged people commit suicide more often than others. This phenomenon is often connected with the middle-age crisis. Men commit suicide around the age of 45 but women a little later – around 55. Suicides of the elderly constitute a serious problem. These suicides are often caused by loneliness, loss of their value and importance in society and by physical health disorders. An alarming problem is the increase in youth's suicides over the past years.

Historically, suicides among Rome Catholics occur less often than among representatives of other religions and faiths. However, currently this assumption is refuted by a traditional Catholic country Lithuania, where the suicide rate is the highest in the world.

People who are married, who live with their family and who have children commit suicide less often than single or divorced persons.

The frequency of suicides depends also on the social status. The higher the social status, the higher the suicide risk, though the loss of the social status also increases a suicide risk. Employed persons present lower suicide risk than the unemployed. Physicians rank highest among professions regarding suicides. Traditionally, doctors are mostly subjected to a suicide risk, most probably due to their psycho-emotional load, mental illnesses among doctors, as well as due to comparatively easier access to medications used for committing suicide[2].

The link between suicides and somatic diseases is crucial. 25 to 75 percent of people, who have committed suicides, have had another disease, e.g. malignant tumour. People who have diseases caused by alcohol consumption, patients of serious chronic illnesses and those who have to take medicine on a regular basis face a higher risk of committing suicide because it is easier for them to accomplish it.

Mental health disorders increase a suicide risk. Estimates show that approximately 95 percent of those committing suicide have mental health disorders. The 95 percent can be divided as follows: depression has been diagnosed in 80 percent of the cases, schizophrenia – in 10 percent and dementia or delirium – in 5 percent. About one fourth or more of those who have committed suicide had alcohol-related problems, dual diagnoses – alcoholism and mental ilnesses[2]. A psychological autopsy study carried out in Estonia shows 60 percent alcohol abuse or dependence among suicidents[31]. These facts are important for planning and organizing assistance, i.e. preventive measures to preclude suicides and to decrease their number. A special

attention should be paid to identifying symptoms of depression in order to organize timely aid.

Attention should also be paid to patients of mental health services since such patients commit suicide three to twelve times more often than people who are not patients of these services. It can be explained by the fact that patients with serious illnesses such as heavy repeated depression, schizophrenia of an unfavourable course and chronic alcoholism come into contact with mental health services. Patients commit suicide in premises of psychiatric in-patient treatment institutions, i.e. in wards, shared premises, as well as outside the ward during weekends and at home. Such suicide cases are related with the seriousness of the disease and peculiarities of its course, work organization of the respective institutions and the offered types of assistance. When patients' condition starts improving, they become physically more active and are able to commit suicide. Such patients have not psychologically fully convalesced and their suicidal thoughts are still alive. Unfortunately, work of mental health services will always be connected with suicides. It is impossible to completely prevent them, but it is possible to reduce their risk. A small but significant part of suicides have been committed due to the fact that people do not want to stay in hospital. Staff rotation in a psychiatric ward might seem an insignificant aspect, but the number of suicides is increasing during such rotation periods.

Suicide causes

Causes of suicides can be relatively divided into:

- sociological,
- psychological, and
- physiological.

Sociological causes include an individual's interaction with society and inclusion into it. Social estrangement, dissociation and isolation due to economic and other reasons can be a cause of suicide.

Freud and his followers viewed suicide as an aggression against oneself, the transfer of aggression targeted at others to oneself, a narcissistic crisis, fantasies about suicide and the loss of hopes (especially regarding depression patients) which dominate among psychological causes. According to researchers, suicides and attempted suicides are committed by people with specific personality traits: polarization, dichotomic way of thinking (in categories "black – white"), impulsiveness combined with anger and hostility, inflexibility of views, getting stranded in feelings and thoughts, difficulties to address problems, exaggerated requirements and expectations towards oneself and continuous comparison of oneself with others.

Significance of genetic factors and inheritance proved by researches and surveys carried out in suicides' families, as well as importance of neurochemical processes by

emphasizing the role of neuromediators, e.g. serotonin, prevail among biological causes.

Suicide risk factors

The following groups of people are subjected to a higher risk of committing suicide:

- people over 45,
- men,
- the unemployed,
- single persons, divorcees,
- people with an inclination to conflicts,
- patients with chronic illnesses,
- users of alcohol and addictive substances,
- patients having depression and personality disorders,
- homeless people,
- those who think about suicide intensely and for a long time,
- those who have committed attempted suicides repeatedly,
- those who have carefully planned suicide,
- patients who have not seeked help,
- those who have chosen serious and lethal suicide methods,
- those who have socially isolated themselves or who have been socially isolated,
- people who do not find responsiveness in their families, and
- those who are not able to control fluctuations of their mood.

Criteria of seriousness of an attempted suicide

When assessing seriousness of an attempted suicide, the following circumstances and patient's statements[8] have to be taken into account:

Isolation. If a patient plans his or her suicide so that nobody would be able to help him or her and when nobody would be around at the moment of suicide, it has to be evaluated as a very serious one;

Timing. If a person plans the time of suicide at the moment when nobody is at home and thus would not be able to arrive and save him or her, then the attempted suicide is serious;

Securing against revealing one's intentions and against intervention. If a person actively makes arrangements to avoid thwarting of his or her suicide attempt, e.g. locks the door and behaves quietly then the attempt is serious;

Action in order not to get any help during suicide. If a patient has not said anything to anyone, if he or she has excluded a possibility that somebody will help him or her and has not left a suicide note in an accessible place then the risk to commit suicide is high;

Last action before a suicide attempt. The more detailed and planned the action is, the more time is devoted to prepare for an attempted suicide, the more carefully the preliminary actions are carried out (suicide means have been prepared, e.g. the necessary amount of medicine has been collected, one's will has been made, the started work has been finished, etc.), the more serious the suicide attempt is;

Suicide note. If such a note has been written then the risk is higher since it testifies about a well-considered and weighted determination to die;

Thoughts about a successful attempted suicide. The clearer the determination and thoughts about a successful attempted suicide are, the more seriously such an action has to be assessed;

A wish to die by committing an attempted suicide. If the wish is clear then the attempt is serious;

Intention. If a patient has considered a possibility of committing suicide for more than a day then the intention is clear and a risk to accomplish this objective is high;

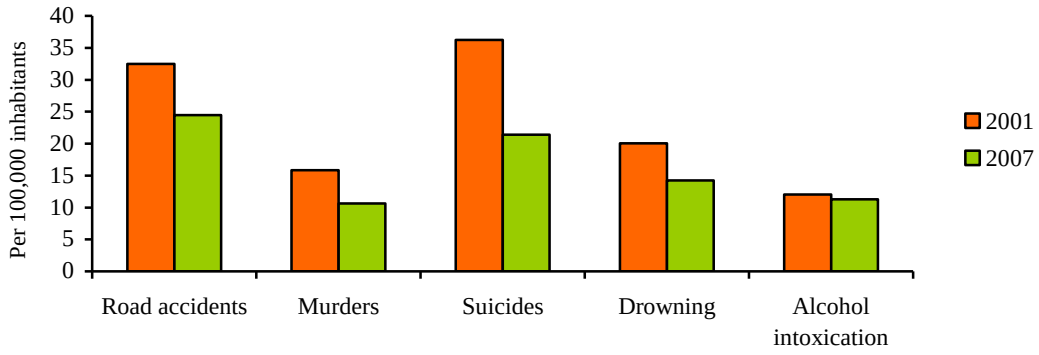
Response to an attempted suicide. If a patient regrets that he or she has survived then the attempted suicide has been serious and a risk to accomplish the intention remains high.

Situation in the field of suicides in Latvia

Despite the fact that the number of suicides in Latvia has been decreasing[9] since 1993, their number is still high. Lithuania, Hungary and Slovenia[5] are the only EU member states where the suicide rate is higher than in Latvia.

Suicides ranked first in the population mortality structure regarding external causes for a long time in Latvia. More people died as a result of suicide than in road accidents. Only in 2007 road fatalities outnumbered the ones of suicides.

Graph 2 Mortality caused by external factors in the age group 15-64 per 100,000 inhabitants *(VSMTVA data)*



The UN Committee on Economic, Social and Cultural Rights in its resolution of 22 May 2007 expresses concerns about the high number of suicides in Latvia. Unfortunately, the positive dynamics of suicide rates did not continue in 2008, when the number of suicides during 11 months exceeded the total number of suicides in 2007. In general, the number of committed suicides is higher in Eastern European countries and lower in Mediterranean countries. Such a division of countries makes it possible to assume that the major causes of suicides could be the bad socio-economic situation, the extent of alcohol consumption, as well as non-preparedness and inability of people to address changes and challenges[10,11,12] posed by a socio-economic environment. When Latvia was a republic of the Soviet Union, suicide rates were high in the country but they did not change dramatically from year to year. The situation improved at the beginning of the 1980s which could be linked with an anti-alcohol campaign[11] introduced by Gorbachov. Unfortunately, the suicide rate sharply increased during the time period until 1993. Most probably, the rapid increase was caused by the hard socio-economic situation, by problems faced by the renewed Latvian state, i.e. the collapse of industry, political and economic instability, financial reforms, unemployment, as well as by difficulties people faced to adjust to the new circumstances. Illusions of many people also collapsed as they could not enjoy the expected welfare. The suicide rate of men was higher than the one of women which is very characteristic of Latvia. Men were more subjected to various fluctuations during the formation period[13] of the Latvian state. As a result of suicides, many men die at the giving age of 40 – 49 but women – at the age of 50 – 59.

Graph 3 Dynamics of suicide rates in Latvia between 1970–2006

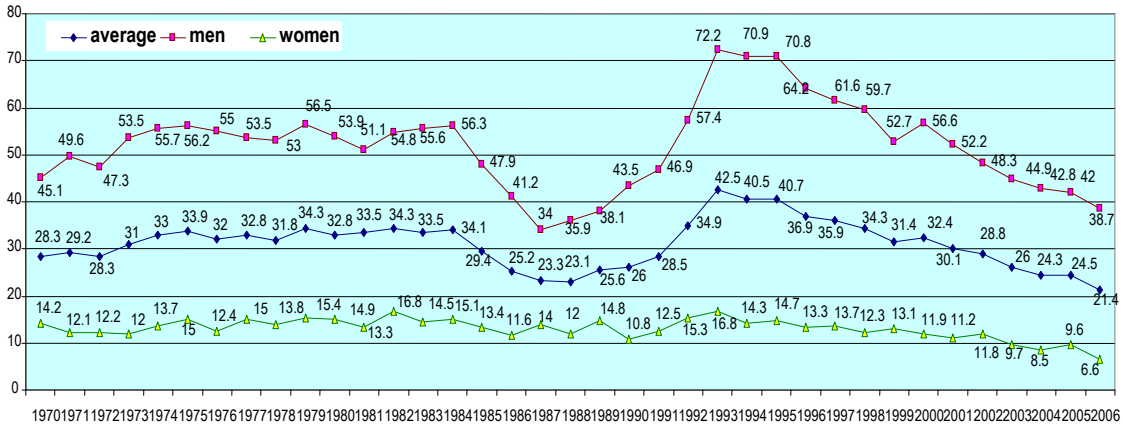


Table 1 Dynamics of suicide rates in Latvia between 1970–2007

Year	*Total (in absolute numbers)*	*Including*		*Per 100,000 inhabitants*		
		Men	*Women*	*On average*	*Men*	*Women*
1970	668	486	182	28.3	45.1	14.2
1971	695	539	156	29.2	49.6	12.1
1972	678	520	158	28.3	47.3	12.2
1973	750	593	157	31.0	53.5	12.0
1974	804	624	180	33.0	55.7	13.7
1975	833	634	199	33.9	56.2	15.0
1976	791	625	166	32.0	55.0	12.4
1977	814	612	202	32.8	53.5	15.0
1978	795	609	186	31.8	53.0	13.8
1979	861	652	209	34.3	56.5	15.4
1980	825	623	202	32.8	53.9	14.9
1981	844	663	181	33.5	51.1	13.3
1982	868	639	229	34.3	54.8	16.8
1983	852	653	199	33.5	55.6	14.5
1984	874	666	208	34.1	56.3	15.1
1985	757	571	186	29.4	47.9	13.4
1986	657	495	162	25.2	41.2	11.6
1987	611	414	197	23.3	34.0	14.0
1988	613	442	171	23.1	35.9	12.0
1989	685	473	212	25.6	38.1	14.8
1990	695	541	154	26.0	43.5	10.8
1991	759	581	178	28.5	46.9	12.5
1992	919	703	216	34.9	57.4	15.3

1993	1100	867	233	42.5	72.2	16.8
1994	1033	838	195	40.5	70.9	14.3
1995	1024	825	199	40.7	70.8	14.7
1996	918	740	178	36.9	64.2	13.3
1997	886	704	182	35.9	61.6	13.7
1998	839	677	162	34.3	59.7	12.3
1999	764	593	171	31.4	52.7	13.1
2000	770	618	152	32.4	56.6	11.9
2001	708	566	142	30.1	52.2	11.2
2002	672	522	150	28.8	48.3	11.8
2003	605	483	122	26.0	44.9	9.7
2004	562	456	106	24.3	42.8	8.5
2005	564	445	119	24.5	42.0	9.6
2006	489	408	81	21.3	38.6	6.5
2007	453	358	95	19.9	34.1	7.7

The number of suicides increased at the end of the 1980s and at the beginning of the 1990s due to the socio-economic changes taking place in the country. This increase can also be explained theoretically by analyzing information about the most frequent causes of suicides and their risk factors, i.e. depression, alcohol abuse and unemployment. Different types of depression are more typical for women but alcohol-related problems and loss of the social role due to unemployment affect men more than women. Supposedly, men's traditional social role as a breadwinner and materially independent guarantor of stability imposes an additional burden which might be too heavy for them. Many men are not able to address their problems and discuss them openly. Possibly, these aspects facilitate committing suicide. Manifestation of hidden, latent forms of mental illnesses (depression, schizophrenia) caused by socio-economic turmoil should not be excluded either.

In order to plan further action and forecast situation development in Latvia, it is necessary to assess circumstances enhancing the decrease in the suicide rate since 1993. There is neither a clear answer to the question why it decreased nor a precise explanation of this phenomenon. Latvia has not had a clear policy and/or programme targeted at decreasing the number of suicides. However, activities which could influence and improve the situation in the suicide field have been included in other policy and action documents.

The following factors could facilitate the decrease in the suicide rate:

- Stabilization and improvement of the overall socio-economic situation. However, the socio-economic situation did not improve for all people. The country continued developing and functioning according to the principles of

the free market and competition, and many people had and still have a problem to adjust to this situation and feel comfortable. Nevertheless, the country's macro-economic development, the key political development principles and objectives to create a democratic and full-fledged EU country generated a sense of stability. Development of the social sphere and addressing of social security issues which provided support (disability pensions, unemployment benefits, employment services, etc.) in life crisis situations (illness, disability, job loss, family loss, etc.) played an important role;

- Access to new medications (antidepressants) in the Latvian market, improved knowledge of specialists (psychiatrists, family doctors), regular updating of the list of medications included in the system of medications reimbursed by the state, as well as an opportunity for people having depression to obtain medicine reimbursed by the state[14,15] in total of 75 percent;

- Stricter regulation and control[16] regarding circulation and prescription of medications which can be used for committing suicide, e.g. tranquillizers;

- Implementation of activities targeted at the reduction of the number of individual suicides include psychologists' counselling in hospitals of psychiatric and general profile after attempted suicides, as well as information campaigns about identification[17] of depression symptoms;

- In Riga it is possible to receive fast and qualified psychiatric help provided by a specialized emergency medical aid team;

- Free medical aid provides an opportunity for mentally ill persons to get psychiatric help free of charge, even without paying a patient's fee[18];

- Work of a crisis hotline provided by the Crisis and Consultation Center "Skalbes";

- Psychological consultations were provided to patients after suicide attempts in general hospitals during the implementation of projects supported by the Soros Foundation.

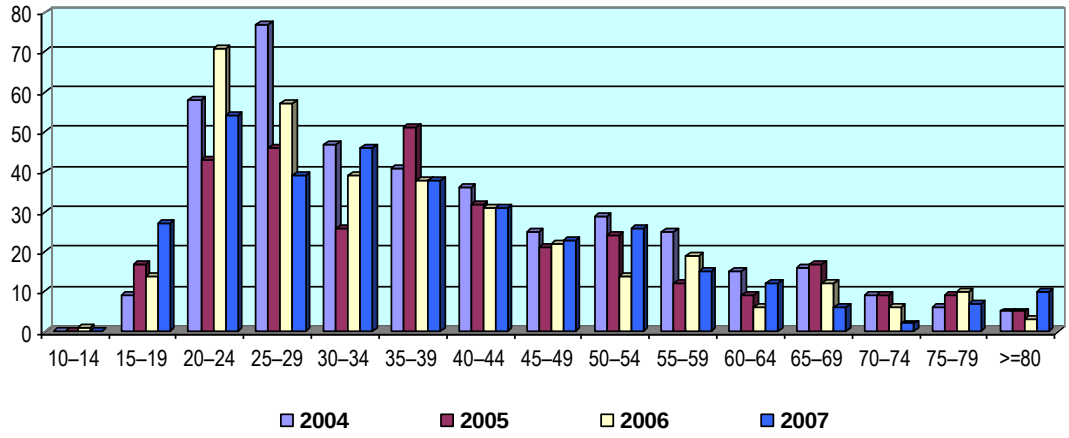
The attempted suicide rate can be an informative and practical tool for prognosis of potential suicide in future. However, its use is cumbersome when individual cases have to be assessed. Quite often both a real, targeted attempted suicide and parasuicide, when a person does not have an intention to die, are classified as an attempted suicide, i.e. an act that failed to be lethal. It would be necessary to assess each individual case separately, to have a detailed interview with the respective patient and accurately document suicide circumstances. Unfortunately, it is not always possible and not always carried out. It is easier to perform such an unbiased

assessment in hospital, e.g. in Riga Psychiatry and Narcology Centre. In Riga it is possible to carry out qualitative analyses regarding the situation of attempted suicides since specialists of psychiatry are employed by the emergency medical aid service. There are also specialized psychiatric emergency aid teams, and patients are hospitalized after attempted suicides in order to assess the situation.

Table 2 Medically treated attempted suicides in Riga according to age groups and sex between 2002 – 2007[19]

Age	Total						Including											
							Men						Women					
	2002	2003	2004	2005	2006	2007	2002	2003	2004	2005	2006	2007	2002	2003	2004	2005	2006	2007
05–14	3	0	0	0	1	0	1	0	0	0	0	0	2	0	0	0	1	0
15–19	41	29	9	17	14	27	20	18	3	10	4	11	21	11	6	7	10	16
20–24	79	33	58	43	71	54	50	22	30	20	46	33	29	11	28	23	25	21
25–29	74	47	77	46	57	39	55	35	60	28	34	26	19	12	17	18	23	13
30–34	62	45	47	26	39	46	38	26	37	18	26	31	24	19	10	8	13	15
35–39	42	21	41	51	38	38	27	9	21	22	20	24	15	12	20	29	18	14
40–44	46	33	36	32	31	31	22	20	20	21	17	13	24	13	16	11	14	18
45–49	30	39	25	21	22	23	6	18	13	9	9	15	24	21	12	12	13	8
50–54	23	22	29	24	14	26	10	6	10	9	4	10	13	16	19	15	10	16
55–59	19	8	25	12	19	15	9	5	8	6	7	4	10	3	17	6	12	11
60–64	14	12	15	9	6	12	6	3	8	2	0	0	8	9	7	7	6	12
65–69	5	7	16	17	12	6	1	3	2	4	5	3	4	4	14	13	7	3
70–74	8	5	9	9	6	2	4	0	2	3	4	0	4	5	7	6	2	2
75–79	4	6	6	9	10	7	2	2	2	3	2	2	2	4	4	6	8	5
>=80	3	0	5	5	3	10	1	0	1	0	0	4	2	0	4	5	3	6
Total	**453**	**307**	**398**	**321**	**343**	**336**	**252**	**167**	**217**	**155**	**178**	**176**	**201**	**140**	**181**	**166**	**165**	**160**

Graph 3 Attempted suicides according to age groups between 2004–2007



The available data about attempted suicides are incomplete, however, certain uniformity can be observed. The total number of registered attempted suicides is not high due to the fact that not all patients are hospitalized in mental hospitals after attempted suicides. Data show that attempted suicides are carried out equally often both by men and women though suicides are committed more often by men than women. This could indicate that men manage to choose lethal means but women want to attract attention by attempting suicides which are "cries for help".

Table 3 Attempted suicide methods most often used by patients of Riga Psychiatry and Narcology Centre

	2002		2003		2004		2005		2006		2007	
	In absol. numbers	% from the total	In absol. numbers	% from the total	In absol. numbers	% from the total	In absol. numbers	% from the total	In absol. numbers	% from the total	In absol. numbers	% from the total
TOTAL NUMBER OF ATTEMPTED SUICIDES												
	453	**100.0**	**307**	**100.0**	**398**	**100.0**	**321**	**100.0**	**343**	**100.0**	**336**	**100.0**
Including												
Poisoning with medications	122	26.9	122	39.7	132	35.7	113	35.2	120	35.0	99	29.5
Other types of poisoning	27	6.0	10	3.3	10	2.5	6	1.9	8	2.3	7	2.1
Hanging	38	8.4	21	6.8	37	9.3	27	8.4	22	6.4	28	8.3
Drowning	4	0.9	2	0.6	8	2.3	3	0.9	3	0.9	5	1.5
Firearms	1	0.2	0	0	0	0	0	0	0	0.0	2	0.6
Use of sharp objects	244	53.9	145	47.2	202	50.8	157	48.9	178	51.9	178	53.0

Jumping from height	12	2.6	6	2.0	8	2.0	6	1.9	8	2.3	8	2.4
Other	5	1.1	1	0.3	1	0.3	9	2.8	4	1.2	9	2.7
Including												
Repeated suicide attempts (number and % from all suicide attempts)												
	131	**28.9**	**91**	**29.6**	**102**	**25.6**	**93**	**29.0**	**99**	**28.9**	**81**	**24.1**
Repeated suicide attempts:												
Poisoning with medications	36	27.5	32	35.2	39	36.3	31	33.3	37	10.8	24	7.1
Other types of poisoning	8	6.1	0	0	5	4.9	4	4.3	0	0.0	2	0.6
Hanging	4	3.0	3	3.3	6	5.9	7	7.5	7	2.0	3	0.9
Drowning	0	0	1	1	0	0	0	0	0	0.0	1	0.3
Firearms	0	0	0	0	0	0	0	0	0	0.0	2	0.6
Use of sharp objects	78	59.6	55	60.5	52	51.0	49	52.7	48	14.0	44	13.1
Jumping from height	2	1.5	0	0	1	1.0	0	0	6	1.7	2	0.6
Other	3	2.4	0	0	1	1.0	2	2.2	1	0.3	3	0.9

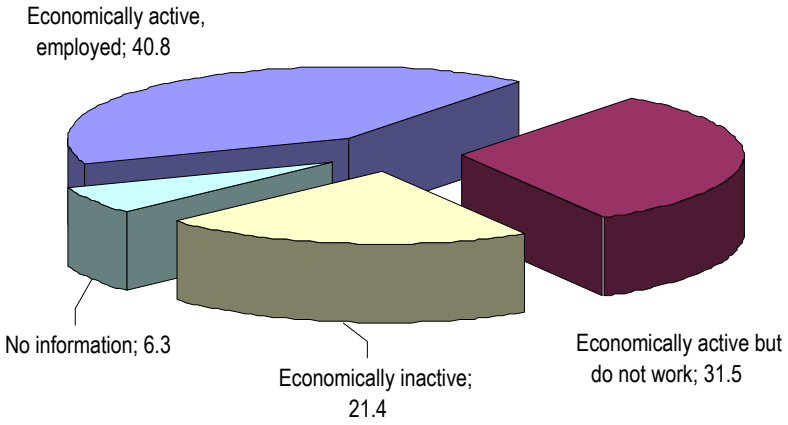
The assessment of methods, used for attempted suicides by patients, shows that the use of sharp objects and medications prevail. Possibly, many of these cases are parasuicides when people do not want to die but threaten their own life as an extreme way of communication to solve their problems.

Table 4 Attempted suicides according to education level

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Illiterate	0	1	0	1	1	0	0	0
Has never learnt	1	0	0	0	1	1	0	1
Special school for the mentally retarded	3	14	15	13	3	10	6	7
Primary school	10	17	18	13	15	9	18	19
Basic school	73	90	98	98	100	63	98	87
Secondary education	31	41	32	31	14	15	12	16
Secondary special education	127	158	149	131	140	110	90	99
Higher education	114	122	97	86	95	79	79	80

Has acquired a trade	41	28	38	37	31	30	40	27
Total	**400**	**471**	**447**	**410**	**400**	**317**	**343**	**336**

Graph 4 Division of the patients, who have committed attempted suicides, according to their economic activity by Riga Psychiatry and Narcology Centre in 2007 (%)



Data of other institutions involved in the registration and assessment of suicide cases can also provide an insight into the suicide situation in the country.

In 2007, Riga emergency medical aid team registered 38 suicides and 1011 attempted suicides.

According to information provided by the Prison Administration, 32 arrested persons committed suicide attempts in 2007 but four persons committed suicide. In 2007, ten sentenced persons committed suicide attempts but one committed suicide.

In 2007, a nongovernmental organization Crises and Consultation Centre "Skalbes" provided consultations to 543 people in person. Six of them confessed that they had committed suicide attempts and 38 said that they had suicidal thoughts. In 2008, the Centre's hotline received 2286 calls; 204 persons talked about suicide.

In 2008, the hotline of the Ministry of Children, Family and Integration Affairs received 111 calls regarding suicidal thoughts.

In 2007, three out of 10,978 clients of the State Probation Service committed suicide.

Children and adolescents' mental health and suicidality in Latvia

When analyzing the situation regarding suicides in Latvia, a special attention should be paid to children and young people by trying to assess the current situation and to identify the key risks. The number of suicides among children and adolescents is not high, but each death is an enormous tragedy for family, relatives and society. In 2007, the suicide rate in the age group from 10 to 14 was 2.8 per 100,000 inhabitants of the respective age, but in the age group from 15 to 19 it was 9 per 100,000 inhabitants of the respective age[20].

Results of numerous studies provide information about mental health of children and adolescents, as well as about possible suicide threats. During a survey of Latvian schools about alcohol and drugs respondents also had to answer questions about mental health[21]. The survey reflects suicidal tendencies and experience of the surveyed schoolchildren.

Table 5 Suicidal tendencies and experience in relation to schoolchildren's age

	13-14 years	15-16 years	17-18 years
A respondent has had suicidal thoughts	21	27	31
A respondent has carried out a suicide attempt before	8	12	12
A respondent has carried out a suicide attempt during this school year	6	7	6

The survey results show alarming data about the large number of children and young people who have thought about suicide and have tried to commit it before or during the respective school year. It would be necessary to study suicide causes. Potentially, cruel mutual relationships at school, violence, including desolation of children, insufficient attention, especially in cases when parents have moved to another country to earn more money[22], would take a significant place.

Policy initiatives to reduce the suicide rate in Latvia

Latvia does not have an individual policy regarding suicide prevention though the World Health Organization recommends having one. Protection and promotion of mental health is one of the health priorities in the European region. WHO has developed policy guidelines *Health-21-Health for All in the 21st Century*[23] for the region. Target 6 focuses on mental health: "By the year 2020 people's psychological wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems".

These guidelines were used as a basis for the development of Latvia's Public Health Strategy[24] adopted in 2001. Target 6 of the Strategy foresees the improvement of mental health: "Improve mental health of Latvia's population and ensure access to

quality mental health care services by 2010". Both policy planning documents stress the necessity to reduce the suicide rate in the country. The Public Health Strategy includes a target to reduce the suicide rate by 25 percent by 2010. Progress has been made to achieve this target. An Action Programme for the Implementation of the Public Health Strategy 2004-2010[25] specifies the implementation of the Strategy. It has been planned to use the chosen activities to develop a psychiatric assistance service and information systems, to work with soldiers of the National Armed Forces and schoolchildren. In general, the chosen activity trends are correct but, unfortunately, a target-oriented and coherent action has not taken place yet.

Guidelines Enhancement of Population's Mental Health 2009-2014[26] were adopted by the Cabinet in 2008. The document focuses on development of the psychiatric assistance service, its accessibility, on work with family doctors and the public. It is possible to specify these activities in the implementation plan of the policy document by paying special attention to the reduction of the suicide rate.

Bearing in mind the negative impact of alcohol use, a Programme for Reduction of Alcohol Consumption and Restriction of Alcoholism 2005-2008[27] was developed. However, an essential improvement regarding reduction of alcohol consumption has not taken place.

Intersectoral cooperation and opinion of the involved institutions

On 14 January 2009, a discussion with the aim to clarify registration of suicides and attempted suicides by different institutions, as well as to hear opinions of representatives of various institutions concerning measures to improve the situation was organized.

Most topical problems in Latvia and their solutions from the viewpoint of participants of the discussion:

- Terminology problems in Latvia. Currently three different terms meaning "suicide" are used in the country. Therefore, it would be necessary to agree on the use of uniform and understandable terms;

- Registration of committed suicides is good in the country but registration of suicide attempts is imprecise. Attempted suicides and parasuicides have been differentiated neither in statistical registration documents nor in the clinical practice. As of 2005, registration of attempted suicides has been facilitated by the introduction of a Register of Patients with Specific Diseases Who Have Had Traumas or Injuries. Unfortunately, not all institutions provide the necessary information for the register. Some of them (treatment and other institutions) register attempted suicides only in the primary medical or local documentation; other institutions carry out only local compilation of data without their further use. Information provided by specialists does not reach family doctors;

- Preventive measures and timely elimination of suicide risks, training regarding identification of depression symptoms have been implemented at schools, social care institutions and structures of the Ministry of Defence. However, there is still room for improvement concerning the implementation of activities. A good example regarding the development of recommendations is the Prison Administration which has been implementing Recommendations for Prison Employees to Work with Suicidal Prisoners as of 2005;

- A crucial problem is jeering at school, a non-friendly school environment facilitated by bad relationships among schoolchildren;

- Reduction of prejudices against people with mental disorders and against people with suicidal behaviour is a serious problem in Latvia;

- Lack of psychological support for representatives of medical and other professions of high risk and tension (specialists of the Accident and Emergency Centre, police officers, the military, etc.);

- Topicality of alcohol, gambling and other addiction problems in Latvia;

- An additional study and information about borderline cases would be necessary, e.g. a fall from height needs to be assessed more carefully in relation to a possibility of suicide. Such clarifications could have an impact on the number of committed suicides both by increasing and decreasing the suicide rate;

- Insufficient possibilities and inadequate suitability of mental health services to provide assistance to patients in cases of suicidal thoughts and suicide attempts:

    1. Unsuitable environment of mental hospitals and the limited offer of treatment services can even deteriorate patients' condition. Weak specialization of in-patient and social care institutions – patients with various degrees of severity and types of illnesses are placed in one ward;

    2. Problems to involve psychologists, social workers and other members of a therapeutic team in the treatment process due to limitations provided by laws and regulations and due to insufficient funding;

    3. Problems to ensure systematic work of the crisis hotline and scarce funding;

    4. Insufficient evaluation of the importance of psychological assistance and its use in work with suicidal patients;

5. Legal problems to employ a psychiatrist in nongovernmental organizations (NGOs). According to the existing legislation, the state is not entitled to provide funding to NGOs for paying salaries to psychiatrists for the services provided.

Further steps to improve the situation in Latvia

The World Health Organization has developed recommendations in the field of suicide reduction policy. The major action trends recommended by WHO to reduce the number of suicides are: detoxication of car emissions, control of toxic substances, provision of sufficient medical aid to patients with mental health problems, gun control, restrictions in places where it is possible to commit suicides, as well as responsive information about suicides[28,29] provided by the mass media. WHO has drawn up specific recommendations for different specialists and regarding various spheres of life to be used in the situation of Latvia[3031].

- **Development of a national policy and action plan[32]**

When developing a policy, it is vital to remember that reduction of suicides is not only a problem of the health sector, therefore involvement of other institutions is crucial. The World Health Organization and the European Commission call for action targeted against depression as one of the most frequent causes of suicides. Such action should be directed at each person individually by encompassing different stages of his or her life - childhood, school years, job, retirement – and at the public at large[28,29,33]. One of the most topical policy documents in which Latvia should emphasize and address the suicide problem is guidelines Improvement of Population's Mental Health 2009-2014 and their implementation plan. Another important document – a Public Health Strategy – is being developed at the moment. This document will focus on health promotion and prevention of diseases and illnesses by consolidating activities of different fields to build a healthier society. WHO actively participated in the development process of guidelines for enhancing mental health and in drawing up the Public Health Strategy by providing expert opinions and support.

The policy, like a Danish suicide reduction programme[2], should focus on specific topical problems in Latvia, i.e. improvement of access to quality care and treatment, implementation of measures targeted at the reduction of alcohol abuse, misuse of medications, drug use, etc.

- **Limiting alcohol consumption[34]**

Real action to decrease access to alcohol can facilitate further reduction of the number of suicides. An effective action to reduce alcohol consumption, especially among youth, could be higher taxes and prices on alcohol thus limiting an opportunity to buy it, advertisement and trading restrictions, relevant fines for selling alcohol to minors and other similar activities. It is important to take into account the fact that alcohol consumption can increase when the socio-economic situation deteriorates in the country. A positive factor is that the aforementioned measures help reduce access to

alcohol without additional funding from the state, especially in the situation when resources of the state budget are insufficient. Activities restricting alcohol consumption can be included in a policy document for alcohol harm reduction which is under development at the moment.

- **Socio-economic security guarantee, assistance to the risk group population**

When the socio-economic situation deteriorates in the country, like it was in the 1990s, the tendency of the decrease in the number of suicides will stop or the suicide rate will even increase.

Unlike the situation in 1993, currently quite a safe support system has been developed in Latvia for people who lose their jobs, home, who fall ill, cannot find a job for a long time, are under-educated, etc. A new and historically unique aspect is people, mainly young men, who have large loans which they are not able to repay in the current conditions of the economic crisis. This is a special suicide risk group.

Particular attention should be paid to prisons, since a large number of people's problems, i.e. mental disorders (antisocial personality disorders, depression), addiction and social problems, etc. concentrate in these institutions. Respective Latvian institutions have focused on the prison environment and have developed a scheme for work with prisoners having suicidal behaviour. Recommendations developed by WHO regarding suicide prevention in detention places and prisons[35] are also useful. In prisons attention should be paid to staff training programmes in order to identify suicidal behaviour, to improve the prison environment, including both premises and communication between prisoners and staff. It is important to provide treatment possibilities in prisons, as well as to develop a reporting system and registration of suicidal behaviour.

Another serious risk group is persons who have committed suicide attempts.

Activities in the framework of projects supported by the Soros Foundation have taken place in this area, e.g. counselling in mental hospitals after attempted suicides. However, such counselling has not taken place on a regular basis. It is important to develop work of aid groups focusing on people who have survived after attempted suicides. WHO recommendations about creation of support groups[36] can be very useful in this regard. They provide technical principles of organization and operation of such groups, as well as substance for providing assistance in different financial and structural conditions.

- **Limiting access to means of suicide**

A strategy of limiting possibilities to commit suicide has been effective in several countries. In Latvia's situation the action could be as follows:

1. Continue a strict control of acquisition of firearms and their registration, carry out regular checks, especially paying attention to representatives of specific professions (police officers, soldiers of the National Armed Forces, etc.).

2. Maintain and improve provisions restricting free acquisition of medications with potential lethal effect (tranquillizers, paracetamol and, for instance, limit the number of packages sold to an individual), control the amount of prescribed medications and indications.

3. Gather information about potentially dangerous places for committing suicide and carry out environmental planning (bridges, railway, motorways, multi-storeyed buildings)[37,38], as well as adjust composition of household gas.

- **Enhancement of the media role in reduction of prejudices regarding depression patients, identification of depression symptoms and prevention of suicides[39,40]**

The media (press, television, the Internet) role is crucial in several aspects, one of which is their participation in information campaigns to raise public awareness about symptoms of depression which is one of the most frequent causes of suicide. The media also play an important role in reduction of prejudices since the public believes that any mental illness, irrespective of its seriousness, is a stigma which must be kept a secret, and that seeking for assistance is a manifestation of one's weakness. WHO has developed recommendations[41] for journalists regarding reflection of suicides in the media. Journalist should be extremely professional when providing information about suicides to the public. They should not present suicide as the main topic and avoid exacerbating and exaggerating the problem, they should not show scenes of suicides, should not praise suicides and should not forget to include information about the available assistance in the prepared material. Educational seminars and trainings should be organized for journalists.

- **Improving and enhancing mental health aid[42,43,44,45]:**

1. Enhancement of identification of suicide risk and depression symptoms, education of primary care specialists (family doctors) [46] and specialists of various medical disciplines working in out-patient and in-patient care. WHO has developed recommendations for general practitioners regarding work with suicide risk patients, as well as special recommendations for primary care specialists[47,48] who often are the first and most frequent contact points with the potential suicide, therefore identification of suicidal tendencies and provision of aid are crucial. Different somatic diseases constitute a risk factor for

committing suicide, therefore it is important for general practitioners to identify suicidal behaviour and assess risks;

2. Development of an in-patient consultative psychiatric service, improvement of access to psychiatric assistance in regions in order to get this help after identification of the respective symptoms. The service has to be client-friendly and reduce prejudices about psychiatry as a mythical, closed system and a "lunatic asylum";

3. Maximum involvement of different specialists in building a multidisciplinary aid model (a family doctor, psychiatrist, psychologist, social worker, etc.). Support to development of human resources in the fields of health care, prevention and health promotion is essential;

4. Support to and maintenance of crises services (hotline, etc.) to ensure provision of pre-hospital assistance and crisis intervention in general hospitals.

- **Work with specific groups – families with children, schoolchildren[49], the employed and the elderly**

Mentally healthy schools, the creation of a working environment, as well as family comfort can substantially reduce a suicide risk. Social isolation, inferiority complex, a lack of motivation for personal improvement and for further life, as well as alcoholization are the problems often faced by elderly people. A critical aspect is also identification of psycho-traumatic situations, their prevention and timely intervention (jeering at school, social exclusion, problems at work, etc.).

WHO recommendations regarding suicide prevention at work places, including improvement of a working environment, provision of a link with aid providers in society, reduction of prejudices against persons with mental health disorders in a working environment and provision of aid[50] are also important.

A school environment and endeavours to reduce and prevent suicides in this environment also play an essential role. WHO recommendations can be very useful for Latvia[51] in this regard. The recommendations focus on risk factors, their identification, the necessity to maintain pedagogues' mental health, as well as provisions for building mutual communication and a school environment. The movement of WHO health promoting schools is a positive aspect in Latvia which should be further developed[52].

- **Reduction of toxicity generated by household and automobile emissions**

Latvia should take into account this WHO recommendation and support initiatives of the involved partners. It would serve as a good example for interinstitutional

cooperation, since reduction of gas toxicity is an important aspect for preserving public health and the environment. Initiatives of automobile manufacturers regarding preservation of nature should be supported.

- **Research about suicides and data aggregation**

It is crucial to bear in mind the extent of the problem and to aggregate the available data from different fields (suicide attempts in specific groups, places where suicides have been committed most often, studies carried out at work places and in society about the spread of depression symptoms).

References

[1] Platt S, Bille-Brahe U, Kerkhof AD, Schmidtke A, Bjerke T, Crepet T, et al. Parasuicide in Europe: The WHO/Euro multicentre study on parasuicide. I:Introduction and preliminary analysis for 1989. Acta Psychiatrica Scandinavica 1992;85:97-104.

[2] Kaplan & Sadocks. *Synopsis of Psychiatry*. Editors Sadock BJ, Sadock VA – 9th ed. – Philadelphia, Williams & Wilkins, 2003.

[3]World Health Organization. The World Health Report 2001. *Mental Health: New Understanding, New Hope*. WHO, Geneva, 2002.

[4] Wahlbeck K & Mäkinen M (Eds). *Prevention of depression and suicide*. Consensus paper. Luxemburg, European Communities, 2008.

[5] McCollam A et al. *Mental Health in the EU, Key Facts, Figures, and Activities*. A Background Paper. Luxemburg, European Communities, 2008.

[6] Health for All Data Base, World Health Organization.

[7] Tooding L-M, Värnik A, Wasserman D. *Gender and Age-specific Dynamics of Suicides in the Baltic States during the Transition Period*. Trames, 2004, 8(58/53), 3, 299–308.

[8] Möller HJ. *Psychiatrie: ein Leitfaden für Klinik und Praxis*. Stutgart, Kohlhammer, 1997.

[9] Taube M, Krievkalna R, Klotiņa R, Kišuro A, Līce V, Šlosberga I. Psihiatriskās veselības aprūpe Latvijā 2006. Statistikas gadagrāmata. Rīga, Sabiedrības veselības aģentūra, 2007.

[10] Rancāns E, Salander Renberg E, Jacobsson L. *Major demographic, social and economic factors associated to suicide rates in Latvia 1980 – 1998.* Acta Psychiatrica Scandinavica, 2001: 103:275-281

[11] Värnik A, Wasserman D, Eklund G. Suicides in the Baltic countries, 1968-90. Scandinavian Journal of Social Medicine 22:(3): 166-169.

[12] World Health Organization, WHO-AIMS Report about the Mental Health System in Latvia, 2006.

[13] Rancans E. *Social Behaviors in Latvia 1980-2000*, Medical Dissertation. Umeå, 2001.

[14] Cabinet Regulation No 899 of 31 October 2006 Procedures for the Reimbursement of Expenses toward the Purchase of Medicinal Products and Medical Devices for the Out-patient Care (with amendments No 219 of 27 March 2007).

[15] State Medicines Pricing Agency, www.zca.gov.lv.

[16] Cabinet Regulation of 17 June 2008 Procedure for Procurement, Receipt, Storage, Distribution, Registration and Disposal of Narcotic and Psychotropic Substances in Manufacturing of Medicines and Veterinary Medicines, in Wholesale and Pharmacies of Medicines and Veterinary Medicines.

[17] Campaign "Small Telephone Directory", www.sva.gov.lv .

[18] Cabinet Regulation No 1046 of 19 December 2006 Procedure for Organization and Financing of Health Care.

[19] Data provided by Riga Psychiatry and Narcology Centre.

[20] Latvian Health Care Statistical Yearbook 2007. State Agency of Health Statistics and Medical Technologies, 2008.

[21] Survey of Latvian schools about alcohol and other narcotic substances (LaSPAD) carried out in 2006/2007. Public Health Agency, 2008.

[22] Putniņa A and others. *Violence and Health*. Report on the situation in Latvia. Riga, 2007.

[23] World Health Organization, Regional Office for Europe, Health 21 - health for all in 21st century, Series no 5, Copenhagen, 1999

[24] Public Health Strategy. Minutes No 43 of a Cabinet meeting on 06.03.2001.

[25] Cabinet Regulation No 150 of 9 March 2004 Action Programme for the Implementation of the Public Health Strategy 2004 –2010.

[26] Cabinet Regulation No 468 of 6 August 2008 On Guidelines "Improvement of Population's Mental Health 2009 –2014".

[27] Cabinet Regulation No 40 of 19 January 2005 On the Programme for Reduction of Alcohol Consumption and Limiting Alcoholism 2005–2008.

[28] World Health Organization. Primary Prevention of Mental, Neurological and Psychosocial Disorders. Geneva, 1998.

[29] World Health Organization, Division of Mental Health. Guidelines for the Primary Prevention of Mental, Neurological and Psychosocial Disorders, Suicide. Geneva.

[30] http://www.who.int/mental_health/resources/suicide/en/

[31] WHO European Pact for Mental Health and Well-being
http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf

[32] World Health Organization. Policies and practices for mental health in Europe – meeting the challenges. WHO, 2008.

[33] European Commission Health and Consumer Protection Directorate-General, Action against Depression, Improving Mental and Well-being by Combating the Adverse Health, Social and Economic Consequences of Depression. European Communities, 2004.

[34] Kõlves K, Värnik A, Tooding L-M, Wasserman D. The role of alcohol in suicide: a case-control psychological autopsy study. Psychological medicine, 2006, 36, 923–930.

[35] World Health Organization, Department of Mental Health and Substance Abuse. Preventing Suicide in Jails and Prisons. WHO, 2007.

[36] World Health Organization, Department of Mental Health and Substance Abuse, International Association for Suicide Prevention. Preventing Suicide. How to Start a Survivors' Group. WHO, 2008.

[37] Care Services Improvement Partnership, National Institute for Mental Health in England, National Suicide Prevention Strategy for England. Annual Report 2007.

[38] Care Services Improvement Partnership, National Institute for Mental Health in England, Guidance on action to be taken at suicide hotspots.

[39] European Communities, Mental health promotion and mental disorder prevention across European Member States: a collection of country stories. European Commission, Directorate General for Health and Consumer Protection, 2005.

[40] Sisak M, Värnik A, Wasseman D. Internet Comments on Media Reporting of Two Adolescents' Collective Suicide Attempt. Archives of Suicide Research, 9:87–98, 2005.

[41] World Health Organization, Department of Mental Health and Substance Abuse, International Association for Suicide Prevention, Preventing Suicide, A Resource for Media Professionals. WHO, 2008.

[42] Knapp M, McDaid D, Mossialos E, Thornicroft G. *Mental health policy and practice across Europe*. WHO, 2007.

[43] Dawson A, Tylee A. *Depression: social and economic timebomb*. Strategies for quality of care. Proceeding of an international meeting. BMG Books, 2001.

[44] European Alliance Against Depression, www.eaad.net .

[45] World Health Organization. Mental Health Atlas 2005.

[46] World Health Organization and World Organization of Family Doctors (Wonca). *Integrating mental health into primary care: a global perspective*. WHO, 2008.

[47] World Health Organization, Department of Mental Health. Preventing suicide. A Resource for Primary Health Care Workers. WHO, Geneve, 2000.

[48] World Health Organization, Department of Mental Health. Preventing Suicide. A Resource for Primary Health Care Workers, Geneva, 2000.

[49] Clift S, Jensen BB (Ed.). *The health promoting school: international advances in theory, evaluation and practice*. Danish University of Education Press, 2005.

[50] World Health Organization, Department of Mental Health and Substance Abuse. Preventing Suicide. A Resource at Work. WHO, Geneva, 2006.

[51] World Health Organization, Department of Mental Health. Preventing Suicide. A Resource for Teachers and other School Staff. Geneva, 2000.

[52] The Centre for Curriculum Development and Examinations, http://www.isec.gov.lv/isec/projekti/vesveicproj.shtml.