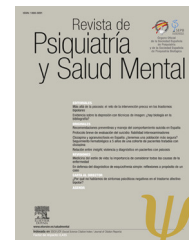


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EDITORIAL

Suicide prevention in Spain: An uncovered clinical need[☆]

Prevención del suicidio en España: una necesidad clínica no resuelta

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Suicide constitutes one of the most important problems in global public health.¹ 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.²⁻⁵ There have been mixed results. The most consistent data supporting such an association came from developed countries in the Anglo-Saxon world.^{6,7} 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^{4,5} and others that contradicted this affirmation.⁸ 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,⁸ while others mention the different crisis indicators in the studies² 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.⁹ 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.¹⁰

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*),¹¹ 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.¹² However, this sensitivity does not seem to have penetrated other levels, with examples of these below.

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Firstly, assessment as well as corresponding verification of suicide risk, either in case histories or clinical reports, is handled poorly in our country.¹³ 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.¹⁴ 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.¹⁵ 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 behaviour¹⁶; created new instruments for assessing suicide risk starting with the more discriminate items from scientifically validated scales for use in evaluation of suicide risk¹⁷; and validated instruments that assess the entire range of suicidal and/or self-harming behaviours.¹⁸ 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.¹⁹

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.²⁰ In fact, there is currently no national plan of suicide prevention as such in Spain and, to date, only a few local initiatives have been developed; these are often framed within specific European projects,^{21–36} 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.³⁷

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,³⁸ 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.³⁹ 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.⁴⁰ 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.⁴¹ 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",⁴² intensive contact through the mail⁴³ or case management.⁴⁴

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.

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