



OBSERVATOIRE  
NATIONAL  
DU SUICIDE

# S U I C I D E

Ethical issues of prevention,

particularities

of adolescents' suicide

SUMMARY OF THE 3<sup>RD</sup> REPORT / 2018



# SUMMARY

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The World Health Organisation's (WHO) 2014 report on suicide prevention<sup>1</sup> highlights that "every 40 seconds, a person dies by suicide somewhere in the world and many more attempt suicide. Suicide occurs in all regions of the world and throughout the lifespan". It is a phenomenon that occurs in all societies, in all categories of the population and in all ages. As early as Antiquity, writings can be found in which death by suicide is mentioned. Since the 1990's, suicide is experiencing a downward trend in countries that are members of the Organisation for Economic Co-operation and Development (OECD), Japan and Korea excluded<sup>2</sup>. However, today it is still the fifteenth cause of death in the world, the second for 15-24 year olds, and is responsible for 1.4% of all deaths (WHO data 2012).

Suicide is a complex subject, with multiple determinants. The suicide rate is first and foremost an indicator of a population's mental health. Indeed, it can be linked to certain psychiatric illnesses, in particular depression. However this link is not systematic. It can also reveal social and economic issues, especially due to the relation between unemployment, working conditions and suicide. Several studies reveal that, following the 2008 economic and financial crisis, the increase in the unemployment rate was accompanied by an increase of the suicide rate for men of working age. This correlation is worth confirming through further research, as highlighted by the literature review on the issue presented in the National Observatory on Suicide Risks' first report<sup>3</sup>.

Thus, it is difficult to identify and untangle the reasons which drive a person to commit suicide. Nevertheless, a certain number of factors have been highlighted (WHO, 2014): individual factors (previous suicide attempts, physical or psychiatric health issues, financial difficulties due to over indebtedness<sup>4</sup> or to job loss, etc.) relational factors (isolation, widowhood or divorce, etc.) and finally social

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1. WHO (2014). Preventing suicide: A global imperative.

2. OECD (2017). Health at a Glance 2017: OECD Indicators.

3. National Observatory on Suicide Risks (2014). Suicide: State of art and research perspectives (1st report). Paris, France.

4. See the digital collection titled Over indebtedness & suicide on the Observatory's website: <http://drees.solidarites-sante.gouv.fr/>

(unemployment and working conditions) or societal factors (easy access to lethal means, barriers to accessing healthcare, inappropriate media coverage of suicide, etc.). As a consequence, multiple risk factors commingle: psychiatric, somatic, demographic, socio-economic and cultural. It is important to take these into consideration to understand the suicidal act (see the dossier on risk factors in the Observatory's 2nd report<sup>5</sup>).

Thus, as underlined by psychiatrist Fabrice Jollant: "Suicide can be found all over the world, albeit at varying frequencies, for various reasons, and motives are more or less the same everywhere. Suicide is a universal phenomenon."<sup>6</sup> Moreover, no single discipline alone can explain the mechanisms of suicidal behaviours. This subject therefore calls for a multi-disciplinary analysis. This is the National Observatory on Suicide's purpose since 2013.

Furthermore, suicide is a phenomenon which is avoidable in part through prevention, as the World Health Organisation underlines in its 2014 report. This is why, since its conception, the Observatory has focused its discussions on the knowledge of effective preventive actions. Literature identifies reducing the access to lethal means as one of these measures. Other measures exist, such as maintaining contact with individuals who have been hospitalised for attempting suicide or community-based prevention involving a large number of actors from various sectors such as: education, health, justice, police, child protection, social services, not forgetting the media. These two measures were studied in detail in the Observatory's first report.

In this report, prevention is addressed under the angle of ethical issues. The first thematic dossier therefore reproduces the Observatory's lines of thought on the issue. Multiple subjects are addressed: the listening-ear provided by suicide prevention hotlines, the conditions for lifting medical confidentiality in the event of a suicide risk, possible interactions between end-of-life legislation and suicide prevention, and, finally, the importance of promoting the right to live in dignity as a preventive action against suicide. In addition, responsible coverage of suicide by journalists and the media in general is the subject of an article in this report.

The second thematic dossier deals with youths' suicidal behaviour. Although the number of deaths by suicide for this age category is relatively low compared to other age groups, a focus on this population seemed appropriate to the members of the Observatory.

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5. National Observatory on Suicide Risks (2016). Suicide - Knowledge as a means of prevention at the national, local and association levels (2nd report). Paris, France.

6. Jollant, F. (2015). Suicide: understanding to help vulnerable individuals. Paris, France: Odile Jacob, p. 28.

Suicide among youths has a particular resonance in their immediate circle, in general media and society. It echoes broader societal debates such as the role played by schools in prevention, the evolution of youth and of families or the role played by digital tools in the contagion of certain high-risk behaviours. This dossier reproduces seven interventions of researchers and representatives of associations on these topics. Completed by elements from literature, it offers a global view of youth suicide, its particularities and the effective means to prevent it, as well as lines of research to develop.

As in previous editions, this report takes stock of the progression of the Observatory's works, with an added glimpse of the works carried out by the Conseil national de la santé mentale - CNSM (National Council for Mental Health), created in 2016 in order to implement a global and cross-sectional mental health strategy. The report describes this Council's approach, and more specifically, that of its working group dedicated to suicide prevention. The coordination of the Council's works, with an operational purpose, and those of the Observatory, with the aim to improve knowledge, should contribute towards improving the effectiveness of suicide prevention. The works of the Santé publique France (Public Health France) agency, aiming to improve suicide and attempted suicide surveillance systems are also included. Finally, researches financed under the framework of the Observatory are summarized.

Following a reminder of the key epidemiological data available today in France, this summary successively addresses the main lines of thought within the Observatory, developed over two thematic dossiers in the report: the ethical issues raised by suicide prevention and youth suicide. A point of information on the works of the Conseil national de la santé mentale's (National Council for Mental Health) suicide prevention group is then provided, as well as a state of the progression of the works carried out by the National Observatory for Suicide Risks. Lastly, this summary takes stock of the recommendations made to improve data, drawn from previous reports, and formulates a few new research recommendations, arising from the works presented in this third report.

## **1. Situational analysis of data on suicide mortality and suicide attempts in France**

### **1.1. Epidemiological data on suicide mortality**

In 2014, in metropolitan France, 8,885 deaths were recorded by Inserm's Centre d'épidémiologie sur les causes médicales de décès (French Epidemiological Centre

for Medical Causes of Death) - CépiDC-Inserm - that is nearly 24 deaths per day.<sup>7</sup> Thus, there is a suicide every hour. However, this figure underestimates deaths by suicide by 10%, bringing this number to nearly 10,000. Despite a 26% decrease in the suicide rate between 2003 and 2014, observed in all French regions, France has one of the highest suicide rates among European countries, behind Eastern European countries, Finland and Belgium.

Death by suicide affects men more than women. The standardised death rate<sup>8</sup> is 23.1 per 100,000 inhabitants for the former, compared with 6.8 per 100,000 inhabitants for the latter. According to the World Health Organisation, this increased suicide mortality rate in men is present in all countries, but in higher proportions in high-income countries, including France.

Though suicide affects all ages, the suicide rate is markedly higher in elderly individuals, in particular for men. In 2014, while the death by suicide rate for 15-24 year olds was of 7.5 per 100,000 men, it is much higher in men aged between 45 and 54 years and after 74 years old, 33.4 and 59.4 respectively per 100,000 men. However, although the suicide rate between the ages of 15 and 24 years old is relatively low compared with the other age groups, it is still the second cause of death for 15-24 year olds and represents 16% of all deaths in this age group in 2014.

The most frequent methods for suicide are hanging (57%), the use of fire arms (12%), the use of medication and other substances (11%) and jump from high places (7%). Gender induces methods' variations. For men, hanging is the cause of 61% of suicides and the use of fire arms represents 16% of suicides. Women mainly resort to hanging (42%), the use of medication and other substances (24%) and jump from high places (13%).

At the same time, as underlined by sociologists such as Émile Durkheim, significant inequalities with regards to suicide are observed depending on socio-professional category. Among higher-risk professions, farmers represent 29% of deaths recorded between 2010 and 2011. However, whereas in 2010 a 20% excess in suicide was observed among all male farmers, in 2011, only farmers aged 45 to 54 years showed a significantly higher excess suicide mortality (33%) compared to the general population of similar age.

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7. The data summarised in this section are the latest data available in the summer of 2017. This data is provided in detail in the statistic sheets at the end of this publication.

8. Represents the standardised rate for 100,000 inhabitants according to the Eurostat population comprised of the European Union and the European Free Trade Association (EU-28 countries as well as Iceland, Norway and Switzerland), in 2014. This rate is calculated by applying the structure by gender and by age of this reference population to the French population. This standardisation allows international and time-based comparisons to be made, by neutralising the effect of differences in structures due to the gender and age of the compared populations.

Other professions are also substantially affected, such as prison guards who experienced a surge in suicides in 2009. In response, a series of preventive actions against suicide were implemented by the penitentiary administration for its staff. These actions focus on improving recruitment procedures, working conditions and cycles, but also on creating an institutional support network.

These figures make no mention of the ramifications that this act has on loved ones. Christian Baudelot and Roger Establet remind us that: “grief following a suicide is a grief like no other. It is always an aggravated grief”, according to psychiatrist Michel Hanus’ formulation. [...] Due to the questions that they raise and to their exceptional nature, each suicide directly affects a large number of people. This rare event never goes unnoticed. It has a commanding presence through the marker that it creates in the fabric of everyday life”<sup>9</sup>.

## 1.2. Epidemiological data on suicide attempts

These figures on death by suicide are compounded by those on suicide attempts. In 2015, 78,128 patients were hospitalised within a medical or surgical unit following an attempted suicide<sup>10</sup>; this figure was in decline between 2010 and 2013. It seems to have since stabilised. Furthermore, the rate of hospital stays for attempted suicide shows regional disparities: Guadeloupe has the lowest rates (respectively 3.9 per 10,000 women and 3.3 for men) whereas the Hauts-de-France region has the highest hospitalisation rates for attempted suicide (30.7 per 10,000 women, and 23.7 for men). This act concerns women much more with an initial peak in young girls aged 15 to 19 (on average 39 in 10,000) and a second peak between 45 and 49 years old (on average 27 in 10,000).

By contrast, for men, hospital stays for attempted suicide increase with age until 40-44 years old (on average 20 in 10,000) before subsequently declining.

Two surveys, the survey on health and consumption on call-up and preparation for defence day (ESCAPAD) and the French section of the European school project survey on alcohol and other drugs (ESPAD), steered by the Observatoire français des drogues et des toximanies - OFDT (French Observatory on Drugs and Drug Addictions), allow for a detailed analysis of suicide risks in 15-19 year olds. In particular, they

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9. Baudelot, C., Establet, R. (2006). *Suicide, l'envers de notre monde* (Suicide, the flip side of our world). Paris, France: éditions du Seuil, p. 41.

10. This analysis is confined to suicide attempts by individuals hospitalised within medical and surgical units, including stays in short-term hospitalisation units within Accident and Emergency. However, it does not take into account patients admitted to Accident and Emergency following a suicide attempt but who are not hospitalised, nor those who are hospitalised in psychiatric units, nor individuals who are not hospitalised following a suicidal act.

demonstrate that 3% of youths aged 17 years old have declared that they have already attempted suicide, resulting in hospitalisation. This is compounded by the fact that one youth in ten has declared that they have thought about suicide at least once in the last twelve months. Suicide attempts are twice as frequent in girls, as are suicidal thoughts. The average age for the first attempt is 13.6 years old for girls and boys alike. Youths in the Hauts-de-France declare more frequent suicide attempts and suicidal thoughts. In contrast, the Île-de-France and Corsica present the lowest rate of teenagers having attempted suicide or had suicidal thoughts (see part 1.2, page 67).

## 2. The ethical issues of suicide prevention

The members of the National Observatory of Suicide Risks, who are committed to preventing suicide, are naturally faced with the topic of the ethical issues related to such prevention. During the Observatory's plenary session on 19 October 2016, new avenues of thought were outlined regarding the principles likely to guide preventive actions against suicide the purpose being to enlighten actors - who are anxious to do well and whose liability is sometimes incurred - on how to deal with suicidal behaviours. In keeping with the Observatory's domain, discussions were not focused on the circumstances of individuals suffering from incurable illnesses, whose condition is life threatening in the short term, who fall under the works of the Centre national des soins palliatifs et de la fin de vie (National Centre for Palliative Care and End of Life). The first dossier in this report repeats the discussions held during this plenary session; it is completed by a presentation of actions aiming to improve communication on suicide in the media<sup>11</sup> and by a digital collection on this topic, which can be viewed on the Observatory's website<sup>12</sup>.

Introducing the Observatory's plenary session on the ethical issues of suicide prevention, Nathalie Fourcade<sup>13</sup> recalled the three internationally accepted major principles in the field of bioethics: respect for autonomy, beneficence and justice. However, in practice, these principles conflict and raise the question of how to best reconcile them. In this respect, it is necessary to respect the decision of persons who wish to put an end to their life (respect for autonomy), whilst helping them to find other solutions for their distress (beneficence and justice), in particular if mental health issues are likely to impair their judgment. Michel Debout's<sup>14</sup> input on this subject is presented in the first dossier.

11. Notredame, C.-E., Grandgenèvre, P., Pauwels, N., Danel, T., Vaiva, G., Walter, M. (2016). Can we consider the journalist an actor in suicide prevention? *L'Encephale*, 42 (5), 448-452. Available at: [www.europepmc.org/abstract/med/27268241](http://www.europepmc.org/abstract/med/27268241)

12. <http://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/la-drees/observatoire-national-du-suicide-ons/article/l-observatoire-national-du-suicide-ons>

13. Then deputy director of Observation of Health and Health Insurance at the Directorate for Research, Studies, Evaluation and Statistics (DREES).

14. Medical examiner at the Saint-Étienne University Hospital (Centre hospitalier universitaire, CHU), member of the National Observatory on Suicide Risks.

Furthermore, each of these principles can hold a different meaning depending on perspective, and in particular depending on whether one considers the consequences of the action or its principles. Thus, the first approach may lead to an attempt to assess the opportunity to take preventive action against suicide when balanced against the expected consequences of said action on the happiness of the individuals involved, whilst the second places the protection of human life above all else. These difficulties echo the complexity and the importance of the questions raised by the ethical aspect of suicide prevention, of which this report provides a mere overview. These difficulties take on particular importance in emergency situations: significant short-term suicide risk, decision to provide medical care following a near-fatal suicide attempt, endangering of others' lives. In particular, the dossier addresses the question of the lifting of medical confidentiality under such circumstances, which was the subject of a presentation given by Jean-Pierre Soubrier<sup>15</sup>. Faced with these difficulties, suicide prevention and helpline associations have adopted various conducting rules, as demonstrated by Jean-Pierre Igot<sup>16</sup> and Enguerrand du Roscoat<sup>17</sup>, which partly reflect the variety of audiences which call upon them.

Finally, the dossier includes speeches made by Françoise Chastang<sup>18</sup> and Gabrielle Pilliat<sup>19</sup> on the link between suicide prevention and assisted death, in light of examples from other countries. Under French law, the right to die is a right-freedom (one is free to kill oneself) but it is not a right-debt (one cannot demand assistance to die). It is important to give thought to the implications of a right-debt to die, in countries having implemented such a right, on suicide prevention. Indeed, in countries where medical assistance with suicide or assisted suicide, and even euthanasia, are legally authorised or under debate, concerns arise regarding the difficulty of organising suicide prevention under such conditions. There is a risk that suicide could become more easily considered as an available option, without actually exploring other ways out.

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15. Resource centre on suicidology, WHO expert, member of the WHO's International Association of Suicide Prevention and suicidology research and member of the National Observatory on Suicide Risks.

16. Federal president of the association "SOS Amitié".

17. Head of department, Directorate of prevention and health promotion, Public Health France and member of the National Observatory on Suicide Risks.

18. Psychiatrist, Caen University Hospital.

19. Holder of a 2-year Master's degree in Criminology, University of Ottawa.

## 3. Understanding teenage suicide to improve prevention

### 3.1. Situational analysis of knowledge on youth suicide

Suicidal behaviour in youths<sup>20</sup> is a main public health preoccupation which has been little addressed in the Observatory's first two reports. The absence of a literature review specific to this population was also lamented by the Haut Conseil de la santé publique (French High Council for Public Health) in its evaluation report on the 2011-2014 Set of national priority actions against suicide. Thus, the Observatory's "Axes de Recherche" ("Research strands") working group decided to devote its 2016 work to this topic. Seven speakers - researchers and association members - shared their thoughts over the course of two working sessions which were held on 22 June and 22 November 2016. The goal of these meetings was to bring the need for knowledge and research issues to light by voicing the questions and concerns of group speakers and participants.

The dedicated dossier reflects these various presentations and discussions. It also proposes a literature review on the current issues relating to the suicidal behaviours of youths which, without claiming to be exhaustive, was guided based on the topics addressed by the various speakers.

As shown by recent data, there are many suicide attempts during teenage years, whereas deaths by suicide are less frequent yet weigh heavily on youth mortality. Although some similarities between the behaviour of girls and boys are observed in practice, wide disparities remain, starting with the prevalence of suicidal behaviour. The profound discontentment and the distress of girls translate into complaints and self-harm (pain, eating disorders, scarification, etc.) whose suicide attempts are a form of expression whereas boys externalise their distress more by resorting to force and violence (delinquency, alcohol, speeding on roads, vagrancy, etc.), of which the most extreme form is death by suicide.

In studies, the combination of multiple sources reveals that a higher proportion of youths declare having already attempted suicide than those hospitalised within a medical or surgical unit following a suicide attempt (hospital statistics). Though all suicide attempts do not result in recourse to care, and though the proportion of suicidal individuals having been admitted to Accident and Emergency and having subsequently been hospitalised is estimated at approximately 40%, it is difficult

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20. The term "teenagers" and "youths" are used indifferently, to translate the fact that there is no reference here to any particular age group. Indeed, the teenage period has no clear delimitation, it starts with physical and psychological changes related to puberty and ends with entry into adulthood, with such a notion itself being unclear and possibly postponed due to more difficult access to employment and independence than before.

to explain why this gap is more significant in young women than in young men. To perfect our understanding of it, it would be appropriate to further question the differences in the meanings that young women and young men give to suicidal thoughts and behaviours, the differences in the declarations made in surveys, and the differences in behaviour as regards recourse to care.

The understanding of teenager's suicidal behaviours, as for other age groups, will benefit from the improvement of information systems, driven by the Observatory (see part 4.2, page 24). Hospital data allows for an understanding of the care pathways of individuals hospitalised for attempted suicide and clarifies how a youth's pathway is different from that of an adult.

### 3.2. The vulnerability of youths and their suicidal behaviours

For a number of speakers, it seemed appropriate to question whether some of our society's evolutions explain the vulnerability of youths and their suicidal behaviours. Firstly, conduct disorders and the lack of social adaptability appear much earlier than before, in particular as regards violence towards oneself or towards others. Furthermore, digital practices have taken a prominent place in the lives of most teenagers. They sometimes have the effect of shortening their sleep time, reducing their physical activity and over-exposing them to the media. This makes them more predisposed to depression and anxiety symptoms as well as to suicidal ideas. In addition, the use of digital technologies appears to accentuate the inequalities between youths with regards to suicide. Indeed, it is an asset for youths who feel well and who evolve in a safe family and school environment, but the digital world is a place that exposes the most vulnerable individuals to distress and suicide risks. Finally, digital tools, and social networks in particular, can in some cases play a role in amplifying the phenomenon of "contagion" of suicidal risks. The vulnerability of youths is also intensified by the decline of the protective family role, whatever its configuration, and an increased expectation to perform, particularly in school.

Youths in distress are sometimes flagged by other behaviours which can have links with suicidal behaviours. Literature on scarification and self-mutilation is not sufficient to conclude whether these are the early warning signs of a suicide risk or, on the contrary, protective alternatives to suicide. Harassment and cyber-bullying appear primarily as behaviours connected to suicidal behaviours and share the same risk factors.

In terms of suicide prevention measures targeting teenagers, programmes or interventions aimed at youths suffer from a lack of rigorous assessments in terms of effectiveness. However, knowledge is improving. Literature stresses the importance

of intervening within school environments at two levels: first by strengthening the psychosocial skills of children from as early as 5 or 6 years old, aiming for results on a longer term, and secondly by targeting high-risk teenagers more specifically. For this second level, it is a matter of identifying those who are struggling in order to guide them towards the healthcare system. The identification of youths in distress can be accomplished by using an auto-questionnaire to detect the most fragile individuals or by training individuals, capable of identifying high-risk youths, to act as “sentinels” or “gatekeepers”, in particular school staff. Another means of intervention which appears effective is to improve the responsiveness and the goodwill of students when faced with their own distress or that of their classmates and to strengthen their readiness to refer to an adult. The change of the communication norms between youths, on the one hand, and between youths and adults, on the other hand, makes it easier to detect those presenting a suicidal risk.

For isolated youths (out of school, residing in rural areas or far from their family, in university housing, for example), proactive measures should be developed: approaching them on a regular basis to deliver prevention messages. Finally, it has been shown that, as for adults, surveillance, maintaining contact and care actions following a suicide attempt are vital in order to prevent recurrence in youths.

Furthermore, connected health applications could open the way for new suicide prevention strategies for youths, which would enable interaction with teenagers. The ease of access to the internet and to mobile technologies for under 20-year-olds allows for a simpler development of specific suicide prevention approaches.

Speeches and discussions between members have resulted in the identification of research recommendations to better understand youths’ suicidal behaviours (see part 6 below).

## **4. State of the progress of work**

### **4.1. Point of information on the works of the National Council for Mental Health’s “suicide prevention” working group**

The Conseil national de la santé mentale (National Council for Mental Health) was created on 10 October 2016 by Marisol Touraine, then Minister of Social Affairs and Health, with the ambition to put forward reflections and proposals, to ensure the coordination of various policies and to bring together the many mental health actors.

The DREES represents the National Observatory on Suicide Risks within this council. Coordination between the two bodies is based on the complementarity of their works. The National Council for Mental Health is a body that determines the policies on mental health and on suicide prevention, with missions of an operational nature, whereas the Observatory has a mission of observation, information and improvement of knowledge and information systems on suicidal behaviour.

Within the National Council for Mental Health, three commissions and a working group have been created. They correspond to the Council's priorities: youths' well-being; suicide prevention; mental health and precariousness; user's paths and territorialisation of mental health policies.

The working group for suicide prevention is co-piloted by professor Pierre Thomas, psychiatrist at the Lille university hospital, and the Directorate General for Health (DGS). Its works focus on defining joint preventive measures, which are combined and territorialised according to the recommendations made by the Haut Conseil de la santé publique (French High Council for Public Health) and on actions supported by international literature.

This group proposes to include suicide prevention in the much broader sphere of mental health, to target individuals who are most at risk (individuals with suicidal thoughts or having already tried to put an end to their life) and to set quantified objectives to reduce the number of suicides and suicide attempts. It underlines the need to implement multimodal preventive actions able to adapt to the different context of each territory and to the available resources. The following five strategic actions are proposed:

- organise monitoring upon hospital discharge following a suicide attempt, taking into consideration available resources;
- improve training to detect suicide risks by focusing on crisis intervention;
- strengthen public information;
- set up a suicide prevention phone number;
- ensure media coverage and the prevention of suicide contagion.

## 4.2. Improving the suicide and attempted suicide surveillance system

In keeping with the recommendations contained in the National Observatory on Suicide Risks' first report on improving the suicide and attempted suicide surveillance system, the Santé publique France agency drives two working groups.

The first group, created in 2015 and steered by Santé publique France (Public Health France) in collaboration with legal-medical institutes and the CépiDc-Inserm, has

launched a feasibility study on the implementation of a suicide surveillance system based on the institutes' data.

In preparation, a telephone survey targeting legal-medical institutes enabled the identification of obstacles to the systematic transfer of the results of an investigation into the circumstances of a death to the Inserm's CépiDc by such institutes, in the event of a suspicious death (sheet 7). Such an investigation should normally occur through the drafting of a second death certificate, which completes, overrides or complements the first certificate drafted by the doctor having witnessed the death. It appears that very few institutes apply this procedure, and even fewer practice it systematically. This telephone survey resulted in harmonisation proposals and provides the first elements for the implementation of the feasibility study.

This study, which received the favourable opinion of the Comité consultatif sur le traitement de l'information en matière de recherche dans le domaine de la santé - CCTIRS (Consultative Committee for the Processing of Health Research Data) and the approval of the Commission nationale de l'informatique et des libertés (French Data Protection Authority - CNIL), is carried out with nine volunteer legal-medical institutes over a period of one year. If the results are conclusive, recommendations will ensue. These will focus on the rolling out of such a surveillance system for deaths by suicide to all institutes and on the evolution of death certificate procedures.

To improve surveillance of suicide attempts, the World Health Organisation also recommends referring to the medico-administrative data drawn from admissions to Accident and Emergency and hospital stays.

A second working group, steered by Santé publique France, brings together the Fédération des observatoires régionaux des urgences (Federation of Regional Accident and Emergency Observatories), experts in medical information departments, emergency doctors and psychiatrists. Its main objective is to improve the quality of suicide attempt encoding by taking action with local data producers. It has therefore committed to working on data regarding visits to Accident and Emergency extracted from the Oscour® database. An assessment of the diagnostic feedback from this database has been carried out. The level of completeness of diagnostics in Oscour® is of approximately 75% but varies widely depending on Accident and Emergency services. Furthermore, a methodology for using the Oscour® database to study suicide attempts is also proposed. Among the possibilities considered, the working group insists on the need to improve encoding for the surveillance of suicide attempts in Oscour® and contemplates the creation of a new thesaurus, with the introduction of the explicit notion of suicide attempt, which would be indicated by the Accident and Emergency reception nurse, as well as an assessment of encoding with return on patients' records.

### 4.3. Progress of research funded by the Observatory

In 2015, the Observatory and the Institut de recherche en santé publique - IReSP (Public Health Research Institute) - launched a call for research on suicide prevention. Twenty-eight projects were submitted and examined by the scientific council, presided by Christian Baudelot<sup>21</sup>. The selection procedure resulted in the funding of five of these projects by the Direction générale de la santé - DGS (Directorate General for Health), the Caisse nationale de l'assurance maladie des travailleurs salariés - CNAMTS (French National Health Insurance Fund for Employees), and the Direction de la recherche, des études, de l'évaluation et des statistiques - DREES (Directorate for Research, Studies, Evaluation and Statistics). These projects focus on various topics: vulnerability to suicide; detection of risks in teenagers; suicide words and the effectiveness of association helplines; the suicide of elderly people; suicide and work. They mobilise various fields: psychiatry, neurosciences, paediatrics, data and communication science, epidemiology, occupational health, etc. The research teams started their works during the first quarter of 2016 and presented their progress to the members of the Observatory on 10 March 2017.

Nadia Younès<sup>22</sup> research focuses on the frequency of suicide risks in the working population and the role played by work-related factors, using the Heracles survey carried out on adults in employment and having consulted their general practitioner, and the GAZEL cohort which proposes the monitoring of agents working for companies Électricité de France (French nationalised electricity company) and Gaz de France (French nationalised gas company). Initial results demonstrate an association between suicidal behaviour and the emotional demands experienced by women (the need to hide and control one's emotions, to control oneself) or the intensity of working times for men (rhythm constraints, unrealistic or unclear objectives, versatility demands, contradicting instructions, long work days, atypical or unpredictable hours).

In the field of neuropsychiatry, Philippe Courtet<sup>23</sup> compares the emotional responses of two groups of female patients to experimental social stress, the first group having attempted suicide, and the second experiencing depression but having never attempted suicide. Initial results reveal that the first group has different emotional response profiles which could explain their increased risk of developing suicidal behaviour.

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21. Sociologist, professor emeritus of the Ecole Normale Supérieure, member of the National Observatory on Suicide Risks.

22. Psychiatrist, Versailles Hospital, University of Versailles Saint-Quentin-en-Yvelines, EA 4047.

23. Professor of Psychiatry, emergency and post-emergency psychiatric department, University Hospital of Montpellier.

Erick Gokalsing<sup>24</sup> is leading a survey through a short questionnaire with a view to targeting teenagers presenting a suicide risk and who visit the emergency services of two hospitals on the Reunion Island, for any reason whatsoever. The questionnaire appears to be fulfilling its purpose as it is allowing the detection of youths who require additional psychiatric assessment and who potentially require care, whereas youths who are not detected do not seem to require such care. This research will answer some questions raised in the second dossier of this report on the effective actions for the detection of teenagers in distress.

The study led by Romain Huët<sup>25</sup> concerns the linguistic and textual analysis of helpline association SOS Amitié's web chat. This research provides a better understanding of the words used by callers and their expectations, and will be useful to improve prevention. It also reinforces knowledge on listening methodologies and could feed the Observatory's reflections on listening ethics.

Lastly, Pierre Vandet<sup>26</sup> is leading a study on the link between suicide attempts in elderly people and a lack of cognitive inhibition (an alteration of the ability to withstand distractions or to inhibit an expected response or a comment that comes into mind). If this link is proven, the decrease in cognitive inhibition related to ageing could be compensated by social interaction with the individual's entourage and family.

## 5. Follow-up on the recommendations contained in previous reports

### 5.1. Reforming the death certificate and accelerating the launch of the electronic certificate

In its first report in 2014, the Observatory had supported the reforming of the death certificate and the acceleration of recourse to the electronic certificate. The necessary regulatory texts for these evolutions have since been published.

Decree no. 2017-602 on the death certificate was published on 21 April 2017. This decree completes the indications that must feature on the death certificate and extends the dematerialisation procedure to the certificate's medical section, paper

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24. Psychiatrist, Indian Ocean medico-psychological emergency unit, Public Institution of Mental Health of the Reunion (EPSMR).

25. Communication sciences lecturer, university of Rennes 2.

26. Psychiatrist, adult psychiatry unit, Regional and University Hospital of Besançon, University of Franche-Comté, integrative and clinical neuroscience laboratory, EA 481.

form being maintained by default. It includes an additional medical section to improve knowledge on causes of death.

The death certificate is therefore comprised of an administrative section containing the place, date and time of death, the deceased's personal information (surname, first name, date of birth, gender and registered address) and the necessary information to issue authorisation to close the coffin and carry out funeral arrangements. It also contains a medical section on the causes of death, to which has now been added a section, available only in electronic format to be used in the event of extensive research into causes of death. The purpose of this section is to provide the causes of death, when such causes are initially unknown. As a consequence, these will be known a few days after the death following the sending of the administrative and medical sections to the competent bodies<sup>27</sup>. The information contained in this additional section confirm, complete or replace those contained in the medical section of the certificate. It is drafted by the practitioner carrying out the additional research, whilst the administrative and medical sections are filled out by the doctor having witnessed the death. The practitioner who carries out the diagnosis of the causes of death will therefore benefit from a procedure to inform Inserm of the results of its research.

An order dated 17 July 2017 details the contents of the additional section. The information contained in this section are:

- the place of death;
- the brutal or unexpected nature of the death;
- the apparent circumstances of the death (including suicide);
- the place where the event having caused the death occurred in the event of violent death (including suicide);
- the existence of a pregnancy;
- the occurrence of the death during occupational activity.

The majority of the fields of this additional section in which death by suicide is indicated, are boxes to tick and not open fields.

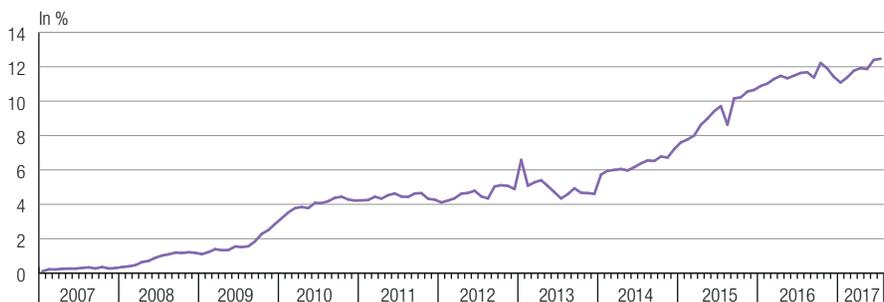
The dematerialised sending of the certificate should accelerate the passing-on of information to the Inserm. In July 2017, the percentage of electronically certified deaths reached 12% (chart 1). Although this percentage remains low, it is steadily increasing since the end of 2013 and should benefit from the ability to use the method of transmission for the two sections of the certificate.

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<sup>27</sup>. See the CépiDc website ([www.cepidc.inserm.fr](http://www.cepidc.inserm.fr)) for a description of the death certificate's administrative circuit.



**CHART 1 • Percentage of electronically certified deaths per month and year of death, from 2007 to 2017**



Source • CépiDc-Inserm.

The inclusion of this additional section should allow for the refining of death by suicide statistics. Their recording by the Inserm could also evolve, probably upwards from 2018, irrespective of the reality of suicide in France.

## 5.2. Matching data from the permanent demographic sample and medical causes of death

In its ultimate version, the *Système national des données de santé - SNDS* (National health data system)<sup>28</sup> will allow the linking of Assurance maladie (health insurance) data, hospital data, medical causes of death, data regarding disability and a sample of reimbursement data from complementary organisations. By the end of 2017, the merge of databases concerned the first three.

Furthermore, a project to match the data held by the Institut national de la statistique et des études économiques - Insee (French national institute for statistics and economic studies) on the permanent demographic sample (échantillon démographique permanent, EDP) with the National health data system is in progress. Co-steered by the DREES and the Insee, in collaboration with the Caisse nationale d'assurance maladie des travailleurs salariés - CNAMTS (French National Health Insurance Fund for Employees), this project will result in the creation of the EDP-Santé database.

28. [www.snds.gouv.fr/SNDS/Accueil](http://www.snds.gouv.fr/SNDS/Accueil)

This database will form an unprecedented source enabling the cross-referencing of medical causes of death, but also of care received and hospital paths, with individual socio-economic characteristics, described in great detail within the EDP. This EDP gathers the data of nearly 4 million individuals from annual census surveys and previous comprehensive census waves, as well as tax data and annual social declaration data. Improved annually, the EDP-Santé will enable a longitudinal monitoring of suicide mortality and its potential determinants, particularly socio-economic.

The implementation of this matching is based on a legal reflection currently carried out by the various actors of the project, in order to assess the conditions for the setting up, hosting and access to the final data. Once complete, steps will be taken with the CNIL to ultimately carry out the operation, planned for the 2019-2020 horizon.

## **6. New recommendations**

Since the publishing of the previous report in February 2016, the recommendations made during the plenary sessions and the working group meetings and validated by all members are mainly centred around the research to promote.

### **6.1. Recommendations on the ethical issues of suicide prevention**

The plenary session dedicated to ethics was a first reflection which must be continued.

As mentioned above, research geared towards reflection on listening in helpline schemes (participatory and active listening but not directive listening, listening accompanied by advice and proposals of care) could be considered. More broadly, works could be developed on the principles of preventive actions in emergency situations: high suicide risk, endangering the lives of others, etc.

Furthermore, the potential impact of decriminalising medically assisted death on the way suicide is perceived in the countries in question is worth studying, in particular when such a procedure is referred to as “medically assisted suicide”. Research would provide an evaluation of the repercussions of authorising medically assisted death on the number of suicides in countries implementing such a procedure.

## 6.2 Recommendations on youth suicide

Despite the scope of current knowledge on the prevention of youth suicide, there are still significant grey areas on which research works could shed some light<sup>29</sup>.

In order to improve knowledge on the epidemiology of youth suicide and to refine the effectiveness of preventive actions, qualitative works on the meaning that boys and girls attribute to suicidal thoughts and acts would enable, on the one hand, a better understanding of the process of declaring their history of suicidal thoughts and suicide attempts in surveys, and, on the other hand, the potential detection of an alignment in the behaviours of both genders. The use of hospital data must be improved to better understand care pathways following an attempted suicide, provided encoding is improved in these sources.

It would also be appropriate to analyse the effects of combining the increasing importance given to virtual worlds, the decline of the family's protective role and the expectation to perform, associated with the psychological and physical changes experienced during teenage years, on youths' suicidal behaviour.

The interaction between these various factors is little known. The role played by the media, the Web and social networks in the promotion and contagion of suicidal behaviours in particular must be elucidated. On the contrary, other works should question the role played by social networks as potential vectors to detect suicidal thoughts and as mediums for preventive intervention.

Furthermore, the links between suicidal behaviour and other types of behaviours (scarification, violence, alcohol consumption, harassment, etc.) are worth developing in order to make progress in reflecting on effective actions to prevent such behaviours. There is also interest in identifying whether these other behaviours are early signs, mediators, moderators or related behaviours.

Lastly, regarding the means to prevent youth suicide, reflections must focus on improving the detection of depression and suicide risks, the effectiveness of schemes to be implemented in schools, in places of entertainment or places of care (doctor's offices, Accident and Emergency, etc.) to detect teenagers in distress. The effectiveness of these types of schemes in France would require further studying.

In prevention programmes focused on youths themselves, it is necessary to reflect on a way of increasing protection or resilience factors in order to limit or reduce the appearance of suicidal ideas or behaviours. The avenues mentioned in literature are

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29. On January 9<sup>th</sup> 2018, the DREES launched a call for research in order to promote works on youth suicide prevention.

the improvement of self-worth and the development of psychosocial skills. Research may also target how to address the topic of death by suicide with youths, the means to limit the risks of contagion, the promotion of the perception of preventive messages and the introduction of new communication and mutual assistance standards which facilitate the expression of feeling of distress. The opportunity to prevent suicide through mobile connected digital tools and the Web, which youths widely use, opens new possibilities for studies. Postvention - which refers to measures to be taken with regards to the entourage following a suicide or an attempted suicide, in particular in school environments - should also be researched in order to adapt interventions to the circumstances at hand.

For all of these issues, it would be useful to encourage evaluative research on programmes, schemes or preventive actions regarding teenagers' suicidal behaviours. More qualitative works characterising the implementation of programmes or schemes under study are also expected. Furthermore, reflections on the indicators used to assess the effects of preventive measures or schemes (suicidal ideas, suicide attempts, propensity to ask for help, knowledge on suicide, attitudes towards depression, other behaviours, etc.) and on methods would be welcomed.

« Suicide : Ethical issues of prevention, particularities of adolescents' suicide »  
3<sup>rd</sup> report of National Observatory on suicide risks / February 2018

The report can be downloaded on the DREES website:

<http://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/la-drees/observatoire-national-du-suicide-ons/suicide-enjeux-ethiques-prevention-singularites-suicide-adolescence>

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