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Confédération suisse
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Eidgenössisches Departement des Innern EDI
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GDK Schweizerische Konferenz der kantonalen Gesundheitsdirektorinnen und -direktoren
CDS Conférence suisse des directrices et directeurs cantonaux de la santé
CDS Conferenza svizzera delle direttrici e dei direttori cantonali della sanità



Gesundheitsförderung Schweiz
Promotion Santé Suisse
Promozione Salute Svizzera

Suicide prevention in Switzerland

Starting point, need for action and action plan



Im Rahmen der Bundesrätlichen Strategie

Gesundheit | Santé
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dialog ständige
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1. Introduction

Switzerland adopted a national action plan on suicide prevention in November 2016¹. This document sets out Switzerland's most important epidemiological benchmarks, the objectives and measures of the action plan as well as the planned implementation by the stakeholders.

The document shows the state of suicide prevention in Switzerland, and is intended to promote knowledge sharing with other stakeholders.

The Parliament mandated the federal government to strengthen suicide prevention throughout Switzerland by "presenting and implementing an action plan on suicide prevention". The suicide prevention action plan focuses on non-assisted suicides.

In the area of assisted suicide, the federal government has only an indirect influence, e.g. by promoting palliative care (see box on pp. 10-11).

The federal government – through the Federal Office of Public Health (FOPH) - has worked closely with the Conference of Cantonal Ministers of Public Health to draw up the action plan on suicide prevention².

Around 100 experts were involved in drawing up the first draft of the action plan. They included:

- Specialists from medical and non-medical fields,
- Representatives of the federal government and the cantons,
- Persons responsible for suicide prevention in other European countries and the World Health Organization (WHO)
- People with personal experience of suicidality.

About 130 stakeholders within and outside the health sector took part in the consultation on the draft in the spring of 2016. This showed that many stakeholders are prepared to help implement the action plan. The action plan was adopted by the Federal Council and the cantons in November 2016, and implementation began in 2017.

The suicide prevention action plan is based on international recommendations on suicide prevention programmes (e.g. the World Health Organization), but also takes specific Swiss conditions into account.

2. Where do we stand: suicide in Switzerland

In Switzerland over 1,000 people die as a result of non-assisted suicides each year. In 2013 the age-standardised rate was 13.3 suicides³ per 100,000 inhabitants (men: 20.3; women: 6.3). The rate has fallen significantly over the last 20 years, but has remained unchanged since 2010⁴. The declining trend in the suicide rate is probably related to general factors, such as the stable economic situation and improvements in care for mentally ill people in Switzerland. Public and private stakeholders have also implemented a range of suicide prevention measures in recent years.

The data show that suicidal acts occur across all age groups, in men and women as well as across all socio-economic levels. Because suicidality can affect anyone, the suicide prevention action plan contains universal suicide prevention measures.

¹ More information available in German, French and Italian: www.bag.admin.ch/suizidpraevention; www.ofsp.admin.ch/preventiondusuicide; www.ufsp.admin.ch/prevenzionedelsuicidio

² Health Promotion Switzerland is a private foundation financed by the cantons and insurers. With a legal mandate, Health Promotion Switzerland initiates, coordinates and evaluates measures for health promotion and disease prevention.

³ The European Standard Population ESP 2010 was used here for the age-standardised rates. Some of the age-standardised suicide rates published by the Federal Statistical Office are based on the ESP 1976. This results in differences in the published suicide rates.

⁴ The Federal Statistical Office identifies suicides and non-assisted suicides separately. Considering the sum of assisted suicides and suicides, it can be seen that the increase in the former compensates for the decrease in the latter over the last 10 years. It should be noted that there is only partial overlap between these two groups.

Because certain groups of people have an above-average suicide risk - e.g. very old men, people affected by long-term unemployment, LGBT adolescents (LGBT stands for lesbian, gay, bisexual and transgender) or prisoners - the action plan also includes measures for selective suicide prevention.

In about 20% of suicides firearms are the method employed - almost exclusively by men. Around 15% of suicides are due to poisoning, mostly with medication. The prevalence of suicide by poisoning is greater in women than in men. Nearly 15% of suicides die by jumping from a height, and about 10% throw themselves in front of a moving vehicle (mostly trains). Railway suicide is the most common method used by adolescents. There are proven preventive measures for the suicide methods mentioned above. These start with reducing availability.

However, almost 30% of Swiss suicides are committed by hanging, and it is difficult to limit availability in public places. About 5% die by drowning – and drowning suicides can hardly be reduced by limiting availability.

3. What do we want to achieve? Objectives

The suicide prevention action plan is intended to lower the rate of suicide and suicide attempts (i.e. the number of suicides in relation to the population size) further and sustainably.

The suicide rate has not changed since 2010, showing that greater effort is required. Generally speaking, the lower the suicide rate, the greater the energy that must be invested in prevention efforts in order to achieve a further reduction.

The action plan aims to reduce the number of suicides per 100,000 inhabitants by about 25% by 2030 (as compared with 2013). The target for 2030 is therefore about 10 suicides per 100,000 inhabitants (men: about 15 suicides per 100,000 inhabitants, women: about 5 suicides per 100,000 inhabitants).

A comparison with suicide rates in other European countries⁵ shows that this reduction is possible. For example, in 2013 suicide rates of less than 15 per 100,000 inhabitants were reported for men in the UK, Spain, Italy and Luxembourg. Norway, Portugal, the Netherlands and Denmark had rates just above these. The rates for women were no greater than 5 suicides per 100,000 inhabitants in the UK, Spain, Italy, Portugal and Greece in 2013.

If this target can be reached in the long term (by 2030), about 300 deaths from suicide and great suffering on the part of about 3,000 relatives and loved ones will be prevented in Switzerland. Nevertheless, about 1,000 suicide deaths will still be lamented every year, due to the increase in the resident population as a whole and particularly the number of people 65 years of age and older.

⁵ <http://ec.europa.eu/eurostat>

4. Goals and measures of the action plan

The suicide prevention action plan sets out 10 goals and 19 key measures.

Goal I	People in Switzerland have personal and social resources that give them resilience in dealing with stress.
1	Promote interventions that strengthen the personal and social resources of children, adolescents, adults and the elderly.
Goal II	The population is informed about suicidality and effective interventions for prevention.
2	Develop a national suicide prevention campaign that informs people about suicidality and effective interventions for prevention.
3	Promote awareness-raising where information providers are in direct contact with risk groups and inform them about suicidal behaviours and effective interventions for prevention.
Goal III	People at risk of suicide and their social environment are aware of counselling and emergency services and make use of them.
4	Consolidate counselling and emergency services and promote their use.
Goal IV	People who provide early detection and early intervention can recognise suicidal behaviour and initiate the necessary support.
5	Promote educational programmes regarding suicidal behaviour and suicide prevention that target audiences in medical and non-medical settings.
6	Establish structures and processes in organisations and institutions that facilitate early detection and early intervention.
Goal V	People who are at risk of suicide and/or have recently attempted suicide are treated and cared for as promptly as required.
7	Implement the measures included in the report "Future of Psychiatry in Switzerland" ⁶ . Take into account the specific care needs of people at risk of suicide and those who have attempted suicide.
8	Consolidate recommendations for effective follow-up interventions in order to prevent recurrence after attempted suicide or discharge from a hospital.
9	Establish suicide prevention in all prisons.
Goal VI	The availability of means and methods of suicide is reduced.
10	Include suicide prevention in building guidelines and standards, and inform specialists in the construction sector accordingly.
11	Take issues of suicide prevention into account in therapeutic products Act and the ordinances in the context of other public health issues.
12	Take suicide prevention into account when prescribing and dispensing medication; promote campaigns for the return and collection of medication.
13	Run firearm return campaigns in combination with information measures.
Goal VII	Relatives, friends and professionals who are affected by a suicide have access to support services to help them cope.
14	Establish needs-based support services for bereaved relatives and involved professionals, and inform them of available services.
Goal VIII	Reporting of suicides by the media is responsible and respectful, so that prevention is promoted and the incidence of copycat suicides is reduced. Digital means of communication are used responsibly and respectfully and do not incite further suicidal acts.
15	Sensitise and support journalists and media spokespersons in responsible reporting of suicide.
16	Sensitise and support adolescents regarding responsible and respectful use of the Internet and digital media.
Goal IX	Those involved in suicide prevention have the relevant scientific background and data required to manage and evaluate their work.
17	Quantitative data should be collected routinely to allow suicide prevention measures to be managed and evaluated.
18	Knowledge gaps regarding primary, secondary and tertiary suicide prevention should be closed through qualitative and quantitative research.
Goal X	Best practice examples of suicide prevention are available to stakeholders
19	Collect best practice examples of suicide prevention and make them available to stakeholders.

⁶ <https://www.bag.admin.ch/bag/de/home/themen/mensch-gesundheit/psychische-gesundheit/politische-auftraege-im-bereich-psychische-gesundheit/postulat-zukunft-der-psychiatrie.html>

Background and clarification regarding the goals and key measures

These key measures are targeted at:

- the whole population,
 - persons who are at risk of suicide due to existing risk factors, or who have attempted suicide
 - Their social contacts
 - Health professionals and information disseminators.
-

Goal I Acute and chronic stress e.g. due to the loss of a loved one or to poverty, are part of life. Personal resources (e.g. empathy) or social resources (e.g. a supportive social network) help to maintain and support mental health when one is under stress. Personal resources such as life skills, as described by the WHO⁷, should be strengthened: knowing and liking oneself, being empathic, thinking critically and creatively, communicating and maintaining relationships, making well-thought-out decisions, solving problems successfully and coping with emotions and stress. Social resources, above all supportive social relationships, should be strengthened. Personal and social resources should be strengthened in people's various life situations and in all life phases.

Strengthening personal and social resources is a general focus of health promotion in Switzerland. Many stakeholders are already playing an active role in these key measures, for example in the context of preventing violence and addiction or in occupational health management. The suicide prevention action plan does not envisage any specific activities for this key measure. It relies on the implementation of existing initiatives, in particular the 'Health Promotion Switzerland' foundation and its cantonal action programmes for promoting mental health.

Goal II Misconceptions about suicide are widespread in the population; people may believe that attempted suicides are rational or autonomous decisions which are impossible to prevent. Risk factors for suicidality, such as mental illness, are burdened with a social stigma. Misconceptions and stigmatisation both make it difficult for the persons concerned and their families and friends to seek help at an early stage and persuade the person to accept it.

Awareness-raising measures should contribute to eliminating taboos and de-stigmatising suicidality, and should inform people about prevention options. The focus of communication should be on successfully overcoming crises, and provide information on easy-access support⁸ (e.g. counselling and emergency numbers). Awareness-raising campaigns and interventions should exploit the opportunities of the Internet and social media. Awareness-raising measures should reach not only the general population, but also people who are at increased risk of suicide as a result of existing risk factors, and their family and friends.

There have already been some awareness-raising campaigns on suicidality in Switzerland (e.g. the youth campaign "là pour toi") or on risk factors (e.g. the "how-are-you?" campaign or the "you-are-you" campaign) for LGBT people. Campaigns for easy-access counselling and emergency numbers (e.g. the services available from 'Die Dargebotene Hand' ('*The Helping Hand*') or Pro Juventute ('*Supporting Youth*')) are also important for suicide prevention.

In 2016, the Swiss Federal Railways (SBB) initiated the first suicide prevention campaign across Switzerland with the theme "talking can save lives". The three-year campaign is supported by many stakeholders. It is generally dedicated to suicide prevention and makes no reference to rail suicides, due to the concerns regarding copycat suicides.

It is important to sensitise people at high risk of suicide via specific communication channels.

⁷ http://www.who.int/school_youth_health/media/en/sch_skills4health_03.pdf

⁸ Definition of an 'easy-access' service: an 'easy-access' structure or service is one that is easy to make use of. It must be both physically (geographically and organizationally) accessible and financially affordable. In addition, it must be perceived as appropriate, i.e. it must ensure anonymity when needed, and be effective and free of social or cultural barriers (such as language, age, gender, religion or ethnicity).

Such an awareness-raising intervention can be part of a campaign or carried out on its own. It makes sense to gain access via information disseminators - if possible with direct (face-to-face) communication.

There are various options for raising awareness of suicidality and prevention - in both medical settings (e.g. in health care) and non-medical settings (e.g. schools, homes, social security counselling centres, the army).

When the action plan on suicide prevention is rolled out, awareness raising interventions will be promoted more extensively, and the topics of suicide and suicide prevention will be increasingly integrated into existing interventions (e.g. prevention of violence, addiction and burnout, prevention interventions in old age).

Extra care should be taken to prevent suicide attempts after such sensitisation interventions.

Goal III Telephone counselling and emergency numbers that are available 24 hours a day, 7 days a week are particularly important in the context of suicidality. In Switzerland, such counselling services are operated by NGOs or medical service providers. The organisation 'Die Dargebotene Hand' (*The Helping Hand*) operates a hotline for adults, while Pro Juventute (*Supporting Youth*) has a hotline for young people. Too many emergency numbers reduce public awareness and are expensive to implement. Counselling and emergency services should be tailored to the needs of those affected as well as their family and friends.

Goal IV Early detection of individuals at risk of suicide and accurate assessment are demanding, even for professionals. Early detection and early intervention play a central role in both medical and non-medical settings. In many cases, there are warning signs (statements or behaviour) before a suicide or attempted suicide. But suicides also take place without any warning signs, especially among adolescents.

Knowledge of warning signs can enable early detection of suicidality and initiation of the necessary help. Supportive internal or external structures and processes are important (e.g. suicide prevention measures in psychiatric clinics, prisons etc.) so that this demanding task is not left to isolated individuals.

There are already numerous educational programmes in Switzerland that have different target groups. For example, in western Switzerland, the interprofessional continuing education programme "faire face au risque suicidaire" (*"confront the risk of suicide"*) has already been established. Courses for professionals in the areas of health or social work are being developed at various universities of applied sciences.

Easy-access events that promote regional and interprofessional networking take place in various cities and regions (e.g. 'suicide reports' in various cities in German-speaking Switzerland, or events organised by the networks 'Réseau Entraide Valais' (*Valais Mutual Aid Network*) and 'AiRe d'ados' in French-speaking Switzerland).

In organisations and institutions, in-house or external structures and processes should support experts and professionals in their responsibilities for early detection and early intervention. Helpful examples include in-house suicide prevention plans in psychiatric clinics, retirement and nursing homes or prisons. In Switzerland, psychiatric clinics and liaison services support health professionals who have relatively little psychiatric expertise.

Goal V Needs-based, timely and specific (social) psychiatric care and treatment of individuals at risk of suicide or who have attempted suicide are very important because, according to the literature, the great majority of those affected are mentally ill. If possible, care and treatment should be guided by the needs of people at risk of suicide, and should take into account their capacity to make sound judgements. Caregivers should be involved in care and be informed about relief programmes. The experience of people who were suicidal but have since recovered should be included

Hospital stays due exclusively to a lack of alternatives should be avoided. Access to intermediate care services (outpatient clinics, crisis intervention centres, day clinics, outreach teams) is necessary for all age groups.

Care gaps (e.g. after discharge from hospital) and care breaks (e.g. a new psychotherapist) should be avoided. Special attention should be paid to young suicidal adolescents who are transferred to other care structures as they grow up.

After suicide attempts and following discharge after hospitalisation, affected persons should continue to receive care and treatment with effective intervention programmes (follow-up care). For example, the "Attempted Suicide Short Intervention Programme (ASSIP)"⁹ is a promising approach.

People who are suicidal because of a fatal, incurable disease or chronic pain should be referred promptly to palliative care.

Suicide prevention should be firmly in place in all prisons. The cantonal authorities have a special duty of care for prisoners.

Goal VI Making the availability of lethal options more difficult gives affected individuals more time. Stress crises or mental illnesses often lead to temporary suicidal tendencies. If access to means and methods for suicide is difficult, it is easier for the affected person's friends and family to intervene. Restricting the availability of means of suicide is effective as suicidal people usually prefer a particular method or even a specific location.

Availability can generally be reduced with regulatory mechanisms or architectural measures ('situational prevention') and awareness-raising measures that encourage the population to make suicidal resources (especially firearms and medication) difficult to access ('behavioural prevention').

Effective measures for suicide prevention sometimes conflict with other social concerns (e.g. the preservation of monuments or the citizen's autonomy, such as possession of weapons or access to medical remedies).

In order to reduce suicides by jumping, the options for suicide prevention in the construction sector should be taken into account (particularly with regard to high buildings, bridges, towers and viewing platforms as well as railway installations, but also in institutions such as psychiatric clinics, hospitals and prisons).

For poisoning, the focus needs to be on therapeutic products. Although chemicals cannot be overlooked as suicidal agents in Switzerland, they are not as important as medication. It is important to recognise new methods of suicide, including chemicals.

For firearms, the options of behavioural prevention should be enhanced and existing options should be maintained. Information measures should be used to inform and raise the awareness of specific risk groups and their relatives as well as relevant professionals. Regulatory measures aimed at making private access to firearms more difficult in Switzerland have been rejected repeatedly by the population and the parliament. They have therefore been omitted from the action plan on suicide prevention. Organisations and institutions involved with firearms should be encouraged to engage in suicide prevention on a voluntary basis.

In order to reduce the incidence of suicides by being "run over", particular attention should be given to improving the options for suicide prevention in the area of rail traffic. Suicides in road traffic are relatively rare. Suicides caused by hanging in public and private spaces are hardly influenced by architectural interventions.

Goal VII Suicide causes great suffering for surviving relatives and work colleagues. Suicides in the family context are also a risk factor for suicidal behaviours. Up to ten relatives or friends experience great mental stress with each suicide.

Surviving relatives should have short and long-term assistance available according to their needs. Coping already begins with news of a suicide. Surviving relatives should be informed about emergency psychological support. This also applies to the care of relatives if mentally ill persons are missing.

⁹ <http://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001968&type=printable>

Involved professionals should also receive short and long-term support according to their needs. This includes emergency services staff as well as railway companies (train drivers, railway conductors and cleaning staff).

Proven professional services or self-help groups should be established throughout Switzerland, and surviving relatives should be informed systematically about these options.

Employers should preserve and improve not only the physical health but also the mental health of their employees. They are required by the Swiss Labour Act and health protection legislation to take suitable measures to ensure that employees who are involved in suicides are not subject to psychological suffering.

Goal VIII Media coverage of suicides can lead to copycat suicides or have a preventive effect. This applies to print media, TV and radio as well as the Internet and social media. In terms of their role in reporting suicides journalists, editors and media managers should be sensitised further to and supported in their work.

In western Switzerland, experts with an influence on the media coverage of suicides are systematically sensitised and supported by the *Stop Suicide* organisation, which is based in French-speaking Switzerland. In Switzerland, various NGOs have developed and made available guidelines and recommendations for suicide prevention in media coverage.

The Internet and digital means of communication are usually used to support suicide prevention, but they are also associated with risks. In particular, adolescents need to be made aware of the responsible and respectful use of the Internet and digital communication, so that they do not contribute to suicides and are not induced to commit suicide themselves.

In Switzerland, Parliament and the Federal Council have repeatedly had to deal with political initiatives and requests regarding cyberbullying, youth media protection and cybercrime etc.

In 2015, the Federal Council came to the conclusion that cyberbullying does not require any explicit regulation as existing criminal and civil law provisions are sufficient to punish activities that involve cyberbullying.

Child and youth media protection is promoted in Switzerland by various state and private initiatives, such as the National Platform for the Promotion of Media Skills. The suicide prevention action plan relies on the continuation of these existing interventions.

Goal IX Only with solid evidence can primary, secondary and tertiary suicide prevention programmes be further developed and reviewed for their effectiveness. The availability of nationwide, high-quality, quantitative routine data needs to be ensured in the long term. These data should be available for non-assisted and assisted suicides as well as for attempted suicides, and should enable the early detection of new methods of suicide. Knowledge gaps should be closed with the aid of quantitative and qualitative research. It is important to take into account the experiences of those affected as well as relatives and surviving dependants as the evidence base for interventions. Interventions need to be evaluated.

The Federal Statistical Office FSO collects data on suicides with statistics on causes of death. Researchers would prefer more detailed information. Attempted suicides are not recorded routinely in Switzerland. However, there are ongoing and past multi-centre studies that systematically record suicide attempts in emergency departments for a certain period of time.

Goal X There are numerous suicide prevention projects in Switzerland and abroad. In 2017, the Federal Office of Public Health (FOPH) collected national examples of best practice. These are then made available to stakeholders via an online platform so that synergies can be exploited.

5. Implementation

In Switzerland, many stakeholders are already active with individual measures of the suicide prevention action plan and are ready to participate in their implementation. This was demonstrated by the discussion of the action plan held in the spring of 2016. This means that in Switzerland, investment is primarily needed for the coordination of stakeholders and measures.

For successful implementation of the action plan, joint commitment of the federal government, cantons, communes, medical service providers, professional societies and associations as well as umbrella organisations and NGOs is essential. The issuers of the action plan (the federal government, the cantons and the Health Promotion Switzerland foundation) are involved in its implementation as follows:

The federal government will continue its (predominantly selective and indirect) engagement in suicide prevention as before. This involves various policy areas, i.e. several departments and offices. Following the adoption of the suicide prevention action plan, the federal government now operates a "Suicide Prevention" project office at the Federal Office of Public Health (FOPH). This supports governmental and civil law stakeholders with the implementation of the action plan via networking and coordination as well as the development of knowledge bases. With regard to networking and coordination, the FOPH works closely with the *Mental Health Network*¹⁰, run jointly by the federal government, the cantons and Health Promotion Switzerland.

The FOPH is primarily involved in Goals IX and X, i.e. in the development of knowledge bases, collection of routine data and the dissemination of best practice examples. All the objectives of the action plan are supported in this way, which means that the federal government participates in the implementation of the action plan as a whole. In fact, with most of the measures, one or more federal agencies are often involved in implementation.

The cantons are responsible for various aspects of implementing the suicide prevention action plan, and are therefore important partners in the implementation process. Key stakeholders in the cantons include the cantonal health, welfare and social services departments, the education directorates, the police and judicial directorates as well as the construction directorates, all supported by the respective management groups.

The contribution of the Health Promotion Switzerland foundation with implementation of the measures consists primarily of promoting mental health throughout the lifespan. This is mainly carried out in the context of cantonal action programmes on mental health, activities related to occupational health management as well as implementation of the National Strategy for the Prevention of Noncommunicable Diseases. Health Promotion Switzerland provides financial and professional support for the stakeholders.

Addendum: Organised assisted suicide

In Switzerland, direct, active euthanasia (intentionally ending a life to relieve the pain and suffering of another person) is forbidden. By contrast, both indirect, active euthanasia (the use of means having side-effects that may shorten life) and passive euthanasia (rejecting or discontinuing life-prolonging measures) – while not governed by any specific statutory provisions – are not treated as criminal offences provided that certain conditions are fulfilled. In Switzerland, it is also legal to assist a suicide provided that no self-serving motives underlie the assistance. A doctor's prescription is essential for acquisition of the lethal drug required for assisted suicide. The drug must be self-administered.

In 2014, the Federal Statistical Office recorded 742 cases of assisted suicide among persons resident in Switzerland. That corresponds to 1.2 per cent of all deaths. The number has increased every year since 2008.

¹⁰ <https://www.npg-rsp.ch/de/metanav/english.html>

According to the Federal Statistical Office, accompanied suicides are predominantly carried out by people with a severe physical illness. The underlying disease reported in 42% of cases was cancer, 14% had a neurodegenerative disease, 11% had cardiovascular disease and 10% had a musculoskeletal disorder. Other diseases included pain syndromes, multimorbidity and other disorders. Depression was mentioned in 3 per cent of cases and dementia in 0.8 per cent.

In the period from 2010 to 2014, 94 per cent of those affected were 55 or older. In the five-year period, 13 individuals were under the age of 35, corresponding to 0.5 per cent of the euthanasia cases.

Federal Office of Public Health FOPH, Bern / Switzerland (2018)