

Suicide and Suicide Prevention in The Netherlands

Remco F.P. de Winter^{1*}, Ad J.F.M Kerkhof²

¹*Bureau 24-uurszorg/KCAP ParnassiaBavo groep Avocadostraat 14, 2552 HS the Hague ,
The Netherlands*

²*Department of Clinical Psychology, Faculty of Psychology and Education, VU University
Amsterdam, the Netherlands*

*Corresponding author:

Remco F.P. de Winter, psychiatrist Bureau 24-uurszorg/KCAP ParnassiaBavo groep
Avocadostraat 14, 2552 HS the Hague, The Netherlands. Dutch representative for the
International Association of Suicide Prevention (IASP)

Tel: +31-88 3576345

Fax: +31-88 3584245

E-mail: r.dewinter@parnassia.nl

Abstract:

During the last 30 years, the Dutch suicide rate has changed. Between 1981 and 1988 the number increased after which the suicide rate decreased until 2007. Since 2007 there is a moderate increase, probably due to the economic recession. The mean Dutch number of suicides is around 1500 suicides a year, with 1600 in 2010. In this paper we discuss some recent developments, research and projects in the field of suicide prevention. We also review scientific developments.

1. Introduction

Over the last 30 years the average Dutch suicide rate was 10.0 (range 8.3 - 12.4) /100,000 inhabitants. Men more often commit suicide than women, which corresponds with other countries in the European Union (In 2010 13.7 men per 100,000 and 5.7 women per 100,000). The Dutch population has grown from 14.2 million in 1980 to, just over 16.6 million inhabitants in 2010.

<Figure 1 around here>

Figure 1 shows the suicide rate per 100.000 inhabitants during the last 30 years (CBS, 2012).

Concerning the suicide ranks over these last decades, The Netherlands has a relatively favorable position in Europe for the suicide rate is below the European average (Chishti et al 2004).

From all non-natural causes of death, suicide takes 2nd place by 28% of the total (See **table 1**). In comparison with the number of traffic fatalities, which steadily decreased from 2116 victims in 1980 to 640 victims in 2010 (CBS 2012), the number of suicides has not

spectacularly reduced during the last 30 years and about 1500 people commit suicide each year.

The small decline over the last 30 years is almost accounted for by the decrease in suicides in the elderly and in women. (van Hemert & the Kruijf 2009).

The number of suicide attempts in The Netherlands, according to self-reports in surveys, are calculated at about 94,000 attempts (ten Have et al 2006). Each year approximately 14,000 patients are treated in the emergency departments (ER) of general hospitals after a suicide attempt (Hoeymans & Schoemaker 2010).

It is estimated that approximately 44% of the persons who commit suicide are being treated by Mental Health professionals (Huisman et al 2010).

<Table 1 and somewhere here? >

<Table 2 and somewhere here? >

The most common method of suicide, for both gender, is hanging (see **Table 2**), woman overdose with medication more often.

The Dutch economy was at its peak in 2007, in this period a number of suicide prevention projects started. Unfortunately the economic crisis turned the steady decrease in suicide figures from 1345 in 2007 into a sharp increase in 2008, 2009 and 2010 with 1600 suicides. During the last decade there was growing attention in the Netherlands for the prevention of suicide and it sat on the agenda as a major priority by the Dutch Ministry of Health (Boel et al 2007). By comparison there was a tremendous decline of traffic fatalities during the last 30

years and over. This improvement in traffic safety was made by great effort of all agencies and legislators in this particular field. It was argued that a similar effort in suicide prevention would show a similar reduction in suicide fatalities.

When the low suicide rate of 2007 appeared many explanations were put forward such as improved financial and living conditions, improved psychiatric care and therefore better identification and treatment of depression, and improved detection and better treatment of suicidal behavior.

Since the year 2008, the year of the onset of the credit crisis, the number of suicides raised sharply. It is known that an economic recession may give an increase in the rate of suicides (Uutela, 2010; Stuckler et al 2011). During the previous recession between 1981 and 1988 there was an increase in the number of suicides as well, with a peak in 1984 with 12.4 suicides per 100,000 inhabitants.

The expectation for the near future is not positive. The Dutch economy is far from recovered and since the beginning of 2012, as part of cut backs, the government has introduced (in addition paying for health insurance), an additional individual financial contribution of 200 Euros for each psychiatric patient on top of a general healthcare contribution of 220 Euros a year. Obviously this will have an impact on the accessibility of treatment in mental health, and beyond the general effects of a worsening economic climate this may have a cumulative effect on a further increase of the number of suicides.

3. Some projects/initiatives

3.1 Development of the multidisciplinary guideline on assessment and treatment of suicidal patients.

In 2009 the development of a Dutch multidisciplinary guideline started (van Hemert et al 2012). Following the previously developed international guidelines. The final version of the

guideline has been launched in May of this year. The guideline emphasizes suicide prevention components such as:

- 1) a stress-diathesis model of suicidal behavior,
- 2) a general model of engaging with suicidal patients,
- 3) assessment of etiology, prognosis and suicide risk
- 4) basics of treatment of suicidal behavior.

The Chronological Assessment of Suicide Events (CASE Approach), an easily learned interview strategy, has a prominent role in the guideline. (Shea 1998).

The guideline emphasizes continuity of care, contact and involvement of relatives, suicidal ideation as a treatment focus, and offers empirical evidence for treatment decisions.

The guideline has become a comprehensive work.

Furthermore, an implementation study of the guideline is enrolled and currently performed in 38 departments of mental health care centers. The application of the guideline is carried out by a train- the- trainer program supported by an e-learning module.

3.2. Suicide prevention via the telephone and the internet: 113Online

113Online is an operational platform for people with suicidal tendencies, their families and survivors who have lost a loved one due to suicide. The platform started in 2009.

The used method offers direct help and advice through the Internet and/or by phone. The platform also offers the possibility for an internet self-help course. The services are free of charge and anonymously accessible. This medium is intended to increase health care by being an alternative if regular help is out of scope and lowering the threshold for seeking help when suicidal. The platform is based on previous initiatives organized elsewhere in the world (Rhee et al 2005; Barak 2007). A recent study shows that there is a strong demand for 113Online.

The platform is reached by high risk suicidal individuals (Mokkenstorm et al 2012).

There is also an extensive self-help course started through the platform 113Online. This course is part of a PhD project (Spijker et al 2010). The first results of this research regarding improvement of suicidal behavior, are promising.

3.3. Gatekeeper project

In the province of Friesland in the north of the Netherlands, a sequel to a former Gatekeeper project in the same province started in 2010, analogous to other international prevention programs as published in the review of Isaac and others (2009). A diverse group of people who professionally deal with suicidal individuals (general practitioners, company doctors, counselors, police, pastoral workers, and volunteers of victim support hotlines) received a course for better recognizing suicidal behavior. The project seems to contribute substantially to improving knowledge, skills and attitude towards suicidal behavior.

4. Status of research concerning suicidality in The Netherlands

An overview of scientific research in the Netherlands is made some time ago, through a quick scan (de Groot et al 2012).

This quick scan inventory showed that Dutch suicide research is primary focused on the prevalence and incidence of suicidal behavior and the delivery of mental health care to suicidal patients.

Little research has been done into the effectiveness of treatment of suicidal behavior. Research about implementation of effective strategies for prevention of (recurrent) suicidal behavior was hardly conducted until 2009. Fundamental research into the etiology of suicidal behavior is absent.

The knowledge of Dutch and international research is only slowly implemented in clinical practice. Perhaps the completion of the multidisciplinary guideline for the diagnosis and

treatment of suicidal patients will be an incentive for improvement.

Research on the effectiveness of treatments for suicidal people is extremely costly. For excellent research it will take a long view when suicide, with relative low frequency, is an outcome measure and long follow-up studies are required. The financing structure for short-term research programs makes such long-term efficacy studies not feasible.

Moreover, because effectiveness research often excludes, for ethical reasons, the persons with the highest risk for suicide by severe suicidal behavior, makes this kind of research very complex.

At least more national collaboration is needed for a balanced Dutch contribution for a joint approach concerning the prevention of suicide. In addition further collaboration is needed for research within this field throughout Europe and the rest of the world.

6. Conclusion

The suicide rate in the Netherlands is below the average rate in the European Union. Since the economic recession in 2007 it rises sharply. There has been increasing interest in the recent years by the government, health care organizations, and politicians. There are some hopeful developments, and some of these are under solid scientific investigation.

The burden of disease of suicidality is becoming increasingly clear, and this calls for a higher priority for prevention of suicide. There is a need for better cooperation of suicidologists in the Netherlands and abroad.

References

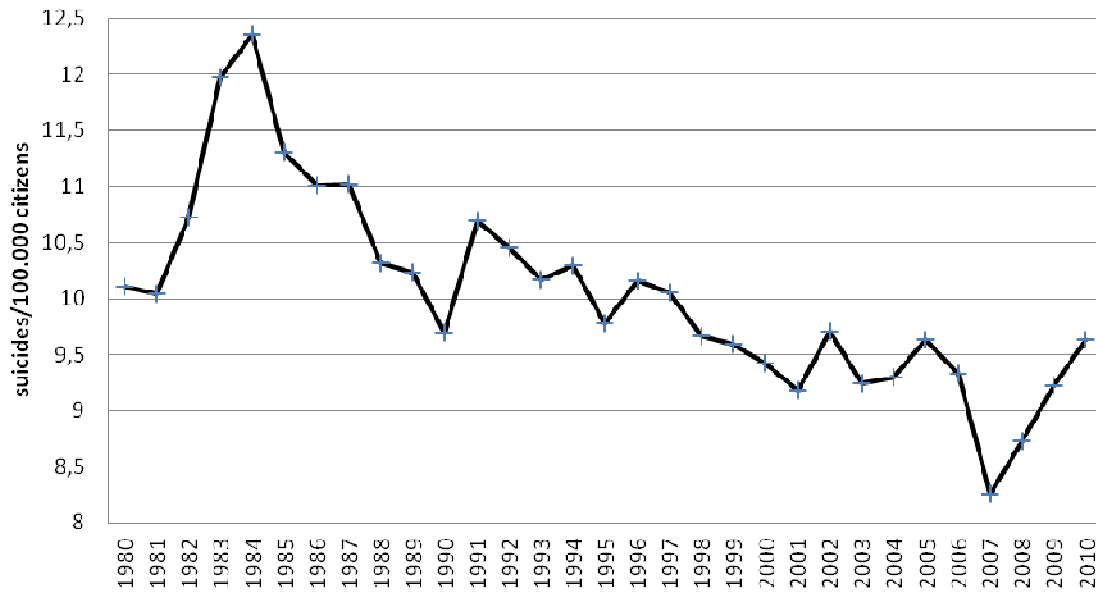
- Barak A, 2007. *Emotional support and suicide prevention through the internet. A field project report.* Comput Hum Behav 23: 971-984.
- Bool M, Blekman J, de Jong S, Ruiter M, Voordouw I, 2007. *Verminderen van suïcidaliteit. Beleidsadvies. Actualisering van het Advies inzake Suïcide, Gezondheidsraad 1986.* Trimbos-instituut, Utrecht.
- Bool M, Majo C, Smit F, 2009. *Daling suïcide in Nederland 2007. Verkenning van achtergronden en verklaringen.* Trimbos-instituut, Utrecht.
- Van Hemert AM, de Kruijf M, 2009. *Decreasing incidence of suicide in the Netherlands, with changing methods.* Ned. Tijdschr Geneeskd 153:1102-1107.
- Centraal Bureau Statistiek (CBS), 2012. <http://statline.cbs.nl/StatWeb/publication/>.
- Chishti P, Stone DH, Corcoran P, Williamson E, Petridou E, 2003. *Suicide mortality in the European Union.* Eur J Public Health. 13(2):108-14.
- Van Hemert AM, Kerkhof AJ, de Keijser J, Verwey B, (van Boven C, Hummelen JW, de Groot MH, Lucassen P, Meerdinkveldboom J, Steendam M. Stringer B, Verlinde AA), 2012. *Multidisciplinaire richtlijn. Diagnostiek en behandeling van suïcidaal gedrag.* Trimbos-instituut, Utrecht.
- Hoeymans N, Schoemaker CG, 2010. *De ziektelast van suïcide en suïcidepogingen.* Bilthoven RIVM.
- Huisman A, van Houwelingen CA, Kerkhof AJ, 2010. *Psychopathology and suicide method in mental health care.* J Affect Disord 121(1-2): 94-99.
- De Groot M, Kerkhof AJ, de Ponti K, 2012. *Onderzoek naar aspecten van suïcide in Nederland 2008-2012. Een quick scan.* GGZ Nederland.
- Isaac M, Elias B, Katz LY, Belik SL, Deane FP, Enns MW, Sareen J, 2009. *Gatekeeper training as a preventative intervention for suicide: a systematic review.* Can J Psychiatry. 54(4):260-268.
- Mokkenstorm JK, Huisman A, Kerkhof AJ, 2012. *Suicidepreventie via internet en telefoon: 113Online.* Tijdschr Psychiatr 54(4):341-348.
- Rhee WK, Merbaum M, Strube MJ, Self SM, 2005. *Efficacy of brief Telephone psychotherapy with callers to a suicide hotline.* Suicide life Threat Behav 35:317-328.
- Shea SC, 1998. *The chronological assessment of suicide events: a practical interviewing strategy for the elicitation of suicidal ideation.* J Clin Psychiatry 59(20):58-72.
- Spijker BAJ, van Straten A, Kerkhof AJ, 2010. *The effectiveness of a web-based self-help intervention to reduce suicidal thoughts: a randomized clinical trial.* Trials 9:11-25.

Stuckler D, Basu S, Suhrcke M, Coutts A, McKee M, 2011. *Effects of the 2008 recession on health: a first look at European data*. Lancet 378(9786):124-125.

Ten Have M, de Graaf R, van Dorsselaer S, Verdurmen J, van 't Land H Volleberg W, 2007. *Suïcidaliteit in de algemene bevolking: gedachten en pogingen. Resultaten van de "Netherlands Mental Health Survey and Incidence Study" (NEMESIS)*. Utrecht: Trimbos-instituut.

Uutela A 2010. *Economic crisis and mental health*. Curr Opin Psychiatry 23(2):127-30.

Figure 1: Suicide rates in the Netherlands during the last 30 years



Source: <http://statline.cbs.nl/StatWeb/>

Table 1: Ranking of non-natural causes of death during 2010 in the Netherlands (CBS 2012)

Non-natural causes of death		number	percentage
Ranking			
Total		5748	100%
1)	Falling	2242	39,0%
2)	Suicide	1600	27.8%
3)	Traffic fatalities	597	10,4%
4)	Accidents in private situation	238	4,1
5)	Suffocation	166	2,9
6)	Murder	144	2,5
7)	Drowning	70	1,2
8)	Industrial accident	57	1,0
9)	Burning	30	0,5
10)	By an object	21	0,4
Unknown		583	10,1

Table 2: methods of suicide during 2010 in the Netherlands and differentiated for gender (CBS 2012)

Methods of suicide	Number all	%	Number males	%	Number females	%
Total	1600	100%	1124	100%	476	100%
Hanging	744	46.5%	569	50.6%	175	37.0%
Medication/alcohol	258	16.1%	134	11.9%	124	26.0%
Jumping in front of a train/subway	182	11.4%	129	11.5%	53	11.1%
Jumping from height	139	8.7%	85	7.6%	54	11.3%
Drowning	103	6.4%	63	5.6%	40	8.4%
Rest	168	10.5%	141	12.5%	27	5.7%
Unknown	6	0.4%	3	0.3%	3	0.6%