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Child and teenage suicide in Europe: A serious public-health issue

Report[1]
Social, Health and Family Affairs Committee
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Summary

Teenage suicide has become a serious public health issue. The importance of the problem is often underestimated, yet there are tens of thousands of suicides every year, that is to say, more deaths than are caused by road accidents. The underlying causes of suicide are often both psychological and social. In addition to ending young lives prematurely, suicide leaves an enormous amount of damage in its wake. Its effects ripple out to impact on those close to the death of a young person.

For many adolescents, suicide is linked to failure or fear of failure. Moreover, alcohol and drug misuse have both been found to be associated with youth suicide and intoxication often provides the context for suicide in young people.

The report reaffirms the importance of fighting against all forms of discrimination (ethnic, religious and sexual) which could have an influence on young people and calls for a better educational role of the media in their coverage of youth suicides.

The report also insists on the risk detection and prevention of repeated attempts in all of its medical, psychological and social components and urges the member states of the Council of Europe to provide youth-appropriate psychosocial measures in order to address this problem.

1. Reference to committee: Doc. 10773 and Reference No. 3164 of 23 January 2006.

Contents **Page**

A. Draft resolution 3
B. Explanatory memorandum, by Mr Bernard Marquet 5
1. Introduction 5
2. Factors involved in suicide 6
3. Factors involved in attempted suicide 7
4. Risk-detection and prevention of repeat attempts 9
5. Conclusions and recommendations 11

A. Draft resolution

1. Teenage suicide has become a serious public health issue. The importance of the problem is underestimated as there are tens of thousands of suicides every year, i.e. more deaths than are caused by road accidents. The underlying causes of suicide are often both psychological and social. Very often it is a call for help and a sign of deep suffering.

2. Childhood and adolescence are stages in life which need our full attention because it is then that young people are forging their future adult personality, integrating into society and learning to live in the community. It is therefore very important that this integration should take place in the best possible psychological and social conditions. Numerous Council of Europe legal instruments such as the Council of Europe Convention on the Protection of Children against Exploitation and Sexual Abuse (CETS No. 201), the European Convention on the Exercise of Children's Rights (ETS No. 160) and the Council of Europe Convention on Action against Trafficking in Human Beings (CETS No. 197) guarantee this integration.

3. The Parliamentary Assembly refers to its previous work on the subject, in particular Recommendation 1532 (2001) on a dynamic social policy for children and adolescents in towns and cities and Recommendation 1632 (2003) on teenagers in distress: a social and health-based approach to youth malaise.

4. The Assembly also wishes to remind member states that ratification of the European Social Charter implies that member states are encouraged to intr²oduce policies for preventing illness, in particular mental illness, and to ensure that people who are mentally ill enjoy a supportive environment. Even if several member states have undertaken preventive measures as regards adolescent suicide, these measures should be generally adopted.

5. It strongly condemns all psychological, physical and economic forms of violence against children and teenagers. It knows that the damage caused and the consequences of such violence for the equilibrium of children and teenagers may be irreversible and push them into committing suicide.

6. It is also concerned at the increase in risk behaviour, suicide and attempted suicide. It believes that suicide prevention plans aimed at teenagers must be more widely implemented and invite the Social, Health and Family Affairs Committee to look into this matter.

7. There should be specific measures and activities to shape children's and teenagers' attitudes to suicide and to death in general. Cross-sectoral programmes, with social, medical and educational components, must be adopted to prevent suicide and establish a dialogue with troubled teenagers.

8. The Assembly believes that certain innovatory methods such as "psychological autopsies" could be used more extensively to improve both understanding of the problem and risk evaluation.

9. It reaffirms the importance it attaches to respecting political, economic, social, cultural, sexual and physical differences. It therefore strongly condemns all forms of religious, ethnic and sexual discrimination and reasserts its commitment to combating racism, homophobia and the stigma attached to all sexual behaviours, including transsexualism.

10. The Assembly is concerned at evidence that suicidality among young lesbian, gay, bisexual and transgender (LGBT) people is significantly higher than in the general young population. It notes that this heightened risk is not a function of their sexual orientation or gender identity, but of the stigmatisation, marginalisation and discrimination which they experience because of their sexual orientation or gender identity. As such, this heightened risk has a significant human rights dimension.

11. The Assembly has over the past few years also noted the dangers of the misuse of the Internet and the need for rules governing its use. Suicide is very often glorified, particularly through websites and in certain blogs, and this may result in major tragedies. Moreover, the way in which the problem is presented by the media needs close attention particularly where adolescents, who are easily influenced by the Internet and television, are concerned.

12. As a corollary, the Assembly is concerned by the risk of harm from online information which promotes suicide. While such content may not be illegal nor conclusively proven by research evidence to induce suicide there is a risk to the physical, emotional and psychological wellbeing of young people in particular with regard to the portrayal and glorification of self-harm. The Assembly notes that the protection of children and young people from such risks forms part of the general obligations of member states pursuant to the European Convention on Human Rights.

13. In this connection, the Assembly considers that, as a means of counterbalancing promotional Internet information on suicide, the provision of information, by member states and other stakeholders, about suicide on the Internet forms part of the public service value of the Internet.

14. The expert knowledge of associations and NGOs working on the subject must also be reflected in government decisions. The Assembly firmly believes that the concerned non-governmental organisations and their institutional partners would make work in this field more effective.

15. Finally, the prevention of repeat attempts must be made a priority, 15% of teenagers who attempt to commit suicide make repeat attempts and 75% are not taken to hospital. The risk of repeat attempts must therefore be addressed as of the first attempt by specialised medical treatments and immediate youth-appropriate social follow-up should be given in order to prevent any further attempts at suicide.

16. Consequently, with a view to identifying people at risk of suicide and to prevention, the Assembly invites member states to:

16.1. address this question and make it a political priority;

16.2. support existing scientific research on this subject and to promote new research among themselves;

16.3. provide health education in primary and secondary schools but also take action to prevent violence and bullying in schools;

16.4. set up training for care staff to help them identify persons at risk and make suicidology an academic subject in its own right;

16.5. strengthen policies to combat drug and alcohol abuse among minors;

16.6. promote family support policies to help families ensure that teenagers successfully integrate into society;

16.7. put in place and/or establish walk-in centres or helplines, so as to be in a better position to hear the cries for help coming from teenagers and prevent crises from occurring;

16.8. improve teenagers' medical knowledge of suicide and suicidal symptoms;

16.9. take steps to ensure that teenagers do not trivialise suicide;

16.10. as far as possible, and particularly in public places, to restrict all means of suicide;

16.11. co-operation with the media to make people more aware of the problem of suicide;

16.12. provide targeted information, advice and assistance on suicide as part of the implementation of the Committee of Ministers Recommendation Rec(2007)16 on measures to promote the public service value of the Internet;

16.13. reinforce measures to combat homophobia through educational activities and discussion groups encouraging self-acceptance and the acceptance of others;

16.14. combat the inhumane practice of forced marriages and to intensify awareness concerning this matter;

16.15. strengthen networks involving associations, NGOs and public services.

17. With a view to preventing repeat attempts, the Assembly also invites member states to:

17.1. provide systematic psycho-social support measures;

17.2. provide psychological assistance not only to the young people concerned but also to parents and close friends;

17.3. introduce a multidisciplinary approach encompassing health, education, employment, the police, the justice system, the religious authorities, politics and the media.

B. Explanatory memorandum, by Mr Bernard Marquet[2]

1. Introduction

1. Suicide is the act of intentionally putting an end to one's own life. Since the work of Emile Durkheim in 1897, suicide is no longer exclusively associated with mental disorders or mental illness, but may also result from social problems. It has become a major public health problem second only to serious diseases, especially since the 1970s. In addition to ending young lives prematurely, suicide leaves an enormous amount of damage in its wake. Its effects ripple out to impact on those close to the death of a young person.

2. Suicide profoundly affects western societies. It kills more people than traffic accidents. Of the Council of Europe member states, the Russian Federation, Hungary and Slovenia are among the countries with the highest suicide rates. It affects all population categories, including children and teenagers and comes second only to serious illness as a public health problem.

3. In the 11 to 24 age-group, two thirds of young suicides are male and one third female. The proportions are the reverse for suicide attempts. While attempted suicides are primarily a cry for help or an expression of deep suffering, suicide itself is a much more violent act which is sometimes planned and rehearsed over a period of time.

4. Adolescence, a transitional period of life which varies according to national traditions, may be roughly situated between the ages of 11 and 24. In particular, it represents a time of searching in order to construct one's own personality, very often resulting in a need to control everything, even one's own death. Adolescents often exchange confidences that sublimate death and anguish.

5. Suicide often involves a complex interplay of factors mental disorder, poverty, drug or alcohol abuse, isolation, bereavement, relationship difficulties and work problems. As an indicator of social malaise, suicide is being mainly bound up with unemployment, economic insecurity and the loosening of family ties. For many adolescents, suicide is linked to failure or fear of failure. Moreover, alcohol and drug misuse have both been found to be associated with young suicide and intoxication often provides the context for suicide in young people.

6. The suicide rate in Europe is often low in countries where religion is important, for example, Italy and Poland, as well as the Muslim countries and some Asian countries. Religious belief can also prevent suicide, because adherents to all religions hold that only God can decide the time of death. Lastly, religions provide a social framework for sharing values relating to truth and peace, and this gives teenagers a feeling of belonging to a group at a time when they are in quest of adult or peer recognition. However, this approach can also lead to problems, particularly within sects or millenarian religious movements where indoctrination can result in collective suicides or a desire to kill oneself in order to gain access to a better world. One example was in Albania in February 2005, when several children between the ages of 9 and 16 committed suicide after contacts with Jehovah's Witnesses.

7. Material on the Internet needs to be addressed in a discriminating manner. Young people value the Internet as a space where they are not subject to adult supervision and scrutiny. It has been argued that young men particularly may find it easier to express troubling feelings and thoughts in the anonymous and unsupervised space of the Internet and some successful initiatives, such as the CALM initiative in the United Kingdom which aimed to intervene to support young men with depression, have used the Internet to encourage young men to express feelings of distress and to access counselling. However, the unsupervised nature of chatrooms and blogs mean that they also offer opportunities for suicide to be glamorised and for information on lethal means of death to be freely circulated.

8. The appearance of "suicide clusters" has also been observed. This is the term used to describe a number of suicides occurring close together in time and place. These have been identified in institutions such as universities, schools and prisons. A suicide occurring at proximity appears to have the effect of lifting the inhibitions associated with the act of taking one's own life.

9. Finally, there is another phenomenon that specialists call the "Mat Syndrome", a process consisting of five phases of varying duration which enables adolescents to transform their distress into a complex path towards suicide. The initial phase is predominantly imaginary, that of escape into one's own head. Then comes the phase of struggle, during which the teenager is alone with his or her anguish, and the third phase

2. The rapporteur wishes to thank Professor Nicky Stanley, Professor of Social Work, University of Central Lancashire, for her valuable comments on the memorandum

which is the one akin to depression. This is the period when the young person calls for help. There follows the phase of revolt, also the phase when the teenager will look for persons who have the same thoughts. The last phase of all is the one called "the eye of the hurricane", the most dangerous. During this period, the young person may flaunt a deceptive calm, but in reality he or she will be preparing the scenario of his or her death.[3]

10. In this context, prevention must therefore become the major concern for countering this ever-increasing problem. Yet, suggesting that a young person approaches suicide through distinct and identifiable sequential stages might be misleading since these stages will not be readily identifiable to those seeking to identify young people at risk of suicide.

2. Factors involved in suicide

11. The first point to remember is that suicidal thoughts are by no means abnormal in a teenager. Where suicidal thoughts become worrying is when the person's only way of solving his/her problems and difficulties is to implement these thoughts. Suicide can indeed be interpreted as "a cry of pain" in response to the feeling that a person is trapped in an impossible situation from which there is not other form of escape.[4]

12. Young suicide has been shown to be associated with a wide range of factors. While mental disorders are associated with a high proportion of all suicides, they are less likely to characterise young suicides as young people are less likely to have a diagnosis of mental illness. In addition to factors related to the individual's mental health, personality traits such as impulsivity and perfectionism, family history and life events such as the break-up of a relationship, bullying or bereavement can be significant for young people.

13. The family environment also poses risks such as loss of a close relative, family violence, sexual abuse (incest, interfering and rape) and exposure to suicide by a family member. Loneliness, unemployment, imprisonment in the case of older teenagers, and very low social status can also be factors in suicide. All these factors can result in diminished self-esteem, shutting the young people into a feeling of malaise and solitude. The Conduites à Risque resource centre in the Bas-Rhin department, France, summarises the situation as follows: "In the more extreme cases, the feeling of loneliness becomes a feeling of drifting away or even becoming detached from a society which fails to provide solid references or existential meaning. The loneliness theme is also germane to much more serious problems such as scarification and suicide."[5]

14. According to a Canadian study,[6] children of divorced parents suffer more frequently from depression than others and may display depressive or anxious behaviour. Yet, the rapporteur believes that as divorce is now a widespread and well-established feature of European society, it may be unhelpful to suggest a direct association with young suicide. It may be more relevant to note that changing family and social structures have deprived young people of some of the traditional forms of emotional and practical support which eased their path through the transition to adult status and independent living. Some of those resources formerly provided by government for young adults such as public housing, apprenticeships or income support are no longer provided by the state.

15. Among young females, suicide often results from rape, sexual abuse or the end of a relationship. In the event of rape, girls develop feelings of guilt and disgust with their own bodies which can drive them to suicide.

16. The distress that manifests itself in delinquent behaviour can also temporarily produce violence towards the self. The question is whether the violence will take the form of delinquency or suicide delinquency or suicide. In fact we might ask ourselves whether the mass killings perpetrated by students in their secondary schools are not another form of suicide, because after all the violence against their peers they turn the gun against themselves. Nevertheless, the rapporteur wishes to underline in this respect that the relationship between suicide and homicide is complex and varies between different countries.

17. Risk taking is generally held to be a normal feature of adolescent development and one of the means by which young people extend their experience and test out boundaries. Yet, for some years now, we have seen an increase in risk behaviour (placing oneself in danger with physical, bodily and health risks – injuries, illness, deaths – but also psychological risks) largely arising from pacts between adolescents. Such suicides

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3. See Meunier, A. and Tixier, G., *La tentation du suicide chez les adolescents*, Payot, Paris 2005.
4. Williams, J.M.G., *Cry of pain: understanding suicide and self-harm,* Harmondsworth, Penguin, 1997.
5. The Pass'âge project, 2006 assessment report, Conduites à Risque resource centre, Bas-Rhin Departmental Council, France.
6. Divorce and the mental health of children", Research Data Centre programme published in *Journal of Marriage and the Family,* 2005. www.statcan.ca/Daily/English/051213/d051213c.htm.

also take place in the context of games in which the teenagers try to come as close as possible to death, either by confusing reality and fiction or in order to experience a sensation halfway between ecstasy and death. Such suicides are the result of roleplaying and other such games.

18. Collective suicide or incitements to suicide are therefore likely to develop via the new communication channels such as the blogs on the Internet. The latter brings lonely youngsters into contact with other "companions in adversity". Instead of talking to their parents, doctors or social workers, they build up a sort of community and thus shut themselves into a world in which suicide becomes an obvious, or even a romantic solution. "In their minds suicide became as commonplace as changing their shirts," says the mother of one Belgian child who tried to commit suicide following intensive exchanges with other teenagers on the Internet blogs.[7]

19. The rapporteur is indeed concerned by the risk of harm from online information which promotes suicide. While such content may not be illegal nor conclusively proven by research evidence[8] to induce suicide there is a risk to the physical, emotional and psychological well-being of young people in particular with regard to the portrayal and glorification of self-harm. The rapporteur believes that the protection of children and young people from such risks forms part of the general obligations of member states pursuant to the European Convention on Human Rights.

20. The most iconic case of such "teenage networked suicides" happened in Bridgend in Wales. In 2007 seven teenagers hanged themselves after allegedly corresponding by Internet on the Bebo social media network. (Despite media speculation, there has been no evidence produced to suggest that the young people who died in Bridgend discussed suicide on the Internet. Yet the media has been heavily criticised in the United Kingdom for its coverage of these deaths.) Many youngsters took this tragedy as a model, because several attempts at teenage collective suicides followed in Europe, the most recent case being in Gent in Belgium. These blogs often create the impression that suicide is easy and commonplace and make adolescents, often in the depressive phase, want to follow this example, especially if it carries a challenge.

21. Teenagers growing up in our media-oriented society are often confronted with media hype surrounding suicide, where it is presented as an heroic, "glamorous" act. Mentioning the site and method of the suicide and the person's identity creates a kind of model for these vulnerable youngsters, who are then tempted to copy them. In 2006 the Austrian Association for the Prevention of Suicide, backed by the International Association for Suicide Prevention (AISP), launched a major media awareness campaign urging the media to exercise caution in their coverage of suicide. Furthermore, at an age when young people are building up their personal identities and need role models, suicides by rock singers (for example, Nirvana and INXS) can give rise to copycat attempts.

22. Special attention must be paid to young people with unconventional sexual orientations. In such cases there is a higher risk of psychological crisis linked to discovering their own homosexuality, rejection by family or friends, harassment or homophobic assault. Social rejection, especially homophobia, more so than homosexuality and its acceptance, is apparently the main factor in suicide among teenagers, particularly among young males. Several studies[9] have found that young people in this category are more vulnerable to suicidal depression. These young people can find themselves trapped between their new sexual identity and their former identity which is the one known to family and friends. The authors of these studies consider that profound acceptance of one's own homosexuality is the only way to protect against suicide.

3. Factors involved in attempted suicide

23. Unlike suicide, attempted suicide is often regarded as a call for help or a result of acute social isolation or neglect by adults. Frequently, suicide attempts develop from apparently trivial situations, such as a poor mark at school, a family reprimand or sentimental setbacks. Lastly, the manner of the suicide attempt sends out a strong message to the young person's family and the medical profession. Some of the less violent methods are more cries for help than any genuine wish on the person's part to kill him/herself.

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7. *Le Soir,* 28 January 2008.
8. Mishara, B.L. and Weisstub D.N., "Ethical, legal, and practical issues in the control and regulation of suicide promotion and assistance over the Internet", *Suicide and Life-Threatening Behavior,* 37 (1), 2007, pp. 58-65.
9. See *Le risque de suicide chez les jeunes à orientation sexuelle non conventionnelle (gays, lesbiennes, bisexuels, transgenre)* (The risk of suicide in young people with unconventional sexual orientations (gays, lesbians, bisexuals and transgender)), UNOG OHCHR – 59th Session of the Human Rights Commission (Geneva, April 2003).

24. At present there are no statistics on attempted suicide but as a rule attempted suicide is found more frequently among young females. This is put down to the fact that young males use more violent means than young females.

25. The consensus conference on teenage suicidal crises organised by the French Psychiatric Federation in Paris in 2000 identified three categories of factors: 1. primary factors with strong predictive values (attempted suicide precedents multiply the risk of a further attempt by 20; depression multiplies the risk by 5; and previous psychiatric treatment multiplies it by 30); 2. secondary factors, which may aggravate the risk if there are primary factors (violence between the parents or between the parents and children, sexual violence, depression, alcoholism, death or brutal separation, disciplinary problems at school); and, lastly, 3. tertiary factors, which are more sociological in nature (including age and sex).[10]

26. In cry-for-help suicide attempts young females generally use medicinal drugs that can kill, hoping to find refuge in sleep and wake up different. In most cases the taking of medicinal drugs by young people is not fatal.

27. Medication and chemical treatment for suicide attempts also raise a number of problems. Taking medicines, particularly antidepressants, creates certain risks for suicidal patients. Apart from the addiction phenomenon, the disinhibiting effect can cause fresh suicidal risks.

28. 28 Where one suicide attempt has been made there is a high risk of a repeat attempt. This may not necessarily occur immediately or within a year but later on in life. It is estimated that 15% of adolescents who have attempted suicide will make a repeat attempt. To help adolescents as much as possible, it is essential that their families and teachers give them the support they need and try to rebuild their self-esteem by emphasising and capitalising on their skills and abilities. As one doctor puts it, “it is important to visit the young patient while they are still in intensive care. You must be there when they regain consciousness, talk with them and immediately set an appointment. The fact of creating a bond, a commitment at that particular moment is essential. In many cases if you wait three days it is too late: the youngsters will swear that they don’t need treatment and that they will not do it again.”[11]

29. Desperation or the perceived impossibility of solving one’s problems provides a possible explanatory link between depression and attempted suicide. Desperation may show up as aimlessness, feelings of incompetence or low self-esteem. Desperation accounts much more often for suicide attempts than does clinical depression, and can be one of the best predictors of a suicide attempt.

30. Student suicide is also a matter for concern. For these adolescents or young adults the student world is often a strange new world where their parents’ authority and benevolence are inoperative, a society in which they are faced with the challenges involved in the transition to independent living and adult status.

31. A British study[12] has shown that the rate and causes of suicide among students are very often similar to those for young adults in general. Nevertheless, some factors (mental health problems, alcohol consumption, drug-taking, active participation in risk behaviours, deliberate selfmutilation particularly among young females, broken relationships, etc.) are intensified in the student environment, an area of renewed freedom in which the students structure their social relations. Moreover, some factors associated with young suicide are specific to the student world, for example, a lack of financial resources and the fear of academic failure.

32. Lastly, student suicide often creates a climate of anxiety and fear if the act is committed on campus or in a hall of residence. Waiting for the police and the undertakers, watching the police investigations, arranging for the identification of the suicide victim by his/her fellow students, accompanying the parents to the morgue and announcing the news to the other students are all events which affect the mental balance of these young adults and can lead to copycat attempts among the more fragile students.

33. Close attention should also be paid to a new phenomenon: blogs (contraction of “web logs”) on the Internet, being a collection of personal pages enabling teenagers to express themselves with texts, photos or snatches of music, and to carry on a dialogue with websurfers. It is not so much a diary, but a public area subject to the laws that govern freedom of expression.

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10. www.has-sante.fr/portail/display.jsp?id=c_271964.
11. French Medical Association bulletin, February 2005.
12. Stanley, N., Mallon, S., Bell, J., Hilton, S. and Manthorpe, J., *Response and prevention in student suicide,* Department of Social Work, University of Central Lancashire, February 2007.

34. In this context, self-harm may also be regarded as suicide attempts in the broad sense. They have indeed become emblematic of adolescence. This practice more often affects girls, whereas boys express their aggression through violent acts directed outwards.

4. Risk-detection and prevention of repeat attempts

35. Suicide prevention was born in the United Kingdom in November 1952. Reverend Chad Varah laid the foundations by placing an advertisement in the London papers begging anyone about to commit suicide to phone Man 2000. It was his own number. He sent out this appeal after the suicide of a young acquaintance and was convinced that if he had been able to speak to his friend just before the deed was done, the young man would have stopped short of going through with it.

36. Mostly, risk-detection involves trying to identify a particular vulnerability in an adolescent or child. Parents, teachers, classmates and everyone else in contact with them need to be alert to tell-tale signs: in the case of a child these might include increased unhappiness, a slump in school performance or signs of agitation. It is important in this context that all signs are taken into account, and one of the most visible signs is cutting on the body, an act by which the adolescent will initially try to sublimate his distress.

37. The World Health Organization (WHO) believes that in order to prevent suicide in Europe, it is first of all necessary to identify the mental illnesses which prompt people to take their despair out on themselves. Some illnesses, such as depression, begin early and according to the medical fraternity, depression among a 14-year-old girl takes a very different form from depression in a 45year-old woman.

38. According to a study carried out in hospitals, a distinction needs to be made between primary, secondary and tertiary prevention. Primary prevention relates to individuals who are not at risk of committing suicide but who do have certain risk factors: the breaking-up of a relationship, family bereavement and emotional losses. Such situations which do not warrant immediate protection measures such as hospitalisation highlight the importance of early psychosocial action. This type of prevention is especially important in the school environment as it is much easier here to identify young people who pose a suicide risk.

39. The aim of secondary prevention is to stop the suicide process before the individual goes through with it. It is very important for those close to the individual to be able to recognise references to suicide. Most of those who commit suicide had spoken about their plans to someone close to them beforehand, whereas others had kept their plans secret.

40. Tertiary prevention seeks to avoid a repeated suicide attempt by trying to identify the factors which could lead to a repeated attempt.

41. A Quebec association active in the field of suicide prevention suggests, as prevention measures, restricting access to the means of impulse suicide (firearms, knives, toxic household products), building anti-suicide barriers, providing specialist supervisors in schools and detention centres who can recognise the signs of depression, and making psychological assistance available both to teenagers and their families for averting repeat attempts.

42. Another example is the Samaritans in the United Kingdom who provide a listening service and face-to-face contact for anyone in psychological distress. The fact is that in the United Kingdom the annual rate for suicides is the lowest in Europe.

43. Suicide prevention consequently involves activities ranging from education to treatment of psychological disorder and environmental control of risk factors. Doctors' response to the problem can no longer be purely pharmaceutical.

44. Medical prevention has developed over the past few years. The medical profession was long helpless in the face of this problem. Today prevention is an integral part of regional and municipal programmes that can fall back on structures that include doctors, nurses and child psychiatrists. Medical provision should, however, be intensified. In February 2005 the French Medical Association revealed that 75% of teenagers attempting suicide were not hospitalised.[13]

13. Medical Association bulletin, February 2005.

45. Consequently, it is important to provide appropriate facilities, from the resuscitation stage and initial treatment onwards. The significance of the suicide attempt must not be played down, and both the adolescent and his or her family must be helped to get over the attempt, put it behind them and face up to the future. Sometimes the suicide attempt marks the end of an adolescent crisis and this gesture, as a means of expressing the entire distress felt, can sometimes be the start of a period of recovery.

46. Moreover, health professionals should also be provided with training and educational programmes in the suicide phenomenon, especially teenage suicide. Health professionals' attitudes towards young people who express suicidal thoughts, self-harm or attempt suicide can be key to engaging young people with counselling or support services. There is a considerable amount of evidence from young people themselves that health professionals' attitudes can be judgemental, dismissive or unsympathetic (Mental Health Foundation, 2006). Challenging and changing such attitudes is a key task for training programmes. Several countries (for example, the Netherlands, Denmark and Norway) have launched extensive programmes to deal with the issue. In Norway, for instance, training is a priority. Educational programmes in suicidology reach right across the board, incorporating new fields of competence (medical, social, regional specificities, etc.).

47. Psychological prevention programmes are also needed for early detection of the psychological dysfunctions which induce adolescents to act out their suicidal thoughts. Finland and Canada, for instance, have included in their prevention programmes a method called a "psychological autopsy" which highlights the factors leading to suicide. Like a conventional autopsy, the psychological autopsy method goes back over the suicidal patient's previous psychological, social and medical history in order to try to understand his or her act and thus facilitate earlier detection in problem teenagers.

48. Of course there is no substitute for social prevention as practised in the teenager's family and circle of friends. The fact of being loved, recognised, valued and feeling that he/she is understood and integrated in a given group is of major benefit to a child in ensuring his or her balance. Adults play a crucial role in helping teenagers in all departments of their lives. The priority must go to listening and engaging in dialogue. Parents should not see references by the teenager to death or possible suicide as blackmail but as a cry for help. As Patrick Delaroche, a child psychiatrist and psychoanalyst and author of *Adolescents à problèmes* (Problem teenagers), puts it: "in conflicts between teenagers and their parents, many adults only see the oppositional crisis and sometimes overlook the genuine suffering which may be lurking beneath the conflict".

49. Lastly, families must realise the extent of the problem and confide in their GPs, because a persistent feeling of shame often prompts parents to conceal teenage suicide attempts from the family circle and from the family doctor. Doctors and families must therefore be fully associated with the psychological reconstruction of the teenagers in question.

50. The parents' role is particularly important for teenagers with unconventional sexual orientations, because their attitude is vital in helping them to live and come to terms with their orientation. Similarly, schools, colleges and universities also have a role to play in encouraging young people, both individually and in groups, to accept diversity with regard to sexuality as well as in respect of race and disability.

51. Where such social prevention is not available in the family home, the social structures must become involved in order to detect such risks of suicide. At school, social workers must link up with medical professionals to provide an area for dialogue on the problems which eat away at these teenagers and may drive them to suicide. However, as WHO points out, "the balance that must be struck in the contact with a suicidal student is between distance and closeness and between empathy and respect".[14] Such associations as Papyrus in the United Kingdom, which deals with preventing youth suicide, provide teenagers and their parents with assistance and also advise policy makers in order to improve the implementation of the relevant political decisions.

52. Many structures have emerged in various countries to serve as dialogue platforms for adolescents at risk of attempting suicide. These centres dealing with risk behaviours provide potential suicides with a listening ear for their anxieties, which reassures teenagers. In Germany, for instance, the Alliance against Depression, a major suicide prevention strategy, has introduced a twenty-fourhour hotline for suicidal people and their families. In France, the Conduites à Risque resource centres provide young people with spaces for listening and dialogue. As Valérie Béguet, the director of one of these centres in the Bas-Rhin Departmental Council in Strasbourg points out, "the work of the counsellors is not confined to listening: they play an active role during the telephone call. They help callers to put new words to their thoughts, fears and indeed their suffering".[15]

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14. "Preventing suicide", a resource for teachers and other school staff, Department of Mental Health, World Health Organization, 2000.

53. Prevention also involves major awareness-raising policies covering both media treatment of teenage suicides and rejection of the trivialisation of such suicides. Such countries as Bosnia and Herzegovina, Slovenia, Norway and the United Kingdom have fully grasped the media impact of suicide on adolescents and are beginning to act accordingly.

54. Such prevention policies also require educational strategies targeting the teenagers themselves. This is the approach advocated by the Papyrus association, which considers that teenagers should be able to recognise the symptoms of mental illness in both themselves and others in order to react promptly and appropriately. Indeed, research addressing a range of issues has shown that the first people young people turn to for support when in distress are other young people.

55. Lastly, the unfortunate fact has to be faced that death is sometimes the outcome, mostly leaving the parents with huge feelings of loss and guilt. Families and the immediate circle live the nightmare of wondering if they could have done something to prevent it. Close attention therefore needs to be paid to the state of mind of young people who have experienced suicide of a relative or friend. They need help to cope with what is a particularly distressing form of bereavement.

56. In this context, the rapporteur wishes to underline the importance of so-called "postvention strategies" and the role of institutions such as schools, clubs, colleges, universities and prisons in delivering such strategies. "Postvention" is a term which is used it to cover a range of planning and support activities which aim to reduce the impact of suicide on survivors.[16] The risk of suicidal thoughts and behaviour being transmitted to other young people within such communities means that schools, clubs, colleges, universities and prisons have a role to play in ensuring that postvention strategies are adopted following a death.

5. Conclusions and recommendations

57. Loss of a child, whatever the cause of it, completely alters parents' lives. In cases of suicide, however, parents are faced with the unbearable.

58. To quote the findings of a conference on the subject in Nantes in 2000 "suicide is always a failure, the failure of someone who has given up, the failure of family and friends who saw nothing and heard nothing, the failure of a society unable to equip itself to help, support or save them".

59. A teenage suicide is a scandal and a trauma which reflects on the whole of society because it affects all the members of the family in question and reflects relations between the members of the whole of society, but above all it always reflects failure on the part of any democratic society which calls itself progressive and egalitarian.

60. The Assembly recommends, among other things, that governments take all possible measures to recognise suicide and attempted suicide as major health issues. As Dominique Gillot, the former French State Secretary for Health, reminds us, "tomorrow's Europe, which represents a factor for hope for the great majority of young people, demands that we must do our utmost to prevent such despairing acts".[17]

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Reporting committee: Social, Health and Family Affairs Committee.

Reference to committee: Doc. 10773 and Reference No. 3164 of 23 January 2006.

Draft resolution adopted by the committee on 14 March 2008.

Members of the committee: Mrs Christine **McCafferty** (Chairperson), Mr Denis Jacquat (1st Vice-Chairperson), Mrs Minodora **Cliveti** (2nd Vice-Chairperson), Mr Konstantinos Aivaliotis, Mr Farkhad Akhmedov, Mr Vicenç Alay Ferrer, Mrs Sirpa Asko-Seljavaara, Mr Jorodd Asphjell, Mr Lokman **Ayva**, Mr Zigmantas Balčytis, Mr Miguel Barceló Pérez, Mr Andris Berzinš, Mr Jaime **Blanco García**, Mr Roland Blum, Mrs Olena **Bondarenko**, Mrs Monika Brüning, Mrs Bożenna Bukiewicz, Mr Igor Chernyshenko, Mr Imre

15. Béguet, V., Heideyer, D. and Lachance, J., "Raconter les 'conduites à risques'" (recounting risk behaviours), *Revue des sciences sociales,* No. 38, Université Marc Bloch, Strasbourg, 2007.
16. Schneidman, E.S., "Postvention: the care of the bereaved", in Pasnau, R.O. (ed.), *Consultation-liaison psychiatry,* Grune and Stratton, New York, 1975.
17. Speech at the European Conference on Preventing Child and Teenage Suicide held in Nantes on 20 September 2000.

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NB: The names of those members present at the meeting are printed in bold.

See 15th Sitting, 16 April 2000 (adoption of the draft resolution, as amended); and Resolution 1608.