

Article

Suicide index reduction in Slovenia: the impact of primary care provision

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ABSTRACT

Background Education of primary care providers about diagnosis and treatment of depression and anxiety is an evidence-based suicide prevention measure.

Aim To analyse suicide index, mental health epidemiological data and primary care provision in Slovenian regions and to identify examples of good suicide prevention practices in different Slovenian regions.

Methods Analysis of existent epidemiological data on mental health in Slovenia.

Results Anxiety and depression are the most common complaints in a representative sample of the Slovene population. The number of suicides in Slovenia had been dropping in the period from 2002 to 2006 and was again slowly rising in 2008. The number of visits to family physicians' practices

because of mental health problems is low in comparison to other European countries, which might be attributed also to the high workload of family physicians. Suicide prevention programmes follow the example of the Suicide Prevention Project in the central-east region of Slovenia. This programme is based on education of primary care providers and the general public about recognition and treatment of depression in line with international guidelines.

Conclusions The differentiation of causes for suicide reduction needs further research, as well as urgent improvement in the accessibility of primary care teams in Slovenia.

Keywords: family physicians, Slovenia, suicide prevention

Introduction

Mental disorders are diverse in their manifestations and affect about one-third of the EU population during any given 12-month period. The data demonstrates generally low treatment rates of those affected.¹ The presence of a mental disorder is an important risk factor for suicide. It is generally acknowledged that the majority (up to 98%) of those who commit suicide have had a psychiatric diagnosis at the time of death, among those most prevalent mood disorders (30.2%), followed by addiction, schizophrenia and personality disorders.² Access

and utilisation of health services are to be encouraged by education of public and healthcare workers about mental disorders and suicide prevention, and incorporated in the national suicide prevention programme of each country.³

In the Slovene's largest longitudinal social empirical research 'Slovene Public Opinion in 2006' about 7% of randomly selected people reported depressive feelings in the last week and 2% reported permanent depressive mood.⁴ The MINDFUL research (2006) presented even larger numbers of people reporting

depressive and anxiety feelings for two weeks or more in a 12-month period, i.e. 61%. One-tenth of those questioned reported suicidal thoughts, 2.1% had a suicide plan, and 1.3% actually attempted to commit suicide.⁵ In 2007 a telephone survey was performed on a representative sample of the Slovenian population older than 15 years. A 4.8% life prevalence of anxiety, 4.6% of chronic depression and 2.7% of other mental health problems were reported.⁶

Suicide being the most severe consequence of mental ill health might be preventable. While it is not known to what degree contact with mental healthcare and primary care providers can prevent suicide, the majority of individuals who die by suicide do make contact with primary care providers, particularly older adults.⁷ Within the last month before death, 66% consulted a general practitioner, 13% and 7% among those being discharged from psychiatric or general hospitals respectively.⁸ Thus, a key prevention strategy is improved screening of depressed patients by primary care physicians and better treatment of major depression.^{9,10} Access to treatment for people with severe mental disorders varies tremendously among European countries, from 19.7% (Ukraine) to 64.5% (Spain). Access for those with less severe disorders varies from one-third to 10%.¹¹

Slovenian primary care providers evidenced 1.8% of first visits because of mental health disorders and only eight cases of self-inflicted harm in all general practices in 2006.¹² Research in Great Britain (2005) found one-third of the patients in primary care settings with mental disorders, and one-third of the time in primary care spent on mental disorder treatment and protection.¹³ The analysis of the register of drug use in Slovenia indicates, however, that 9% of all prescribed medicines were psychopharmacological ones.¹²

The number of family physicians in Slovenia was 49.6 per 100 000 inhabitants in 2008, the number for the European region in the same year was 85.6 per 100 000 inhabitants.¹⁴

Slovenian suicide prevention programmes were introduced in the region of Celje in 2001 and subsequently in the other Slovenian centres (i.e. Ravne, Ljubljana and Nova Gorica). Workshops for family physicians and medical nurses for improving depression and suicide detection and treatment were provided in health centres. Communication skills for working with suicidal patients were presented to healthcare and other professionals, i.e. from pedagogues in schools, health, social and other workers in homes for the elderly, to staff in employment agencies, police and non-governmental organisations (NGOs). The public health work was performed through mental health promotion, and education about symptoms of depression and about self-help. In Ljubljana and Nova Gorica education was not

provided for family physicians, but for medical nurses in health centres. Broad involvement of school personnel was achieved in both of these regions.

Besides the Institute for Public Health, Slovenian NGOs took a major part in this campaign with strong media support. In spite of a lack of official documents and no parliamentary approval for a national anti-suicide campaign, as well as an absence of funds (besides the EAAD campaign financed by EU), the message reached the majority of professionals and public.³ Little was done, however, regarding improving access to mental health and health services also being considered as a major preventive strategy.⁹

The reasons for the high suicide rate in Slovenia and various initiatives to reduce it are thoroughly described elsewhere.¹⁵⁻¹⁸ In this article we present the change over time of suicide in different Slovenian regions during a ten-year period. Possible reasons for suicide reduction are discussed.

Methods

The available data about the suicide index and suicide prevention programmes in the Slovenian regions were reviewed and analysed.

Results

According to the Slovenian National Mortality database, the suicide index in the year 1998 was 31 per 100 000 inhabitants and in 2008 20 per 100 000 inhabitants, which clearly shows the decline of suicides in Slovenia in this decade (see Figure 1).

Suicide index had fallen in the majority of regions, except in the southernmost – Novo Mesto (see Figure 2).

The suicide index in the Slovenian regions of Celje, Nova Gorica and Ravne is compared to the whole Slovene population suicidal index (see Figure 3).

Preventive programmes to reduce suicide in these regions began in Celje in 2000, followed by Nova Gorica in 2004 and Ravne in 2005.

Discussion

Depression and anxiety are common mental disorders in Slovenia, as well as worldwide.⁵ Suicide

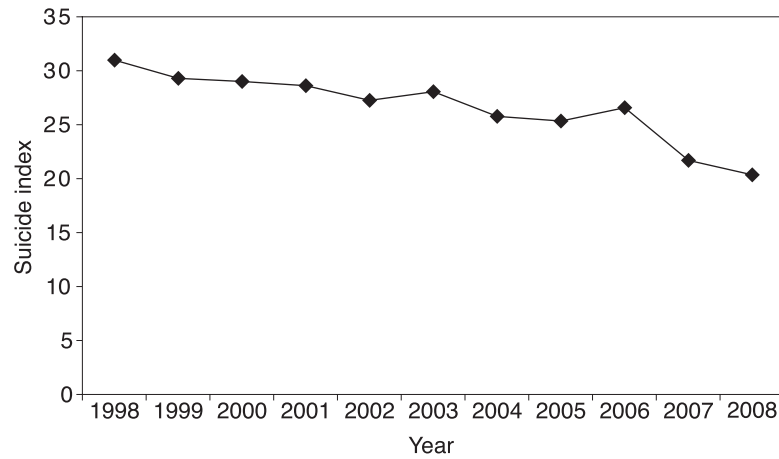


Figure 1 Suicide index in Slovenia 1998–2008

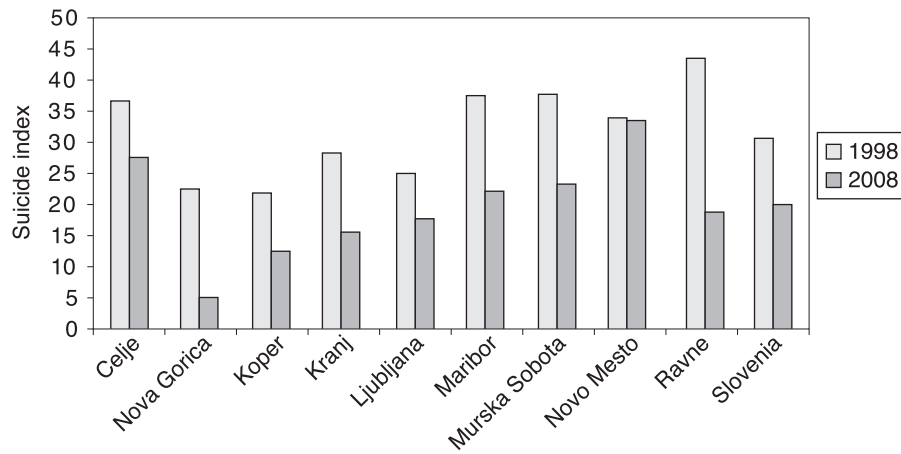


Figure 2 Suicide index in Slovenian regions in 1998 and 2008

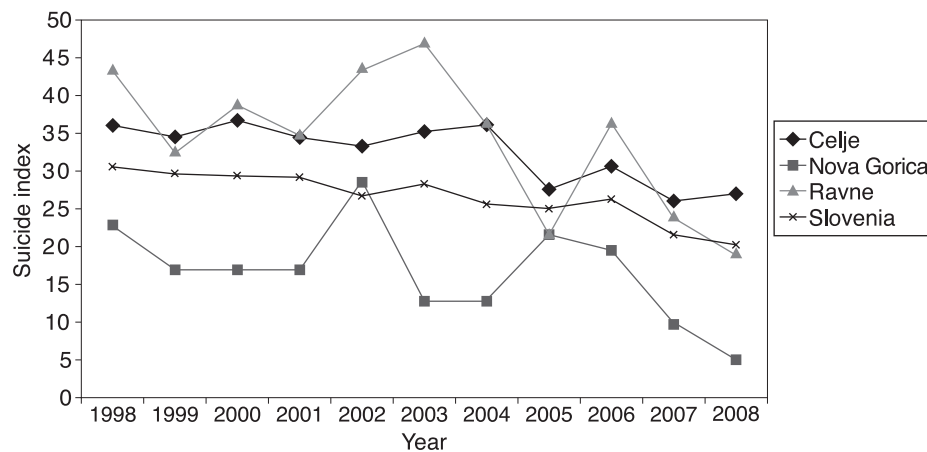


Figure 3 Suicide index in Slovenian regions Celje, Nova Gorica and Ravne 1998–2008

has been the major mental health problem in Slovenia in recent decades. The suicide index was reduced in Slovenia and in the majority of European countries.¹⁹ This reduction could be connected with improved general practitioner diagnostic and treat-

ment skills of depression and other severe mental disorders.²⁰ The treatment of depression and anxiety in primary care in Slovenia has been strongly influenced by educational programmes from various providers during the last few years. These programmes

have influenced the quality of detection and treatment of depression and anxiety in primary care. The evidence that family physicians do recognise patients' mental health problems and provide proper treatment is the quality of prescribing psychopharmacological treatment. This is proved not only by the increase in antidepressant prescription, but also by the decrease in prescribing of anxiolytics achieved in family practices in the last few years.²¹ These improvements might influence the reduction of suicidal risk due to depression and anxiety.

There are, however, vast differences in suicide reduction trends among the Slovenian regions. These differences do not prove major variations in care provision or other protective measures. The number of suicide victims is too low to allow significant statistical conclusions. The results only indicate some goals for further research and that some regions have profited more than others from the suicide prevention measures launched in last ten years. The results indicate that the suicide index could be influenced by education of family physicians, other primary care providers and the general public about depression and suicide. The consequences of the low number of Slovene family physicians should be considered as one of the major obstacles to suicide prevention in this country, as family physicians are the first line in the diagnosis of mental disorders.²² It is important to strengthen the family physicians' practices with human resources and to empower them in fulfilling their tasks of early detection and treatment of mental disorders in Slovenia. Family physicians' time pressures are already described as one of the main barriers to suicide screening, even in much better equipped primary care environments such as those in Great Britain.²³

Conclusions

This is the first description of suicide index reduction in the Slovenian regions, where preventive programmes to reduce suicide were evaluated. Treatment of mental disorders in primary care is a time-consuming task for already overburdened primary care physicians in Slovenia. Low access to primary care could influence the recognition and appropriate treatment of mental disorders. Improved access might be one of the key suicide prevention factors in Slovenia, if accompanied with already well established educational interventions for primary care providers and the general public, which have already proved their impact in regional suicide prevention.

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CONFLICTS OF INTEREST

None.

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