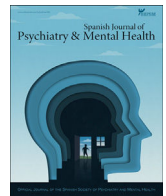




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Viewpoint

The urgent need for suicide prevention tools in Spain

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Suicide is a global health problem. In 2021, over 4000 suicides were recorded in Spain.¹ It causes more years of potential life lost than COVID-19.² We emphasize that these were recorded cases, as we know that the real number of suicides is often higher than those reflected by general reports for many reasons.³ Beyond these shocking numbers, the most tragic thing is that many suicides might be avoided if they were addressed in time. We know how complex human behavior is and, all the more so, when it goes against the most basic instinct to survive. Suicide is a human problem, so it involves biological, psychological, and social factors.

Let us cite two examples of prevention where results have obviously been successful: deaths due to traffic accidents and deaths from cerebral stroke. Both death rates from these two causes have decreased considerably at the national level in recent decades. In the case of traffic accidents, in 2021, the total number of victims in Spain was 1004, i.e. much lower than the 6000 deaths from this cause back in the 1980s.⁴ To achieve the current situation, special emphasis has been placed on different coordinated actions such as public awareness campaigns about traffic safety, penalty points on driving licenses, and amendments to penal code, among other actions promoted by the central government, along with advances in vehicle technology and quick and effective assistance by emergency medical teams. This is easily understood when noting how death numbers continue to decrease despite the increase in the number of deaths per 100 victims, which had dropped from 2.1 to 1.2 from 2009 to 2018.⁵

In parallel to this, cerebral stroke care has also been the focus of a specific coordinated medical plan. According to SUMMA 112, this plan aims to achieve the earliest recognition of associated

symptoms with the objective of transferring each patient to the correct medical setting as soon as possible so that they may benefit from fast and effective intervention in a specialized medical unit to help alleviate short and long-term sequelae and clinical impact. Its implementation in Spain in 1995, following a meeting held by the WHO and the European Stroke Committee, which adopted the 'Helsingborg Declaration on Stroke Management in Europe', has resulted in a dramatic drop in referral and transfer times, and early treatment has started improving the probability of achieving a better neurological prognosis at 48 h. This coordinated medical plan includes not only public awareness campaigns for early detection of this problem, but also a postvention plan for coordinated rehabilitation and specific healthcare programs between specialized medical professionals and primary care professionals.⁶

Like the previous examples, suicide prevention requires public awareness and sensitization campaigns and rapid management of these situations so that the risk is identified and acted upon as soon as possible. There lies one of the keystones of suicide prevention: if it is not visible, it does not exist, and it will thus be ignored or undervalued.

It seems the media and scientific societies are mediating so that the problem of suicide is being revealed as a tangible reality. But once identified, how to manage it is a different matter, involving the healthcare system and its professionals, especially psychiatrists, nurses, psychologists, and other clinical staff who work closely with mental health services. We often find ourselves facing a critical, unstable (and potentially deadly) situation that requires action to prevent major consequences: death, permanent disability, and the suffering of friends and family, estimated to affect as many as 135 people per suicide.⁷

Management involves different key points, from crisis intervention to admission. And, as in the case of cerebral stroke, once the acute risk decreases, there is a need for closer ongoing follow-up of

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these patients to prevent future episodes. For all this a coordinated action plan is needed and, above all, cognizance of all available therapeutic approaches to reduce suicide risk in the most effective and rapid way.

In this context, we know there are drugs that have proven effective in reducing suicidal ideation in the first hours when, as in the case of cerebral stroke, it is crucial to alleviate the essential suffering of individuals contemplating suicide as their only recourse to end their ongoing distress. At the same time, we know that the decision to take one's life is not irreversible at a time when the situation is temporary and solvable, so intervening at this critical stage in time is as important as performing the Heimlich maneuver when someone is choking. In addition to deep intrinsic suffering (called psychological pain, which shares the same pathways as physical pain), other psychological characteristics described in suicidal patients include dichotomous thinking and rigidity.⁸

The pharmacological options that we, as psychiatrists, currently have in Spain do not reflect the full approved treatment arsenal and are reduced to drugs to manage the anxiety associated with suicidal ideation or antidepressants to reduce the all-too-often underlying depressive symptoms, but limited to a weekly basis. Moreover, the treatments that have shown effectiveness in reducing the risk of suicide, such as lithium or clozapine, have been shown to be effective in the long term and in specific diagnoses such as bipolar disorder and schizophrenia. All these treatments, even when useful, are not enough to act directly and immediately on the acute crisis triggered by suicidal ideation.

Therefore, to effectively address suicide, there is a clear need to combine potential clinical and pharmacological advances with public awareness, but is also necessary to have the latest breakthroughs at our disposal to cut through both suicidal ideation and depressive symptoms immediately. In Spain, we have been waiting for months now for the commercialization of intranasal esketamine, a treatment approved by the European Medicines Agency (EMA) since February 2021.⁹ Intranasal esketamine is the only approved psychiatric treatment that has shown a clinically significant immediate reduction in suicidality for the first 4 h after administration.¹⁰ This fast onset of action – supported by both its novel mechanism of action and its route of administration – constitutes a radical change in the acute management of these crisis and is a crucial factor in a reality in which every day counts, as the numbers show.

Conflict of interests

Lucas Giner has been a consultant to or has received honoraria or grants from Janssen, GlaxoSmithKline, Adamed, Angelini,

Pfizer, Exeltis, Esteve, Ethypharm, American Foundation for Suicide Prevention, Instituto de Salud Carlos III and Consorcio para la Excelencia de la Investigación Forense en Andalucía.

Enrique Baca-García has been a consultant to or has received honoraria or grants from Janssen, Lundbeck, Otsuka, Pfizer, Servier, Sanofi, Ethypharm, American Foundation for Suicide Prevention, National Institutes of Health, Instituto de Salud Carlos III, Comunidad Autónoma de Madrid, Fundación Alicia Koplowitz, Plan Nacional de Drogas, European Commission. He is the founder of eB2 and designed the MEMind app.

Pilar A. Saiz has been a consultant to and/or has received honoraria or grants from Adamed, CIBERSAM, European Commission, Government of the Principality of Asturias, Instituto de Salud Carlos III, Janssen, Lundbeck, Otsuka, Ethypharm, Pfizer, Plan Nacional Sobre Drogas and Servier.

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