Summary

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Although suicide has been the subject of a great many studies, knowledge about work-place suicide and the study of the professions most affected by the phenomenon still leave many areas uncovered, even though preservation of mental health in the workplace has become a priority for the public authorities and stakeholders. Further study is therefore essential if we are to understand whether and how work is likely to increase suicide risk. We also need to remedy the lack of studies on links between suicide, job loss and situations of unemployment. In the face of frequent reports of suicides committed in the workplace and by unemployed individuals, advancing knowledge on the subject is of key importance.

In this Report, the *Observatoire national du suicide* (ONS – National Observatory on Suicide) focuses on these questions, giving thought to avenues for study and possible advances in available data. The limitations of information systems are obvious when it comes to apprehending and measuring the nature and extent of the links between people's professional situations and suicide risk. Their limitations are due in particular to lack of data on places where suicides occur and the difficulty of ascribing suicidal actions to work or unemployment.

In this context, the Observatory points out that suicide is by its very nature a multifactorial phenomenon and cannot be explained by a single cause. The role played by working conditions or periods of unemployment in individual suicides is difficult to isolate.

However, it has been well documented that factors relating to organisation of work and certain management practices may generate stressful working conditions and create psychosocial risks. Despite this clear finding from social science research, the complexity of the suicide process does not enable a direct causal link to be established between work and suicide.

A few studies list suicide deaths recorded in specific professions and calculate ratios between their number and suicide deaths in the general population. The Observatory emphasises that such calculation of the increased risk of mortality by suicide is not altogether reliable. Nonetheless, underscoring a high suicide rate in a given profession or company should raise the alarm on potential major psychosocial risks that could lead to suicide and call for implementation of dedicated preventive measures. Likewise, it also remains difficult to prove any direct causal link between unemployment and suicide, as so little is known about

the mechanisms that may lead an unemployed individual to commit suicide. The Observatory finally points out that individual vulnerability cannot be cited as the single determinant of suicides among professionals and the unemployed. Although work or unemployment are seldom the only reason , they may well be one of the factors in the process leading an individual to attempt suicide, given the important place that employment and work have in people's lives and sense of identity.

Taking account of this knowledge and its limitations, the Observatory recommends continued improvement in collection of administrative and statistical data on suicidal thoughts, attempted suicides and successful suicides. As its first report in 2014 recommended, we need to step up the participation of forensic medicine departments as actors in the monitoring of suicides, with a view to increasing feedback on causes of death. Further development of the coding of suicide attempts in hospital information bases would also appear to be a priority.

More specifically concerning the link with work and unemployment, the Observatory considers that further work should be done on unravelling the complex interactions between psychosocial risks, mental health disorders and suicide risks. Likewise, it would be useful if there were further description of the contexts in which mental health problems and difficulties relating to experience of unemployment interact with suicide risks. In this respect, there needs to be more data available from longitudinal surveys tracing health trajectories and career paths. Pairing of administrative sources bringing together health data and sociodemographic data, such as *EDP-Santé* (*Echantillon démographique permanent* / Permanent Demographic Sample - Health), and setup of a system for collection of information on work-related suicides should be supported and made full use of.

1. Work-related suicides: where suicide prevention policy and health at work policy overlap

Prevention of work-related suicides falls under the general suicide prevention policy and the health at work policy alike.

The suicide prevention policy

The general suicide prevention policy took a major new direction with the 1996 National Conference on Health, which put suicide prevention on an equal footing with nine other priority health objectives. Since then, a number of strategies and action programmes have succeeded one another.

Following assessment of the 2011-2014 National Action Programme against Suicide, the *Haut Conseil de la santé publique* (HCSP – High Council for Public Health) recommended basing the suicide prevention policy more on actions regarded as effective in international scientific literature.

In 2018, the *Direction générale de la santé* (DGS – Directorate-General of Health) proposed a multimodal suicide prevention strategy that took account of the HCSP's recommendations and comprised six complementary actions which are currently being deployed: developing post-hospitalisation care for patients who have attempted suicide, continuing with training on identification and handling of suicide crises, ensuring responsible media coverage of suicide in order to prevent suicide contagion, and setting up a suicide prevention hotline and informing the public on existing resources (see Sheet 1).

In parallel to this transition to a suicide prevention policy based on scientific evidence, the ONS, which was created in 2013, is tasked with improving knowledge and providing assistance to public decision-making through its members' expertise, on various suicide-related issues.

The health at work policy

The legal framework covering health at work evolved in the early 2000s with a view to combating distress in the workplace, in particular due to psychological harassment. In addition, in-company prevention now bears on workers' mental health as much as on their physical health (see Dossier 1).

The problem was also referred to social partners, which went on to sign interprofessional agreements, on stress at work in 2008, harassment and violence at work in 2010 and quality of life at work in 2013. In parallel, the 2016-2020 *Plan santé au travail* (PST 3 – Health at Work Plan) designated psychosocial risks[1] as priority risks. They are also the focus of a number of coordinated preventive actions designed to improve knowledge among actors involved in in-company prevention. In addition, apart from general psychiatric care structures, the development of specialised reception and treatment schemes for patients with

1. Psychosocial risks are defined as risks to workers' physical and mental health whose causes are to be found in employment conditions, factors relating to organisation of and relations at work.

work-related psychological problems testifies to how much the issue is being taken into account.

These developments have led to growing awareness and acknowledgement of distress in the workplace. There has been an increase in numbers of recognitions of psychological disorders as occupational accidents and diseases since 2011. Their recognition as an occupation disease is less usual, however, as psychological disorders are not included in the tables of occupational diseases entailing presumption of imputability to work[2]. Hence, in 2016, over 10,000 psychological disorders resulting from a specific, dated triggering event were recognised as occupational accidents while only 600 as occupational diseases (*Assurance Maladie*, 2018). Jurisprudence on work-related suicide has also developed but is still scanty (see Loïc Lerouge's contribution in Dossier 1). However, the verdict in the France Télécom trial, delivered on 20 December 2019, introduced the notion of "institutional psychological harassment" into jurisprudence. The notion refers to a company strategy, implemented in the context of a restructuring plan, which led to destabilisation of employees and creation of an anxiety-provoking professional climate.

The disappearance of *Comités d'hygiène, de sécurité et des conditions de travail* (CHSCTs – Committees for Health, Safety and Working Conditions) and creation of *Comités sociaux et économiques* (CSEs – Social and Economic Committees) have opened a new chapter in promotion of health at work in general, and of mental health and prevention of psychosocial and suicide risks in particular. The creation of CHSCTs in 1982 led to advances in risk prevention, occupational accidents in industrial environments in particular, but proved to have limitations in recent years. The decoupling of economic issues, work organisation and health in the workplace was one such limitation. Setup of CSEs through the merger of traditional staff representation bodies, instituted by the "Labour" Ordinances of September 2017, was specifically aimed at mitigating this mode of operation in silos.

CSEs made it clear that there were new opportunities for deployment of preventive actions that took account of health at work issues. The decompartmentalisation of economic questions, work organisation and health in the workplace and potential improvement of social dialogue that CSEs were

2. There are two tables, maintained by the Social Security's General and Agricultural Regimes and listing so-called occupational diseases. To be recognised as such, a disease must be the direct consequence of a worker's exposure to a physical, chemical or biological risk or result from the conditions in which he/she exercises his/her professional activity (INRS).

designed to ensure should enable in-company discussions on health at work at strategic level and ensure that it is better taken into account.

At the same time, the creation of CSEs gave rise to new worries as to how far health at work would be taken into account in companies. The disappearance of staff delegates and centralisation of staff representation led a number of stakeholders to fear that the new committees would be too far removed from the realities of the workplace and work carried out there, even though the law provided for the new possibility of instituting local representatives by collective agreement. Concerns were also raised as to how exactly prevention of psychosocial risks might be ensured in this new context, compared with the previous situation in which this particular issue was handled by a dedicated body.

These questions were discussed at the ONS. As the way in which CSEs operate is yet to stabilise and it is still too early to reach any useful conclusions on their activities, the first analyses of the changes brought about by their introduction do not yield enough data to make an initial assessment, still less to decide on the merits of the various viewpoints expressed. In its future work, the ONS will therefore continue to pay close attention to the effects that the merger of staff representation bodies have on the way in which the issues of psychosocial and suicide risk prevention are handled in companies. The merger raises a good many questions, in particular as regards CSEs' mode of operation and how far participants in collective negotiation will avail themselves of the opportunities to innovate that come their way. Debate at the ONS will continue on this point when the research work currently underway on this subject produces its results. Two studies, funded in the context of the "mental health and experiences of work, unemployment and precarity" call for research, should provide some of the answers to these questions (Appendix 3). Likewise, the work to be carried out by the *Comité d'évaluation des ordonnances Travail* (Committee for Evaluation of Labour Ordinances) under the aegis of *France Stratégie*, with a view to studying implementation of CSEs and their effects, should bring further light to bear on these questions.

Finally, despite such community initiatives as the 2018 study carried out by *Solidarités nouvelles face au chômage* (SNC – New Solidarity against Unemployment) and the recent Opinion delivered by the *Conseil économique, social et environnemental* (CESE / ESEC – Economic, Social and Environmental Council) on the consequences of unemployment on the individuals who experience it and their families (Farache, 2016), there is still little awareness of or action taken on the mental health of the unemployed.

2. Suicides related to work and unemployment, a causal link difficult to apprehend or measure

Despite all stakeholders taking greater account of mental health at work, suicides relating to work and unemployment are difficult to identify and put a figure to.

First of all, establishing a direct causal link is never easy. It is difficult to apprehend as relationships between individuals' wellbeing or ill-being and their situations vis-à-vis work and employment are so complex. Moreover, suicide is a complex, multifactorial phenomenon that is hard to put down to a single cause. Hence, an individual's professional or social situation is seldom the only possible explanation for a suicidal action. Psychological, family or personal factors may also come into play (see Christian Baudelot's contribution in Dossier 1).

Secondly, there is currently no national data enabling monitoring of the evolution of the number of suicides, per profession, in the workplace, and *a fortiori* connected with work or unemployment.

Administrative sources of information on causes of death and hospitalisations for suicide attempts contain little data on individuals' situations on the labour market. Hence, apart from a few professions for which tallies have been made; it is currently impossible to connect deaths by suicide or hospitalisations for suicide attempts to the professions of the individuals concerned or link them with work or unemployment. Developments in information systems are nonetheless beginning to meet such needs (see Dossier 2). In general, the results of statistical surveys questioning people on their past suicidal thoughts and suicide attempts can be broken down in accordance with a good many professional characteristics, but only enable analysis of a part of the phenomenon.

Hence, if we want to know if suicides are more frequent in a given profession or company, we measure the differences in suicide rates between the people practicing that profession or working in the company under study and France's general population Such statistical reasoning has its weaknesses, however. How significant differences in suicide rates appear to be depends on workforces that often yield too little data per profession or company. In addition, people pursuing a particular profession or working in a given company may present very different characteristics from the French population taken as a whole. They stand apart in that they are in a job or have a level of education that differs from the average; they are older or younger; they have special

professional trajectories, etc. And finally, some professions and companies are more "male" and others more "female" than France's general population. Finding the appropriate reference population to establish the comparison is therefore a complex challenge.

Statistical establishment of an abnormally high death rate by suicide in certain professions and companies does not automatically make it possible to infer that those suicides have anything to do with working conditions or organisational or relational factors in a company. They may partly depend on the individual characteristics of those who choose to pursue such professions or work in such companies. An abnormally high suicide rate is nonetheless a definite indication that there may be underlying professional causes that could well interact with individual aspects. In any event, it highlights a degree of vulnerability that calls for special preventive measures to be implemented, whatever the cause may be.

3. Suicide and professional situation: complementarity of quantitative and qualitative studies

There are a great many studies in the fields of epidemiology, psychiatry, psychology and social and human sciences (sociology, economics, law, etc.) that document the connection between mental health and experiences of work and unemployment, even though grey areas certainly exist (see Dossier 1). All of these disciplines have seen significant quantities of research carried out on the question of suicide.

Epidemiological studies adopt a quantitative viewpoint seeking to establish a statistical "excessive risk" of suicide in a given category of workers and analyse the professional determinants affecting mental health and suicide rates. Similarly, economic studies focus on the impacts of various social and professional factors and their interactions. One of the aspects common to the two disciplines is that they attempt to unravel the effects that the various closely interwoven factors have on mental health. When suicide risk is studied separately, the importance of mental disorders comes under examination. Do such disorders have their own effect on the suicide risk or do they have a mediating effect in relation to professional and social factors? By making use of the still inadequate data on career paths and health, these studies finally attempt to take account of reciprocal effects, whether positive or negative, between mental health and professional situations as well as the dynamics of their interactions. More specifically, the development of this type of study is of major importance in better understanding the interactions between psychosocial risks, mental health and suicide risks. Detrimental working conditions are harmful to mental health but, unlike psychological problems, may reduce

performances at work. Likewise, unemployment may cause a deterioration in mental health but poor mental health may eventually limit participation in the labour market, the search for and obtainment of a job. From a statistical viewpoint, the goal is therefore to clarify the direction of causality between mental health and work and between mental health and unemployment. Most probably, mental health problems and episodes of unemployment are fostered by a generally unfavourable life path and depend on a wider social context, which makes it still more complex to establish a causal relationship (Meneton *et al.*, 2017).

Generally speaking, psychological and sociological studies are based more on qualitative methods, making use of field surveys. By relying on the clinical approaches to work developed by Dominique Lhuillier and the psychodynamics of work as- outlined by Christophe Dejours, they put the emphasis on the actual experience of work and unemployment as described by the individuals themselves. Such descriptive studies of work and unemployment situations as experienced have established that the distress caused is not the result of individual weaknesses alone, but that certain organisational factors and managerial practices in companies and the ordeal of unemployment also play a part in deterioration of mental health. According to Dejours, suicides at work result from work overload and lack of cooperation between colleagues or with the hierarchy. He also highlighted the fact that people who commit suicide due to work are often the employees who are most committed to and get the best results from their work. Professional conscience generally plays a part in state of health, but when it is adversely affected, the very meaning of work is impacted, which may go to explain this *a priori* counter-intuitive phenomenon. The subjective experience of unemployment may also worsen mental health and lead to suicide, although the exact psychological mechanisms at play are yet to be explored. In particular, it would be well worth studying the diversity of contemporary experiences of unemployment and precarity in order to assess their impact on suicide risk. Deterioration of mental health should most certainly be studied in the light of part or all of an individual's career path, depending on whether it is characterised by a long period of unemployment or, conversely, by a series of alternating episodes of precarious employment and unemployment.

Psychiatric studies have highlighted the fact that most suicides occur in a context of psychiatric disorders, depression and anxiety disorders in particular. They have also emphasised the major role played by disorders arising in childhood. Abuse in childhood in particular can cause serious psychiatric conditions and have psychological and social consequences in adulthood (difficulties in adapting or in stress management, etc.) and consequences on professional situations as a result.

Finally, legal studies, which are still few and far between, focus on understanding how to prevent work-related risks and remedy the consequences of work-related distress.

The psychosocial risk-based approach constituted a turning point insofar as it enabled bridges to be built between quantitative and qualitative research. In 2011, a report on measurement of psychosocial risk factors at work, drawn up by a panel of experts chaired by Michel Gollac, identified six types of psychosocial risk factors: intensiveness of work and working hours, emotional requirements[3], lack of autonomy, poor quality of social relationships at work, value conflicts[4], and insecure work situations. It also defined a series of indicators for measuring these risks and makes recommendations on how best to conduct statistical surveys, which found concrete expression, for example, in the Working Conditions-Psychosocial Risks survey carried out in 2016 by the *Direction de l'animation de la recherche, des études et des statistiques* (DARES – Directorate for Research, Studies and Statistics). The report therefore helped to corroborate sociologists' and psychologists' qualitative studies by providing quantitative data.

In 2019, with a view to filling in the gaps in research, the *Direction de la recherche, des études, de l'évaluation et des statistiques* (DREES – Directorate for Research, Studies, Assessment and Statistics) and DARES launched a joint call for research projects on the theme of mental health and the link with work, unemployment and precarity. The goal was to encourage and fund innovative scientific work on the impact of working conditions, new managerial practices, new forms of employment, and unemployment on individuals' subjective experience and distress, as well as on suicide risk. Ten research projects were selected and are being funded by DARES and DRESS over two years. One project is also funded by the *Conseil d'orientation des conditions de travail* (COCT – Advisory Council on Working Conditions) and another by the Ministry of Agriculture and Food (See Appendix 3).

4. Development of prevention in certain professions is reducing numbers of suicides and suicide attempts

Although there are no figures available on numbers of suicides in the workplace or related to work, a considerable quantity of data from statistical surveys or collected in the context of programmes addressing work-related distress enables analysis of the connection between mental health and working

3. Emotional requirements correspond to the needs to control and shape one's own emotions, in particular so as to control and shape those sensed by people with whom one interacts at work. Being able to hide one's emotions is also required.

4. Value conflicts may result from the aim of the work or its secondary effects being at odds with the worker's convictions, or from his having to work in a way that is not in line with his professional conscience.

and employment conditions. Hence, the Working Conditions-Psychosocial Risks survey carried out by DARES in 2016 enabled study of the relationships between psychosocial risks at work as defined by the Gollac report, mental health disorders and suicidal thoughts. One of the results was that the effect of psychosocial risks on frequency of suicidal thoughts may be direct or partially related to the existence of mental disorders (see Sheet 5). Thanks to the size of the sample it used, the 2016 Working Conditions- Psychosocial Risks survey also enabled targeting analysis on hospital staff (see Sheet 6).

The *Réseau national de vigilance et de prévention des pathologies professionnelles* (RNV3P – National Occupational Disease Surveillance and Prevention Network) comprises the 30 *centres de consultations de pathologies professionnelles* (CCPPs – Occupational Disease Consultation Centres) and collects information gathered during consultations, so enabling identification and characterisation of risk situations in work environments. Between 2001 and 2017, there was a significant increase in the number of mental illnesses considered as being imputable to work in the context of consultations, partly due to modifications of practices in sending patients to CCPPs (see Sheet 7). The 2017 Health Barometer survey conducted *Santé publique France*, France's National Public Health Agency, enabled measurement of the prevalence of suicidal thoughts by activity sector. It turns out that such thoughts are associated with verbal threats, humiliation and intimidation at work, the fact of being afraid of losing one's job, and the fact of having recently experienced a period of unemployment lasting more than six months (see Sheet 8).

Certain work environments have seen implementation of special suicide prevention actions and information feedback systems dedicated to a given activity sector or profession. Such is the case with the agricultural environment, where the suicide rate in a major source of concern for the public authorities (see Sheets 9, 10 and 11). A statistically excessive suicide rate among farmers, compared with the general population, was highlighted. In contrast, figures for *Mutualité sociale agricole* (MSA – Agricultural Social Mutual Fund) employees show a light suicide rate (see Sheet 9). Between 2011 and 2014, the Ministry of Agriculture and Food entrusted the MSA with the task of setting up a national suicide prevention plan as part of the Ministry for Solidarity and Health's *Programme national d'actions contre le suicide* (PNAS – National Action Programme against Suicide). Among other things, the plan provided for the opening of multidisciplinary suicide prevention units at MSA branches across French soil and creation of an AGRI'ÉCOUTE hotline in 2014, which was reinforced in 2018 (see Sheet 11). Along the same lines, the Ministry of Agriculture and Food wanted to extend mental illness and suicide prevention actions between 2016 and 2020 via social accompaniment and economic aid schemes designed to lend support to farmers in situations of professional burnout or experiencing financial difficulties (see Sheet 10).

Since 2013, entrepreneurs faced with financial difficulties or showing signs of work-related distress have been able to obtain assistance from the *Aide psychologique aux entrepreneurs en souffrance aiguë* (APESA – Aid to Entrepreneurs suffering from Psychological Distress) scheme. Based on a network of "sentinels" in commercial courts, trained in spotting suicide risk, and on a national network of psychologists, the scheme has provided 2,173 men and women entrepreneurs in distress with care since its creation (see Sheet 12).

There are also well-identified risks specific to police officers. Since the 2000s, the national police have been very active in suicide prevention (see Sheet 13). A new *Programme de mobilisation contre le suicide* (PMS – Anti-suicide Mobilisation Programme) was implemented in 2018 and a *Cellule d'alerte et de prévention du suicide* (CAPS – Suicide Alert and Prevention Unit) was set up on 29 April 2019 in the context of a steep rise in numbers of suicides.

Since 2009, the prison administration has also increased actions designed to prevent psychological distress and deterioration of quality of life among its employees. Such actions mainly target surveillance staff, providing continuous assistance and support with a view to reducing suicide risk (see Sheet 14).

5. Ongoing improvement of information systems

Development of knowledge on suicidal thoughts and attempted and successful suicides, in particular those related to professional situations, requires improvement of information systems (see Dossier 2).

The database on causes of death maintained by the National Institute for Health and Medical Research's Epidemiology Centre on Medical Causes of Death (CépiDc-INSERM) is the main source of information on deaths by suicide. In this field, deployment of electronic death certificates, introduction of a new death certificate in 2017 and communication of a *Volet médical complémentaire* (VMC – additional medical section) by medicolegal institutes if an autopsy or additional examination has been performed should enable reduction of the time it takes to make information available, as well as increase the quality of information communicated. By improving identification of suicides, these evolutions in the information system on causes of death could even lead to an artificial rise in numbers of suicides in the years to come.

Pairing the database on causes of death with other sources of medico-administrative data such as hospital information bases (the PMSI[5]) and the *Assurance Maladie* database (SNIIRAM[6]), in the context of the *Système national des données de santé* (SNDS – National Health Data System), opens up promising avenues for studies and research on suicides, hospitalisations for

5. The PMSI (*Programme de médicalisation des systèmes d'information* / Information System Medicalisation Programme) is a tool for medico-economic measurement of hospital activity.
6. SNIIRAM (*Système national d'information inter-régimes de l'Assurance maladie* / National Inter-Regime Information System on Health Insurance) is the French database maintained by the National Insurance Fund for Salaried Employees (CNAMTS).

attempted suicides and take-up of care. In this respect, the National Observatory on Suicide asks the various actors involved to coordinate their work with a view to covering all relevant questions and so help guide public policies on suicide prevention.

Aside from these advances, there is still considerable room for development as regards inclusion of attempted suicides in hospital information bases. Thought on improvement of their coding should be one of the priorities of the ONS's working group on statistical data. Production of data on suicides and attempted suicides according to professional situation should also be a priority, through pairing of such administrative sources as *EDP-santé*[6] or testing out systems for collecting information on work-related suicides, such as the one initiated by *Santé publique France* in collaboration with forensic medicine institutes.

The various recent statistical surveys enabling measurement of suicidal thoughts and suicide attempts as stated by respondents, and their potential pairing with the SNDS, should be subjected to enough statistical evaluations to nourish public debate. Despite their shortcomings, current information systems provide a description of the general evolution of suicides, attempted suicides and suicidal thoughts in France.

6. The suicide rate is showing a downward trend

The suicide rate dropped between 2000 et 2016, continuing with a downward trend in evidence since the 1980s. Even so, France still recorded around 9,300[8] deaths by suicide in 2016 and is one of the European countries with high suicide rates. Regional and international comparisons, along with recent variations, should be interpreted with caution due to disparities in information feedback on causes of death (see Sheet 2). It is hard to say how far the downward trends observed attest to the effectiveness of the suicide prevention schemes implemented since the 2000s. A good many other factors may well have been at play at the same time, without it being possible to unravel their respective effects: dissemination and consumption of antidepressants, improvements in the psychiatric care available, development of suicide prevention associations and their actions, etc. (Baudelot and Establet, 2018).

6. *EDP-santé* matches socioeconomic data from the Permanent Demographic Sample (EDP), and data on take-up of care, hospitalisations and causes of death from the National Health Data System (SNDS).
7. In 2016, 8,435 deaths by suicide were recorded in Metropolitan France. As information obtained from death certificates was incomplete and under the hypothesis of a 10% underestimation, the number of suicides after correction would be 9,279.

Hospitalisations for attempted suicide in general medicine, surgical and obstetrics wards also decreased between 2010 and 2013 but have evolved little since then. However, they only include a percentage of attempted suicides treated in hospitals as they do not take account of patients hospitalised in psychiatric wards or who have been treated in emergency departments following suicide attempts that have not required hospitalisation in general medicine, surgical and obstetrics wards. Here again, the quality of data communicated and coding habits prevalent in hospital bases make analysis of this source a delicate affair (See Sheet 3).

However, indicators of suicidal thoughts and attempted suicides as stated by respondents in the *Santé publique France* Health Barometer do not show any upward or downward trend linked to gender or age (see Sheet 4).

7. Special risk factors among the elderly, adolescents and prison inmates

Even though most suicides occur in the working-age population, it should be borne in mind that the highest suicide rate is among 75-year-olds and above: 33.3 for every 100,000 inhabitants as against 15.4 for 25-54 y/o and 18.1 for 55-74 y/o (see Sheet 2). There are still a good many grey areas in knowledge on this phenomenon. Recent research has focused on the effects of training sentinels in identification of the risk, mostly professionals dealing with the elderly, especially in institutions. Breaking down social isolation also seems to be an effective measure for reducing suicide risk among the elderly. Prevention through improving the image of old age in society could finally be a useful research focus.

At the other end of the age scale, the suicide rate among adolescents is low overall, although suicide is the second most common cause of death in young people, after road accidents. Young girls show the highest attempted suicide rate compared with all other age groups, with a narrow peak at around 16 y/o. Research work highlights the key role played by adolescents' state of mental health in suicide risk (see Sheets 16 and 17). Nonetheless, numerous behaviours (self-inflicted bodily harm, poor dietary habits, tobacco and cannabis consumption, etc.), some of which might sometimes seem insignificant (skipping classes, not having breakfast, etc.), may well be warning signs of pupils' ill-being. Future work should focus on bullying, on the Web and social networks in particular.

Finally, prison inmates are particularly at risk. Prevention of suicide in prison environments is a public health priority. It has formed the subject of an active policy in France for several years. The *Direction de l'administration pénitentiaire* (DAP – Department of Prison Administration) and *Santé publique France* have

implemented an information feedback system designed to identify factors related to suicide risk among prison inmates. It distinguishes factors connected with imprisonment itself from those to do with their life paths, in order to try to separate the various factors involved and so improve prevention (see Sheet 18).

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