



Towards Evidence-Based Suicide Prevention Programs

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Suicide is a global challenge and poses a serious public health problem worldwide. It accounts for nearly 1 million deaths and an estimated 10 million failed attempts each year. It is estimated that approximately 32% of all suicide deaths occur in the Western Pacific region (Hendin et al., 2008; Yip, 2008), a disproportionate number in an area consisting of 37 countries and a total of 1.78 billion people or about 29% of the world's population. The suicide rate in this region is calculated to be about 19.3 per 100,000 (De Leo, Milner, & Wang, 2009). Suicide rates in some of its countries like Japan, the Republic of Korea, and Taiwan have seen significant increases since the Asian financial turmoil in 1997 and have remained at historically high levels since. Suicide is the leading cause of death among young people in this region and causes significant economic losses to society (Law & Yip, 2011; Yip, Liu, & Law, 2008).

Traditionally, suicide has been viewed as a mental health issue best addressed primarily through clinical interventions, especially through the treatment of depression (Mercy & Rosenberg, 2000). However, it has been found that the majority of people who committed suicide had not received psychiatric services prior to death (Andersen, Andersen, Rosholm, & Gram, 2000; Appleby et al., 1999; Cavanagh, Carson, Sharpe, & Lawrie, 2003; Lee, Chan, Lee, & Yip, 2002). Furthermore, in view of the size of the problem and the limited resources, the medical and clinical model involving intensive professional care service might not be practical in Asia (Chen & Yip, 2008).

In our daily lives, stopping people from reaching the edge of a cliff is always easier than trying to save once they're on the edge. In the same sense, drug-clot busters might be useful in providing temporary relief for those who suffer from cardiovascular diseases, but this is not as cost-efficient or cost-effective as a healthy diet and routine exercise for the population as a whole. The public-health approach to suicide prevention shares the same vision.

Aiming to prevent illness, disability, and premature death through early and active intervention, this approach provides a strong framework for creating an effective and

concerted effort across different sectors to prevent suicide. In particular, public-health approach combines four fundamental activities: (1) surveillance to identify patterns and epidemics of suicide and the different rates of suicide, (2) epidemiologic research to identify the chain of causes leading to suicide, (3) design and evaluation of interventions to interrupt this chain and prevent suicide, and (4) implementation of programs consisting of proven intervention.

Rigorous calculations (Lewis, Hawton, & Jones, 1997) have shown that high-risk clinical strategies only have a modest effect on a population's overall suicide rates, even if effective interventions have been developed. It is thus imperative that, in addition to improving the effectiveness of clinical interventions, multiple avenues should be utilized to prevent suicide deaths, particularly in populous countries such as those in the Western Pacific region. In this region, the mental-health services can hardly meet the huge demands of large populations due to limited resources and stigmatization toward turning to mental health services in the community.

Illustration of Public Health Approach in Suicide Prevention

A concept behind the public-health approach is that its effect would resonate throughout the whole population. To illustrate how the public-health approach aims to reduce the number of suicides, a simple diagram can be used (Yip, 2005). If the mental health of a population were drawn as a normally distributed curve with the x-axis representing suicide risk and the y-axis representing the number of people, a universal program would in theory shift the whole curve to the left (see Figure 1). This in turn would reduce the number of individuals found in the high-risk bracket (relative to the size of the shift), while making the whole population less susceptible to suicide. Also, "a large number of people at a small risk may give rise to more cases of

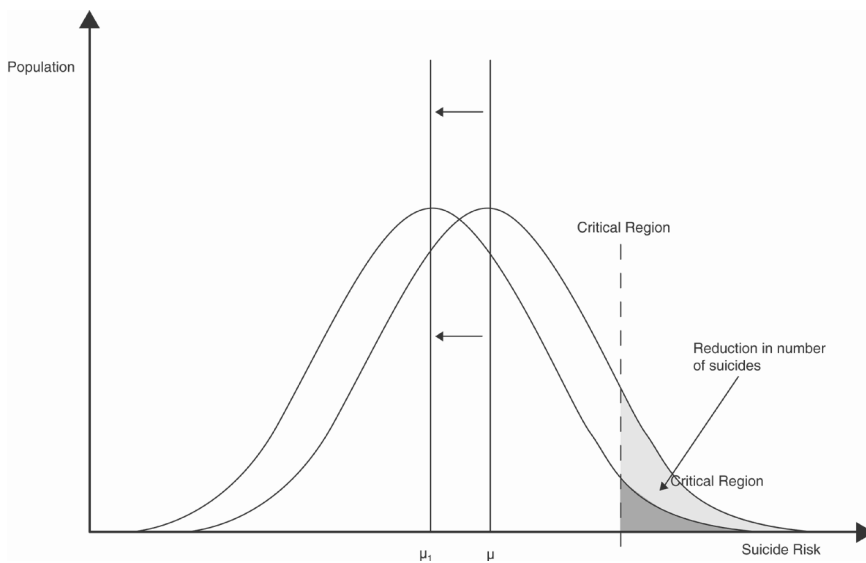


Figure 1. The effect of a shift in the mean suicidal risk of a population. Note: μ_1 = original population mean; μ = new population mean (Yip, 2005).

disease than the small numbers who are at high risk” (Rose, 1992). Therefore, it is believed that a reduction in general risk would reduce suicide cases more than interventions that only target high-risk individuals.

The public-health approach focuses on identifying patterns of suicide and suicidal behaviors in a group or population. It aims at changing the environment to protect people against diseases and changing the behaviors that put people at risk of getting them. An “evidence-based” approach is vital and allows us to determine which intervention or program is best fit for the current situation – and which is most cost-effective.

The Public Health Approach in Practice

The United States, England, Scotland, Australia, New Zealand, Finland, and Norway are among the areas that have developed comprehensive national suicide prevention strategies incorporating the public-health approach (Taylor, Kingdom, & Jenkins, 1997). National strategies for suicide prevention in these areas share a number of common elements (US Department of Health and Human Services, 2001). These include:

- Using educational settings as sites of intervention;
- Promoting research on suicide and suicide prevention;
- Attempting to change the portrayal of suicidal behavior and mental illness in the media;
- Increasing and improving the detection and treatment of depression and other mental illnesses;
- Emphasizing reducing the stigma associated with help-seeking behaviors;
- Designing strategies to improve access to services;
- Promoting effective preventive efforts with rigorous evaluation; and
- Reducing access to suicide means.

It has been argued that the national suicide prevention programs in Australia, Finland, Norway, and Sweden had little or no impact on reducing suicide rates among youth and the general population (De Leo, 2004). Although definitive evidence to demonstrate the implementation of a national suicide prevention policy has yet to be confirmed, the establishment of a national policy reflects a commitment by the local government to deal with the challenges. It also offers more coordinated policies and measures for the community. From the experiences of other countries, we advocate the importance of incorporating a similar public-health approach in preventing suicide in Asia, especially in countries with a large population.

The public-health approaches also promote strong collaborations among various parties of suicide prevention in the territory, as these efforts need to be strategically coordinated to maximize their effectiveness. A clearly identified role of each sector of the community, better identification of service gaps, stimulation of new and innovative modes of service, and the development of evidence-based guidelines for intervention and evaluation of program effectiveness are undoubtedly necessary.

We plead for the formulation of a task force to lead in the implementation of an operational plan and to develop schedules for a coordinated community-based suicide-prevention strategies. This is not a static process, but rather a continuous and evolving strategy that envisions sustainable development on suicide prevention based on the best research knowledge available and the cooperation of all community stakeholders. In this case, any nationwide suicide prevention program should ideally be supported by the government, so that it works more effectively among all the community stakeholders. The task force should also be financially sustainable. Moreover, partnership and cooperation are emphasized, building upon many activities within the community that have already contributed to suicide prevention.

Suicide prevention is multidimensional, whether we are

tailoring diverse solutions for different cultures or developing distinctive approaches for various segments of the population within a country. In other words, *one size doesn't fit all*, and there is *no silver bullet*. Each of us must develop culturally attuned, locally relevant, and evidence-based suicide prevention programs. Also, all suicide prevention programs need to be evaluated. And where we do not have the necessary evidence, we must simultaneously implement novel approaches and rigorously evaluate them. Anything less is undesirable. The importance of evaluation is even more critical in Asia, partly because of the culture and limited resources. In our recent monograph entitled *Towards Evidence-Based Suicide Prevention Programmes*, published by the World Health Organization of the West Pacific Region (Yip & Law, 2010), it was our hope to demonstrate and introduce some promising effective programs at reducing the number of suicides and/or its associated outcome. Also, there is an encouraging trend of greater acknowledgment by the government (for example, Taiwan, China, South Korea, Japan, People's Republic of China, and Hong Kong) as well as by local community leaders and professional groups. This is a vital step toward implementing effective and comprehensive suicide prevention strategies.

We should also emphasize knowledge exchange and transfer of the best practices in suicide prevention programs. A knowledge platform should be set up to exchange current knowledge and promote ongoing discourse both internationally and within the community. Such information and knowledge needs to be continuously updated and modified in view of the latest research findings, and we must remain open and responsive in light of new discussions and evidence. We cannot emphasize more that "suicide is everyone's business." It will work only when individuals representing every facet of our community collaborate and work together to confront this serious problem in order to reduce tragedies and sufferings to the surviving families and friends. Minimizing the number of suicides has always been a challenge, even using available resources and latest technology (for example, Web 2.0) effectively while identifying new resources, but we certainly can make a difference.

In sum, there is no quick fix for suicide prevention – yet it is always preventable. A holistic and integrated approach is needed to make the suicide-prevention program focused and sustainable. We are appealing to the support from the Government, nongovernment organizations, and other stakeholders in the community to join our effort for suicide prevention. We can all contribute to suicide prevention. Connecting the disconnected individuals in our community, especially the young ones, is a challenging task. Though we can't prevent all suicides, we can make a difference.

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