10th September, 2006

World Suicide Prevention Day

"With understanding, new hope"

IASP AN INITIATIVE OF THE INTERNATIONAL ASSOCIATION FOR SUICIDE PREVENTION (IASP)
CO-SPONSORED BY THE WORLD HEALTH ORGANIZATION (WHO)

September 10, 2006 is World Suicide Prevention Day. Each year the International Association for Suicide Prevention (IASP), in collaboration with the World Health Organisation, uses this day to call attention to suicide as a leading cause of premature and preventable death. This year's theme is **"With understanding, new hope"** and the focus is upon translating current scientific knowledge and research about suicidal behaviour into practical programmes and activities that can reduce suicidal behaviour and save lives. We invite the public, societies, communities, researchers, clinicians, practitioners, politicians and policy makers, volunteers, those bereaved by suicide and interested groups and individuals to join with us on World Suicide Prevention Day to develop activities to enhance understanding about suicide and to demonstrate ways in which knowledge about suicide can be translated into effective suicide prevention programmes. This year the World Federation for Mental Health has joined IASP in promoting activities on World Suicide Prevention Day.

SUICIDAL BEHAVIOUR: THE EXTENT OF THE PROBLEM

Already in this new century there have been more than 5 million suicide deaths worldwide. Each year approximately one million people in the world die by suicide. This toll is higher than the total number of world deaths each year from war and homicide combined. Suicide is an important public health problem in many countries, and is a leading cause of death amongst teenagers and young adults.

In addition, it is estimated that there are from 10-20 times as many suicide attempts as suicide deaths. These suicide attempts range in intent and medical severity from mild to very severe. At a personal level, all suicide attempts, regardless of the extent of injury, are indications of severe emotional distress, unhappiness and/or mental illness.

Suicide and suicide attempts have serious emotional consequences for families and friends. The burden of bereavement by suicide can have a profound and lasting emotional impact for family members. The families of those who make suicide attempts are often especially anxious and concerned about the risk of further suicidal behaviour, and about their responsibilities in trying to prevent further attempts.

There are also substantial economic costs associated with lives lost to suicide. These costs arise from the loss of economic potential due to lives lost to suicide, from the often devastating effects of symptoms of bereavement by suicide, from the medical and mental health costs associated with suicide attempts, and from the burden of family care for those who have made suicide attempts. Internationally, the annual economic cost of suicidal behaviour is estimated to be in the billions of dollars.

SUICIDAL BEHAVIOUR: WHAT IS KNOWN

The early 21st century is becoming a period of consolidation for the explosion of research about suicidal behaviour that took place in the 1980s and 1990s. There is now a large volume of information from mental health, epidemiological, genetic, psycho-social and biological research which gives a generally coherent and consistent picture about the risk factors for suicidal behaviour and how to develop prevention programmes in both developed and developing countries.

This research suggests that suicidal behaviour is a complex issue, with multiple and inter-related causes. However, this complexity does not mean that we do not know why people take their own lives or how to reduce suicidal behaviour in individuals and within a society. Much has been learned from recent research about the causes of suicidal behaviour and effective prevention strategies.

Mental illness is the most important factor that predisposes people to suicidal behaviour. People with mental illness have a 10-fold increased risk of suicide compared with people without such illness. In most Western countries almost 90% of people who die by suicide have a diagnosable mental disorder. In some Asian countries, including China, the proportion with mental disorder is much less, although mental disorders still play an important role in suicidal behaviour. The mental disorders most commonly associated with suicidal behaviour are depression and bipolar disorder, alcohol and substance abuse and schizophrenia. Of these, depression is the most common, and two thirds of those who die by suicide have a depressive illness at the time they die. Furthermore, having a problem of alcohol or drug abuse along with another mental disorder greatly increases the risk of suicidal behaviour. Nevertheless, the vast majority of persons with a mental illness will never commit suicide. This means that despite the increased risk associated with mental illness, most persons with a mental health problem do not experience the life stresses or other risk factors that contribute to high suicide risk, or they receive adequate help to deal with their problems.

A family history of suicide is also a strong risk factor for suicidal behaviour with a four-fold increased risk of suicidal behaviour in the relatives of those who attempt or die by suicide, compared with families without a history of suicidal behaviour. People who have made a previous suicide attempt have increased risks of making further suicide attempts and of dying by suicide, especially in the first 6 to 12 months after an attempt. Poor socio-economic, educational and social circumstances, and poor physical health are also associated with suicidal behaviour. Knowledge of these risk factors may help us identify persons at greater suicide risk in order to provide prevention programmes to those who need them most.

Against this background, stressful events such as relationship break-ups, loss of loved ones, arguments with family or friends, financial, legal or work-related problems and events that lead to shame or humiliation can precipitate suicide attempts. The availability of lethal methods of suicide is an important risk factor for suicidal behaviour and an important determinant of whether an attempt will result in death. When people feel desperate or experience an acute stressful situation, there is a greater likelihood to engage in impulsive suicidal behaviour if the means to end one's life is readily available, especially when their judgement is clouded by a mental illness, drugs or alcohol.

In addition, there have been recent developments in genetic research which are helping us better understand the possible genetic basis for susceptibility to suicidal behaviour and the ways in which genetic predispositions to suicidal behaviour may be influenced by the environment. The wide variations in suicide rates between countries and within the same country (for example, rural and urban differences) indicate the importance of social and other environmental factors. Biochemical abnormalities in the brain, particularly in the serotonergic system, and particularly related to impulsivity and aggression, also appear to be involved in increasing the risk of suicidal behaviour.

SUICIDAL BEHAVIOUR: WHAT NEEDS TO BE DONE

Despite our increasing knowledge of the causes and consequences of suicidal behaviour our scientific understanding of what works best in preventing suicide is relatively underdeveloped. The challenge facing the 21st century lies in translating our very considerable knowledge about why people attempt to take their lives into effective strategies, policies, programmes and services to reduce the tragic loss of life and the devastating effects of suicidal behaviour.

It would be premature to suggest that certain interventions and policies will inevitably produce the best results. However, based on our current understanding, the promising areas for suicide prevention include:

Educating physicians about recognising, treating and managing depression and suicidal behaviour can reduce suicide rates. This approach is based on our knowledge that, often, depression is under-recognised and inadequately treated, and that, in many countries, those who die by suicide see a physician in the weeks before their death. Educating physicians about better recognising and treating depression has been shown to result in better treatment of patients with depression and in lower suicide rates. These results have been found in studies of physician education conducted in selected regions of Sweden, Hungary, Slovenia and Japan. This is a very promising approach to suicide prevention, and needs to be replicated in other countries. This approach also needs to be extended to enhance physician detection and treatment of, not only depression, but other mental illnesses, including substance abuse, that increase risk of suicidal behaviour. Furthermore, physicians need to better understand how to assess suicide risk and develop treatment plans that involve the person's social supports and various community agencies and caregivers.

Restricting access to lethal means of suicide is an approach to preventing suicide that is sometimes undervalued. However, there is evidence from a number of countries that indicates that reducing access to particular means of suicide reduces the rate of suicide by that method, and sometimes, can reduce total suicide rates. Findings in this area span a

range of different methods including reducing access to domestic gas, various forms of gun possession control, reducing carbon monoxide emissions from vehicles, reducing the pack size of analgesics, installing barriers at sites that become popular for suicide, and prescribing drugs which are clinically safer if taken in overdose. Restricting access to means does not address the suicidal person's despair and the causes of the suicidal ten dances. However, when easy access to a lethal means is not available it is less likely that an impulsive suicide will occur, and the delay in finding the means allows for help to be sought and provided. Restricting access to means of suicide can potentially play an important role in decreasing rates of suicide in such countries as China, India and Sri Lanka, which have high rates of suicide by ingestion of pesticides. Because of their large populations, these countries account for a substantial proportion of all world suicides and if we are to achieve significant reductions in world suicide rates, it will be important to reduce suicides by pesticides in these countries. For example, simply providing locked boxes to store pesticides appears to reduce pesticide ingestion in rural areas.

Educating community gatekeepers: Programmes that focus on enhancing the skills of community, organisational and institutional gatekeepers (including clergy, and those who work in schools, prisons, juvenile detention and welfare centres, workplaces, and homes for the elderly) can improve identification and referral of people at risk of suicidal behaviour. The United States Air Force Suicide Prevention programme is a successful example of this type of activity. In this programme a united effort by community agencies within the US Air Force was followed by a significant reduction in suicides among Air Force personnel. Reduced suicide rates have also been reported for a similar programme in the Norwegian Army and in several prisons and penitentiaries and various workplaces. Since few have been evaluated we should encourage the evaluation of existing programmes and the development of new programmes as we learn more about the effective components of gatekeeper education.

Providing help in crisis situations: Telephone helplines, crisis centres and Internet support services around the world respond to many thousands of suicidal crises daily. Based upon the great popularity of voluntary and professional services provided by organisations such as the Samaritans, Lifeline and suicide prevention and crisis helplines, one must conclude that these helplines and Internet support activities meet an important need. Recent research from the USA and Canada suggests that people at risk of suicide are often helped by these organisations, however the best help is not always provided by some centres. Furthermore, telephone and Internet support is usually part of a process of referral and encouragement to seek treatment and services from other mental health and community organisations. Best practices in telephone and Internet help need to be perfected, evaluated and disseminated.

Screening programmes: A series of programmes have been developed that screen directly for suicide risk or for mental illnesses, such as depression or substance abuse, which are known to increase suicide risk. These programmes have typically been used in schools or universities. While these programmes appear promising, they need further evaluation to determine their cost-effectiveness, to identify and refine the tools for screening which best discriminate between those at risk and those not at risk and to identify ways to ensure that those who are identified as being at risk obtain the help they need.

Improving mental health treatment and management: Given the high rate of mental illness in those who die by suicide, treating mental illness effectively and providing long-term mental health care and support are, clearly, major approaches to preventing suicide. A number of treatments for specific mental illnesses have been shown to reduce suicidal behaviour. These include long-term therapy with lithium for people with bipolar disorder or severe depression, and the use of antipsychotic medications by people with psychotic illnesses, including schizophrenia. However, because of recent controversial findings, there is a need for more research investment to explore how effective antidepressant medications are in reducing suicidal behaviour in people with depression. Behavioural or psychological therapies have also been found to be effective in reducing suicidal behaviour, either alone or in combination with medication. There is a need for more research to explore various combinations of medication and therapy to determine the most effective ways of treating and supporting people at risk of suicide.

Providing support after suicide attempts: People who make suicide attempts are at increased risk of making further attempts, and of dying by suicide. A small number of interventions, which focus on enhancing treatment and support for these people, have been shown to reduce the risk of repeated suicidal behaviour. A Norwegian initiative that focuses on providing follow-up care to people after discharge from hospital after making suicide attempts via an integrated chain-of-care network is effective in reducing further suicide attempts. There is a need to develop new programmes which provide follow-up care and support for suicide attempt patients, both in the immediate aftermath of a suicide attempt, and in the longer term involving coordination between hospital settings and a wide variety of community agencies and caregivers.

Media coverage of suicide: Certain ways of presenting and portraying suicide in the media appear to precipitate suicidal behaviour in vulnerable people. This evidence has led many countries to develop media guidelines for reporting and portraying suicide. However, there are few evaluations of these guidelines, and there is a need to assess the impact of these guidelines on both reporting practices and suicide rates. A related issue is how to best develop and implement media guidelines to encourage adherence by media personnel. In the meantime there is much that can be done to promote responsible and informed media coverage of suicide by

maintaining, implementing and promoting the use of existing media resources. It is also important to develop better ways of working collaboratively with media to disseminate information about suicide and to promote knowledge and information about suicide and mental health in a non-stigmatising manner.

PREVENTING SUICIDE: WHO CAN HELP

To be effective suicide prevention needs to incorporate a multi-faceted and intersectoral approach which acknowledges the multiple causes and pathways to suicidal behaviour. The range of people who can be involved in suicide prevention includes heath care professionals, volunteers, researchers, families and others bereaved by suicide or affected by suicidal behaviour, and people from outside the health sector, including those who work in central and local government, education, justice, police, law, the employment sector, religion, politics, and the media. The theme of World Suicide Prevention Day 2006, **"With understanding, new hope"**, is an opportunity for researchers, clinicians and practitioners to share with representatives from other sectors, information about what is known about the causes of suicidal behaviour, to highlight ways in which this knowledge can be applied and what approaches to preventing suicide seem likely to be effective, and to encourage evaluation of existing suicide prevention programmes and policies. Those who work in all areas of suicide prevention can use the day to highlight activities which increase public understanding and awareness of suicide as a preventable public health problem.

WORLD SUICIDE PREVENTION DAY ACTIVITIES: WHAT CAN BE DONE

On World Suicide Prevention Day a range of activities can be used to translate and transfer knowledge about suicide and suicide prevention to various sectors of the population and increase communication between caregivers and members of the research community. Initiatives that actively engage and involve people, and encourage participation and personal contact, will play an important role in encouraging people to learn and absorb new information. Such activities include:

- Launching new initiatives, policies and strategies on World Suicide Prevention Day
- Holding conferences, open days, educational seminars or public lectures and panels
- Writing articles for national, regional and community newspapers and magazines
- Holding press conferences
- Securing interviews and speaking spots on radio and television
- Organising memorial services, events, candlelight ceremonies or walks to remember those who have died by suicide
- Asking national politicians with responsibility for health, public health, mental health or suicide prevention to make relevant announcements, release policies or make supportive statements or press releases on WSPD
- Holding depression awareness events in public places and offering screening for depression
- Organising cultural or spiritual events, fairs or exhibitions
- Organising walks to political or public places to highlight suicide prevention
- Holding book launches, or launches for new booklets, guides or pamphlets
- Distributing leaflets, posters and other written information
- Organising concerts, BBQs, breakfasts, luncheons, contests, fairs in public places
- Writing editorials for scientific, medical, education, nursing, law and other relevant journals
- Disseminating research findings
- Producing press releases for new research papers
- Holding training courses in suicide and depression awareness
- Conducting forums where researchers learn from practitioners about their needs in research knowledge

YOUR ACTIVITIES AND INITIATIVES MAY INSPIRE OTHERS

A list of initiatives and activities that have been undertaken around the world on previous World Suicide Prevention days is available on the website of the International Association for Suicide Prevention *(www.iasp.info)*. We encourage you to consult this list and see what others have done to publicise suicide prevention. Also, please fill out our form on the IASP website to tell us about your activities on WSPD 2006. You may also send information by mail to:

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A selection of these activities, with links to web-based information, will be provided on the IASP web site. Further information about suicide and suicide prevention is available on the website and the links we have posted on it.

www.iasp.info