September 10, 2007

World Suicide Prevention Day

"Suicide Prevention across the Life Span"

IASP AN INITIATIVE OF THE INTERNATIONAL ASSOCIATION FOR SUICIDE PREVENTION (IASP)

CO-SPONSORED BY THE WORLD HEALTH ORGANIZATION (WHO)

World Suicide Prevention Day on **September 10** is an annual event sponsored by the International Association for Suicide Prevention, in collaboration with the World Health Organisation. This year the theme of World Suicide Prevention Day is "**Suicide Prevention across the Life Span**". This theme has been adopted to emphasise the fact that suicide occurs in all ages and suicide prevention and intervention strategies may be adapted to meet the needs of different age groups.

There is a common misperception that suicide occurs mostly amongst the young. This belief has it's origins in research in the mid-1980s which showed that suicide had increased dramatically in young males in many countries. This trend focused attention on suicide as a major social issue for young people and led to an extensive focus on suicide research and prevention amongst young people.

While this focus was justified and led to much useful research and the development of appropriate interventions, it has tended to obscure the fact that suicide occurs across the lifespan. In almost all countries the majority of suicides, every year, occur not in young people, but in adults and older adults. Consequently, this year's theme for World Suicide Prevention Day is that **suicide occurs across the lifespan** and we must invest in suicide prevention programmes which address suicide in people of all ages.

We invite all those with an interest in suicide prevention – the public, organisations, 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 in organising activities to focus on preventing suicide for people of all ages.

SUICIDAL BEHAVIOUR: THE EXTENT OF THE PROBLEM

Each year approximately one million people die by suicide worldwide. Suicide is a major public health problem in many countries and accounts for nearly 3% of all world deaths.

- In very young adolescents (under age 15) suicide is the leading cause of death in China, Sweden, Ireland, Australia and New Zealand.
- In teenagers and young adults aged 15-24 suicide is a leading cause of death in many countries.
- In adults, suicide is a leading cause of death, accounting for more deaths than all wars and homicides combined.
- In most countries, the risk of suicide increases with increasing age. In many countries suicide rates are highest amongst the very old, aged 85 and older.

However, deaths from suicide are only one part of the problem. Attempted suicide is conservatively estimated to be 10 to 20 times more frequent than suicide, especially in younger women. While suicide attempts may vary in intent and medical severity, all attempts are indications of severe distress, unhappiness and/or mental illness.

Suicide and suicide attempts have a profound impact on family and friends and are the source of much distress and suffering. For individuals bereaved by suicide the emotional impact may last for many years, and for families the consequences may extend for generations.

The economic costs of suicide to society are substantial, estimated to be in the billions of dollars, and reflect the economic potential of years of life lost, the medical and treatment costs of suicide attempts, and the burden of care and suffering of families and friends of those who die by suicide and those who engage in various forms of suicidal behaviour.

SUICIDAL BEHAVIOUR ACROSS THE LIFE SPAN

Fortunately, suicide is not an inevitable burden that must be accepted by society. There are many ways in which suicide can be prevented. There is a great need for effective, coordinated and comprehensive suicide preventive initiatives throughout the world if we are to reduce the enormous numbers of completed suicides, suicide attempts and problems related to suicide and self-destructive behaviours.

Effective suicide prevention calls for an innovative, comprehensive multisectorial approach, including both health and non-health sectors, including education, labour, police, justice, religion, law, politics and the media.

SUICIDE IN CHILDREN AND YOUNG ADOLESCENTS (UNDER AGE 15)

In all societies suicide amongst children and young adolescents under the age of 15 is very rare and accounts for less than 2% of all suicides. There is a greater likelihood of suicidal behaviour in children who come from families in which there is parental violence, sexual or physical abuse or neglect, or in which there are family histories of alcohol and drug abuse, depression and suicidal behaviour. Depression in children appears to be a risk factor for

suicide although depressive symptoms in children may be difficult to recognise and diagnose. Symptoms of depression may include long lasting sadness, inability to concentrate, somatic complaints and anxiety. Some children may express depression by acting out or being angry. If children have several of these symptoms or the symptoms are intense and long-lasting they should be referred for professional consultation, particularly if they become interested in suicide or threaten suicide.

Young adolescents in welfare care are a population at particular risk of suicide since they tend to come from the most dysfunctional and disadvantaged families. In a number of countries children and young adolescents from indigenous communities, especially young males, are those most at risk of suicide. While indigenous young people may share risk factors with non-indigenous people, their cultural and historical background may present different risk factors and interpretations for suicidality. Factors such as cultural alienation, identity confusion, the impact of history through intergenerational modelling and behavioural transfer, and colonisation, may contribute to suicidal behaviour.

Although children and young adolescents very rarely die by suicide, they invariably experience suicidal behaviour, hear about it, see it on television and discuss it with other children. Since adults seldom talk about suicide with children, children's experiences and understanding of suicide tend to come from television and from other children and therefore tend not to be realistic.

Children usually understand that suicide is something that one should not do, but they tend not to appreciate the finality of death. It is important that children who are bereaved by suicide are given opportunities to express their feelings about the loss and, if necessary, given counselling or outside help.

The prospects of preventing suicide in very young adolescents at an individual level are limited by the fact that suicide is a very rare event and suicidal tendencies are difficult to identify. This suggests that the most effective approaches may be public health policies targeted at reducing sources of childhood adversity such as social inequity, and supporting early intervention programmes which provide assistance for at-risk and problem families.

A second approach is to support school-based programmes which focus on improving children's social, coping and problem-solving skills. A more targeted approach is to improve access and delivery of mental health services to children and young adolescents with mental health problems, with a particular focus on providing appropriate mental health care for the high risk population of young people in welfare care.

An important issue that arises with young adolescent suicide is the role that school policies may play in encouraging or inhibiting suicidal behaviour. While it may be appealing to locate suicide prevention programmes within schools in order to reach all children, few of these programmes have been rigorously evaluated.

Although it appears that some school based programmes that focus on identifying and offering help to at-risk and suicidal youth, including encouraging young people to use available mental health resources, may be potentially helpful, there is no evidence that brief information sessions in classrooms are useful, and there are suggestions that they may do more harm than good.

Finally, the way in which schools, organisations and communities manage the aftermath of suicide may play a role in suicide prevention. Young people are especially vulnerable to imitative suicidal behaviour and this may be encouraged by funeral and memorial services that eulogise the young who die by suicide.

SUICIDE IN ADOLESCENTS AND YOUNG ADULTS (AGE 15-24)

Youth suicide is a major public health problem and a leading cause of death in young people in many countries. Starting in the 1950s youth suicide rates, especially amongst young men, increased substantially. These increases are thought to reflect changing social and family conditions which impact on young people, including increased alcohol and substance abuse. More recently, in the 1990s, youth suicide rates have generally begun to decline. The reasons for this decrease are difficult to determine but may include socio-cultural differences in recent youth cohorts, decreased substance use and increased treatment of depression.

In most countries young men more often die by suicide than young women, although young women make more suicide attempts. This difference has been explained in many ways including men using more lethal methods for suicide attempts, being more reluctant to seek help for emotional problems, and being more likely to use alcohol and drugs. In China, however, young women in rural regions are more likely than men to die by suicide. This difference is attributed to the availability and use of lethal pesticides in suicide attempts, limited access to appropriate emergency treatment, and difficult personal, social and economic circumstances for young rural women.

Most young people who die by suicide tend to have mental health problems, including, notably, depression and alcohol and substance abuse. They are also likely to have histories of previous suicide attempts and psychiatric hospitalisation. Young people with antisocial and offending behaviours are also at risk. In young adolescents, childhood adversity, including family violence and parental mental health problems, increase suicide risk, particularly for those with experiences of multiple and enduring family problems. Suicidal behaviour is often precipitated by personal crises including the loss of a relationship, family or disciplinary problems or getting into trouble with the law.

Young people are more likely to make impulsive suicide attempts, and those with poor problem solving and coping skills are particularly vulnerable. Risks of suicidal behaviour are increased in gays and lesbians, those who have problems with school including school work, truancy or family expectations of high achievement, and those who are alienated from society and are not affiliated with school or work environments. Young people are also especially vulnerable to peer and media influences which may precipitate suicidal behaviour. Some young people, more often women, may make suicide attempts repeatedly as a means of coping with stressful situations.

The multiple risk factors associated with youth suicidal behaviour suggest several opportunities for prevention. One approach has focussed on educating "gatekeepers" who may, in the course of their work, come into contact with young people at risk of suicide. These include school staff, child welfare workers, community volunteers, coaches, family doctors, police and clergy. Gatekeepers may be provided with training to help them better identify and assess at-risk youth, improve identification and treatment of depression and other mental health problems and provide information about resources for young people with problems.

Another approach is to encourage help-seeking, particularly by young men, and to promote programmes which improve coping, problem solving and anger management skills in both young men and women. Restricting access to means of suicide,

where practicable, may reduce the risk of some impulsive suicide attempts.

Schools and colleges are obvious sites for prevention programmes. However, there is limited evidence for the effectiveness of programmes which involve students as identifiers and supporters of suicidal peers, and concerns and cautions have been raised about the safety of some such programmes. Overall, it seems the most prudent approach for suicide prevention in these sites is to use programmes which provide and encourage the use of a range of resources within the school and community, including trained teachers and counsellors, and information and training for parents, along with ensuring ready access to mental health services.

An important strategy is to provide appropriate treatment and care for young people with mental health disorders, particularly depression. Effective treatment may involve counselling, therapy and/or medication. Given the high rate of suicide attempts requiring hospitalisation among young people, it is important to ensure that this group receives appropriate treatment and care, both for the crisis which precipitated the attempt and in the longer term follow up after discharge from the hospital.

Suicides involving school and college students occur relatively infrequently. However, when they do, it is important that these institutions react in a way which minimises the risk of imitative suicidal behaviour to which young people are particularly vulnerable. There are well-recognised protocols to reduce such risks which can be adapted to the specific circumstances and environment.

It is important to avoid actions which glorify the suicide death, to minimise media coverage, to identify and give help to vulnerable peers and generally to ensure that vulnerable students do not come to believe that suicide is an effective way of gaining attention, sympathy or retribution.

SUICIDE IN ADULTS

Suicide is a leading cause of death in adulthood, especially amongst males. In many countries almost half of all suicides are accounted for by males aged 25-60. The profile of risk and protective factors for suicide in adults is similar in many ways to that for youth. The major exception is that childhood and family experiences appear to play a lesser role in suicidal behaviours in adults, and, conversely, mental health factors, difficult life circumstances and stressful life events emerge as being more influential. This is particularly evident for depression and alcohol and substance abuse disorders which play an increasingly significant role with increasing age.

The major implication of these findings is that suicide prevention approaches for adults should focus strongly on the improved identification, treatment and management of depression and the better recognition of the life stresses, social, family and related factors that may contribute to the development of depression and suicidal behaviours in this age group.

While depression is the strongest risk factor for suicidal behaviour in both adult men and women, women are more likely to seek help than men. This suggests that a major approach to addressing suicide in adult men is through programmes which seek to educate the public about the symptoms of depression and encourage help seeking amongst men who are depressed. Many of those who seek help for depression do so through their family doctors and many people who die by suicide see a doctor in the week before their death. Educating doctors about recognising, treating and managing depression can reduce suicide rates. These visits provide an opportunity for doctors to assess the extent of depression and of suicide risk, and to develop appropriate treatment and management plans that involve the person's social support and various community agencies and caregivers.

This approach can also be extended to enhance doctors' recognition and management of other mental illnesses, including alcohol and substance abuse. Other community members including family, employers, work colleagues and clergy can be helpful in recognising symptoms of depression and substance abuse in men and encouraging them to seek treatment.

The workplace offers an important site for suicide prevention for adults. Workplace programmes could focus on destigmatising help seeking for mental health and personal problems in men, and encouraging identification and treatment of depression and alcohol and substance abuse problems. Work stresses such as changing industry, agricultural or workplace practices, economic downturns, threats of unemployment and financial stresses place adult men at risk of suicide. However, there has been relatively little investment thus far in developing workplace-based suicide prevention programmes.

Family stresses including separation, divorce and child custody disputes also increase risk of suicide, suggesting that the family court system is, for some, an appropriate site for developing programmes which identify at-risk men. Other sites that may be important for locating vulnerable men include courts, prisons, pubs and sports and leisure facilities.

Restricting access to lethal means of suicide, including firearms, pesticides, vehicle exhaust gas, drugs which are lethal if taken in overdose, and installing barriers at sites which become popular for suicide are all approaches which can reduce suicides, especially those which occur impulsively.

SUICIDE IN OLDER ADULTS

In many countries suicide rates are highest amongst older adults, especially those aged 85 and older. Generally, older men are at much higher risk of suicide than older women. The progressive ageing of the population in the developed, and developing, world suggests that both the numbers and rates of suicide amongst older adults can be expected to increase as a consequence of the cumulative effects of longer life expectancy, pressure on health resources and an increased fraction of the older population with physical illnesses and disabilities. Older adults are less likely to survive suicide attempts than younger people, they tend to choose more lethal methods of suicide which may reflect a stronger intent to die and they tend to make suicide attempts which are more carefully planned and implemented.

Depression plays a more important role in older adults. Many older suicide victims are seen by their primary care provider a few weeks prior to their suicide attempt and diagnosed with mild to moderate depression. Older adults who are suicidal are also more likely to be suffering from physical illness or pain, and older men tend more often to be divorced or widowed. At-risk older people may also fear a prolonged illness, be socially isolated and lonely, and have recently had major changes in social status, such as retirement. Depression is often unrecognised in older adults since it is difficult to differentiate from the effects of many illnesses that are more common in old age and the side effects of some medications that are used to treat these illnesses.

Older adults seem to be protected from suicide if they have a supportive, close relationship, social support and interaction, participation in organisations, interests and hobbies, strong religious

or spiritual values, adequate support following bereavement and respite from family discord and conflict.

While improving recognition of depression is a major approach to suicide prevention in older adults, other approaches include: exploring the effectiveness of community gatekeepers who have contact with older people in identifying and referring those who might be at risk of depression and suicide; developing community programmes which promote social contact, interventions and support; ensuring older adults receive adequate support after bereavement; restricting access to lethal means of suicide especially firearms and medications, and developing more effective ways of maintaining contact with older adults by health services.

Efforts to prevent suicide in older adults often face barriers since suicide in older people may be regarded as a more understandable and rational decision while youth suicide is seen as more tragic and deserving of prevention. Research on ageing has found that older people often have better coping skills than youth and they respond as well or better than younger age groups to psychotherapeutic interventions. This suggests that suicide prevention amongst older adults may need to include education of the public and health care providers about features of healthy ageing, signs and symptoms of depression and community and health care provision of supportive care.

PREVENTING SUICIDE: WHO CAN HELP

Effective suicide prevention involves a multifaceted and intersectoral approach to address the multiple causes and pathways to suicidal behaviour across the lifespan. The range of people who can be involved in suicide prevention includes heath and mental health 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 2007, "Suicide Prevention across the Life Span", is an opportunity for researchers, clinicians, practitioners, community and voluntary organizations to disseminate information about the nature of suicidal behaviour in different age groups, and the most effective approaches to preventing suicide. 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 across the lifespan.

WORLD SUICIDE PREVENTION DAY ACTIVITIES: WHAT CAN BE DONE

On World Suicide Prevention Day a range of activities can be used to highlight this year's theme. Initiatives which actively engage, educate and involve people, and encourage participation and personal contact, will play an important role in helping people 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

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 what activities you plan for WSPD 2007. Further information about suicide and suicide prevention is available on the website and the links we have posted on it.

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