

ABOUT THE WORLD FEDERATION FOR MENTAL HEALTH

Founded in 1948, the World Federation for Mental Health advances, among all peoples and nations, the prevention of mental and emotional disorders, the proper treatment and care of those with such disorders, and the promotion of mental health. WFMH's organizational and individual membership includes mental health workers of all disciplines, consumers/users of mental health services, family members, and concerned citizens. It is accredited in consultative status to the United Nations and its specialized agencies, and works closely with the World Health Organization. Throughout its history, WFMH has actively advanced the concerns of persons with mental illnesses before international forums, both private and governmental, and in supporting the efforts of its member organizations at the national and regional level.

Vision

WFMH envisions a world in which mental health is a priority for all people. Public policies and programs reflect the crucial importance of mental health in the lives of individuals.

Mission

WFMH's mission is to promote the advancement of mental health awareness, the prevention of mental disorders, advocacy, and best-practice recovery-focused interventions worldwide.

Goals

WFMH works to:

- Heighten public awareness about the importance of mental health, and gain understanding and improve attitudes about mental disorders
- Promote mental health and prevent mental disorders
- Improve the care, treatment, and recovery of persons with mental disorders



ABOUT WORLD MENTAL HEALTH DAY 2006

World Mental Health Day 2006, observed on October 10, marked the launch of a year-long, global awareness campaign. Its theme: *“Building Awareness—Reducing Risk: Mental Illness and Suicide.”*

Objective

World Mental Health Day aims to raise global awareness to counter the commonly held perception that mental illnesses are a secondary health concern that can be delayed until more immediate and pressing health care issues have been tackled. Left undiagnosed and untreated, mental illnesses can be fatal, and they must be addressed as an issue of utmost importance.

World Mental Health Day serves to unify the global mental health effort, to create one purpose, and to mobilize and speak in one voice in educating the world about mental health.

Key Issues

The urgency of WFMH’s awareness-raising campaign on suicide and suicide prevention is based on the following facts:

- Suicide is one of the world’s greatest public health epidemics.
- The World Health Organization estimates one million deaths by suicide annually. This tally represents fully 1.4 percent of the total global burden of disease.
- Mental illness is the greatest single risk factor for suicide. People with mental illnesses are a special population at risk.
- Good mental health care can reduce the risk of suicide among people with a mental illness.
- Culture, religion, and media play important roles in how the relationship between mental illness and suicide is addressed in different countries.

Activities

Since the first World Mental Health Day in 1992, more than 4,000 organizations in 150 countries have joined in action. Grassroots advocacy groups, national and local governments, and many other diverse organizations sponsor activities to highlight mental health as a global concern.

Each participating organization decides on its own activities, and WFMH makes available guidelines and background for both social programming and policy action designed to involve communities, government officials, and the media. Materials for Mental Health Day, translated into a variety of languages, can be accessed and downloaded at www.wfmh.org.

WORLD SUICIDE PREVENTION DAY 2006: WITH UNDERSTANDING, NEW HOPE

The International Association for Suicide Prevention (IASP), in collaboration with the World Health Organization (WHO), uses World Suicide Prevention Day each year on September 10 to call attention to suicide as a leading cause of premature and preventable death. World Suicide Prevention Day 2006 was organized by IASP with the collaboration of the World Federation for Mental Health. World Suicide Prevention day aims to:

- Raise awareness of suicide at a global level
- Bring together available knowledge and expertise
- Facilitate wider dissemination of the fundamentals of effective suicide prevention to both professional groups and the general public

Suicide is a complex issue with multiple causes, a statement that might give the message that, because of suicide's complexity, it is not preventable. But IASP asserts that it is important to project a message of recovery and hope, that prevention of suicide indeed is possible.

World Suicide Prevention Day 2006 focused on translating current scientific knowledge and research about the etiology of suicide into practical programs and activities that can reduce suicidal behavior and save lives. The following presents an overview of the knowledge and research.

Extent of the Global Problem

The following statistics illustrate the extent of the global problem:

- One million suicides per year, every year
- Suicide attempts amounting to 10-20 times as many suicides
- Five to six people estimated to be affected directly by each suicidal person's behavior
- Strong multiplier effect leading to 100-120 million people impacted by suicide each year
- More suicides each year than deaths by war and homicides combined
- Significant source of economic loss where suicide death and attempts affect productive life years
- Preventable public health problem

Etiology of Suicide

The pathways to suicidal behavior often are complex. Typically, multiple risk factors are present, as well as reduced protective factors. Research has helped refine the range and type of risk and protective factors, but many of the efforts have focused on populations of developed nations. Research efforts in developing nations, and among indigenous populations in particular, have highlighted the importance of dire economic conditions and threats to protective aspects of cultural identities in suicide risk. The following have been found to be risk factors, but it is unlikely that any one risk factor leads to suicide behavior:

- Although most people with mental illness do not die by suicide, mental illness increases the risk of suicide tenfold.
- Genetic and biochemical factors, such as impulsivity and aggressiveness, contribute to risk.
- Family history increases risk of suicidal behavior.
- A prior suicide attempt increases risk of suicide.
- Childhood adversity is a risk factor.
- Socioeconomic, educational, and social disadvantage are risk factors.
- Religious and cultural influences play roles in suicidal behavior.
- Access to lethal means is a risk factor.
- Stressful life events constitute a risk factor.
- Etiological research has been dominated by a Western perspective.

Promising Areas for Intervention

Information about suicide risk exceeds information on proven approaches to decrease suicide risk. Nevertheless, the following approaches are seen as either tested or promising areas for intervention:

- Educating physicians
- Restricting access to lethal means of suicide
- Educating the community and gatekeepers
- Screening programs for depression and substance abuse
- Improving mental health treatment and management
- Providing support after suicide attempts
- Improving media depictions and portrayals
- Crisis interventions and psychotherapeutic interventions

For more information about the International Association for Suicide Prevention and World Suicide Prevention Day, visit IASP's website at www.med.uio.no/iasp.

ABOUT THIS PUBLICATION

Evidence Base

To review the evidence base for the WFMH Initiative on Mental Illness and Suicide and for the 2006 World Mental Health Day campaign, a group of international experts participated in an invitational forum and roundtable discussion on the topics of mental illness, suicide, and suicide prevention. The distinguished panelists represented a variety of disciplines, perspectives, and regions of the world. (See International Expert Panel: Participants, on pages 47–48).

Several panelists set the context in the following presentations:

- Global perspective of mental illness and suicide (pages 8–11)
- Relationship between mental illness and suicide (pages 12–14)
- Epidemiology of suicide in regions around the world (pages 15–20)

The group of experts then contributed their knowledge to the discussion and subsequently formulated key messages to guide the awareness campaign. The compiled knowledge in this publication is published primarily to inform the large grassroots mental health advocacy, educational, consumer/caregiver, and service constituencies represented by WFMH's membership and the more than 4,000 organizations that participate in World Mental Health Day.

Major Topic Areas

Major topic areas considered by the panelists included:

- Mental illness as a major risk factor for suicide
- Addressing mental illness and suicide across the life span
- Reducing risk: how suicide rates can be reduced for people with mental illnesses
- Culture and religion: cross-cultural perspectives
- Media matters!

2006 World Mental Health Day, focusing on the theme ***“Building Awareness-Reducing Risk: Mental Illness and Suicide”***, proved to be one of the most widely commemorated and most successful in the 14-year history of the WMHDay global mental health awareness campaign. WFMH greatly appreciated the opportunity to collaborate with the International Association for Suicide Prevention (IASP) and to coordinate the activities of both World Suicide Prevention Day and World Mental Health Day. Many other organizations, institutions, and corporations supported this campaign and made its success possible.

Preston J. Garrison
Secretary-General & Chief Executive Officer
World Federation for Mental Health



At the Dulles Forum (left to right): Addressing the meeting, José Manoel Bertolote (WHO, Geneva); L. Patt Franciosi (Immediate Past President, WFMH); Lakshmi Vijayakumar (Head, Psychiatry Department, Voluntary Health Services, Chennai, India); and Susan Thonell (Executive Director, Lifeline International, South Africa).

KEY MESSAGES

Expert panelists addressed the main task of the meeting—to capture key messages and themes to communicate on World Mental Health Day 2006 and beyond. For details that underpin the messages summarized here, as well as additional concepts, see the chapter *What We Know* (page 21).

- 1 Relationship between mental illness/disorders and suicide
 - More than two thirds of suicides are linked to mental disorders.
 - Depression, alcohol and drug abuse, and schizophrenia are associated with the majority of these suicides.
 - Mental disorders can be treated, and suicides can be prevented with appropriate care.
 - People can help prevent suicide.
2. Reducing the risk of suicide for people with mental disorders
 - Improve recognition, treatment, and long-term management of mental disorders.
 - Provide intensive follow-up and support for persons who make suicide attempts.
 - Offer support from the community. Individual treatment linked to community support can save lives.
 - Provide help in crisis situations.
 - Increase public awareness that suicide is preventable.
 - Restrict access to means.
3. Treating mental illness/disorders to prevent suicide
 - Effective psychotherapeutic approaches
 - Establish a relationship with a helper.
 - Talk about suicide or why you are suicidal.
 - Stay connected.
 - Role and impact of medication
 - With appropriate evaluation, diagnosis, and follow-up, many medications can be a part of an effective management strategy.
 - Education about the risks and benefits of medication—for the person with a mental illness, family members, and/or significant supporters—can help the person adhere to a treatment plan and manage the illness.
4. Cultural and religious considerations in addressing issues of mental illness and suicide
 - Suicide and mental illnesses/disorders always have a social/cultural context.
 - Spiritual and religious beliefs can either protect against or enhance suicide risk.

- Understanding the individual's belief system—both spiritual and cultural—can enhance the capacity to help individuals with mental and substance-use disorders, family and social stressors, and, therefore, suicide risk.
 - Engaging and enabling the inherent strengths and networks of each culture are important strategies.
 - Any suicide prevention program must be locally relevant and culturally appropriate.
5. Media depiction of mental illness and suicide
- Media matters in the responsible depiction of mental illness and suicide.
 - Media
 - Follow guidelines on reporting suicide, according to country and culture.
 - Suggest referrals to reputable resources, including help lines and clinicians.
 - Be part of the solution, not the problem.
 - Advocates
 - Foster partnerships with the media and be prepared.
 - Develop public service announcements about the message; produce sample public service announcements to be used on radio.
 - Be simple, not simplistic.
 - Offer incentives to the media, such as an award program, for responsible depictions of suicide.
 - Parents. Be aware of what your children are doing on the Internet.



At the Forum, (left to right): Brian Mishara (Canada), Myron Belfer (United States), Sylvia Paláez (Uruguay) and John Connolly (Ireland).

THE CONTEXT

Mental Illness and Suicide: A Global Perspective

The World Health Organization (WHO) reports that at least a million suicides occur each year—but suicide is underreported virtually everywhere, making the problem far greater than the available data indicate.

Deaths by suicide occur unevenly in geographical regions around the globe. Most recorded incidents take place in Asia, Australia, and Europe. North America, along with a number of other countries, is next, followed by Latin America and several additional nations. Incomplete statistics are available for deaths by suicide for most of Africa.

Suicide Rates

Researchers have studied only a small percentage of suicides, and enormous data voids make broad characterization of the relationship between suicide and mental disorders problematic. Furthermore, most data come from Western countries, and recent studies suggest that the situation may be different in other parts of the world, such as in China. Of the diagnoses described in the few studies conducted, mood disorders (including depression) were linked to suicide in 30.5 percent of cases, followed by substance-related disorders (with emphasis on alcohol and a minor contribution of drug abuse) at 17 percent; schizophrenia, 14 percent; personality disorders, 12 percent; and other diagnoses, 22 percent. Many of these conditions are co-occurring. Fully 80 percent of the cases studied came from only three nations: the United Kingdom, Denmark, and Israel. Again, the amount of information that is not known about suicide, especially about suicide in less developed parts of the world, remains staggering, and the difficult-to-conduct research requires resources beyond the means of most nations.

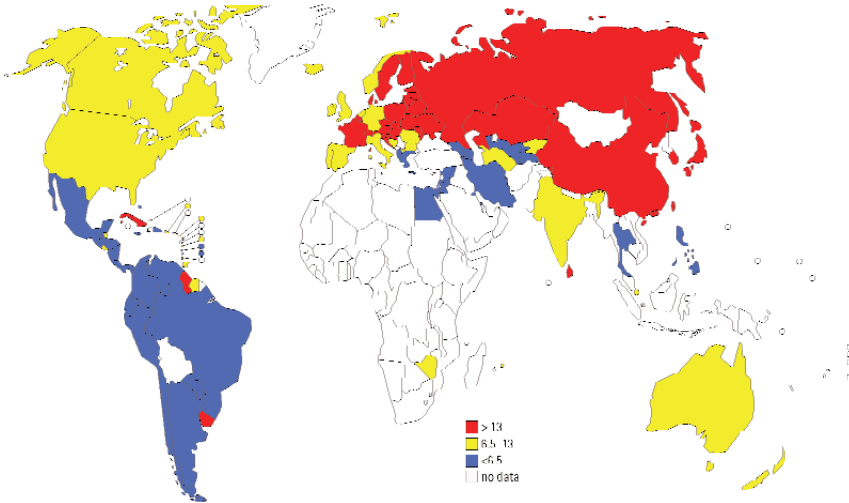
A WHO list of suicide rates by country is presented at Table 1 (pages 9–11). There is a significant difference between rates for males and for females. Only in China do more women take their own lives than men, particularly in the countryside where highly toxic pesticides are the most common means. Countries with the highest rates of suicide are Lithuania, Belarus and Russia. Reflecting population size, countries with high numbers of suicides include China, India, Russia, the United States and Japan.

WHO advocates for effective public health interventions for suicide prevention using the following strategies:

- Control of toxic substances
- Treatment of mental disorders
- Handgun control
- Deglamourizing media reports

More people die from suicide than from all homicides and wars combined.

Map of Suicide Rates
(per 100,000, most recent year available as of 2007)



Source: World Health Organization (2007)

The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dashed lines represent approximate border lines for which there may not yet be full agreement.

Table 1. Suicide Rates (per 100,000), by Country, Year, and Sex
Source: World Health Organization (2007)

Country	Year	Males	Females
ALBANIA	03	4.7	3.3
ANTIGUA AND BARBUDA	95	0.0	0.0
ARGENTINA	03	14.1	3.5
ARMENIA	03	3.2	0.5
AUSTRALIA	03	17.1	4.7
AUSTRIA	05	26.1	8.2
AZERBAIJAN	02	1.8	0.5
BAHAMAS	00	6.0	1.3
BAHRAIN	88	4.9	0.5
BARBADOS	01	1.4	0.0
BELARUS	03	63.3	10.3
BELGIUM	97	31.2	11.4
BELIZE	01	13.4	1.6
BOSNIA AND HERZEGOVINA	91	20.3	3.3
BRAZIL	02	6.8	1.9
BULGARIA	04	19.7	6.7
CANADA	02	18.3	5.0
CHILE	03	17.8	3.1

continued on pages 10-11

Table 1. (continued)

Country	Year	Males	Females
CHINA (Selected rural & urban areas)	99	13.0	14.8
CHINA (Hong Kong SAR)	04	25.2	12.4
COLOMBIA	99	8.2	2.4
COSTA RICA	04	12.1	1.6
CROATIA	04	30.2	9.8
CUBA	04	20.3	6.6
CZECH REPUBLIC	04	25.9	5.7
DENMARK	01	19.2	8.1
DOMINICAN REPUBLIC	01	2.9	0.6
ECUADOR	04	8.6	3.7
EGYPT	87	0.1	0.0
EL SALVADOR	03	12.2	4.2
ESTONIA	05	35.5	7.3
FINLAND	04	31.7	9.4
FRANCE	03	27.5	9.1
GEORGIA	01	3.4	1.1
GERMANY	04	19.7	6.6
GREECE	04	5.2	1.2
GUATEMALA	03	3.4	0.9
GUYANA	03	42.5	12.1
HAITI	03	0.0	0.0
HONDURAS	78	0.0	0.0
HUNGARY	03	44.9	12.0
ICELAND	04	17.7	6.2
INDIA	98	12.2	9.1
IRAN	91	0.3	0.1
IRELAND	05	16.3	3.2
ISRAEL	03	10.4	2.1
ITALY	02	11.4	3.1
JAMAICA	90	0.3	0.0
JAPAN	04	35.6	12.8
JORDAN	79	0.0	0.0
KAZAKHSTAN	03	51.0	8.9
KUWAIT	02	2.5	1.4
KYRGYZSTAN	04	15.0	3.0
LATVIA	04	42.9	8.5
LITHUANIA	04	70.1	14.0
LUXEMBOURG	04	21.9	7.4
MALTA	04	7.0	4.9
MAURITIUS	04	12.7	3.6
MEXICO	03	6.7	1.3

Table 1. (continued)

Country	Year	Males	Females
NETHERLANDS	04	12.7	6.0
NEW ZEALAND	00	19.8	4.2
NICARAGUA	03	11.0	3.7
NORWAY	04	15.8	7.3
PANAMA	03	11.1	1.4
PARAGUAY	03	4.5	1.6
PERU	00	1.1	0.6
PHILIPPINES	93	2.5	1.7
POLAND	04	27.9	4.6
PORTUGAL	03	17.5	4.9
PUERTO RICO	02	10.9	1.8
REPUBLIC OF KOREA	04	32.5	15.0
REPUBLIC OF MOLDOVA	04	29.3	5.2
ROMANIA	04	21.5	4.0
RUSSIAN FEDERATION	04	61.6	10.7
SAINT KITTS AND NEVIS	95	0.0	0.0
SAINT LUCIA	02	10.4	5.0
SAINT VINCENT AND THE GRENADINES	03	6.8	0.0
SAO TOME AND PRINCIPE	87	0.0	1.8
SERBIA AND MONTENEGRO	02	28.8	10.4
SEYCHELLES	87	9.1	0.0
SINGAPORE	03	12.5	7.6
SLOVAKIA	02	23.6	3.6
SLOVENIA	04	37.9	13.9
SPAIN	04	12.6	3.9
SRI LANKA	91	44.6	16.8
SURINAME	00	17.8	6.4
SWEDEN	02	19.5	7.1
SWITZERLAND	04	23.7	11.3
SYRIAN ARAB REPUBLIC	85	0.2	0.0
TAJIKISTAN	01	2.9	2.3
THAILAND	02	12.0	3.8
TFYR MACEDONIA	03	9.5	4.0
TRINIDAD AND TOBAGO	00	20.9	4.9
TURKMENISTAN	98	13.8	3.5
UKRAINE	04	43.0	7.3
UNITED KINGDOM	04	10.8	3.3
UNITED STATES OF AMERICA	02	17.9	4.2
URUGUAY	01	24.5	6.4
UZBEKISTAN	03	8.1	3.0
VENEZUELA	02	8.4	1.8
ZIMBABWE	90	10.6	5.2

UNDERSTANDING THE RELATIONSHIP BETWEEN MENTAL ILLNESS AND SUICIDE

Why do people with mental illnesses have a greater risk of suicide? The answer may *seem* obvious, but suicide rates and methods vary from region to region. With regard to method, in the United States, for example, handguns are the means of choice in 61 percent of suicides. Pesticides account for 58 percent of suicide deaths in China, and 48 percent of suicides in Canada result from hanging.

In general, suicide is a rare event. Most people who seriously consider suicide do not make an attempt, but rather find other ways to handle their problems. Many persons who attempt suicide do not die by their attempts, because they change their minds or find help along the way. Although people generally get help, a wide net must be cast to target high-risk groups and to have a significant preventive effect.

Suicide results from multiple factors,* but people with mental health problems are at highest risk. Mental disorders (including alcohol and drug problems) are highly associated with suicide (up to 90 percent in the West, but less so in Asia). Nevertheless, a relatively small proportion of persons with mental disorders die by suicide.

Why is the risk greatest for persons with mental disorders? Why do most people with mental illnesses not kill themselves? Why, with some mental disorders does greatest risk occur at the onset, while with others risk increases with time? Several explanations are possible:

1. **Suicide and mental illness may have a common etiology.** Suicide and mental illness relate to the same risk factors, and therefore may have an association. Perhaps the biogenetic and psychosocial vulnerability that leads to mental illness also brings about suicide, triggered by negative life events, isolation, and loneliness. Nevertheless, some studies illustrate different biogenetic pathways for mental disorders and suicide.
2. **Some mental disorders may be alternatives to suicide.** A person may turn to alcohol or drugs as self-medication to treat his or her problems—or, alternatively, a person may use substances as a slow, indirect means to take his or her own life. Perhaps obsessive-compulsive disorders may be a means to control suicidal impulses.
3. **Suicide can be a direct consequence of some types of mental illness.** In this scenario, a mental disorder results in cognitive distortions, depressive delusions, or psychotic command hallucinations that signal to a person there is no way out.
4. **People with a mental illness can feel hopeless and/or stigmatized.** They may be under-employed or unemployed, unable or unlikely to sustain satisfying family relationships, marginalized, and dependent. With these consequences of living with a mental illness, suicide chances increase.

*The World Health Organization cites a large number of complex underlying causes for suicidal behavior, including poverty, unemployment, loss of loved ones, arguments, breakdown in relationships, legal or work-related problems, family history of suicide, alcohol and drug abuse, childhood abuse, social isolation, physical illness, disabling pain, and some mental disorders.

5. **Higher risk can be linked to inadequate, inappropriate, or incomplete treatment of mental illness.** Suicide may follow when a person does not have adequate outpatient follow-up after a suicide attempt, when the level of medications is insufficient, or when persons do not fill their prescriptions or take prescribed medications. In addition, controversial studies of the class of antidepressants known as SSRIs show that a possible side effect may be increased risk of suicidal thoughts or attempts.

Many clinicians believe that suicidal risk can increase during treatment when energy improves, but mood or hopelessness has not improved. Care providers—professionals as well as family members—need to be vigilant and watch for warning signs throughout treatment. Where appropriate, such a “team” approach can provide for both enhanced support and improved safety during treatment.

The following model can be useful to explain the interaction of mental illness and suicide: Substantial research shows that biogenetic vulnerability, activated in the presence of negative life experiences, can increase the risk of developing mental disorders. People with mental disorders experience cognitive distortion and adverse impacts from the stigma of their disorders, and they may or may not obtain sufficient or appropriate treatment. In other words, the effects of living with mental disorders can increase the risk of suicide. For someone to become suicidal, the risks may be triggered by a crisis—some event on a particular day. To take one’s own life, an acceptable means must be available, such as a gun or poison.* People with social supports and confidants have less risk for taking their own life. How one copes with the various problems with which one lives is related to suicide prevention. Table 2 summarizes these risk factors and suggests preventive interventions.

Table 2. A Suicide Prevention Model

Risk Factors	Preventive Interventions
Biogenetic vulnerability	Identify vulnerable individuals (depends on future biogenetics research)
Past and recent negative life events (for example, child abuse or neglect, loss of job, or divorce)	Prevention of negative life events
Mental disorders <ul style="list-style-type: none"> • Stigma and negative impacts of mental illness • Disinhibition • Cognitive distortions • Insufficient/inappropriate treatment 	Treat mental disorders <ul style="list-style-type: none"> • Reduce stigma and negative impacts • Educate caregivers and the general public • Promote best practices among people who treat and help persons with mental disorders • Create supportive environments
Crisis situation	Crisis intervention
Availability of acceptable means	Control of access to means
Lack of help or social supports	Increase social supports
Poor coping skills	Teach effective coping skills

*According to the World Health Organization, worldwide the most common methods are pesticides, firearms, and medications such as painkillers, which can be toxic when consumed in large amounts.

Research has investigated the relationship of suicide risk to the onset of disorders. What mechanisms account for differences in suicide risk?

The degree of suicide risk varies depending on the mental disorder, but the severity of symptoms may not be solely at issue. The suicide risk associated with mental disorder may be related to inadequate treatment and/or unsatisfactory treatment outcomes. It also is possible that the consequences of living with the disorder, including discrimination and stigma and their impact on an individual's life, may increase the risk of suicide. On the other hand, some severe mental illnesses may protect against the ability to arrange one's own suicide—for example, severe depression immobilizes a person, and psychoses reduce one's ability to organize an attempt. In the case of alcohol abuse, increased incidence of suicide after a long period of alcohol abuse may be explained not so much by increased symptoms, but by the build-up of the social burden of living with the problem. Alcohol abuse may produce biochemical changes in the brain, and the social impact of being an alcoholic in society may increase one's vulnerability to suicide. (See Table 3.) It is important to note that evidence of a history of a suicide attempt in the context of any of these disorders is the greatest predictor of risk for death by suicide.

It is not possible to draw simple conclusions about the link between mental illness and suicide risk. Nevertheless, a combination of causal pathways may explain the link (and, as noted above, in some instances, the pathways may lead in the direction of protection against suicide).

Table 3. Mental Disorders and Suicide Risk

Mental Disorder	Time of High Suicide Risk
Affective disorders	Early (first episode of major depression: 1-3 months)
Conduct disorders	3 years after initial diagnosis
Schizophrenia	2-16 years, with greater risk earlier in the illness
Alcohol abuse	10+ years of alcohol abuse

MENTAL ILLNESS AND SUICIDE: REGIONAL PERSPECTIVES

To provide a context for the discussions of the Forum, several members presented brief regional overviews regarding mental illness and suicide based on their experience and observations. (Comprehensive insight into understanding the relationship between mental illness and suicide in the parts of the world covered is beyond the scope of this publication.) Those observations and perspectives are summarized here.



At the Forum, left to right: Myron Belfer (United States), Annette Beutrais (New Zealand), Richard McKeon (United States) and Loraine Barnaby (Jamaica).

Africa

Suicide is shrouded in secrecy and attracts stigma in most African countries. Most African countries do not report data on suicides to the World Health Organization. African authorities often record suicide as "death by unnatural causes," creating difficulty in compiling accurate statistics. Ostracization of individuals and families is common, which explains in part why suicide often is hidden. On many African countries' statutes, suicide is a criminal act. African nations' limited mental health specialists and inadequate mental health infrastructure are compounded by underfunding of research and the official system for reporting deaths. South Africa produces few, but good, studies of suicide. Attention to general mental health and suicide in Southern Africa, and South Africa in particular, takes second place to infectious diseases (particularly HIV/AIDS) and trauma (due to high crime rates).

As Western-style individualism has developed, South Africa has suffered from breakdowns in traditional communal systems, extended families, and community networks. Migration also is an issue in the region. The return of families from exile for political reasons creates adjustment and acceptance difficulties among foreign-born children. A major increase in suicide in Black communities has occurred, especially among youth in Soweto. South African police officers experience high rates of trauma and also of suicide; with no supports in place to address mental health issues, officers are unable to debrief. Family murder-suicides are a South African phenomenon, predominantly in the white community.

In most African countries, where suicide is shrouded in secrecy and attracts stigma, it is recorded as death by unnatural causes.

HIV/AIDS is poorly researched, but its highest incidence occurs among persons ages 25-29. A causal link exists between receiving positive results of HIV/AIDS infection and suicide, particularly in this age group. In HIV/AIDS-related suicides, five times more males take their lives than females, while three times more females than males attempt suicide. Depression is implicated in about 80 percent of HIV/AIDS-related suicides. Substance abuse is a significant component of the HIV/AIDS pandemic. South Africa also sees suicide related to relationship problems and depression, adjustment disorders and depression, major depressive disorders, and inadequate access to health care.

Asia

Asia accounts for 61 percent of the world's suicides, with 500,000 annually in India, China, and other parts of Asia. Because Asian censuses are unreliable and registration systems are inadequate, the undercount may amount to 50 percent or more. For 68 percent of Asian nations, no data is available; however, since data is available for both India and China, data are lacking for only 20 percent of Asia's population.

In the majority of Asian nations, most suicides take place before age 30, which results in great economic and social losses to the family and community. More Asian females take their own lives than men, with Asian females at highest risk in the world. In Japan, a developed country, the gender ratio is considerably less. In Asia the majority of people who die from suicide are married, with married women at highest risk.

Suicide methods used in Asia include poisoning, hanging, and self-immolation (almost 10 percent). These methods indicate major differences in suicidal behavior between developed Western countries and Asian countries.

In Pakistan and other Asian Muslim countries, which have low suicide rates, data show that suicidal ideation appears at a high level. Religious strictures may account for this dichotomy. Depression as a cause of suicide has limited validity in Asia, particularly because most depression identified is mild to moderate, rather than chronic, depressive illness. In Asia the majority of suicides occur at earlier ages, while the severity of depression increases as years go by.

Substance abuse plays a large role in suicide, nearly equal to that of depression at almost 35 percent, except in China because of lack of availability. Availability of alcohol is gradually increasing, however, as is alcoholism. Social drinking is not a way of life in Asian countries, and most suicides related to alcoholism occur in later years after a minimum of ten years of severe dependence. Schizophrenia accounts for only 4-7 percent of persons with mental disorders who die by suicide, while personality disorders are common. In many cases of males with paranoid schizophrenia who suspect their wives' fidelity, their wives take their own lives; research shows that desertion or separation from one's husband creates more stigma than mental illness.

Similar to findings in Western studies, almost one third of Asian people who die by suicide have made a previous attempt. Nevertheless, a family history of suicide has significance for suicide in Asia, whereas previous attempted suicide does not. Far fewer co-occurring disorders in Asia than in Western countries are identified along with mental disorders. Few persons are treated for depression or other disorders. On the whole, mental disorders probably occur less frequently in Asia, compared to

Western countries, but even at the lowest estimate, more than two-thirds of Asian persons who die by suicide have mental disorders.

According to the WHO Atlas, in Southeast Asia, mental health professionals in various disciplines account for only 0.8 per 100,000 persons. This represents a serious lack of personnel. In 80 percent of Asian countries, nongovernmental organizations and traditional healers provide mental health services.

Latin America

Indicators of conditions on the Latin American continent show dramatic contrasts and inequalities. Life expectancy, population growth, illiteracy, and unemployment constitute extreme problems; they affect women in particular. Teachers and doctors may have insufficient awareness of the languages, customs, and traditions of rural areas. Access to physical and mental health care is limited in many areas. Infant mortality is high. Public health and educational expenditures are limited. As a result suicide is a major—though hidden—concern in Latin America.

Latin American women suffer from poverty, discrimination, acculturation, adolescent pregnancy, unsafe abortions, illiteracy in rural areas, lack of documentation in rural areas, sexual abuse in the community and within the family, and trafficking in women. Problems in addressing these issues include lack of research and funds. Children and young adults also are particularly vulnerable in many parts of Latin American society.

Mental health has not been a priority in Latin America. Treatment often is unavailable for those who need it. An estimated 12-29 percent of adults in developing countries have a mental illness. Although in most Latin American countries official suicide figures are far lower than studies indicate, suicide is a serious problem for the population ages 15-24 years in Chile, Uruguay, Costa Rica, and Ecuador. Suicidal behaviors often are linked to easy access to firearms and abuse of alcohol and drugs.

The Mexican suicide rate is 3.7 per 100,000 people, with hanging the method used most commonly. The greatest increase in suicides from 1990 to 2001 occurred in both males and females ages 11-19 years and among men over 65 years. Suicide is the second leading cause of death for Mexican youth ages 15-19 after traffic accidents (Puentes-Rosas et al., 2004).

The Association of Suicidology in Latin America and the Caribbean recently has been established. In 2009 the 25th World Congress of the International Association for Suicide Prevention will convene in Uruguay.

Caribbean

The Caribbean Basin refers to the islands and mainland territories that abut and contain the Caribbean Sea. These territories, though similar in some respects, are a culturally heterogeneous group composed of four language groups—English, French, Spanish, and Dutch—that correspond to the nationalities of their European colonizers. Because of enslavement by their colonial masters, harsh working conditions, and disease, many of the native Indian people died. Large numbers of African slaves replaced them, and, later, around the time of abolition (the middle half of the nineteenth century), Indian indentured servants were deployed to several countries. Among all the groups enslaved in the Caribbean (native Indians and Africans) and

impacted by enforced separation from family, harsh conditions of servitude, and a sense of lack of control or means of escape, suicide rates were higher than in contemporary Caribbean society. Acts of suicide during the period of enslavement are well documented in historical treatises and by the presence of mental hospitals for slaves run by Catholic priests.

The Pan American Health Organization/WHO has obtained statistics from Caribbean nations, but the figures are not always complete. Nevertheless, Holder and Lewis (1997) contend that suicide is one of the ten leading causes of death in the Caribbean. Their epidemiological review of mortality and morbidity for 1980-90 found staggering statistics regarding homicide and suicide. Among males ages 25-44, homicide and suicide rates quadrupled during the decade studied, from 8.6 and 9.6 percent to 29.7 and 31.9 percent, respectively. Males and females ages 15-24 also were found to be at high risk; suicide was the second leading cause of death.

Major issues include youth suicide, pesticide use, cannabis and suicide, and murder-suicide. Various nations have varying demographics, but the range in vulnerability to suicide starts early in life. Jamaica, for example, has risk factors in the preteen age group due to failure at an important exam at the secondary-education level. In Trinidad and Tobago, so-called "Romeo and Juliet" teen suicides peaked in 1997-98 as teenagers rebelled against the strict Indian traditions to which they were expected to conform.

Pesticide use is implicated in suicides among persons of all ethnicities, but is particularly common among the East Indian populations of Trinidad and Tobago and Guyana. Hanging is implicated in Jamaica in about 80 percent of suicides for both men and women. The proportion of males to females who die by suicide is 4-7:1, with many more males killing themselves than women. Women who have attempted suicide are admitted to hospital or treatment in reverse proportion to suicides. The issue of murder-suicide is emerging in Jamaica, long having been a factor in all territories, particularly English-speaking areas, and this trend has been associated with increased use of firearms.

One study has shown that gross national product correlates positively with male suicide but not female suicide, which related more to such factors as divorce and employment (Yang & Lester, 1994). A study of coroners' cases of sudden death reveals serious under-recognition of suicide (Burke, 1985). A study of psychological autopsies in Jamaica shows that 90 percent of persons who had died by suicide had mental disorders. Younger and older men were most at risk, with many adverse life events reported. The suicide rate was found to be 2.8 per 100,000, which is quite low compared to most areas of the world.

Suicide rates and numbers in Jamaica began to rise in the 1990s, ascribable to sociological factors in the area at the time (Irons-Morgan, 1998). Since 2000 rates and numbers have declined, but not dramatically (Barnaby, Barrett, & Leitch, 2000). Police officers in particular have been killing themselves, possibly as a result of post-traumatic stress disorder (PTSD). A study in Trinidad found that 81 percent of suicides resulted from paraquat poisoning, and another large group hanged themselves. Half the men had mental disorders, and females had much lower rates of completed suicides than males.

Concerns remain great about suicide among young Caribbean persons. Women account for most nonfatal attempts, mainly women with personality disorders and

depression. Concern is evident also about the number of persons using firearms, the use of pesticides in rural areas, and the growing incidence of murder-suicide in Jamaica.

The Caribbean Psychiatric Association has looked at prevention and treatment of persons who attempt suicide, and a Jamaican organization supports persons with losses to suicide.

Europe

A 2005 WHO European Ministerial Conference on Mental Health found an increase in mental disorders and self-destructive behavior in both poor and rich countries. In 2002 self-inflicted injury accounted for 1.4 percent of the total burden of disease worldwide and for 2.3 percent of the burden in Europe.

In the WHO European Region from 1950 to 1995, the rate of suicide for men and women combined increased by 60 percent. Among young and middle-aged people, especially men, suicide currently is a leading cause of death. Youth suicide is a particular European problem. A high correlation exists between suicide and alcohol. Binge drinking in young people is another area of high correlation with suicide, and in this trend women are catching up to their male counterparts. Nevertheless, elderly persons have the highest suicide rates in Europe.

The European Union reports that, on average, men ages 20-44 are four times more likely than women to die by suicide. Suicide is the second leading cause of death in this age group, after transport accidents. The three Baltic States reported the highest rates of suicide in this age group among men: Lithuania, 90 deaths per 100,000; Estonia, 55 deaths; and Latvia, 54 deaths. Lithuanian women in this age group had the highest rate of suicide, at 12 deaths per 100,000 (Niederlaender, 2006).

WHO's statistics on suicide also illustrate the high suicide rates in Eastern Europe, including the former Soviet republics. Although the Soviet Union kept statistics on suicide, authorities did not make them public until after perestroika. Although suicide rates in the former USSR varied greatly by region, recorded suicide rates doubled from 1966 to 1984 in the former USSR, declined by about a third through 1988, and then rose dramatically during the early 1990s (Bille-Brahe, 1998). Clearly many Eastern European nations have endured intense social turmoil over the past decade and a half as new political freedom has radically altered their political, economic, ideological, legal, and social underpinnings. The incidence of serious mental disorders has increased; alcohol and drug use is on the rise; and suicide rates are higher, particularly among men (Krasnov, 2004).

A WHO survey of 38 European nations regarding national suicide prevention strategies found that many countries have created official documents, but parliaments have approved few of them. Several countries have developed wide-ranging official plans, however, including England, Scotland, France, and the Scandinavian countries. Positive mental health programs enacted and suicide prevention programs developed tend to be in those countries where politicians have been touched by mental illness in their own lives. Nevertheless, stakeholders currently undertake a variety of suicide prevention efforts throughout Europe, and several countries with national strategies are beginning to see declines in their suicide rates.

North America

In the United States 90 percent of all suicides are related either to mental illness or substance abuse, according to the nation's Surgeon General. About 30,000 suicides occur in the U.S. annually. Suicides combined with attempts are estimated at 650,000 annually. During the period 1992-2003, some years have shown a decline in numbers and rates of suicide for certain age groups, but not for ages 35-64. For ages 10-24, although rates have been declining, suicide is the third leading cause of death in the United States and the second leading cause among college students. Young American Indian and Alaska Native males ages 10-24 have suicide rates that are twice the national average. Rates have risen slightly among African American males, with lowest rates for African American females. Highest rates appear among white men over age 75. Regional variations have been identified, with highest rates of suicide in the Intermountain West and lowest rates in the East and North. Possible explanations for regional variations may be deduced by the means of suicide: Firearms were implicated in 53.7 percent of suicide deaths in 2003 (but it is not clear that firearm availability accounts for increased suicide rates in the Intermountain West). The next common means was suffocation, usually by hanging, followed by poisoning.

The U.S. has developed its national suicide prevention strategy using a public health approach. Several administrations, Congress, and state governments have experienced successes in addressing suicide prevention, with money beginning to flow into states to address suicide prevention.

According to WHO data, Canada's overall suicide rate is 15 per 100,000 people, although studies show higher rates for specific populations. For example, among Inuit peoples in northern Canada, the suicide rate is 60-75 per 100,000 people. Other populations at risk for suicide include youth, inmates in correctional facilities, people with mental illnesses, and persons who previously have attempted suicide. Statistics Canada notes a 10 percent increase in suicides across Canada between 1997 and 1999. Men take their lives at a rate four times greater than do women (Canadian Mental Health Association, 2006). Mental health is considered to be mainly a provincial responsibility, and several provinces have developed suicide prevention strategies that have been implemented with varying levels of success.

Recognition of the link between the separate, but interrelated, fields of mental health and suicide prevention is not something that suddenly happened. We all are maturing on the same path with our diverse emphases contributing in different ways.

—Susan B. Thonell, Executive Director Emeritus
Lifeline International, South Africa

WHAT WE KNOW

Two dozen international experts who met in March 2006 in Dulles, Virginia, shared their expertise and experiences on selected topics related to the link between mental disorders and suicide, and suicide prevention in particular. Their ultimate task was to distill their discussions and formulate concise messages to disseminate to the public. The experts covered five areas: the relationship between mental illness/disorders and suicide; effective approaches to reduce risk of suicide for people with mental disorders; treating mental illness/disorders to prevent suicide: effective psychotherapeutic approaches and the role and impact of medications; cultural and religious considerations in addressing issues of mental illness and suicide; and media depiction of mental illness and suicide.

The five sections in this chapter present synopses of the targeted discussions and highlight key messages.

1. Relationship Between Mental Illness/Disorders and Suicide

- More than two thirds of suicides are linked to mental disorders.
- Depression, alcohol and drug abuse, and schizophrenia are associated with the majority of these suicides.
- Mental disorders can be treated, and suicides can be prevented with appropriate care.
- People can help prevent suicide.

1.1 Suicide Linked to Mental Disorders

With more than two thirds of suicides linked to mental disorders worldwide, mental illness clearly is the greatest risk factor for suicide and other self-destructive behaviors. Depression, alcohol and drug abuse, and schizophrenia are associated with the majority of these suicides. Other disorders also are linked to suicide, including bipolar disorder, anorexia nervosa, bulimia nervosa, and certain personality disorders. (Although persons without a mental disorder also take their own lives when they experience relationship disruptions and other adverse life circumstances, these and additional causes fall beyond the scope of this discussion.)

In most cases people who attempt suicide or take their own lives have a mental disorder that is unrecognized or untreated.

Although people may think of suicide primarily as a problem in young people, this misperception is untrue around the globe. Mental disorders and suicide risk occur throughout the life span—in childhood and adolescence, and among college students and other young adults, adults, and elderly persons. Although some regional variations exist, suicide rates worldwide increase with age, and the elderly have the highest suicide rates. Both males and females are at risk.

In some mental health disorders, the risk of suicide occurs early on, perhaps within a few months after a diagnosis or a first episode of major depression. By contrast, ten or twenty years may elapse before suicide risk linked to a mental disorder increases to a significant level.

Although two-thirds of people who die by suicide have a mental disorder, a common mistaken belief is that suicide cannot be prevented unless the mental illness is cured. The presumed association of "mental illness, therefore suicide, and nothing can be done about it" has no basis in fact. Suicide is preventable in spite of a mental illness. In fact, most individuals with mental illnesses do not contemplate or attempt suicide.

1.2 *Mental Disorders Treatable, Suicides Preventable*

Suicide is preventable. Suicide prevention measures for persons with mental disorders should include several key actions (see also section 2):

- Improve recognition, treatment, and long-term management of mental disorders (including alcohol and other drug abuse)
- Provide intensive follow-up and support for persons who make suicide attempts
- Increase public awareness about mental disorders and suicide prevention
- Offer support from the community
- Provide help in crisis situations
- Restrict access to means to suicide

Mental illness/disorders are treatable (see sections 2.1, 2.2, and 3 for considerations regarding treatment approaches). But certain prerequisites are important to enable access to treatment and care:

- Awareness of mental illness and the possibility, even likelihood, of recovery
- Adequate, appropriate screening and evaluation for mental disorders
- Availability of and access to treatment
- Help-seeking behaviors that lead a person to treatment

Methods of treatment vary in different parts of the world—and, to be sure, even within a single community. Modes of treatment depend on country, culture and tradition (see section 4), human and financial resources, training, accessibility of treatment and care, and countless other factors.

1.3 *People Can Help Prevent Suicide*

Preventing suicide among people with a mental disorder requires more than just treating the mental illness. Prevention also rests on trying to change the adverse impacts—loneliness, marginalization, reduced economic status, to name a just few—of living with a mental illness in society. Well-grounded hope and alternatives for a good life are important protective factors. Reducing the discrimination and stigma associated

with mental disorders, in places where this process has begun to take hold, results in increased access to treatment, better treatment, and better life outcomes. (See section 2.3 for additional discussion of the role of community support in suicide prevention.)

2. Reducing the Risk of Suicide for People with Mental Disorders

- Improve recognition, treatment, and long-term management of mental disorders
- Provide intensive follow-up and support for persons who make suicide attempts
- Offer support from the community. Individual treatment linked to community support can save lives.
- Provide help in crisis situations
- Increase public awareness that suicide is preventable
- Restrict access to means

Comparatively little evidence-based information exists about programs that successfully reduce or prevent suicidal behavior. Nevertheless, a large volume of evidence from psychiatric, epidemiologic, genetic, and biological research now reveals more commonalities than differences, despite variations among countries. The current body of research offers a generally consistent picture about risk factors for suicidal behavior, knowledge that can frame effective approaches to suicide prevention.

Several overarching conclusions may be drawn from the existing research, highlights of which are discussed below:

- Because suicide is a complex behavior with multiple causes, a multidimensional approach is critical. Multiple small prevention programs in a variety of different areas that contribute to suicide risk, perhaps with small gains in each area, aggregate to make a substantial overall impact on suicide rates.
- The most promising interventions are physician education, gatekeeper education, and means restriction.
- Limited funding for suicide prevention must be tempered by knowledge and an understanding of the likelihood for making most gains. In terms of population-attributable risk, the percentage of potential annual decrease in suicide rates in Western countries is given for the following preventive interventions:
- Education of primary care physicians, 22-73 percent
- Gatekeeper education (such as the U.S. Air Force and Norwegian Army suicide prevention programs), up to 40 percent
- Restricted access to means, up to 25-53 percent

Assessments of the likely effectiveness of other programs are not available. It is important to recognize, however, that absence of evidence does not imply absence of effectiveness.

For more in-depth discussions of psychotherapeutic and psychopharmacological approaches to treatment, see section 3.

2.1 Recognition, Treatment, and Long-Term Management of Mental Disorders

Increasing suicide rates in countries around the world highlight the need to improve recognition, treatment, and long-term management of mental disorders. An important goal is to identify high-risk persons and to position a safety net under and around them in terms of continuity of care, mindful of the cultural context and resources available in particular environments. Balancing the risks and benefits of available treatments for each individual patient remains a challenge.

An overall approach to the problem is more important than any one potential strategy. Research demonstrates that the following strategies improve recognition and treatment of mental disorders and reduce the risk of suicide (see also section 3):

- **Information and educational programs for professional groups.***

Primary health care providers, in countries where they are available, typically under-recognize and under-treat much of mental illness. A series of educational, collaborative care, and nurse case-management programs designed to enhance the ability of primary care groups to identify, treat, and manage depression and suicidal behavior are among the most effective interventions for decreasing suicide rates. Evaluations suggest that these types of programs increase the detection and treatment of depression, increase prescription rates for anti-depressants, and result in decreased suicide rates. Further large-scale evaluations are needed for a range of outcome measures.

- **Community "gatekeeper" programs.*** A range of programs focus on enhancing the skills of persons in organizations, institutions, and the community at large to recognize and refer for appropriate assessment people who might be at risk for suicide. Guidelines have been developed for such gatekeepers as clergy, school personnel, corrections workers, workplaces, and caregivers for elderly persons. Evaluations of gatekeeper programs run by the U.S. Air Force and the Norwegian Army report reduced suicide rates. Many programs have been developed in a number of countries, but few have been evaluated.

- **Screening programs.*** Programs designed to screen for depression or substance abuse applied in a variety of youth settings have been shown to be reliable and valid in identifying at-risk individuals. No evidence has emerged that screening young people increases their risk for suicidal thinking or behavior.

Reviews of adult screening programs for depression found increased rates of detection of depression. Some studies found increased rates of treatment, especially in small geographical areas. To date no evaluations have been conducted on suicide-risk screening programs in primary care.

* This approach has demonstrated effectiveness in reducing the risk of suicide (Mann et al., 2005).

- **Treatment and support for mental illness and suicide attempts.*** Western research shows that 90 percent of persons who die by suicide or have made at least one suicide attempt have at least one mental disorder when they die, and 80 percent of persons who die by suicide are untreated. Most depression is untreated or under-treated, even after suicide attempts.

A suicide attempt is a strong risk factor for further suicidal behavior. Thus, treating mental illness and providing long-term management and support for those who have made suicide attempts are major approaches to suicide prevention. Current treatment approaches include psychopharmacological treatments and psychological and psychosocial interventions.

The research also highlights the need for community support and education in the recognition of mental illness and warning signs for suicide. Family and friends often are unaware that a person has depression or another disorder that might put him or her at risk.

It is critical to treat depression (or other mental disorder) along with the confounding problems of co-occurring disorders in order to avoid partial solutions. Co-occurring disorders may include alcohol and other drug abuse, chronic illnesses, and conduct disorders. Suicide and depression are linked, and depression often is accompanied by co-occurring conditions or adverse social and familial issues. Because people typically do not come to clinical settings with isolated, simple conditions, a better understanding of co-occurring disorders is needed—along with better approaches to address all their issues.

2.2 *Intensive Follow-Up and Support for Persons Who Make Suicide Attempts*

A previous suicide attempt is one of the strongest risk factors for suicide. Nevertheless, globally speaking, more than half the persons who attempt suicide never come into contact with health services.

The following evidence-based strategies reduce the risk of suicide:

- **Follow-up care after suicide attempts.*** Increasing evidence shows that depression and other mental illness are recurrent and chronic, and suicidal behavior in a number of people follows a similar path. Moreover, in people who have made suicide attempts and who have recurrent suicidal ideation and suicidal behaviors, adherence to medication and treatment regimes often is poor. Furthermore, after hospitalization, attempters often are returned to the same problematic environments that contributed to their suicide risk. Thus, improved acute and long-term care and psychosocial interventions have potential to decrease rates of suicidal behavior.
- **Treatment and support for mental illness and suicide attempts.*** (see section 2.1).

* This approach has demonstrated effectiveness in reducing the risk of suicide (Mann et al., 2005).

Follow-up and continuity of care have critical importance, especially during the four weeks after a suicide attempt and particularly after discharge from an inpatient facility or hospital emergency room. In addition, the intent and intensity of suicidal feelings vary over time and require ongoing assessment.

Even the poorest of countries usually have emergency hospitals staffed by physicians. Persons who make the most serious attempts come to hospitals, and, particularly in developing countries, the community cares for persons who make less serious attempts.

2.3 *Community Support*

Individual treatment linked to community support can save lives.

Stigma and discrimination associated with mental illness—in addition to the disorder itself—can cause severe emotional pain. Persons may feel hopeless and shunned. They may be unable to secure or hold a job. Even after beginning treatment, it may take considerable time to feel better.

But community support—from family members, caregivers, other concerned persons in the community, and help lines, for example—makes a difference. And reducing the discrimination and stigma associated with mental illnesses is the business of everyone in the community. Community support can fill a number of critical gaps. In some countries providing community support is a natural feature of the culture. In others, certain programs, including peer-support initiatives emerging in many countries, offer connections that can pierce through loneliness and provide encouragement, psychosocial support, and often training in life skills—all of which can point to hope for more productive lives. When medications are administered, support from families and/or others in the community can help bridge the gap before the drugs take effect. In some areas in the world that lack sufficient primary or mental health care personnel—even in developed countries—community support may represent the state-of-the-art treatment available.

Gatekeeper programs (see section 2.1) draw on communities' strengths to recognize the need for mental health care and to recognize persons at risk for mental illness and suicide. People need education to recognize the symptoms and signs of mental disorders and suicidal behaviors. Anyone can have a hand in preventing suicide, and enhancing knowledge and involvement in communities is key to forming networks of support.

When school systems include mental health education as part of the curriculum, teachers, too, learn about suicide prevention. In turn the information students bring home helps to educate their parents, who have a critical need to understand the symptoms of mental disorders and warning signs for suicide.

No statistic on suicide is meaningful in terms of human suffering, and no number is acceptable.

2.4 *Help in Crisis Situations*

Help lines offer people at high risk for suicide a friendly, confidential ear and a compassionate presence. Help lines operate around the world—in both developed and developing countries. More rigorous research and evaluation are required to determine the extent to which help lines are effective in actually reducing suicide attempts.

Developed countries typically have infrastructure sufficient to handle medical emergencies such as suicide attempts. But special follow-up attention—ideally, individual treatment, social supports, and case management—must be focused on persons who have attempted suicide to prevent another attempt.

2.5 *Increased Public Awareness*

The following research findings can guide public awareness strategies to reduce the risk of suicide:

- **Public awareness education and mental health literacy.*** Improving public health literacy about mental illness may contribute to suicide prevention by changing public recognition and attitudes towards mental illnesses. Public awareness of depression, for example, may lead to better identification of the illness, treatment seeking, and support.

Studies from the United Kingdom, Germany, Australia, and New Zealand suggest, however, that these types of programs have modest impacts on attitudes toward mental illness, especially depression, and typically fail to produce reductions in suicide or attempts at suicide, increased treatment seeking, or increased use of antidepressants. Some evidence suggests that generic programs are unlikely to be effective, while highly targeted, specific programs in small geographical areas may be more effective.

- **Media coverage of suicide.*** Every country with a national suicide prevention program has included media guidelines for the safe, cautious, and muted portrayal and depiction of suicide by the media. While the content of the guidelines is similar across countries, extensive differences in the way in which the guidelines were developed, the extent to which journalists contributed to their development, and the way guidelines are implemented appear to make a great deal of difference in the extent to which the media are willing to take up the messages promoted by those guidelines.

If messages are framed and targeted strategically, raising public awareness has potential to reduce stigma, shame, and discrimination—and to change community attitudes about mental illness and suicide prevention. Even in countries with more accessible mental health care, emphasis on an awareness that treatment works can lead to increased help-seeking behaviors. In addition, public awareness can lead to

* This approach has demonstrated effectiveness in reducing the risk of suicide (Mann et al., 2005).

understanding the need for training of primary and mental health care practitioners in suicide prevention practices.

Public awareness can be harnessed to achieve political ends. Champions along the political and social spectrum—at the national through the neighborhood levels—can give people permission to discuss mental disorders and suicide openly, without shame, guilt, or fear of embarrassment, and to seek help. That public message has potential to inspire behavioral change throughout the system, including among health care providers, neighbors, and family members of a person with a mental illness.

Voluntary grassroots organizations have inspired, organized, and implemented many suicide prevention initiatives around the world. They have started help lines and other local initiatives. In China, for example, long before anyone in the government dared mention the word suicide, communities had funded and operated a national toll-free suicide prevention help line headquartered in Beijing.

Motivated people can start an initiative, momentum may gather, and perhaps at some point a "champion" may bring additional attention and resources to bear. Survivors of suicide (see Survivors of Suicide Loss) are speaking up; public leaders are beginning to share their own personal stories; and resources for effective programs are emerging.

Initiatives in highly targeted, geographically specific areas—which are fertile ground for suicide prevention—are well advised to tailor specific messages and approaches that reflect cultural, age, and gender differences.

The media and advocacy groups, ideally in collaboration, can play an important role in reducing the stigma and discrimination associated with mental illness and suicide—and thus in suicide prevention (see section 5 and Role of Advocacy).

2.6 *Restricted Access to Means*

The following evidence-based, universal prevention strategy has been found to reduce suicide risk:

- **Restrict access to potentially lethal means to suicide.*** Research from a number of countries suggests that reducing access to particular methods of suicide leads to reduced suicides by that method—and, in some cases, to reductions in the overall suicide rate. Research findings span a range of means in different countries, but the following strategies have resulted in decreased suicide rates:
 - Reducing toxicity of domestic gas
 - Legislation regarding firearm ownership and safety
 - Reduced carbon monoxide emissions from vehicle exhaust gas
 - Reduced package size of analgesics
 - Barriers erected at sites popular for jumping
 - Introduction of clinically safer drugs
 - Locked storage for pesticides

* This approach has demonstrated effectiveness in reducing the risk of suicide (Mann et al., 2005).

Research suggests also that national suicide rates reflect various levels of restriction of alcohol use.

Restricting postings on the Internet of detailed instructions for methods of suicide poses a difficult challenge.

3. Treating Mental Illness/Disorders to Prevent Suicide

- Effective psychotherapeutic approaches
 - Establish a relationship with a helper.
 - Talk about suicide or why you are suicidal.
 - Stay connected.
- Role and impact of medication
 - With appropriate evaluation/diagnosis and follow-up, many medications can be a part of an effective management strategy.
 - Education about the risks and benefits of medication—for the person with a mental illness, family members, and/or significant supporters—can help the person adhere to a treatment plan and manage the illness.

The goal of any treatment for a mental disorder is to reduce symptoms and improve quality of life. This section discusses effective psychotherapeutic approaches in general and, in more detail, the role and impact of medications. It is important to acknowledge that many countries in the world have insufficient resources to incorporate medication into therapies for mental illnesses for all who need it. Nevertheless, it is helpful to take an approach that integrates psychosocial interventions and medication, where available.

3.1 Effective Psychotherapeutic Approaches

Behavioral or psychological therapies have been found to be effective in reducing suicidal behavior, either alone or in combination with medication. Although therapists report success in their individual interventions, sufficient research studies have not been conducted on psychotherapeutic approaches to understand the effectiveness of the wide variety of approaches that are practiced. Furthermore, most research studies on the effectiveness of psychotherapies have focused on specific high-risk groups, such as persons with previous suicide attempts and persons with a "borderline" diagnosis. Research using the most rigorous methodologies (randomized controlled trials) has shown that Cognitive-Behavioral Therapy (CBT) and Dialectical Behavior Therapy (which combines CBT with supportive psychotherapy) result in less repetition of deliberate self-harm in persons who have attempted suicide; CBT is particularly effective with persons with a borderline diagnosis. Providing psychotherapy has been shown to reduce the risk of suicidal behaviors. Unfortunately, psychotherapy is not available for many suicidal persons, and costs often limit access to psychotherapy for persons in need.

3.1.1 Establish a relationship with a helper

Psychotherapy, CBT, and other forms of interpersonal therapy can be conducted by persons in a variety of roles, including trained professionals, traditional healers, and religious persons. In developing countries, where physicians, psychologists, and other health care professionals are few in number and difficult to access, traditional or religious healers play an integral role in mental health care.

3.1.2 Talk about suicide or why you are suicidal

In areas that lack access to psychotherapy or other face-to-face interpersonal approaches, or where people feel keenly the effects of stigma, technology has broken important ground. Vast numbers of people in many developing and developed countries now can make a personal connection and get support by accessing real-time telephone and Internet help lines. Help lines often serve as the entry point for people who require mental health services.

3.1.3 Stay connected

Ongoing relationships offer protection against suicide, whether in the community or in a health care setting. Among people who have attempted suicide, the provision of a brief intervention and the creation of a social support network, particularly during the first month after the attempt, are significant preventive measures. Simple outreach interventions, such as sending a caring letter and telephone follow-up by non-professionals, may greatly increase compliance with treatment plans and thus result in more suicidal individuals receiving the help they need.

3.2 Medications in the Treatment of Mental Illnesses

With appropriate evaluation, diagnosis, and follow-up, many medications can be part of an effective treatment strategy for mental disorders. As an effect of treating mental illnesses, medications may have a positive effect on suicide prevention.

3.2.1 What is known and accepted about medications

In the wake of U.S. court decisions, it now is considered irresponsible in that country for a psychiatrist to treat adult depression without the consideration and use of antidepressants (*Osheroff*, 1985). But this point of view does not represent universal clinical practice (American Psychiatric Association, 2003), and some argue strongly against it. Nevertheless, practice parameters developed by professional organizations endorse the use of antidepressant medications in patients who meet the diagnostic criteria for depression, and following these parameters is considered to be part of good clinical practice.

Despite the widespread use of medications demonstrated to treat mental illness—and therefore to prevent suicide—their use has engendered considerable controversy.

3.2.2 Prescription concerns

In terms of medications' risks and benefits, epidemiological studies show that suicide rates decline with increased SSRI use.

It is important to distinguish suicidal ideation from suicide attempts when prescribing medications. The important trigger occurs when a person starts to talk about suicide. Suicidal ideation or attempted suicide may occur during medication or in the post-medication phase, highlighting the need for monitoring. Suicidal ideation or attempts rarely result directly from the effects of medications.

3.2.3 State of the research

Filling the gaps in the body of research on psychotropic medications will contribute to enhancing the available array of methods to treat mental illnesses—and, therefore, to prevent suicide. Opportunities for study may be informed by the following research deficiencies:

- Less research has been conducted with children and adolescents than with adults.
- Prospective studies and good outcome data are lacking.
- Studies of the effectiveness of medications generally exclude suicidal individuals, thus making it impossible to verify the usefulness of the medications in suicidal individuals.
- Controlled, blinded studies are lacking, and many studies are open-label studies.
- Current headlines on psychiatric medications are based on meta-analyses of older published studies, rather than on new studies. Meta-analysis is only as good as the original studies, and the quality of many older studies is not necessarily good.
- Studies are lacking on barriers to care, including insurance, lack of medications, and lack of mental health services infrastructure. This deficiency exists in both developing and developed countries. Accessing medications may be difficult or impossible, due to cost, inadequate transportation to a facility that offers medications, or lack of insurance to cover adequate follow-up.

3.3 Education about Risks and Benefits of Medication

It is important for a person with a mental illness, plus his or her family and/or significant supporters, to know about the risks and benefits of any medications prescribed to treat the disorder. That understanding can help the person follow a treatment plan and manage his or her illness. In addition to consumer and family education, education of mental health practitioners on a variety of issues can enhance their helpfulness and boost the likelihood for effective treatment.

Family involvement is a key factor in treatment with medications. The most effective way found to increase a person's appropriate medication use is to involve the family. Whenever possible, family members should be present when a physician talks with the person about possible side effects and the importance of taking the medication consistently.

Practitioner education is necessary to prepare them to discuss the benefits and risks associated with medications. Factors shown to con-

tribute to greater observance of the medication regime are perception of the warmth and friendliness of the physician, and the length of time the physician spends discussing the medications. Since the majority of antidepressant medications are not prescribed by psychiatrists, primary care physicians in particular need broader education on the medications' use in order to avoid making medical mistakes.

Black box warnings of adverse effects on prescription labels may prompt clinicians' reluctance to use antidepressant medications by patients who might benefit from them. Conversely, concern exists that such warnings may inhibit pharmaceutical companies from pursuing development of medications that may be even more appropriate.

The period between the start of a medication regime and the time the medication begins to work is a period of significant risk for suicide, and physicians, nurse-practitioners, and other providers along the health care spectrum need education on the necessity and protocols to monitor that risk. Few clinicians conduct adequate monitoring or follow-up of patients for whom they prescribe psychotropic medications. Monitoring is essential to recognize and ensure proper care in the event of adverse side effects, including physical or mental discomfort and/or suicidal ideation. Some side effects may impede adherence to the medication regime.

4. Cultural and Religious Considerations in Addressing Issues of Mental Illness and Suicide

- Suicide and mental disorders always have a social/cultural context.
- Spiritual and religious beliefs can either protect against or enhance suicide risk.
- Understanding the individual's belief system—both spiritual and cultural—can enhance the capacity to help individuals with mental and substance-use disorders, family and social stressors, and, therefore, suicide risk.
- Religious faith or affiliation may be a protective factor.
- Engaging and enhancing the inherent strengths and networks of each culture are important strategies.
- Any suicide prevention program must be locally relevant and culturally appropriate.

4.1 Social/Cultural Context of Suicide and Mental Disorders

Suicide and mental disorders always have a social/cultural context. Culture is an all-embracing term that defines the relationship between an individual and his or her environment. When mental disorders lead to suicide, culture influences how and when the suicide happens.

Protective and risk factors for mental disorders and suicide can vary by social class, ethnicity, level of wealth or poverty, education, political and economic outlook, child rearing practices, standards of behavior, re-

ligious persuasion, age, values, and other aspects of life. Culture and environment interact in such contexts as family, community, nation, region, continent, and the world. Cultural differences may be observed between urban and rural populations, young and old, and even between congregations of the same religious affiliation.

In any individual or community, risk and protective factors interact to produce an effect. Values that may impact particularly on mental illnesses, mental health, suicidal behaviors, or suicide include child rearing, discipline, adolescents' social lives (especially sexual relationships and drug use), values on aging and toward elderly persons, legal issues related to suicide, and religion. Social, personal, and biological factors have an age component that works much like culture, and it is important to be mindful of variations between and among children, adolescents, young adults, adults in mid-life, and elderly persons.

Emil Durkheim's work has influenced how people have since studied suicide, but suicide also may be considered from other perspectives. Specific cultural factors play roles in how mental disorders are viewed, identified, and treated. For example:

- Deviance and differences from the norm have implications for identification and treatment of mental disorders.
- Dominance and power. Politics affects individuals' and communities' decision-making regarding drug use, especially alcohol and cannabis, both of which may play a role in suicidal behavior.
- Disease. Negative cultural attitudes toward both mental and other medical illnesses, and also comorbidity, increase suicide risk markedly.
- Death. Religious and other cultural proscriptions against suicide and the acceptance of assisted suicide and euthanasia influence decisions about suicide. Culture-bound syndromes for suicide occur in certain countries.
- Dichotomies such as the distinction between mind and body influence treatment and attitudes about mental disorders and suicidal behaviors differently from a holistic perspective.
- Distance, either geographical or emotional, may play a role in suicide. Migration places stresses on minorities in a majority culture.
- Discrimination due to ethnicity, compounded by mental or other medical illness, may play a role in suicide.
- Depression is a major cause of suicidal behavior.
- Discrimination and stigma—and acceptance and support from the community—regarding mental and other medical illnesses influence how persons deal with their disorders and the likelihood that they might end their lives early.

*Treatment
for
underlying
mental
disorders,
plus social
supports,
can help
reduce the
risk of
suicide.*

People with anxiety disorders are seen as increasingly at risk for suicide. Terrorism and natural disasters place cultures under political and environmental stress, and even preparedness messages heighten anxiety. Eastern and Western cultures seem to be adopting the values of the other. While some Western cultures increasingly embrace respect for the elderly and family values—in contrast to their value of rugged individualism—some Eastern cultures have begun to lean in the opposite direction.

Understanding, accepting, and respecting different cultures enhance one's capacity to better support individuals with a mental disorder and/or suicidal behavior. For example, the pervasive "American hero" cultural model, portrayed in American films screened around the world, reinforces the concept that real men do not ask for help but instead solve their own problems. This cultural image represents a major impediment to seeking help.

4.2 Religion as a Protective Factor

Although religious prohibitions against suicide—a tenet of virtually all the world's great religions—may play a role in dissuading people from attempting suicide, these prohibitions might not tell the whole story. Where there is a protective effect, the protection may reside in dogma and religious tradition—but it might just as well derive from the "connectedness" associated with affiliation with a religion or specific congregation.

Considerable evidence shows that people affiliated with a religion or a congregation have better health outcomes than people who do not (examples of these outcomes relate to tuberculosis, teenage pregnancy, mortality, and HIV/AIDS). From a cultural perspective, however, a person's formal religious identity is not a protective factor for suicide in and of itself.

Some people have speculated that in cultures oriented more toward the collective, the community, and connections, suicide rates are lower. When the culture strives toward individual success and individual action, people may be unprepared to face setbacks. When successful, isolated persons do encounter setbacks, they may be less prepared to face adversity. Strengthening community ties through religion or social action can be considered to constitute suicide prevention work, but no hard evidence developed to date substantiates this assertion, despite many attempts to confirm the benefits of these practices.

Religious beliefs among adolescents may protect against substance abuse, studies show. The values of shame and sin may serve as protective factors against suicide, but they also create stigma for people who have attempted suicide and their families (see also *Survivors of Suicide Loss*).

4.3 Locally Relevant and Culturally Appropriate Programs to Harness Cultures' Inherent Strengths and Networks

Although suicide is an individual act, it takes place in a community environment. In order to contribute maximally to reduced risk of suicide,

prevention programs must be locally relevant and culturally appropriate. Evidence shows that implementing local communities' prevention strategies helps lower their suicide rates.

Values and attitudes may differ—whether Eastern or Western, rural or urban, and on any number of other variables—and awareness of cultural differences in addressing mental disorders and suicidal behaviors is critical when designing or implementing prevention programs. Within communities it is important to accommodate the characteristics and needs of people who may be from diverse cultures, notably those with differences in ethnicity, national origin, values and attitudes, language, religion, age, gender, and/or gender orientation.

Treatment for mental disorders is not readily available in the vast majority of the world by psychiatrists, primary care physicians, nurses, or other health care professionals. People in those places must depend on other sources of help, and sources are available. Even in places where government support for mental health is limited, untapped energy and resources reside in communities.

Experience with help lines reveals the need to educate members of the community how and where to seek help. Help lines are in place around the world, but many people do not know they exist or know how to use them.

Family connectivity serves as a protective factor under positive conditions, but members of the community may serve as a support system when family is unavailable or dysfunctional. In some places (Jamaica, for example) priests who serve as counselors are commonly sought out as a source of comfort and assistance, and they play a vital role in preventing suicidal behavior.

The aging of society in some parts of the world may be an important factor to consider in the future in suicide prevention. Another factor to consider is the absence in many cultures of societal validation of help-seeking behaviors, especially by males, which delays and impedes access to treatment.

The media can activate culturally competent approaches by educating the community at large about mental illnesses and suicide prevention, based on nationally, organizationally, and locally developed guidelines (see section 5.1).

5. Media Depiction of Mental Illness and Suicide

The media plays an undeniably significant role in shaping public opinion and in raising public awareness. This section focuses on educating the media on how to depict suicide and on training mental health and other suicide prevention advocates to interact with the media (see also Role of Advocacy, page 40). In addition, a cautionary note is sounded to parents.

5.1 Media

Media matters in the responsible depiction of mental illness and suicide. Historically, and even today, both news accounts and works of fiction

- Media matters in the responsible depiction of mental illness and suicide.
- Media
 - Follow guidelines on reporting suicide, according to country and culture.
 - Suggest referrals to reputable resources, including help lines and clinicians.
 - Be part of the solution, not the problem.
- Advocates
 - Foster partnerships with the media and be prepared.
 - Develop public service announcements about the message; produce sample public service announcements to be used by radio announcers.
 - Be simple, not simplistic.
 - Offer incentives to the media, such as an award program, for responsible depictions of suicide.
- Parents. Be aware of what your children are doing on the internet.

romanticize and sensationalize acts of suicide, and most media portrayals are inaccurate. Common inappropriate media approaches to suicide can lead in worst cases to copycat suicides and, at best, to increased discrimination and stigma related to mental disorders.

Reasonably good evidence shows that effective media portrayal reduces suicide, while sensational portrayal increases suicide. Just two months following sensational news coverage in Hong Kong of a carbon monoxide poisoning due to charcoal burning, this means of suicide became the third most common in that country. Conversely, media restriction and sensitive portrayal of suicide has led to reduced incidence of suicides and attempted suicides in the subway systems of Vienna, Austria, and elsewhere.

The dual goal for the media is to depict a mental health consumer as it might any other person with a health disorder and to dispel the myth that the majority of people with a mental illness act violently. The media and the entertainment industry have the tools readily at hand to avoid both provoking imitation suicides and perpetuating discrimination and stigma. Accessing these tools requires just a few computer clicks.

Many groups have developed guidelines for reporting on suicide. Virtually every country with a national suicide prevention strategy embeds a set of guidelines in its strategy, and mental health advocacy groups around the globe also have developed guidelines. With an eye to their audience's country and culture, reporters can make reasonable selections (see, for example, www.sprc.org/library/at_a_glance.pdf).

Universally critical principles for depicting suicide include:

- Avoid sensationalizing suicide.

- Avoid a connotation of tragedy or heroism.
- Include no pictures.
- Make no specific mention of methods.
- Provide no simplistic explanations, because suicide is a complex process.
- Make the link between suicide and mental illness (for example, "died as a result of clinical depression").
- Report with the understanding that the vast majority of people with mental disorders are not violent, that suicide is preventable, and that help is available.
- Omit the phrases "commit suicide" and "successful suicide."
- Publicize help lines and other paths to get help.

Regarding depiction of suicide and mental illness, the impact on the public does not emanate solely from news media. When the entertainment industry treats suicide as a theme, if care is not taken, the same adverse consequences of irresponsible news reporting can occur.

Examples abound of dramatic portrayals and real-life situations in which individuals identify with the stories. In one instance, despite expert consultation on responsible content and tone, a U.S. television network broadcast a highly emotionally charged drama about suicide. At the end of the program, two of the show's actors presented a public service announcement. They stated simply: "If you or someone you care about is thinking about suicide, call this number." The telephone number of a national help line network then flashed on the screen. Seven million mostly younger viewers saw the program, and, within five minutes, more than 1,300 of them called the help line, thus highlighting the dramatic personal impact of a single episode of a TV drama.

Problems with fictional accounts of suicide include the following:

- Links are never made to mental illness.
- Ambivalence is never shown.
- The impact on the family is not portrayed.
- Help is never sought or offered; no acknowledgement is made that help was available.
- Suicide never hurts. The media do not depict the extended suffering of people who experience grave injury, but not immediate death.
- Suicide attempts are shown to be 100 percent effective.

Obstacles to suitable portrayals also include media executives who choose not to believe that irresponsible reporting of suicides can lead to subsequent suicides or who ignore the guidelines while pursuing their profit motives.

An issue to be addressed in portraying suicide as a result of mental disorders relates to the tension between normalizing the person, to minimize stigma, while at the same time not normalizing suicidal behavior.

Another issue is determining how to approach any long-term effects of media events on mental disorders and suicide in the absence of sufficient data.

Still another difficult issue, which is emerging as the Internet matures, is monitoring and counteracting the activities of websites that promote suicide and offer detailed instructions.

As discussed above, research has shown that media portrayals of suicide underplay considerably the link between mental disorders and suicide. By following guidelines on reporting and portraying suicide according to guidelines specific to country and culture, media can be part of the solution, not the problem, and can seize an opportunity to contribute to public health.

5.2 *Advocates*

Advocates for suicide prevention who wish to enlist the media's collaboration to accomplish their aims are encouraged to follow the several proven strategies discussed in this section.

5.2.1 Foster partnerships with the media and be prepared

Advocates can engage in dialogue with reporters and other media representatives in a framework of partnership to tell their stories and make their points. Forearmed with strategies, advocates can help the media modify their story lines in positive directions. Advocates also can help media make the connection between mental disorders and suicide with accurate data. Publications downloadable from the Internet describe best-practice strategies (for example, from the Suicide Prevention Action Network USA [SPAN USA]).

Media need to know statistics about suicides in their geographical areas of interest. They should be informed that most suicides are believed to have a component of mental illness or substance abuse. They also need to know that they should report not on the "loss of a loved one," but that "an illness took my loved one."

Advocacy organizations can lobby deans of journalism schools and media organizations to teach reporting on suicide, particularly on the need to adhere to all the guidelines on reporting on suicide and not just a selected one or two. England's MediaWise runs a program in which journalists educate journalists. Australia's Friends of Media, a group of consumers with schizophrenia, has a Media Reference Group, and the country's MediaWatch surveys the entire media for portrayals of mental illness. Both Australian programs have been evaluated highly, and MediaWatch has developed evidence that effective media portrayal reduces suicide while sensational portrayal increases suicide. The Asian Coalition of Journalism works with soap opera producers in India, who have agreed for two years not to depict onscreen self-immolation, a common method of suicide in that country.

Evidence suggests that media reporting can encourage imitation suicides, reports the World Health Organization, as it urges the media to show sensitivity in its reporting on deaths by suicide. WHO asserts that the media can play a major role in reducing stigma and discrimination associated with suicidal behaviors and mental disorders.

5.2.2 Offer simple messages

Advocates' messages must be simple. For example:

- Help-seeking matters.
- Treatment is available and effective.
- Help is available through help lines.

Advocates must have ready a simple response to the media's question: "Why should I care about how we portray suicide?"

5.2.3 Develop and produce public service announcements

In devising an awareness-raising campaign, it is useful to know that 60 percent of all information broadcast in the world is transmitted by radio.

5.2.4 Offer incentives for responsible portrayals of suicide

Positive reinforcement is a tried-and-true agent for change. Advocates and their organizations can reward, honor, and otherwise acknowledge journalists and persons in the entertainment industry who portray suicide responsibly. Conversely, advocacy organizations can harness the power of their grassroots networks to communicate about irresponsible coverage and to seek change.

5.3 Parents

Parental awareness, if not vigilance, is warranted for their children's media habits, including handheld video games, computer games, the Internet, and also text messaging. The number of suicides associated with text-message bullying among school-age children is rising.

Moreover, some Internet sites provide information on suicide means and actively encourage people to kill themselves. Predators on the Internet seek out people in despair and suggest to them that suicide is the answer. Some sites connect people who then kill themselves in suicide pacts.

ROLE OF ADVOCACY

The World Mental Health Day 2006 theme, *“Building Awareness—Reducing Risk: Mental Illness and Suicide,”* promoted developing the necessary public awareness and political will to motivate organizations and governments around the world to address the unmet needs of people with mental illnesses and at risk for suicide. Advocates play a critical role in the process. They work toward creating expanded public understanding of the need for suicide prevention, enhanced intervention and treatment services, and enlightened public policies.

Three essential components of prevention—a knowledge base, political will to support change, and a social strategy to accomplish change—are delineated in Richmond and Kotelchuck’s (1991) health policy model. Many resources, including this WFMH monograph, offer a firm knowledge base upon which to work to build political will and to develop successful strategies for change. To begin with, according to SPAN USA, successful advocates know their issues and their facts, figures, and statistics.

Political will refers to an organization or individual’s ability to gather groups together to support a cause or movement. Identification of and collaboration among local and national organizations—governmental as well as those in the private sector—concerned about mental illness and suicide are critical elements in developing political will. Working together in multidisciplinary partnerships, organizations and individuals can share information, create consistent and compelling key messages, and create opportunities to influence public policy decisions. Successful advocates know what they want to achieve and what others say about the issue.

A number of countries have established national suicide prevention plans or strategies. Their principles and action steps represent good sources for developing



*Dr. José Bertolote discusses
WHO’s work on suicide prevention*

specific policy recommendations to present to governmental and legislative leaders. Common elements of these plans and strategies include:

- Campaigns to increase public awareness of suicide as a preventable problem, to develop broad-based support for prevention efforts, and to reduce stigma
- Community development to support creation and implementation of suicide prevention programs
- Improved access to services to suicidal people and their loved ones, and improved service delivery efforts through development of guidelines and linkages
- Media education to improve reporting and portrayals of suicide in the media
- Training for caregivers to improve recognition of at-risk behavior and delivery of effective treatments
- Incorporation of licensing standards for professional caregivers
- Development and promotion of effective clinical and professional practices
- Means restriction initiatives to reduce access to lethal means and methods of self-harm
- Research and evaluation to promote and support research, improve surveillance systems, and evaluate the effectiveness of new or existing suicide prevention interventions (Centre for Suicide Prevention, 2004)

Successful advocates know how the legislative process works, the position of the person(s) they want to influence, and who supports and who opposes the policies the advocates want to promote. Advocates can communicate with officials by signing petitions, writing letters, writing letters to the editors of newspapers, and visiting legislative offices. A number of useful advocacy tools are available online (for example, from SPAN USA).

SURVIVORS OF SUICIDE LOSS

Suicide claims a great many lives, and every suicide death affects an estimated six survivors. It is important, then, that the general public and members of the helping professions (including health care, education, and clergy) understand the grief experienced by survivors of suicide loss.

When a death results from suicide, the sadness of loss experienced by family and friends may be compounded by confusion, anger, and other overwhelming emotions. The media may shine an unwelcome spotlight on the event, thus adding to the stress of the tragedy. And, although attitudes toward suicide are changing, stigma still may produce discomfort, uncertainty, and embarrassment among many people in talking about the death as well as comforting the survivors of suicide loss.

Survivors commonly feel intense shock and disbelief. They may engage in speculation about whether and how the death could have been prevented. Survivors often feel abandoned and isolated. Long-time caregivers in particular may feel relief along with their grief, accompanied by intense guilt about their emotions. Typically the period of bereavement lasts longer than for a death due to natural causes.

A variety of supports can bolster survivors of suicide loss. Family and friends, religious or spiritual or community activities, the passage of time, and psychotherapy or counseling each can contribute to healing. In addition, participation in self-help groups can provide invaluable support. These groups help survivors to talk about the suicide, put suicide in perspective, deal with any family problems caused by the suicide, feel better about themselves, obtain factual information about suicide and its effects, feel safe to express their feelings, and understand and deal with others' reactions to suicide.

Guidelines for coping with suicide loss and for helping and comforting friends and family are available from a variety of sources, including the International Association for Suicide Prevention, Befrienders Worldwide, the Royal College of Psychiatrists, the American Foundation for Suicide Prevention, The Charles E. Kubly Foundation, The Jed Foundation, and SPAN USA, among others.

The information, perspectives, and opinions included in this monograph reflect the discussions and contributions of the members of the International Experts Forum panel assembled by WFMH to provide background for the development of the 2006 World Mental Health Day global awareness materials packet and guidance for the development of future WFMH program activities relating to mental illness and suicide. This monograph is a compilation and summary of the information and perspectives shared and discussed during the day and a half Forum. Effort has been made to provide references and citations for specific material wherever possible. As with any summary of discussions involving people from diverse backgrounds and countries, it is highly likely that the members of the Forum may have differences of opinion on some of the issues discussed and summarized herein, as may some of the readers of the Monograph.

RESOURCES AND REFERENCES

Selected Resources

- American Association of Suicidology
5221 Wisconsin Avenue, NW
Washington, DC 20015 USA
www.suicidology.org
- American Foundation for Suicide Prevention
120 Wall Street, 22nd Floor
New York, NY 10005 USA
www.afsp.org
- American Psychiatric Association
1000 Wilson Blvd., #1825
Arlington, VA 22209 USA
www.psych.org
- American Psychological Association
750 First Street, NE
Washington, DC 20002 USA
www.apa.org
- Australian Institute for Suicide Research and Prevention
Griffith University—Mt. Gravatt Campus
Brisbane Queensland 4111
Australia
www.griffith.edu.au/aisrap
- Befrienders Worldwide/Samaritans
The Upper Mill, Kingston Road
Ewell, Surrey KT17 2AF
United Kingdom
www.befrienders.org/www.samaritans.org
- Canadian Mental Health Association
Centre for Suicide Prevention
Suite 320, 1202 Centre Street S.E.
Calgary, AB T2G 5A5 Canada
www.suicideinfo.ca
- Canadian Association for Suicide Prevention
The Support Network
301, 11456 Jasper Avenue
Edmonton, Alberta T5K 0M1 Canada
www.suicideprevention.ca
- Center for Mental Health Services/
Substance Abuse and Mental Health Services Admin
1 Choke Cherry Lane
Rockville, MD 20857 USA
www.mentalhealth.samhsa.gov/cmhs
- The Charles E. Kubly Foundation
P.O. Box 170284
Milwaukee, WI 53217 USA
www.charlesekublyfoundation.org
- Depression and Bipolar Support Alliance/DBSA
730 N. Franklin Street, #501
Chicago, IL 60610 USA
www.dbsalliance.org
- Gay, Lesbian, Bisexual, and Transgender Resources
www.youth-suicide.com/gay_bisexual/index.htm
- Help lines:
<http://suicidehotlines.com/international.html>
www.preventsuicidenow.com/suicide-hotlines-international.html
National Suicide Prevention Lifeline (USA):
www.suicidepreventionlifeline.org
800-273-TALK
- IFOTES
11, Palace du Port
Rolle 1180 Switzerland
www.ifotes.org
- International Association for Suicide Prevention
Le Barade, F-32330 Gondrin
France
www.med.uio.no/iasp
- Irish Association of Suicidology
16, New Antrim Street
Castlebar, Co. Mayo,
Ireland
www.ias.ie

The Jed Foundation
583 Broadway, #8B
New York, NY 10012 USA
www.jedfoundation.org

Lifeline International
P.O. Box 553
Anerley 4230 KZN
South Africa
www.lifeline.web.za
LivingWorks
www.livingworks.net

Mental Health America
2000 N. Beauregard Street, 6th Floor
Alexandria VA 22311
www.nmha.org

Mental Health Ireland
6 Adelaide Street
Dun Laoghaire, County Dublin
Ireland
www.mentalhealthireland.ie

MIND, the Mental Health Charity
15-19 Broadway
London E15 4BQ
United Kingdom
www.mind.org.uk

Ministry of Health–New Zealand
P.O. Box 5013
Wellington, New Zealand
www.moh.govt.nz/mentalhealth

National Institute for Mental Health
6001 Executive Boulevard,
#8184 MSC 9663
Bethesda, MD 20892 USA
www.nimh.nih.gov/suicideprevention

Rethink
5th Floor, Royal London House
22-25 Finsbury Square
London EC2A 1DX
United Kingdom
www.rethink.org

Royal College of Psychiatrists
www.rcpsych.ac.uk

Samaritans of Singapore
Blk 10, Cantonment Close, #01-01
Singapore 080010
www.samaritans.org.sg

Suicide Awareness Voices of Education
(SAVE)
9001 E. Bloomington Freeway, #150
Bloomington, MN 55420 USA
www.save.org

Suicide Prevention Action Network USA
(SPAN USA)
1025 Vermont Avenue, NW #1066
Washington, DC 20005 USA
www.spanusa.org

Suicide Prevention Resource Center
55 Chapel Street
Newton, MA 02458-1060 USA
www.sprc.org

Suicide Research and Prevention Unit
University of Oslo
Sognsvannsvn 21, Bygning 12
N-0320 Oslo
Norway
www.med.uio.no/ispy/ssff/hovedengelsk.htm

Sumaitri
1 Bhagwandas Lane
Aradhana Hostel Complex Basement
New Delhi 110 001
India
www.sumaitri.org

World Federation for Mental Health
6564 Loisdale Court, #301
Springfield, VA 22150 USA
www.wfmh.org, www.wfmh.com

World Health Organization
Avenue Appia 20
1211 Geneva 27
Switzerland
www.who.int

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- Suicide Prevention Resource Center. At a glance: Safe reporting on suicide. www.sprc.org/library/at_a_glance.pdf
- U.S. Department of Health and Human Resources, Substance Abuse and Mental Health Services Administration. National Strategy on Suicide Prevention. www.mentalhealth.samhsa.gov/suicide-prevention
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International Experts Forum: Participants

Loraine Barnaby, M.D.
Consultant Psychiatrist
Caribbean Regional Representative
International Association for Suicide
Prevention
U.W.I. Mona, Jamaica

Annette L. Beauvais, Ph.D.
Member, Executive Board
International Association for Suicide
Prevention
Associate Professor and Principal
Investigator
Canterbury Suicide Project
Christchurch School of Medicine
Christchurch, New Zealand

Myron Belfer, M.D.
President, International Association for
Child and Adolescent Psychiatry and
Allied Professions
Professor of Psychiatry
Harvard Medical School
Boston, Massachusetts USA

José Manoel Bertolote, M.D.
Coordinator
Management of Mental and Brain Disorders
Department of Mental Health and
Substance Abuse
World Health Organization
Geneva, Switzerland

Arthur H. "Mike" Bredenbeck, J.D.
Kailua, Hawaii USA

Paula Clayton, M.D.
Medical Director
American Foundation for Suicide Prevention
New York, New York USA

John F. Connolly, M.D., Secretary
Irish Association of Suicidology
Castlebar, County Mayo, Ireland

L. Patt Franciosi, Ph.D.
Immediate Past President
Chair, World Mental Health Day
World Federation for Mental Health
Mequon, Wisconsin USA

Brian Howard, Chief Executive Officer
Mental Health Ireland
Dun Laoghaire, County Dublin, Ireland

Billie Kubly
Founder, Charles E. Kubly Foundation
Milwaukee, Wisconsin USA

Richard McKeon, Ph.D., M.P.H.
Special Advisor, Suicide Prevention
Center for Mental Health Services
Substance Abuse and Mental Health
Services Administration
U.S. Department of Health and Human
Services
Rockville, Maryland USA

Brian L. Mishara, Ph.D., President
International Association for Suicide
Prevention
Director, Centre for Research and
Intervention on Suicide and Euthanasia
Professor, Psychology Department
University of Quebec at Montreal
Montreal, Canada

Jane Pearson, Ph.D., Chair
NIMH Suicide Research Consortium
Associate Director, Preventive Interventions
Division of Services and Interventions
Research
National Institute of Mental Health
Bethesda, Maryland USA

Silvia Palázquez, M.D., Director
Ultimo Recurso
President
Suicidology Association of Latin America
Montevideo, Uruguay

Jerry Reed, M.S.W., Executive Director
Suicide Prevention Action Network USA
(SPAN USA)
Washington, D.C. USA

Shona Sturgeon
President, Board of Directors
World Federation for Mental Health
Senior Lecturer
Department of Social Development
University of Cape Town
Cape Town, South Africa

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Mental Illness and Suicide

Susan B. Thonell
Executive Director Emeritus
LifeLine International
Anerley, South Africa

Lakshmi Vijayakumar, M.D.
Head, Department of Psychiatry, Voluntary
Health Services
Founder, SNEHA
Chennai, India

Observers and Guests

Erin Dalter
Program Manager
Office of International Affairs
American Psychiatric Association
Arlington, Virginia USA

Joel Raskin, M.D., FRCPC
Eli Lilly & Company
Toronto, Ontario, Canada

Sally Leverty
International Affairs Assistant
Office of International Affairs
American Psychological Association
Washington, D.C. USA

Janet LeMonnier
Director of Communications
Mental Health Association of New York
City
New York, New York USA

Donna Satow, Founder and Vice President
The Jed Foundation
New York, New York USA

Jan Schadrack, M.D.
Bristol-Myers Squibb Company
Princeton, New Jersey USA

Quynh-Van Tran, DPharm
Otsuka America Pharmaceutical, Inc.
Rockville, Maryland USA

John H. Simmons, M.D.
Organon International, Inc.
Roseland, New Jersey USA

WFMH Staff

Elena Berger, D.Phil.
Director of Communications and
Affiliate Relations

Preston Garrison
Secretary-General and
Chief Executive Officer

Betty Jones, Executive Assistant

Deborah Maguire, Director of Programs

Facilitator

Jane E. Pierson
Cavanaugh, Hagan & Pierson
Washington, D.C. USA

Writer

Irene Saunders Goldstein
Arlington, Virginia USA