INTRODUCTION

The 2006 World Mental Health Day Campaign, "*Building Awareness-Reducing Risk: Mental Illness and Suicide"* focuses attention on a major public health problem. The World Health Organization estimates that there are one million suicide deaths each year, representing 1.4% percent of the total global burden of disease; more people die by suicide each year than are killed by homicide, wars and terrorist attacks combined.

The risk factors for suicide are multiple and typically individuals who die by suicide experience more than one risk factor. The WFMH has initiated an awareness and educational campaign that highlights the role that mental illness (including substance abuse and dependence) can play in risk for suicide. While the vast majority of persons with a mental illness will not die by suicide, studies in Europe and the U.S. report that up to 90% of individuals who died by suicide evidenced some form of mental disorder, including alcohol and drug abuse. In less developed nations where lethal methods of suicide(in particular, pesticides) are more commonly available, suicidal acts in response to social loss and stress may become fatal because of the availability of this method. The periods of risk for suicide among persons with mental illness vary with the illness or illnesses faced (multiple psychiatric and/or physical conditions), individual psychiatric and family history, course and success of treatment, as well as the individuals' social context.

The 2006 World Mental Health Day campaign will provide an in-depth look at the role that mental illnesses play in suicide, and will serve as a powerful strategy to counter the commonly held perception that mental illnesses are a secondary health concern that can be delayed until more immediate and pressing healthcare concerns have been addressed. In the United Kingdom, 50% of all suicide cases occur in current or former diagnosed psychiatric patients[1]. The lifetime risk for suicide among people experiencing a mood disorders (primarily depression) is 6-15%, while for schizophrenia the risk is 4-10%[2]. A national audit in the United Kingdom[3] found that 25% of those who die by suicide have been in contact with mental health services in the last 12 months. Of these, 16% are psychiatric inpatients, and 24% have been discharged from inpatient care in the last 3 months. Non-compliance with treatment and loss of contact with services are common factors. It is thus clear that those suffering from mental illness are much more likely to die by suicide if they are not being treated or are receiving inadequate treatment. This fact should give all involved in the mental health care community a renewed sense of urgency in the work they are carrying out all around the world. The devastation that suicide brings for relatives, as well as the immense personal suffering the victim endures makes this one of the most pressing issues for the mental health care community to address. Left undiagnosed and untreated, mental illnesses can be fatal, and thus they must be addressed as an integral public, physical and mental health issue of utmost priority.

Good mental health care and mental health promotion can reduce the risk of suicide among people with a mental illness. Suicides should not be seen as a tragic and unavoidable aspect of mental illnesses. Tackling the problem of suicide amongst the mentally ill requires both health care based and public health initiatives. Health care schemes must strive towards prompt diagnosis of those with mental illnesses, adequate treatment (including careful monitoring of pharmacological treatments at both an individual and population scale and increased access to proven psychotherapeutic interventions) and comprehensive rehabilitation programs. In addition, there is an urgent need to improve the safety of many psychiatric facilities[4]. Public health approaches need to emphasize that mental illness is treatable and that suicide is preventable. Hope must be conveyed so that those in need of help are more likely to come forward. Efforts to monitor and reduce suicide rates should be among national and community concerns.

World Mental Health Day 2006 offers a unique opportunity to highlight these interlinked strategies and the potential role they can play in reducing suicide among people with a mental illness. The materials included in this year's campaign packet offer a variety of background summaries, fact sheets and reproducible handouts

That can be used in preparing community-based awareness and education programs and workshops. These materials cover a number of important campaign sub-topics, including:

- Mental illness and suicide across the life span;
- Reducing risk of suicide for people with mental illnesses;
- Key suicide indicators and risk factors;
- Efficacy of mental health care and promotion in reducing risk of suicide;
- Cultural and religious context and variation in addressing suicide and mental illness.

Major emphasis in this year's packet is also directed to two critical, and related, issues to which mental health organizations need to give special attention in conducting outreach and awareness efforts on this theme. Those two issues are the effect of stigma and misunderstanding that continue to serve as barriers for early recognition and treatment of mental illnesses, and the importance of responsible media coverage of mental illness and suicide. We urge you to make these topics key elements of your 2006 World Mental Health Day campaign strategies.

WFMH is extremely pleased to be entering into collaboration with the International Association for Suicide Prevention to jointly promote World Suicide Prevention Day (September 10) and World Mental Health Day (October 10). This collaboration will add to the impact and benefit of both of these global awareness days, and will increase the value that each of the days has in improving public awareness, reducing stigma and discrimination, and promoting service and policy advocacy to address the global impact that suicide associated with mental illnesses has on the global burden of disease. We encourage all organizations participating in World Mental Health Day on October 10 to connect with suicide prevention and service organization in their communities and seek opportunities for joint programs and events to maximize public awareness and attention to the important topics addressed by these campaigns. Establishing adequate referrals and identification of local experts prior to awareness events is essential for both effective and ethical awareness efforts.

Building Awareness-Reducing Risk: Mental Illness and Suicide

KEY MESSAGES

Mental illness: A major risk factor for suicide

Suicide, especially when viewed in global terms, represents a huge and complex public health problem. A full understanding of this problem demands the recognition that many factors come together when a person attempts or completes a suicide. Biological, psychological, social and cultural factors all have a significant impact on the risk of suicide. Nonetheless, mental illness stands out at the greatest risk factor for suicide. In the United States, more than 90% of suicides are linked with mental illness and/or substance abuse. In less developed nations, such as China, social stressors and loss may be more potent risk factors in the context of more fatal methods of attempting suicide. Because most people who have a mental disorder do not kill themselves, it is important to understand the potential factors that work with mental illness to increase suicide risk.

Treatment of mental illnesses can reduce suicide risk

Suicidal tendencies can be treated. Psychiatric medications including lithium for bipolar disorder, anti-psychotics and antidepressants also show promise for the reduction of suicidal behavior. Individuals with schizophrenia are at greatest risk early in the course of their disorder; if they can develop early and adequate management of their illness their risk appears to be reduced over time (Palmer, Panrkatz & Bostwick, AGP 2005). It is important to note that a prescription for a medication is not sufficient for the adequate treatment of mental disorders or suicidal tendencies. Individuals need to trust that their provider can listen and provide support through stressful periods of managing mental disorders. Treatment continuity is also key. Individuals with a mental disorder are at much greater risk of suicide in the weeks immediately following discharge from the hospital. Patients who continue care either through community services or with medication following discharge, tend to have lower suicide rates.

Myths that surround suicide need to be exposed

Many people hold beliefs about suicide that have no basis in reality. Education programs can dispel the following sorts of widespread and dangerous misconceptions:

- That "people who talk about suicide won't really do it:" In truth, almost everyone who attempts suicide does give some prior warning. Ignoring such warnings can be deadly. People who say things like "you'll be sorry when I'm dead" or "I can't see any way out" must be taken seriously. This is true no matter how casually they say the words. Such expressions can indicate serious suicidal feelings.
- That "if a person is determined to kill him/herself, nothing can stop him/her:" In fact, the overriding wish of most suicidal people is not specifically to die. They want an end to pain that they feel is unbearable and interminable. The impulse to end it all, however overpowering does not last forever.
- That "talking about suicide may give someone the idea." Supportive individuals do not give a suicidal person morbid ideas by acknowledging that the at-risk person is thinking about self-destruction. The opposite is true–honest and respectful acknowledgement of an individual's distress can help the person cope with the impulse and seek alternative solutions.

Rapid, easy access to helping resources must be available for people in imminent danger

This will occur when gatekeepers (persons who may have contact with suicidal individuals in their work or social roles), health care providers and the general public develop a greater awareness of available resources – of help centers, suicide prevention hotlines, effective medications and psychotherapies, community mental health services, and family/caregiver support programs. Providing easily accessible directories about these resources as part of the World Mental Health Day campaign, and publicity to reduce the stigma associated with seeking help can be a major service to the community.

Responsible and informed media coverage is critical to community awareness

Suicide contagion is a phenomenon linked with the reporting of suicide deaths. Sensationalist journalism can contribute to this tragic phenomenon. Communities should meet with and inform local news media prior to an

awareness rollout on suicide and mental illness in order to improve helpful coverage and avoid possible harmful outcomes. Matter of fact guidelines on reporting on suicide are available at: www.sprc.org.libraryat_a_glance.pdf.

The cultural context of suicide and mental illness is important

Both mental health and suicide are viewed within varying contexts shaped by culture, religion, and legal and social systems around the world. Patterns of suicide among subgroups or subcultures should be considered in shaping awarness materials for communities. Oversimplifying facts regarding high-risk groups can inadvertently suggest that all members of that group are suicidal beyond hope. It may be more fruitful to point to efforts where high risk communities have begun to address historically high rates by strengthening protective factors (despite historical discrimination or injustice) and show signs of progress. It is important to note that in an era of cultural globalization, attitudes towards suicide will be in a constant state of flux with old cultural norms interacting with new values and cultures from around the world. Understanding cultural differences in the approach to mental illness and suicide is not simply an end in and of itself. Rather such understanding should shape the way programs are designed and implemented. Programs must be culturally appropriate, and recognize that people will often approach their mental illness and suicidal thoughts in the context of religious and cultural values.

PEOPLE WITH MENTAL ILLNESS WILL REQUIRE ADVOCACY AND ACTION AT THE LOCAL, NATIONAL, AND GLOBAL LEVELS

As you work to plan and conduct your mental health awareness and education activities to commemorate WORLD MENTAL HEALTH DAY 2006, it is crucially important to turn the information and knowledge generated by your campaign into strategies that promote advocacy and action for long-term and lasting change – change in national public policy, change in public attitudes, and change that results in improved services for early diagnosis, adequate and appropriate intervention and treatment, and effective prevention programs and services. Only through the development and implementation of effective policy, services and prevention will communities and nations be able to reduce the burden of suffering and loss (personal, economic, and social) caused by mental illnesses and suicide.

This “Advocacy and Action” section is designed to suggest some ideas and examples that can help your organization to address these important issues during the months and years ahead.

The greatest thing you can do with what you have learned is to pass that knowledge on to others and work to better your community, country, region and world. WFMH Past President and famous Anthropologist, Margaret Mead, once said *“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it’s the only thing that ever has.”*

The health policy model devised by JB Richmond and M Kotelchuck state that there are three necessary ingredients that make prevention happen:

- The Knowledge Base
- The Political Will to Support Change, and
- A Social Strategy to Accomplish Change

All three of these components must be present and working for prevention action to proceed.

Your Knowledge Base can start with the information in the 2006 World Mental Health Day packet and through further research and collaboration on the topic. Continue to seek further information on the subject and from information in your country. Use this knowledge and information to begin your campaign for change.

Political Will refers to the ability of an organization or individual to gather groups together to support a particular cause or movement. In a time of tight budgets and competing priorities, it is critically important to bring the various local and national organizations concerned about mental illness and suicide together to share information, create consistent and compelling key messages, and to seek opportunities to influence public policy decisions. Speaking in a unified voice, even in a small way as issuing a Proclamation calling attention to the theme of World Mental Health Day is an important step. Having local or national elected officials take part in WMHDay and encouraging them to speak out in support of the WMHDay theme will help to further increase the public’s awareness of the topic.

A Social Strategy around the World Mental Health Day theme will define and clearly state the plan of action or blueprint for goals that your organization and its collaborators hope to achieve, and will begin to describe the strategies to be employed to achieve them. A number of countries (as well as states and provinces) have already created and begun to implement plans or strategies to reduce the risk of suicide in their jurisdictions. There is no need to "reinvent the wheel," or start from the beginning to build recommendations and strategies for your own advocacy efforts. Use these existing plans and strategies to formulate your own recommendations, according to the specific needs of your community or country (do you have high rate of suicide among youth? Are suicide among women higher than average, etc.?)

Policy Responses: In 1999 the World Health Organization launched a global initiative for the prevention of suicide, with the following objectives:

1. To bring about a lasting reduction in the frequency of suicidal behaviors, with emphasis on developing countries and countries in social and economic transitions.

2. To identify, assess and eliminate at early stages, as far as possible, factors that may result in young people taking their own lives.

3. To raise the general awareness about suicide and provide psychosocial support to people with suicidal thoughts or experiences of attempted suicide, and to the relatives and close friends of those people who have attempted or died by suicide.

The main strategy for the implementation of this global initiative has two strands, along the lines of the WHO's primary health care strategy:

1. The organization of global, regional and national multi-sectoral activities to increase awareness about suicidal behaviors and how to effectively prevent them.

2. The strengthening of countries' capabilities to develop and evaluate national policies and plans for suicide prevention.

Action is needed! Although a lot of good work is currently being done, there is a strong need for intensified and coordinated action in order to prevent suicide in the many contexts which it occurs. We will particularly mention:

1. The need for improvement of treatment methods and facilities for those with a psychiatric illness through the development of newer and more effective medications for psychiatric disorders and psychotherapeutic interventions. Research funding should be directed towards devising more effective techniques of psychotherapy and counseling for suicidal individuals. In particular, there should be more specific techniques for those people whose personality disorders are more frequently associated with suicidal behavior.

2. Many more people need to be aware of the signs and symptoms of suicidal behavior and of where help, if needed, can be obtained – whether from family, friends, doctors, voluntary organizations, telephone hotlines, social workers, religious leaders, employers or teachers and other school staff. In particular, doctors and other health care providers should be educated and trained to recognize, refer and treat those with psychiatric disorders, especially affective disorders.

3. An urgent priority for governments and their health care planning departments is the early identification and treatment of individuals suffering not only from mental disorders, but also from drug and alcohol abuse and dependence often associated with suicidal behavior.

4. A range of environmental changes can be suggested for restricting access to methods of suicide. These include modifications to motor vehicles, exhaust pipes or limiting idle times, safe storage and secure access to pesticides and the availability of insecticides; reducing the maximum size of prescriptions, packaging medications in plastic blisters and where possible, prescribing medication in the form of suppositories; limiting access to firearms and constructing high fences along bridges.

Action must be coordinated: Suicide prevention efforts will be less effective if they are not set within the framework of large-scale plans developed by multidisciplinary teams, comprising government officials, health care

planners and health care workers, survivors, consumers, advocates and researchers and practitioners from a variety of disciplines and sectors. Major investments in planning, resources and collaboration between these groups will go a long way towards reducing this important public health problem. (Adapted from: IASP's First World Suicide Prevention Day "Suicide Can be Prevented" at www.med.uio.no/iasp/english/wspd/2003/wspd_text/html)

Where to Start in Developing an Effective Advocacy Strategy?

Getting started in devising a plan of action around a public policy issue usually begins with asking a number of key questions in order to gain background and information on which to build. The "Northern Territory Strategic Framework for Suicide Prevention" developed in 2003 by the Ministry for Health and Community Services of Australia's Northern Territory offers some good examples of questions to ask and research when working to create a policy for suicide prevention. In their framework the following areas were considered:

- What are the current trends in suicide rates?
- What influences suicide?
- What is the political context in which suicide prevention needs to be considered?
- What are the effective responses to suicide?
- What are some potential areas for action?

AREAS FOR ACTION

The Northern Territory (AU) settled on six areas for action in the Strategic Framework for Suicide Prevention:

- Promoting wellbeing, resilience and community capacity
- Enhancing protective factors and reducing risk factors for suicide and self-harm
- Services and support within the community for groups with increased risk
- Services for individuals at high risk
- Partnerships with indigenous people
- Progressing the evidence base for suicide prevention and good practice

The Northern Territory's framework provides some useful directions for creating policy advocacy recommendations for creating a strategic framework for suicide prevention for a community, state/province or nation. (http:// www.nt.gov.au/health/comm_svs/mental_ framework_for_suicide_prevention.pdf)

National Suicide Prevention Plans and Strategies

A number of countries have developed and adopted "national suicide prevention plans or strategies." These existing plans are an excellent source for developing policy recommendations to present to governmental agencies and legislative leaders to promote adoption and implementation of similar plans for your country.

Following is a summary and link to a sampling of national Suicide Prevention Plans. We suggest you look into them further and if they are from your country – use them and promote them more. If your country does not have such a plan or strategy – learn from those that do exist and seek opportunities to build a coalition of organizations to help produce a plan that can become a National Strategy. This is the place where building "political will" becomes of utmost importance.

England

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009474&chk=sr1kpe

The Department of Health of the UK has stated a goal of reducing suicide in England by 20% by 2010. Details of the nation's suicide prevention strategy are available at this link, including both an on-screen and a PDF version of the strategy document.

Australia

http://www.health.gov.au/internet/wcms/publishing.nsf/content/mental-suicide

Australia initially developed a national youth suicide prevention plan, which has been recently expanded to target all age groups. Both the youth plan and the new plan are available here, as well as several documents relevant to youth suicide prevention that have been produced by the Department of Health.

New Zealand

http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/60d848b6ce1b7289cc2570a6006f6951?OpenDocument

New Zealand has a national youth suicide prevention plan developed in 1998, which can be found at this link, along with additional documents regarding suicide prevention.

United States

www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp

Under the guidance of the US Surgeon General, the Call to Action to Prevent Suicide was produced in 1999. Two years later the plan was finalized and the National Strategy for Suicide Prevention was published.

Ireland

http://www.dohc.ie/publications/reach_out.html

The National Strategy for Action on Suicide Prevention builds on the work of the National Task Force on Suicide (1998) and takes account of the important strategic and operational initiatives developed by the former health boards in recent years.

Commonalities Among National Strategies[5]

As you study the national suicide prevention plans and strategies currently in place, you will note a number of common elements, upon which your coalition can build specific policy advocacy recommendations. These commonalities include:

- Public awareness campaigns to increase awareness of suicide as a problem that is preventable; to develop broad-based support for prevention efforts; to reduce stigma.
- Community development to support development and implementation of suicide prevention programs.
- Access to services to improve services to suicidal people and their loved ones; to support service delivery effort 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 behaviour 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; to evaluate the effectiveness of new or existing suicide prevention interventions.

Summary - A Call to Action

The World Federation for Mental Health hopes that the selection of this theme for World Mental Health Day 2006 will help create 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, and that these efforts will result in wider public understanding, enhanced intervention and treatment services, and enlightened public policies.

References:

1 WHO Press Release, 8th September 2004: Suicide huge but preventable problem, says WHO.

2 WHO, Mental Health - Suicide Prevention: Map of Suicide Rates: www.who.int/mental_health/prevention/suicide/suicideprevent/en/

3 One example is the material released by the International Association for Suicide Prevention, in collaboration with WHO to mark World Suicide Prevention Day, September 10, 2005.

4 Gunnell, D et al 1994, 'Prevention of suicide: aspirations and evidence', British Medical Journal, vol. 308, pp. 1227-1233.

5 Centre for Suicide Prevention, SIEC Alert #55, www.suicideinfo.ca/csp/assets/Alert55.pdf

Building Awareness-Reducing Risk: Mental Illness and Suicide

AN OVERVIEW OF THE RELATIONSHIP BETWEEN SUICIDE AND MENTAL ILLNESS

Within the general theme of mental illness and suicide, there are a number of important issues that are the subject of much research and public policy around the world. These issues are reflected in the various sections of the 2006 World Mental Health Day campaign materials. This section takes a look at some of the major types of mental disorders and describes how they may increase the risk of suicidal behavior in persons with these disorders. Included in this discussion are the principal disorders – depression, bipolar disorder, and schizophrenia; in addition, the relationships between suicide and postpartum depression, eating disorders, self-mutilation, post-traumatic-stress-disorder, and alcohol/substance abuse are briefly considered. With each of these disorders there is great need to provide information to the general public about the symptoms of the disease, its epidemiology, risk factors, clinical best practice, and research needs. Mental health education and awareness efforts also need to provide information on the various options for mental health treatment and their efficacy in reducing risk of suicide, the debate surrounding the safety of Selective Serotonin Reuptake Iinhibitors (SSRIs), and the need to balance the possible benefits and risks in the selection of any method of treatment for mental illnesses.

Suicide and depression

Depression is a very common mental health problem worldwide. The World Health Organization estimates that 121 million people currently suffer from depression, with 5.8% of men and 9.5% of women experiencing a depressive episode in any given year[1]. It is estimated that depression will become the second most common cause of disability, after heart disease, by 2020[2]. Women are twice as likely to be diagnosed and treated for depression. However, it is believed that men suffer depression to a larger extent than the statistics show, since men are less likely to seek medical help and when they do, doctors are less likely to detect depressive symptoms[3]. In light of these high rates of depression, it is a cause for concern that mood disorders (of which depression is the major example) are the most common psychiatric condition associated with suicide[4]. It is important to note, however, that depression encompasses a wide range of experiences and illness forms from mild to severe, transient to permanent, and the risk of suicide varies substantially with the type of depression. Amongst those diagnosed with depression, a study in Finland[5] found that key indicators for suicide include: previous self-harm, severity of the illness, alcohol or drug abuse, serious or chronic physical illnesses, lack of a partner, anxiety and personality disorders.

Given the high prevalence of suicide in the community, and the high rates of depression amongst those who die by suicide, it is vital that those who are suffering from depression seek effective treatment that addresses both depression and suicidality. Since there is no evidence that antidepressant medications alone reduce suicide risk, practitioners' ability to recognize and address suicidality can be a life-saving skill. Since males in the industrialized nations are at higher risk for suicide and are less likely than females to seek medical attention for depression, considering alternative settings to reach at-risk males may require innovative approaches by communities (e.g., providing hot-line numbers in pubs).

Distinguishing Between Depression and Normal States of Sadness and Grief: Experts report that from 20% to 60% of the deaths by suicide occur among people who have a mood disorder. Suicide among such people is more common among those with more severe and/or psychotic symptoms, with late onset, and with coexisting metal and addictive disorders. Death through suicide is also more common among those who have experienced stressful life events, who have a medical illness and who have a family history of suicide.

The sadness of a major depressive disorder differs both in degree and amount from the sadness that strikes anyone at times when life is especially hard. Normal states of grief or sadness generally have less pervasive effects and last for shorter periods of time than those that mark major depression. Furthermore, certain symptoms of severe depression only rarely occur in those experiencing times of normal sadness. These include anhedonia (the inability to experience pleasure), hopelessness, and loss of mood reactivity (the ability to feel a mood uplift in response to something positive). Suicidal thoughts and psychotic symptoms, when associated with depressive symptoms, usually means that a person truly does have a diagnosable depressive disorder.

Nevertheless, many symptoms commonly tied to major depressive disorders do also occur during times of severe stress. Among them: sleep disturbances, changes in appetite, troubles with concentration, brooding on sad thoughts or feelings, or substance use. When a person with these kinds of problems sees a healthcare provider, the challenge to that professional is to distinguish normal sadness from pathological states and then to provide treatment.

Suicide and postpartum depression

It is somewhat startling that in many countries suicide is now the leading external cause of death amongst new mothers[6]. In most of these cases, women are suffering with postpartum depression. Between 8-15% of women suffer postpartum depression, and the condition is usually mild and manageable. Severe postpartum depression, however, is linked to an elevated suicide risk, with those who are admitted to hospital up to 70 times as likely to die by suicide[7]. Risks are especially high in the first year after childbirth.

The huge stigma that women suffering from postpartum depression face must be tackled if suicide rates in this high-risk group are to be reduced. Recent developments including a number of high profile celebrities (including Brooke Shields, Natasha Hamilton and Elle Macpherson) talking about their experiences with postpartum depression are to be applauded, but more needs to be done. In particular it is important that high-risk women are identified during pregnancy and adequate preparations are made for their care. Furthermore, women presenting with postpartum depression must not slip through the cracks in primary health care clinics. One recent study found that only 29% of women presenting with high levels of depressive symptoms on the psychiatric symptom index were diagnosed with postpartum depression[8]. Increasing this figure might require changes in the way medical professionals are trained to identify this condition. Once diagnosed, there are a host of effective pharmacological and psychotherapeutic treatment options whose efficacy has been well documented[9 10].

Suicide and bipolar disorder

Bipolar affective disorder is a common condition, and among mental illnesses ranks second only to unipolar depression as a cause of worldwide disability[11]. Bipolar depression affects men and women equally, and afflicts about 5 people in 1000[12]. For those with bipolar depression, suicide risks are approximately 15 times that of the general population[13]. Suicide often first occurs when work, study, family or emotional pressures are at their greatest. In women, suicidal risks can increase postpartum or during menopause.

Most persons with bipolar affective disorder have the potential, with optimal treatment, to return to normal functioning. With sub-optimal treatment, however, many will have a poor long term outcome with increased risk of suicide. Yet there is evidence that treatment is generally sub optimal. Longitudinal observational studies suggest that the very high lifetime prevalence of suicide attempts in people with bipolar affective disorder (50%[14]) could be reduced by maintenance drug treatment and adequate treatment of depression and comorbid alcohol and drug abuse[15]. Adequate treatment goes beyond the simple provision of treatment regimes, and it is at these times that suicide risk is particularly high. People with bipolar disorders need encouragement to initiate and stick to treatment regimes and continued follow-up of their treatment. Despite its shortcomings, lithium has long been the mainstay of treatment for bipolar affective disorder. Several newer drugs have emerged over the past 10 years, but evidence of their suicidal protection effectiveness remains sparse.

Suicide and schizophrenia

Approximately 24 million people worldwide suffer from schizophrenia, with equal rates (7 per 1000) reported amongst men and women[16]. It is estimated that there is a 4 to 10 percent lifetime risk for suicide among persons with schizophrenia and a 40% lifetime risk of suicide attempts[17]. A World Health Organization study found the most common cause of death in those with schizophrenia was suicide[18]. Risk factors for suicide amongst those suffering from schizophrenia include: positive symptoms, co-morbidity with depression, lack of treatment, downgrading in level of care, chronic illness, a good educational background and high performance expectations. Suicide is more likely to occure earlier in the course of the illness.

If we are to prevent suicide in persons with schizophrenia it is vital that all staff working in mental health receive dedicated training in both risk assessment and management, something that is too often left to experience to provide[19]. Training should also emphasize the importance of addressing co-morbid conditions that have been found to heighten risk, such as depression, substance use and loss of functioning. The simple measure of improving record keeping and care plans may help ensure the entire clinical team is aware of all the risk factors present and

how they can be minimized. This also highlights the need for good communication between the patient's multi-disciplinary team, general practitioner, caregivers and relatives.

Preventing Suicide in People who have Schizophrenia: The future holds better treatments for people with schizophrenia. It is important for both caregivers and loved ones of people with this disease to encourage them to hold on to life. Emphasize that improved treatments promise to emerge from scientific laboratories in years to come. There is real reason to expect that life will get better.

In 2005, The British Journal of Psychiatry published an analysis that combined a large number of international studies of suicide risk among this population. The most robust finding of this review was that suicide was more likely when people with schizophrenia showed agitation and expressed feelings of worthlessness and/or hopelessness; also when they had a history of suicidal thoughts and of suicide attempts. A family history of suicide also raised the risk

Among the other important findings of this study:

- The living situation of a person with schizophrenia affects risk. Those who live alone, or do not live with their families, are at increased risk of suicide.
- Recent losses (such as a divorce or death) increases risk, as is true for the general population.
- Those individuals who are better educated seem to be at higher risk for suicide.This may reflect the greater awareness of and fear of mental deterioration.
- Poor adherence to treatment greatly increases risk. In some patients the use of medications known to have anti-suicide effects may be advisable.
- Alcohol misuse did not appear to be a major risk factor for people with schizophrenia. However, abuse of drugs was strongly correlated with heightened risk. Such drug abuse is twice as common among those with schizophrenia compared to the general population.

High-Risk Times for Suicide: People with schizophrenia need extra support and supervision at these times:

- Periods when the person is very psychotic and out of touch with reality
- Periods when they are very depressed
- In the first 6 to 9 months after they have started first taking medications, when they are thinking more clearly and learn that they have schizophrenia (with all the negative implications of this)
- The period after hospital discharge. Discharge plans ought to be made with care. Whenever possible, a person at high risk ought not to be left alone, and certainly not for long periods. Suicide often occurs when a person with schizophrenia has been left alone all day.

Anorexia nervosa and Bulimia nervosa

Eating disorders have the highest mortality rate of any mental illness. This includes both suicide deaths and deaths from direct complications of their eating disorder. Studies have found that prevalence rates for attempted suicide vary depending on the eating disorder diagnostic subgroup and study setting. The prevalence of suicide attempts is lowest among outpatients with anorexia nervosa (16%). Prevalence rates are higher for bulimic individuals treated as outpatients (23%) and inpatients (39%). The highest rates of suicide attempts are reported among bulimic individuals who have co-morbid alcohol abuse (54%)[20]. It should be noted that these rates do not include those who die from other complications of the disorder. Further complicating this picture is the high prevalence of non-lethal self-mutilation amongst those diagnosed with eating disorders. Unsurprisingly, most of the women in the study had other psychiatric disorders besides an eating disorder, including depression, drug or alcohol abuse or fearfulness or anxiety. Almost 84 percent of the patients had at least one other psychiatric problem.

Given these statistics it is concerning that the incidence of eating disorders has doubled since the 1960s. Eating disorders, which used to be a largely Western disorder, are also being reported in high levels in many Asian countries for the first time[21]. More than 90% of those diagnosed each year are young women[22]. Dr Mike Shooter, president of the Royal College of Psychiatrists has argued that eating disorders are "poorly understood by the public and clinicians alike"[23] and that there is a need for intensive research into clinical best practice guidelines.

Self-mutilation

Self mutilation, especially among young people, is an emerging area of concern. One widely cited estimate is that self-mutilation occurs in at least 1 person per 1,000 annually. Self-mutilation takes many forms and can include self-binding and amputation, banging ones head, biting oneself, pulling ones hair, and cutting, scratching or burning ones skin.

Self-mutilation should not be confused with suicide attempts, but research suggests that those with mental illnesses are more likely to self-mutilate, with one study of psychiatric outpatients finding that 33% reported engaging in self-harm in the previous 3 months[24]. Furthermore, self-mutilation is an early predictor of suicidal behavior. About half of all people who kill themselves have a history of deliberate self-harm, an episode having occurred within the year before death in 20-25%[25] [26].

Substance Abuse and Suicide

International health researchers point to alcohol as the most widely abused substances in the world. Globally, the extent of problem drinking varies widely; overall about 1.7% of the world's people abuse alcohol. In parts of Eastern Europe and in North America, experts estimate that 5% of the population abuse alcohol. The prevalence of illegal abuse of drugs and drug addiction in the worlds' nations ranges from 0.4% to 4%. In 2003, the World Health Organization estimated about 5 million people inject illicit drugs. In studies that examine risk factors among people lost to suicide, substance abuse and problem drinking occur more often among youths and younger adults, compared to older people. Also, male gender is a risk factor for both substance abuse and suicide. For particular groups at risk, such as indigenous peoples surrounded by an alien majority culture, depression and alcohol abuse may be co-existing risk factors for suicide.

Alcohol and substance abuse problems contribute to suicidal behavior in several ways. Persons who use and abuse substances often have several other risk factors for suicide. In addition to being depressed, they are also likely to have social and financial problems. Substance use and abuse tend to occur more often among people who are prone to act on impulse. They also occur often among those who engage in many types of high-risk behaviors that can cause self-harm. In addition, people who are intoxicated may make suicide attempts impulsively and aggressively that they would not make if they were not intoxicated.

Key Facts about Substance Abuse and Suicide[31]

- People with severe alcohol dependency or alcoholism have increased risk for suicide.
- Depression and other mood disorders are involved with the majority of suicides; substance abusers have profoundly increased rates of depression. Left untreated, substance abuse worsens the outcomes of mood disorders.
- Suicide attempts occur more often within the context of a binge-drinking episode.
- People whose drinking causes trouble at work are six times as likely as others to die by suicide in the home.
- Problem drinkers who have been hospitalized for reasons related to alcohol abuse have ten times the risk of suicide, compared to problem drinkers not so hospitalized. Substance dependence raises the risk of work, family and physical health problems that can become more severe over time.
- If a person who is dependent on alcohol also uses cocaine the risk rises significantly.
- Places that have higher per capita spirits sales tend to have higher suicide rates.
- Alcoholics who die by suicide are more likely to have partner-relationship troubles and other severe life stressors than alcoholics who have not tried suicide.
- Canadian research indicates that up to 80% of people with schizophrenia will abuse substances at some time; such abuse is associated with suicidal behavior.
- High-risk alcoholics can be defined as those with a co-occurring depression diagnosis, those in treatment for a prior suicide attempt or those who have tried to ill themselves in the past.
* The risk of suicide among alcoholics increases over time; suicide risk is highest after 10 or more years of having drinking problems.

Treating Mental Illnesses including Substance Abuse Disorders Lowers Risk: There are effective ways to lower the risk of problem drinking and drug abuse among young people. There are also effective treatments, which often combine medications with various forms of psychotherapy and support groups, for alcoholism and substance abuse. New treatments, tailored to people with both substance abuse problems and suicidal tendencies, are forthcoming. These may offer greater promise for saving many individuals.

People who drink too much often seem to die by suicide in the throes of severe relationships difficulties. Accordingly, for people at risk of suicide who drink too much, marital or couples based treatment is showing particular promise.

Alcohol and substance abuse clinicians and counselors need training in and an understanding of depression and other mental illnesses that can lead to suicide. If these caregivers can better recognize mental illnesses, it will help them better treat people with alcoholism.

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MENTAL ILLNESS AND SUICIDE ACROSS THE LIFE SPAN

Suicide is a major public health concern worldwide. The World Health Organization estimates that over a million people die by suicide every year, and it is widely believed that the true number of self-inflicted deaths is higher due to underreporting in many countries. The impact of non-fatal self-inflicted injuries may be as much as 20 times higher than the number of reported deaths by suicide. From an economic and social health point perspective, suicidal behavior places a major burden on the healthcare resources of countries across the world.

Suicide is also a social and health concern that reaches across the lifespan, as well as around the world. Suicidal behavior among young people, working adults, and the elderly takes a heavy toll on families, communities, and countries in all regions of the world. Suicide among people with a mental illness, such as depression or schizophrenia, adds to the global burden of disease represented by mental and behavioral disorders – all too often without recognition, diagnosis, and treatment.

The following information provides a brief overview of the relationship between mental illness and suicide in different age groups, and graphically demonstrates the critical need for a lifespan strategy to address this major public health issue.

Childhood

Although suicide rates are generally very low during childhood, according to a study of 32 countries conducted by the Australian Institute for Suicide Research and Prevention (2003), there has been an almost universal increase of suicide rates among children during the past four decades in most countries in all regions. The rise in rates have been noted in Australia and New Zealand, North America, Europe and in particular the Scandinavian countries. For example, rates in Australia rose by 92% between 1960 and 1999, compared to 240% in Canada, 646% in New Zealand, 420% in Scotland, and 3900% in Ireland. While the actual numbers of children who die by suicide remain among the lowest across age groups, the increase in rates among youngest children is especially alarming particularly in nations where there have been downward trends in most other age groups.

Despite the dramatic increase of depression and suicidal behavior in children, research within this field is limited. Suicide is the 10th leading cause of death in children under 14 years of age. For each child who dies by suicide, it is estimated that there are at least 50 more who experience a non-fatal attempt. It is difficult to collect statistics on suicide in children owing to the lack of standard criteria applied to determining suicide in this age group. Children of all ages can experience depression, but it will be manifested differently across each age group. In addition to mental illness, factors that have been found to increase risk for child suicide include family history, loss of a loved one before the age of 12, violence, decreased family ties, and increased family pressures. (Source: Http://www.ncbi.nlm.nih.gov/query/ - PubMed - www.pubmed.gov "Depression and suicide in young children, Workman, CG & Prior, M.)

Some of the primary risk factors for suicide in children are:

- Previous suicide attempts
- Close family member who has died by suicide.
- Past psychiatric hospitalization
- Recent losses: This may include the death of a relative, a family divorce, or a breakup with a girlfriend.
- Social isolation: The individual does not have social alternatives or skills to find alternatives to suicide
- Drug or alcohol abuse: Drugs decrease impulse control making impulsive suicide more likely. Additionally, some individuals try to self-medicate their depression with drugs or alcohol.

- Exposure to violence in the home or the social environment: The individual sees violent behavior as a viable solution to life problems.
- Handguns in the home, especially if loaded.

(Source: http://www.baltimorepsych.com/Suicide.htm, Carol Watkins, MD - Suicide and School: Recognition and intervention in the school setting)

ADOLESCENCE

In almost all countries suicide rates among male adolescents have increased at some point during the 1980s and/or 1990s. The most notable exception to this trend is Western Europe, where most countries have experienced declining suicide rates among adolescent males. Since 1997, it appears that this decline is also taking place in Eastern Europe, Southern Europe, Asia, Australia and New Zealand. Although the overall global rate of suicide rates among adolescent girls appear to be declining as well, some countries, such as India, report relatively very high rates of suicide among girls in this age group.

Increases in adolescent suicide rates have been attributed to increases in psychiatric illnesses among the young. Consistent with adult research, up to 90% of adolescents who die by suicide have at least one mental illness.

The Suicide Information and Education Centre in Alberta, Canada indicates:

- **Young people report higher rates of attempts than adults and have a lower suicide rate.** Adolescent girls are 4 to 7 times more likely to attempt suicide than their male peers.
- **Males typically use more lethal means** (firearms, hanging) than do females (who usually use drugs, poisons or gasses). Sadly, recent trends indicate that females are starting to choose more lethal means than they did before.
- **Studies show that significant percentages of adolescents contemplate, plan and/or attempt suicide without seeking or receiving any help**. Males are less likely than females to seek help. This finding underscores the importance of adults being aware of the warning signs of depression and suicide. With such awareness, they can begin potentially life-saving discussions that the young people may never initiate themselves.

Research has shown that young people prefer to confide in their peers first and relatives second. Some estimates suggest that only 25% of young people who know that a peer is suicidal in turn seek adult support. Concern over the ways an adult will react and a desire to protect the friend's confidences often keep a young person who is aware of a danger from turning to an adult. It is common knowledge that many youth simply avoid seeking help. The reasons that young people do not seek help include: Fear of stigma or shame; fear of negative consequences (including institutionalization), lack of faith in caregivers based on past experiences, belief that no one and nothing can help, adherence to group values that restrict help seeking; lack of the awareness of or access to helping resources.

Parents, educators, health and mental health professionals, and other adults that work with adolescents should recognize that individuals among certain groups may have a higher than average risk for suicide or self-inflicted injury. These special risk groups include:

- Youth who engage in risky or self destructive behavior (smoking, dangerous driving, unprotected sex, substance abuse)
- Youth exposed to violence towards themselves or others or with a history of being violent towards others
- Homeless youth
- Those who have experienced a significant loss or relationship disruption
- Those with excessively high expectations of themselves
- Those facing issues around their sexual orientation (self-acceptance in the face of stigma)
- Youth who self-injure in ways other than a suicide attempt
- Youth with severe mental illnesses (including depression, mood disorders, schizophrenia)
- Aboriginal youth
- Young people in the custody of youth protection agencies

Efforts to build understanding of the reasons that young people attempt suicide can play a major role in preventing avoidable deaths. Understanding must become widespread. Suicide occurs within all classes and cultures. For efforts aimed towards the prevention of youth suicide to work best, both adults and young people themselves need to learn what leads to suicide attempts and to deaths.

Young Adults and College Students

Dr. Kay Redfield Jamison, in her book Night Falls Fast: Understanding Suicide, says that when the body's disease fighting forces are weakened by stress, it succumbs to physical illness more readily. When the mind's balance is weakened by stress, mental illnesses more easily take hold. In turn, hopelessness can set in and suicide can become more likely. The early adult years represent a prime interval in life for the onset of severe mental illnesses. When mental illnesses take hold a person's risk of suicide multiples many times.

Why are the late adolescent and early adult years so risky? A person born with a genetic predisposition to problems in brain chemistry confronts a great deal of stress as he or she moves toward adulthood and independence. Young people confront the pressure to assume adults roles, in relationships and in the world of work. Some, within colleges and universities, confront stiff academic pressures. They feel obliged to perform intellectually and/or athletically, and meet the high expectations of parents, peers, society and themselves. When the pressures become too much for a vulnerable mind to bear, mental illness can take hold and, if the illness is not well handled, the risk of suicide can greatly rise.

"Unlike most disabling physical diseases, mental illness begins very early in life. Half of all lifetime cases begin by age 14; three quarters have begun by age 24. Thus, mental disorders are really the chronic diseases of the young," says the US National Institute of Mental Health. For example, anxiety disorders often begin in late childhood, mood disorders in late adolescence, and substance abuse in the early 20's. Unlike heart disease or most cancers, young people with mental disorders suffer disability when they are in the prime of life, when they would normally be the most productive." The World Health Organization reports that, based on data available in 2001, people under the age of 45 now account for more than half of all the suicides that occur in a given year. This is a rise above the comparable figure in the 1950s, which was 44%. By 2000, suicide had become one of the three leading causes of deaths among young adults worldwide.

Despite sometimes-sensational coverage by the media of deaths by suicide on college campuses, college students do not kill themselves more often than other young adults. Because, overall, relatively few college students die by suicide, there are only small studies of the occurrence. These suggest the following tentative findings:

- Some groups of students are at especially high risk. Foreign students at American and British schools seem to be especially vulnerable. This may reflect their social isolation. The last studies done in the area (in the 1950s) indicated that the annual rate of death by suicide for foreign students was 80 per 100,000, many times the rate for other students

- Psychosis and depression are major risk factors for college students as for other age groups. Suicide disproportionately takes the lives of college students who take more than four years to complete their degrees; this may reflect the fact that these students have had their academic careers interrupted by periods of disabling mental illness.

- College students who die by suicide show different personality traits than those shown by young adults who kill themselves and are not college students. Most young adults who kill themselves have high-risk taking, impulsive personalities; they are often substance abusers. In contrast, college suicides are largely depressed, quiet, socially isolated young people who do not abuse drugs or alcohol, and who attract little attention.

- Many suicidal students experience anxiety, insomnia, and other symptoms, although these may disappear shortly before the final, fatal act, as their plan to die seems to soothe their psychic pain. Nearly half of the suicidal students do seek some medical attention in the months before their self-destructive acts. However, few mention their suicidal intentions and few receive any psychiatric care.

Adult Women

"One in every five women in the United States suffers from depression and women are more likely to attempt suicide than men are. Since both depression and previous suicide attempts are risk factors for suicide, it is vital that clinicians who work with women screen for depression and be alert for signs of suicide intent," say Douglas G. Jacobs, M.D. and Nancy L. Deutsch in an article entitled *Recognizing Suicide Potential in Women,* published in the journal Women's Health in Primary Care.

Depression is highly prevalent among women who die by suicide; in general depression disproportionately affects women. Studies done in countries throughout Europe and Asia, as well as in the US, have consistently shown that the prevalence of depressive disorders among female decedents is between 59% and 91%. Linda H. Chaudron, M.D., M.S. and Eric D. Caine cited these statistics in an article called *Suicide among Women*, published in the Journal of the American Medical Women's Association.

A high proportion of patients who receive mental health care do through their primary care provider. Often that provider also has the role of deciding which women require specialized mental health care. Primary care providers need a familiarity with the attributes of a woman who may be considering killing herself. Such providers need to feel comfortable discussing suicide, and they must know the correct procedures for handling a patient at risk. This means that caregivers need to do more than look for signs of depression. They also need to be aware of certain factors that heighten a woman's risk for suicide.

Women seem to be more prone to suicide when serious disruptions occur in their relationships with others. This implies that caregivers ought to pay special attention to the home environments of their female patients. For women, family stresses or violence may play an important role in a decision to attempt suicide.

Caregivers ought to take careful note of any signs of self-mutilation such as lacerations on the wrists, burns or other self-inflicted injuries. In women, self-inflicted injuries appear to be strongly linked to a history of physical or sexual abuse. A caregiver ought to perform a suicide inquiry upon noticing such wounds. The woman also needs a referral to a mental health counselor.

Adult Men

When hospital emergency rooms receive people who have attempted suicide doctors usually are able to save their lives. But there's something striking about the thousands every year whose decision to end it all is reversed in the emergency room, in many western countries. In the year 2003, the latest year for which statistics are available, men died four times as often as women.

According to the National Institutes of Mental Health, men are more likely to abuse drugs and alcohol than women are. But people rarely take their own lives on a whim, no matter how severe their substance abuse may be The fact that men tend not to seek help for depression may be key to understanding why their suicide attempts are so often fatal.

Men Need Education About Depression: Despite the far more frequent diagnosis of depression in women than in men in the US and in many other industrialized countries, about four times as many men as women die by suicide in those countries. This is true even though women make far more suicide attempts. Some researchers note that suicide is an aggressive behavior and that males, in general, display greater aggression than do females. One factor that contributes to the far higher risk of suicide for men is the fact that men are likelier than women are to attempt suicide using highly lethal methods. The massive amount of research that shows a link between suicide and depression also comes into play. The alarming suicide rate among men may reflect the fact that men are less likely to seek help for their depression, help that could be life saving.

In some countries, including several in Asia and Latin America, the frequency with which men and women die by suicide is roughly equal (according to an article posted on WebMD, reviewed by Brunilda Nazario, M.D.) It will take more research before medical experts fully understand depression in men. Nonetheless, concerned parties (including members of the general public, employers, clergymen and healthcare providers of all sorts) can play major roles in recognizing depressive symptoms in men and helping them get treatment.

The Elderly

Elderly adults, those above age 65, kill themselves at rates that are the highest of any age group, in many countries. Future suicide rates among the elderly will reflect several important global trends. One is the growth in

numbers of people above the age of 65, both in absolute terms and as a fraction of the overall population. According to Mike Magee, M.D., in 1998, there were approximately 184 million global citizens above the age of 65. Dr. Magee cited projections that this number will climb to 678 million by the year 2030. Dr. Magee the host of an Internet-based program called Health Politics with Dr. Mike Magee. He is also director of the Pfizer Medical Humanities Initiative.

In its comprehensive fact sheets on suicide (www.mind.org.uk/information/Fact Sheets/Suicide/), MIND, The Mental Health Charity in the UK, notes "Although suicide rates in older people of both sexes have dropped considerably since the 1950s, they are still high, with older men showing the highest rates. Suicide in older people is strongly associated with depression, physical pain or illness, living alone and feelings of hopelessness and guilt. Community surveys suggest that from 10 per cent to over 20 per cent of older people may be experiencing depression, but that only a fraction of these may be known to GP and psychiatric services. Most suicides in older people occur in the community, and most have had no contact with old age psychiatry services. Cattell & Jolley's research found that community old age psychiatry services were seeing less than 25 per cent of older people with depression who later went on to kill themselves, and most of these people had not seen their family doctor within the month prior to suicide.

The US Department of Health and Human Services (DHSS) states "risk factors for suicide among older persons differ from those among the young. In addition to a higher prevalence of depression, older persons are more socially isolated…and have more physical illnesses." Among the elderly, states Dr. Magee, "Depression is often misdiagnosed as cognitive impairment, in spite of the fact that there are many good reasons to be depressed: retirement, widowhood, bereavement and isolation." He points out as well, though, that "the cause of depression can be much more subtle. For example, having a hearing impairment is often associated with depression. More aggressive approaches to hearing loss would be beneficial. Hearing loss affects quality of life and interpersonal relationships…And if other diseases cause depression in the elderly, the reverse is true as well. Depression increases the risk of disability from all other causes in the elderly by 67%." Caregivers in all realms of healthcare need to understand the interrelatedness of depression and a variety of physical ailments.

Depression often co-occurs with other serious illnesses such as heart disease, stroke, diabetes, cancer, and Parkinson's disease. Because many older adults face these illnesses as well as various social and economic difficulties, health care professionals may mistakenly conclude that depression is a normal consequence of these problems–an attitude often shared by patients themselves. These factors together contribute to the under diagnosis and under treatment of depressive disorders in older people. Depression can and should be treated when it co-occurs with other illnesses, for untreated depression can delay recovery from or worsen the outcome of these other illnesses. With regard to recognizing depression, health care workers may need to think carefully about the best ways to discuss the problem with their elderly contacts. They must learn approaches that can help older people be more forthcoming about their mental health status despite all the barriers to openness (stigma, feelings of hopelessness and worthlessness, etc.). It is clear from these findings that the major focus of suicide prevention in older people must be the improved recognition, treatment and management of depression.

Other Risk Factors for Elderly Adults

Having lost a spouse through divorce or death increases an old person's suicide risk. In the US in 1998, among males aged 75 years or older, the rate for divorced men was 3.4 times that rate for married men; for widowed men it was 2.6 times as high. In the same age group, the suicide rate for divorced women was 2.8 times that of married one. Among widowed women, the rate was 1.9 times that of married women.

Other major upheavals in life also raise the suicide risk in elderly people. According to the American Association of Suicidology (AAS). These include major changes in social roles, such as retirement. The AAS states that elderly suicide is also associated with physical illness, uncontrollable pain and the fear of a lengthy illness, as well as the perception of having poor health. Researchers writing in the American Journal of Geriatric Psychiatry (AJGP) noted that "suicide in elderly persons is more likely to be associated with medical illness and physical impairment than it is in younger age groups." They continued, "specific types of medical illness may confer greater risk...there is some evidence that cancer has a stronger association with suicide than other medical illnesses."

Mental Health Consequences of Suicide for Family Members and Friends: "Death by suicide is not a gentle deathbed gathering: it rips apart lives and beliefs, and it sets survivors on a prolonged and devastating journey," writes Kay Redfield Jamison, M.D. in her book Night Falls Fast: Understanding Suicide. She explains that, while it

may be somewhat surprising, most aspects of grief after suicide aren't so different from the reactions of those who lose members of their family or friends to death in other ways. But certain things intrinsic to such grief do distinguish it.

Attention and Stigma Can Magnify the Pain: A death by suicide (or by other unexpected or violent causes) can arouse public interest. A police inquiry can draw attention to the deceased person and to relatives and friends. Media attention can greatly augment the stress for survivors. This is especially true when journalists cover the death insensitively or inaccurately.
Another distinguishing feature is stigma. A Bereavement Information Pack, distributed by The Royal College of Physicians, discusses the toll that stigma extracts: "Social attitudes to suicide are changing, but they may still limit the support that is available. The silence of others may reinforce feelings of stigma, shame and 'being different'. If others are embarrassed, uneasy or evasive about suicide, the survivor may be left feeling intensely isolated. Opportunities to talk, remember and celebrate all aspects of a loved one's life and personality may be denied. A strong need to protect a loved one, and oneself, from the judgment of others may also be felt."

Understanding the Grief of Suicide Survivors Needs to Become Widespread: Suicide claims a great many lives. Therefore it is important for the general public as well as for members of all helping professions (healthcare, education, religious vocations, etc.) to understand some of the special troubles experienced by survivors. With such an understanding, people will know what to say to someone who has lost a loved one to suicide. People need to learn to discuss the death of a person who kills him- or her with the same compassion and concern they would muster in talking about the death of any cherished human being. Suicide survivors need to hear the same kinds of things that might be said to anyone else who had experienced the death of someone close.

Survivors Face Questions without Answers and Often Overwhelming Emotions That Can Last a Long Time: The website of Befrienders Worldwide, which runs volunteer centers in 38 countries, points out that bereavement due to suicide is often especially prolonged.

Some of the complex emotional responses that often occur in suicide survivors:

- **Intense shock and disbelief:** A common aspect of grief is recurring images of the death, even if it was not witnessed. If the survivor actually did see the suicide or if he or she discovered the body, that person may experience posttraumatic stress reactions. It is common for survivors to need to go over and over the painful images and feelings created by these events (or by their imagined recreations of these events).
- **Wondering why it happened:** After a suicide, those left behind often search for some explanation of the tragedy. During the search, different members of the same family may have conflicting ideas as to why the suicide happened. This can create additional tensions within the family, especially when some family members blame others.
- **Asking themselves if the suicide, somehow, could have been prevented:** Survivors may torture themselves with endless "what-ifs." They may ponder how the person might have been saved and come up with answers that seem obvious, in retrospect.
- **Feelings of rejection:** Survivors often feel abandoned and wonder "How could he or she do this to me?"
- **Feelings of relief, often accompanied by intense guilt:** The prolonged depressions and other mental illnesses that often precede a suicide take a huge and exhausting toll on caretakers. The death of their loved one may leave them feeling both grief struck and relieved, which in turn can bring on intense guilt.

Particular Needs of Particular Sorts of Survivors: Dr. Jamison makes these comments about particular groups of suicide survivors:

- **Parents** of children who die by suicide "are left particularly devastated. For months, if not years, they are overwhelmed not only by the loss of the child but by guilt as well" and by deep feelings of failure and shame.
- **Siblings** of children who kill themselves share in the misery and anxieties of their parents, but have been described as the "forgotten bereaved." (Dyregrou article) Siblings are too often left out of the outreach efforts after a suicide. Hoping that parents will be able to provide the appropriate needed support may be assuming too much capacityfrom these overwhelmed caregivers. In particular younger bereaved siblings may suffer from PTSD (or more likely the some of the symptoms associated with the disorder, grief reactions, depression and anxiety. In addition to feeling the loss of their brother or sister, many children feel guilty and responsible, much like their parents.

- **Spouses** who survive a suicide, according to research, experience about the same long-term psychological outcomes as do people who lose their spouses to either suicide or to death by other causes. Most go through an initial period of depression after the suicide but them go on to remarry and bring up their children with less difficulty than might be imagined.
- **Children** are devastated and sometimes permanently scarred by the suicide of parent. They do, however, generally survive the death without severe or lasting pathology. They often experience deep grief, guilt and anxiety lasting months or years. Children with a history of their own psychiatric disturbances are likely to be hardest hit, for the longest time.

Survivors' Groups Can Help Greatly: Survivors manage to go on by relying on a variety of supports. These include family and friends, faith, the passage of time and psychotherapy or counseling. Participating in self-help groups for suicide survivors can provide invaluable help of a unique sort. Groups can help survivors in the following ways:

- Talking about the suicide
- Putting the suicide in perspective
- Dealing with family problems caused by the suicide
- Feeling better about themselves
- Obtaining factual information about suicide and its effects
- Having a safe place to express their feelings
- Understanding and deal with other peoples' reactions to suicide

Other Life Span Issues to Consider

(We have attempted to cover a number of the major topics and areas of interest around the theme of "Mental Illness and Suicide" in this year's World Mental Health Day campaign materials. However, we are well aware that there are many other topics and issues we have not been able to address in any detail. We're also aware that some of the topics and issues not covered may have particular interest in different communities and countries, due to current situations that exist. Listed below are some of the topics that may have specific interest to your locale and constituencies that you might include in your World Mental Health Day campaign awareness and information activities)

Suicide and sexuality: There is strong evidence to suggest that gay, lesbians, bisexual and transgendered people have higher rates of suicide and attempted suicide than the general population. Young gay men and lesbians are particularly at risk of suicide. In 1993, the Department of Health published the Health of the nation key area handbook: mental illness, which makes reference specifically to lesbian and gay mental health issues. A Department of Health leaflet says that those at increased risk of suicide include people 'whose sexual orientation brings them into conflict with their family or others'. Gay people generally, and young gay people in particular, may face a number of pressures due to their sexuality. Many can feel isolated; they may have difficulties coming to terms with their own sexuality, problems arising from society's attitude towards them, direct experience of facing discrimination and being stigmatized. Added to this, levels of substance abuse in the gay population are high. American statistics suggest that alcoholism affects the gay community at a rate of 20-33 per cent, which far exceeds the general population at 10 per cent. Reasons suggested for this include the problems of dealing with societal oppression, using alcohol and drugs as a means of coping with depression, and the pivotal role of bars in gay social networks.

Reducing Suicide through the prevention of bullying: While bullying has been a common behavior in all cultures through the ages, it rarely receives great public attention and is seldom treated as a public health issue. Now, recent research has begun to call attention to the negative effects of bullying behavior, and its relationship to suicide. We know that at least sixteen children in the UK kill themselves each year because of bullying at school. Each of these deaths is foreseeable, preventable and unnecessary. The true total could be as high as 80 or more.

These estimates, which are published in the book, *Bullycide: death at playtime* by Neil Marr and Tim Field, are endorsed by leading childcare charities. People who are bullied have many common characteristics including an unwillingness to resort to violence (or legal action) to resolve conflict, and a tendency to internalize anger rather than express it outwardly. Focusing anger inward is a recognized cause of depression. Bullying is perpetrated over a long period of time, perhaps measured in years, and sometimes results in major stress reactions, self destructive behavior, or by exhibiting the same behaviors as the bully.

It's likely that many suicides are the result of bullying, but the target's lack of awareness of what is going on, their unwillingness to confide what is happening, the traumatization, and the inability to articulate, everyone else's denial, the bully's accomplished lying and Jekyll and Hyde nature, plus the general lack of knowledge and awareness of society, prevent the real cause from being identified. (Source: www.bullyonline.org/stress/health.htm)

Suicide and HIV/AIDS in Africa: South Africa is experiencing an HIV/AIDS epidemic of shattering dimensions. To date, up to 200 000 have died of AIDS-related illness in South Africa, and more than four million are infected with HIV or have AIDS. The inevitable disruption of HIV/AIDS on all aspects of society will be so profound that it is virtually impossible to contemplate its dimensions. In 1991, the national survey of women attending antenatal clinics found that only 0.8 % was infected in South Africa. In 1994, when the ANC government took power, the figure was still comparatively low at 7.6 %. In 2001 it was 25%. South Africa has one of the worst epidemic of HIV require a multi-dimensional approach to curb the tide. There is a prediction that approximately 500 000 AIDS-related deaths in the year 2010. Against this backdrop, a study of mortality records at Umtata General Hospital in Transkei, South Africa suggested that suicide rates have risen in parallel to the rise in mortality due to HIV/AIDS over the same period. Accurate estimation of suicide in relation to HIV/AIDS is necessary in measuring the costs of the epidemic and for effective strategic planning. More follow up study is needed to understand the non-natural deaths in association with HIV/AIDS. Evidence underlying conclusions made in the present study were recognized as being circumstantial, but its credibility was considered enhanced by the fact that the observed mortality trends are similar to data for the whole country recently reported by the Medical Research Council.

Internet Suicide in Japan: An Internet suicide is a suicide pact made between individuals who meet on the Internet. The majority of such Internet-related suicide pacts have occurred in Japan, which has one of the highest overall suicide rates in the world, but similar incidents are also being reported in Hong Kong, South Korea, Germany, Australia, Norway, the United Kingdom, Canada, the United States, and Sweden Despite the alarmed response of the media, however, Internet-connected suicide pacts are still relatively rare. Even in Japan, where most of such pacts have occurred, they still represent only 2% of all group suicide-pacts, and less than .01% of all suicides combined. However, they do seem to be on the increase in that country: 34 such pacts occurred in 2003; at least 50 are estimated to have occurred in 2004; and 91 occurred in 2005 (sources: "Japan suicide reports", Japan Mental Health, January 31, 2005)

Building Awareness-Reducing Risk: Mental Illness and Suicide

HOW SUICIDE RISK CAN BE REDUCED FOR PEOPLE WITH MENTAL ILLNESS

Suicide: A Growing Global Burden

This theme warrants keen focus. For several decades the human toll taken by suicide, which usually results from unrecognized, untreated or under treated mental illness, has been mounting alarmingly. According to the World Health Organization, suicide rates have increased by 60% in some countries during the past 45 years. Furthermore, in many places there has been a marked change in recent times in the nature of the groups hardest hit by suicide.

Older people, for whom depression is the strongest risk factor for suicide were once the group most likely to die by suicide. In recent decades, though, suicide rates have been climbing among the world's young people. In one third of all countries, says the WHO Initiative for the Prevention of Suicide, young people are the group at the highest risk. Many experts believe that the spread of substance abuse among young people has led to the two- to fourfold increase in youth suicide since 1970.

Dr. Catherine Le Gales-Camus, Assistant-director General, Non-communicable Diseases and Mental Health at the World Health Organization (WHO), has said, *"For every suicide, there are scores of family and friends whose lives are devastated emotionally, socially and economically. Suicide is a tragic global public health problem. Worldwide, more people die from suicide than from all homicides and wars combined. There is an urgent need for coordinated and intensified global action to prevent this needless toll."*

The following statistics, adapted from various WHO sources*, convey the weight of the growing global burden of suicide.

- In the year 2000, approximately one million people died from suicide. Experts estimate that for every completed suicide, at least twenty times as many suicide attempts occur. Failed suicides often lead to injury, hospitalization and both emotional and mental trauma.
- In 2000, one completed suicide occurred every 40 seconds and one suicide attempt occurred every 3 seconds, on average.
- Globally, more people die from suicide than they do from all the homicides and wars combined. In 2001, murder claimed 500,000 lives and war 230,000 lives, compared with approximately one million suicides.
- Estimates suggest that the number of suicides could reach 1.5 million by the year 2020.
- Worldwide, suicide ranks among the three leading causes of death for people aged 15 to 44 years.

Factors involved in suicidal behavior

Suicidal behavior has a large number of underlying causes, which are complex and interact with one another. Identifying these factors and understanding their role in both fatal and non-fatal suicidal behavior is central to preventing suicide. Factors such as living in poverty, unemployment, loss of loved ones, arguments with family or friends, a breakdown in relationships and legal or work-related problems are all acknowledged as risk factors when affecting those who are predisposed or otherwise especially vulnerable to self-harm. A family history of suicide is a recognized risk factor with both social and genetic correlates. Other predisposing factors include alcohol and drug abuse, a history of physical or sexual abuse in childhood, and social isolation. Psychiatric problems, such as depression and other mood disorders, schizophrenia and a general sense of hopelessness also play a central role. Physical illnesses, particularly those that are painful or disabling, are also important factors. Having access to means to kill oneself (most typically guns, medicines, and agricultural poisons) is both an important risk factor in itself and an important determinant of whether an attempt will be successful or not.

Having made a previous suicide attempt is a powerful predictor of subsequent fatal suicidal behavior, particularly in the first 6 months after the first attempt.

A number of factors nevertheless appear to protect people against suicidal feelings or acts. They include high self-esteem and social "connectedness", especially with family and friends, having social support, being in a stable and happy marriage, and commitment to a religion. (International Association for Suicide Prevention's First World Suicide Prevention Day "Suicide Can be Prevented" at www.med.uio.no/iasp/english/wspd/2003/wspd_text/html)

Mental illness is a major risk factor for suicide

Suicide, especially when viewed in global terms, represents a huge and complex public health problem. A full understanding of this problem demands the recognition that most of the time many factors come together when a person attempts to or succeeds at killing him- or herself. Biological, psychological, social and cultural factors all have a significant impact on the risk of suicide. Nonetheless, mental illness stands out as the greatest risk factor for suicide. Experts agree that having a major mental illness greatly increases the chances that a person will die by suicide. Many western studies have shown that more than 90% of those who take their own lives did suffer from one or more psychiatric illnesses at the time of death. It is also important to remember though that most people who do have a mental disorder do not kill themselves. In Asian countries mental illness is a strong risk factor suicide, as in Western countries, with studies from Taiwan, India, China and Hong Kong providing evidence of strong links between depression, schizophrenia, alcohol abuse and suicide. However, in China the association between suicide and depression is reported to be less than that found in some other Asian countries, and less than that found in the West. This may be accounted for by the ready availability of a highly lethal method of suicide (pesticides), which turns impulsive suicide attempts, made in acutely stressful situations by people without depression, into deaths.

The lifetime risk of suicide in people with depression is estimated to be approximately 10-15% - People with bipolar disorder are 12 to 20 times as likely to die by suicide that people without such illnesses. Among those with schizophrenia, in the US, the lifetime risk of suicide is 4%. Eating disorders and anxiety disorders also significantly heighten the risk. People with personality disorders (such as borderline personality disease) are approximately three times as likely to kill themselves than are people without such disorders.

Alcohol or substance abuse issues further, and greatly, multiply the risk of suicide for people with mental illness. One study conducted in both Canada and Italy found that people with mental illness who were dependent upon drugs or alcohol had a 40% lifetime rate of attempted suicide. Such patients without a substance dependency had a 24% risk. (* The sources include a WHO press release from 8 September 2004, a brochure entitled the Prevention of Suicide and a fact sheet, Figures and Facts about Suicide)

The importance of seeking and getting help early

Suicidal tendencies can be treated. Medications can help control the symptoms of mental disorders and make life more hopeful and manageable. Individuals who are able to maintain lithium treatment for their bipolar disorder appear to have lower suicide rates. In fact, lithium may have specific anti-suicidal effect for people with bipolar disease since the effects may be separate from its antidepressant and antimanic effects. Other psychiatric medications including antipsychotics (especially clozapine) may help persons with schizophrenia experience lower rates of suicidality. Antidepressants also show promise for the reduction of suicide. Medications alone, however, are not enough for the treatment of mental disorders or suicidal tendencies. Psychotherapy provides a needed supportive relationship that reduces the risk of suicide. Cognitive-behavioral therapies (CBT) show particular promise. These kinds of therapies include problem-solving training that seem to reduce the occurrence of suicidal thoughts and attempts.

Individuals with a mental illness are at much greater risk of suicide in the weeks immediately following discharge from hospital. Discharged patients who died by suicide were 3.7 times more likely to have had their outpatient care reduced at their last session. On the other hand, patients who continued care either through community services or with medication had lower suicide rates. Psychological autopsy studies reveal that only 6-14% of depressed suicide victims were adequately treated. Such studies also show that only 8-17% of all suicides were under treatment with prescription drugs for psychiatric illnesses. (Psychological autopsies assess many factors such as the actions, thoughts, feelings and relationships of a person who has died. A psychological autopsy can thereby provide a picture of the mental, social and environmental influences that led someone to die by suicide.)

People who attempt and die by suicide, though often under treated or untreated for their mental illnesses, generally have been in contact with heath care providers shortly before their deaths or attempts. This means that significant opportunities to deliver adequate care, and to perhaps prevent many suicide attempts and death, do exist. In fact, more than 50 to 70% of those who complete suicide have had contact with healthcare providers in the days and months before they die.

Reducing suicide risk by improving access to and quality of treatment

There are major barriers that keep to people from receiving effective mental health treatment. About two-thirds of people with diagnosable mental disorders do not receive any form of treatment. The stigma of mental illness often deters people who need help from seeking it. The fragmented organization of mental health services and the cost of care are also among the most often cited barriers to mental health treatment. Economic analyses of patterns of use of mental health services clearly show that use is affected by price. Use falls as costs rise, while use increases with better insurance coverage.

Suicide has close links to both mental illness and substance abuse; effective treatments exist for both. The stigma surrounding these kinds of disorders keeps many people from seeking help. The stigma of suicide itself-as a shameful and/or sinful act–also keeps high-risk people from treatment. People with suicidal tendencies may hide from, rather than seek out, those who can help them. According to a United Kingdom study, more could have been done to reduce the risk of suicide among two-thirds of those who died by their own actions. (This finding emerged in the 1994 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.) That study estimated that more than 20% of suicides in the UK were preventable.

The high price of stigma

The stigma attached to mental illness, substance abuse and suicide has also fostered other problems that impede access to competent care for people at high risk for suicide. These problems include:
Inadequate attention to, and inadequate funding for, preventive services: Preventive services and treatment for mental illness and substance abuse are much less available than for other health problems
Low insurance reimbursements for treatments for mental illnesses and substance abuse disorders
The establishment of separate systems for physical health and mental health care: The systems devoted to physical health have received greater attention and funding than those devoted to mental well being. Barriers between the two systems complicate the provision of services and further impede access to mental health care.

In contrast, when the stigma attached to mental illness and substance use disorders can be overcome, matters improve. People are more willing to seek treatment. They have better access to such treatment when financial barriers are lowered and mental health care is integrated with other settings for the provision of routine health care services.

With such integration of services, stigma fades and the public learns to view mental and substance use disorders as “real” illnesses, equal in importance to physical illness. From that knowledge grows the awareness that mental illnesses respond to specific treatments. The public then comes to view people who obtain treatment for mental illnesses as obtaining basic health care.

Everyone has a role to play

Everyone – family members, mental health professionals, educators, primary healthcare practitioners, friends and colleagues – all have a role to play in recognition, referral, and early intervention with people who have a mental illness and may be at high risk for suicide. At the most basic level of early prevention, understanding of mental illness and the factors that heighten a person’s risk of becoming mentally ill needs to be very widespread. Such understanding needs to be expanded among the public and among healthcare providers of many sorts. Beyond that, both the public and healthcare providers need a basic understanding of the key factors that increase a person’s risk of attempting or committing suicide.

Healthcare providers also need specific knowledge about where to send people who are at high risk for further assessment and treatment, and of the importance of follow-up. The right interventions can keep people from resorting to suicide. Such interventions reduce the personal and the situational factors that are associated with suicidal behavior (such as depressed mood, hopelessness, alcohol and other substance abuse, and others). Another way to prevent suicide is to promote and support the presence of protective factors, such as helping people

to learn skills in problem solving, conflict resolution and the nonviolent handling of disputes. Promoting the presence of protective factors for those at high risk for suicide can greatly lower their risk.

The role of primary care settings cannot be overestimated: Understanding of mental health and suicide is especially important for doctors, nurses and others who work in primary care settings. However, such understanding also needs to exist among social workers, providers of family planning services, caregivers at school and workplace health centers, and others who can serve to widen the safety net. The World Health Organization (WHO) encourages these actions, with regard to improving the primary care response to mental health issues:

- All people ought to have good access to mental health services within their primary care settings.
- Primary care providers need to be able to detect and treat problems such as depression, anxiety, stress-related disorders, substance abuse disorders and psychotic disorders, as appropriate. This will often involve expanding the numbers and skills of their staff.
- Primary care providers ought to provide access to psychotropic medicines and to therapies for common as well as severe mental disorders. This is especially true for people with long-term stable disorders within a community.

Many serious mental health problems can be addressed within the community: WHO stresses that the experiences of people in many countries support the development of community based services. Such services may include hospital beds for psychiatric inpatients. WHO emphasizes, though, "there is no place in the 21st century for inhumane and degrading treatment in large institutions." Special consideration ought to be given to the family and friends responsible for the support and care of their mentally ill loved ones. Such support people often need support themselves. Among the services needed:

- Specialist community-based services, accessible 24-hour-a-day, seven days a week, with multidisciplinary staff to deal with people with severe mental health problems.
- The provision of crisis care services where people live and work to avoid deterioration and hospital stays wherever possible
- Programs to "develop the caring and coping skills...of families and [caregivers]"

Gatekeepers to mental health care should wear many hats: Members of many professional groups also need to understand mental illness and suicide, in order to help those at risk of dying by suicide. Such groups include clergymen, teachers, coaches, police officers, correctional personnel, and emergency medical technicians. All of these people can act as key gatekeepers to help those who are in need to access appropriate mental health services. Members of these professional groups also need to know how to respond to the special mental health needs of those family members who are bereaved when suicide occurs.

Attacking root problems underlying both mental illness and suicide

Judi Clement, CEO of the Mental Health Foundation of New Zealand, has written: "Tackling the root causes of mental health problems with preventive measures is far more effective in the long run than traditional symptom-based treatments."

People all over the world experience harmful and severely stressful changes in society. These include economic and political unrest, natural disasters and wars. All these stressors lead to increased anxiety and depression, substance abuse and violence including suicide. The impact of outside stressors can be magnified in certain settings such as the home, schools, work sites and in other institutions. Yet sometimes, in some ways even these huge forces can be controlled and countered. The risk of mental health problems and suicide is also heightened for groups on the edges of society (migrants and refugees) as well as inmates and former inmates.

Any programs that support society's weakest members and strengthen community institutions (such as home and school) indirectly but powerfully decrease the risks of mental health and suicide.

The World Health Organization, in 2005, urged the "promotion of mental health as a long-term investment." WHO also urged the [development] of parenting support and education programs, starting during pregnancy" to foster awareness of mental health. All such efforts will, ultimately, diminish the impact of suicide.

Reducing access to means of Suicide

Evidence from a number of countries suggests that reducing access to particular means of suicide reduces the rate of suicide by that method, and sometimes, can reduce total suicide rates. Findings in this area span a range of different methods including reducing access to domestic gas, various forms of legislative restriction on gun possession and control, reducing carbon monoxide emissions from vehicles, restricting availability of pesticides; reducing the pack size of analgesics, installing barriers at sites that become popular for suicide, various restrictions on prescribing drugs which are toxic in overdose and prescribing drugs which have relatively low lethality if taken in overdose.

Increased Access to Means Aggravates Suicidal Tendencies among Young People– Guns in the West, Pesticides in China, India and Other Nations

In industrialized countries, access to guns is a major risk factor, particularly among young men. In the US, suicides by firearms have increased more rapidly than suicides by other methods, according to Dr. Guo-Xin Jiang, a Karolinska Institute researcher. One 2001 study suggested that a drop of 10% in gun ownership in the US could cut the overall suicide rate by 3%.

In rural villages in Asian countries including, in particular, China, Sri Lanka, Malaysia and India, young women often end their own lives by drinking pesticides (that are often stored in their family homes). In fact, About, Inc. (a segment of the New York Times Company) reported "suicide is now the leading cause of death for those aged 15 to 34 in China. It is the fifth leading cause of death overall for the Chinese…the current suicide rate is ten times that of the United States."

That report also noted the unusual fact that, in China, women's suicides outnumber men's (Chinese women are 25% more likely than Chinese men to die by suicide). In China, rural residents are four times more likely to kill themselves than urban ones. More than half of Chinese suicide attempts involve the consumption of pesticides.

The Voice of America recently reported that unaddressed mental health problems are a major contributor to China's enormous suicide problem, though not the only cause. In rural areas, awareness of mental illness is extremely low. Also, China has a serious shortage of mental health workers. The World Health Organization states that while mental illnesses account for 20% of China's disease burden, related services receive only 2% of the national health budget.

Canadian psychiatrist Michael Phillips, director of the Beijing Suicide Research and Prevention Center, points out that life stressors play a huge role in many Chinese suicides. "If you talk to people in rural and urban areas," he says, "it's always conflicts and failure at school, negative social events." Stressors of an external sort may be both easier and more acceptable to discuss, as opposed to the stresses associated with mental illnesses.

Use of mental health promotion strategies to reduce the risk of suicide among people with mental illnesses

When a person ends his or her own life, their action usually reflects a complex interplay of many causes. These often include mental illness (especially under treated- or untreated mental illness), poverty, unemployment, the loss of loved ones, arguments, the breakdown of relationships and legal or work-related problems. Accordingly, a very wide range of programs that can help people to prepare for and to cope with these kinds of deeply disturbing events and situations can all serve to reduce suicide.

Recognizing the complex causes behind suicide, efforts and programs designed to reduce the risk of suicide can also work at many levels. In the broadest sense, efforts that reduce poverty, support families and children, and bring marginalized members citizens into fuller, fairer participation in society all serve to reduce suicide.

Knowledge of Suicide Warning Signs Needs to Be Widespread: In the narrower and more immediate sense, efforts towards the following kinds of goals can also help to save lives that might be lost to suicide:

- Basic knowledge about suicide need to grow among members of certain professions workers and the general public: Education can heighten understanding of basic matters related to suicide risk and prevention. Such matters include which groups of people are at special risk and what other additional factors predispose people to kill themselves. In addition to mentally ill people, these high-risk populations

include people with severe and debilitating physical illnesses, the poor, prisoners and other persons at the edges of society.

Such education may be of greatest value when it reaches key gatekeepers, workers who come into regular contact with high-risk individuals. These groups include prison and school personnel and caregivers in primary care settings, mental health care settings, and other settings frequented by high-risk groups.

Gatekeepers need to know where to refer people who are showing warning signs of suicidal tendencies. Furthermore, they need to understand how to react when the threat is imminent or when a suicide attempt has occurred, and how to follow up to ensure that a person at risk is receiving needed care.

- Gatekeepers need to understand suicide warning signs that are common among members of the various high risk groups (such as teenagers, young adults and the elderly)

Warning signs for suicide include:

- Talking about suicide (killing one's self)
- Always talking or thinking about death
- Making comments about being hopeless, helpless, or worthless
- Saying things like "It would be better if I wasn't here" or "I want out"
- Depression (deep sadness, loss of interest, trouble sleeping and eating) that gets worse
- A sudden, unexpected switch from being very sad to being very calm or appearing to be happy
- Having a "death wish", tempting fate by taking risks that could lead to death
- Losing interest in things one used to care about
- Visiting or calling people to say goodbye
- Putting affairs in order, tying up lose ends, changing a will
- Preoccupation with means to die by suicide and seeking information about how to do it (e.g. over the internet), as well as seeking to obtain means to kill onself.

People need to understand that when a person does these kinds of things, he or she needs to be seen quickly, by a counselor or physician.

- The general public needs to understand certain key facts about suicide prevention, facts about which they can easily take action. They ought to realize that young people living in a home with a gun are far more likely to end their own lives than are young people living in homes without such weapons.

  Many people at risk of suicide have recently suffered a major loss or more than one loss or traumatic event in quick succession. People need to understand that suicidal thoughts are often only temporary reactions to extreme pain. They often need help and protection during times of greater vulnerability.Traumatized individuals may benefit from referral or self-referral to bereavement or divorce support groups.

- Myths that surround suicide need to be exposed as such. Many people hold beliefs about suicide that have no basis in reality. Education programs can dispel the following sorts of widespread and dangerous misconceptions:

  * *That "people who talk about suicide won't really do it:"* In truth, almost everyone who commits or attempts suicide does give some prior warning. Ignoring such warnings can be deadly. People who say things like "you'll be sorry when I'm dead" or "I can't see any way out" must be taken seriously. This is true no matter how casually they say the words. Such expressions can indicate serious suicidal feelings.

That "anyone who tries to kill him/herself must be crazy:" In fact, most suicidal people do not have severe mental illnesses. They are almost always feeling hopeless, deeply despairing or grief-stricken.

That "if a person is determined to kill him/herself, nothing can stop him/her:" In fact, the overriding wish of most suicidal people is not specifically to die. They want an end to unbearable pain. The impulse to end it all, however overpowering does not last forever.

* *That "people who commit suicide are people who were unwilling to seek help:"* Many studies of suicide victims have shown that more than half had sought medical help within six months of their deaths. **The challenge is to accurately identify suicide risk when people consult for mental health or general health problems.**

* *That "talking about suicide may give someone the idea."* A loved one does not give a suicidal person morbid ideas by acknowledging that the at-risk person is thinking about self-destruction. The opposite is true–raising the subject and helping the person cope with the impulse is one of the most helpful things a loved one can do.

- Rapid, easy access to helping resources must be available for people in imminent danger: This will occur when gatekeepers, health care providers and the general public develop a greater awareness of available resources - of help centers, suicide prevention hotlines, etc. Some of these resources are made available through the efforts of groups such as Befrienders International. This group runs help centers, many of which have round-the-clock help lines, in about forty countries worldwide.

  Gatekeepers need to have accurate, up-to-date lists of such resources readily on hand. The public ought to be familiar with such resources as well. People in many countries know to dial an emergency phone number if a heart attack or stroke seems to have occurred or to be imminent. Likewise people ought to know who can provide help fast when a person is in imminent danger of suicide or an attempt has occurred.

  Public understanding of mental illness and other major risk factors for suicide needs to become far deeper and more widespread. People need to grasp that mental illnesses, like other illnesses, are best handled with early diagnosis and treatment and with consistent care when a condition is chronic. They need to better appreciate what kinds of stressors and upheavals in a person's life can serve as flash points for suicidal acts. In this way, many crises related to suicide can be prevented through the earliest possible intervention in the lives of people at risk.

Promising Approaches to Treatment

There have been numerous programs and strategies developed and implemented in countries around the world with the intent of reducing the incidence of suicide and preventing self-inflicted injuries. Few of those approaches have been subjected to rigorous research and evaluation. However, in contrast to the paucity of programs for which strong evidence of efficacy exists, there have been a growing number of studies suggesting promising results. These studies include the following areas:

Providing support after suicide attempts

People who make suicide attempts are at increased risk of making further attempts, and of dying by suicide. Many of those who make suicide attempts have mental disorders, such as depression, which are recurrent and chronic (Keller et al., 1986). A small number of interventions, which focus on enhancing treatment and support for these people, have been shown to reduce the risk of repeated suicidal behaviour. A Norwegian initiative which focused on providing follow-up care to people after discharge from hospital after making suicide attempts via an integrated chain-of-care network was shown to be effective in reducing further suicide attempts and in maintaining adherence to treatment regimes. A programme that employed case managers to follow up primary care patients was effective in encouraging patients to keep appointments and to adhere to medication and treatment regimes. Relatively simple interventions, which consisted of sending letters to people who had been discharged from inpatient psychiatric units or medical units following admission for self-poisoning, have been shown to reduce suicide attempts and suicides. Other interventions including a 'green card' for emergency access to mental health services and employment of counsellors to co-ordinate follow-up services for people who had made suicide attempts were successful in reducing further suicide attempts. These findings suggest there may be a range of minimal cost but effective interventions which can be developed to provide follow-up care and support for suicide attempt patients,

both in the immediate aftermath of a suicide attempt, and in the longer term, since many of these patients will have chronic mental health problems.

Pharmacotherapy for mental illness

Given the high rate of mental illness in those who die by suicide, treating mental illness effectively and providing long-term mental health care and support are, clearly, major approaches to preventing suicide. A number of treatments for specific mental illnesses have shown promise in reducing suicidal behaviour. These include long-term therapy with lithium for people with bipolar disorder or severe depression, and the use of the antipsychotic medications clozapine and olanzapine by people with psychotic illnesses, including schizophrenia.

Randomised Controlled Trials (RCTs) of antidepressant therapy (versus placebo) show significant reductions in suicidal ideation. Patient population studies show reduced suicide attempt rates in adults treated with antidepressants and in adolescents treated with antidepressants for 6 months rather than for 2 months or less. Population based studies suggest that the recent widespread introduction and use of the class of antidepressants known as selective serotonin reuptake inhibitors (SSRIs) has been associated with decreased suicide rates, however, the fact just showing that more medications where used during periods when suicide rates decreased does not constitute proof of a causal relationship. There are also examples of countries, for example Singapore, where increased use of SSRIs was associated with increasing suicide rates. There are conflicting interpretations of these data, with suggestions that suicide rates began to decline prior to the widespread availability of antidepressants.

However, recent controversy regarding reported adverse events that occurred in clinical trials of SSRIs for children and adolescents led to re-evaluation of the research evidence, and to the US Food and Drug Administration (FDA) recommending that a 'black box' warning be added to the health professional labelling of all antidepressant medications to describe an increased risk of suicidal thoughts and behaviour in children and adolescents, and perhaps, adults, being treated with antidepressant medications. Physicians prescribing these medications are advised to carefully monitor suicide risk in patients using SSRI medications. There are concerns that these warnings may lead to decreased use of these medications in depressed patients, and that this may influence suicide rates. There is a need for more research to explore how effective antidepressants are in reducing suicidal behaviour in people with depression. In considering this issue there is a need to weigh concerns about possible adverse events with the fact that most depressed people who die by suicide are not receiving treatment. More generally there is a need for better-designed evaluations of antidepressants, including randomised controlled trials (RCTs).

Psychotherapy and psychosocial interventions for mental illness

A series of psychotherapies and approaches has been shown to reduce suicidal behaviour, hopelessness and depressive symptoms, and to increase compliance with treatment, when compared with treatment as usual. These therapies include cognitive behavioural therapy (CBT), interpersonal behavioural therapy (IPT), dialectical behavioural therapy (DBT) and some forms of problem-solving therapy (PST). An example is provided by a 10-session cognitive therapy intervention provided to adults who had recently attempted suicide. Compared to treatment as usual, this intervention led to significantly lower reattempt rates, less hopelessness, and less severe self-reported depression, but to no change in suicidal ideation.

Another example is provided by a study which suggests that cognitive behavioural minimal contact psychotherapy for sub-threshold depression, involving a prevention worker supporting patients with six short telephone calls to use a self help manual with instructions on mood management, reduced the risk of developing a full-blown depressive disorder fro 18% to 12%. Furthermore, this intervention had a 70% probability of being more cost-effective than treatment as usual.

Psychosocial interventions that reduce suicidal behaviour include psychoanalytically informed partial hospitalisation and programmes that involve intensive care plus outreach, and previously mentioned postal mailings and provision of 'green cards' to people who had made suicide attempts. For example, in people with borderline personality disorder, psychoanalytically informed partial hospitalisation and dialectical behavioral therapy are two approaches that have each been shown to decrease suicide attempt rates and improve treatment adherence.

In young people with psychiatric crises, Multi Systemic Therapy (MST) has been shown to be more effective than emergency hospitalization in decreasing rates of suicide attempt in the following year. A psycho educational social network intervention with psychiatrically hospitalized, suicidal young people reported significantly less suicidal ideation and their parents reported less functional impairment related to depression.

These studies, and others, provide evidence that psychological and psychosocial therapies can reduce suicidal behavior either alone or in combination with medication. Some of these approaches appear to involve minimal contact and are very cost-effective. Further research is needed to explore what combinations of psychopharmacological, psychological and psychosocial interventions are most effective in reducing suicidal behavior. Evaluations should include assessment of efficacy, effectiveness and cost-effectiveness.

Building Awareness-Reducing Risk: Mental Illness and Suicide

MENTAL HEALTH IN THE MEDIA

We know little about how people acquire knowledge and beliefs about mental health, mental illness and suicide. There is evidence that personal experiences with family and friends are one important source. A UK study found that 32% of respondents cited the media as their main source of information. In an authoritative US survey, the majority of 1,300 respondents cited the mass media as their primary source of information about mental illness.

Unfortunately, the mass media often cover mental illness in a strongly negative light. In a survey of the German public, 64% said that they had read about a person with a mental illness who had committed a violent crime and 50% about someone who became addicted to prescribed drugs, but only 17% had read about persons with mental illnesses who became able to lead a normal life through treatment. Clearly, such negative reporting has an impact.

The media holds a very important position when they try to influence the community on mental health, mental illnesses and those people affected by mental health disorders. As it sometimes is with the general population, members of the media may not be fully educated or aware of the facts surrounding mental illnesses and their affects on people and the surrounding communities. With media saturation so great in so many countries, many people today do come to see themselves, others and the world as they are portrayed in the media. Studies confirm that there is a connection between negative media portrayals of mental illness and the public's negative attitudes toward people with mental health issues.

On the other hand, it is also widely acknowledged that the media can play a positive role in reducing stigma and creating further understanding of mental illnesses. The way people with mental illness are presented is particularly important. Changing media representation of mentally ill behaviors is one of several strategies needed to reduce overall stigma, discrimination and possibly in the end suicide rates.

What Can Be Done?

Education may help: Governments in certain large, relatively wealthy nations have run public education campaigns to help foster greater public understanding of mental illness and suicide. Dr. Otto Wahl, Prof at George Mason University, USA, has also observed that alerting people to the prevalence of pernicious images in the media heightens their awareness of them. They can then become more critical consumers, questioning those images.

Caregivers may want to carefully differentiate for patients and their families what psychiatric terms really mean, in contrast to the way those terms are often misused. Where they are available, the provision of straightforward pamphlets, brochures or referrals to accurate websites, can help a family sort out reality from media fantasies about specific disorders.

Often journalists and entertainment professionals are willing to be educated about issues of mental health and suicide. They can be approached as partners for change and be included in workshops and conferences about such topics. Mental health professionals, including psychiatrists and therapists, may need to overcome a certain natural desire to keep a distance between themselves and reporters or other media professionals. The experts may fear being misquoted or misrepresented. However, their comments and viewpoints are valuable. When they present their ideas in simple (non-jargon) terms that members of both the media and the general public can understand, they perform a valuable public service.

Advocacy has a role to play as well: Another course that has been growing in force in recent years includes active monitoring and forceful responses to hurtful media depictions. Consumer complaints, even from individuals contacting a media outlet or advertiser, have often had positive results. (One consumer voiced his displeasure over a Volkswagen ad that read "You're crazy if you don't take this deal." Volkswagen stopped running that ad.) The media needs to know that readers or viewers perceive a problem or they have no impetus to change.

As mentioned above, positive portrayals are starting to provide needed doses of reality regarding mental illness. In recent years, more and more accurate and sympathetic portrayals of people with mental illnesses have begun working their way into the media, although they are still not common enough. Newspapers and magazines often do have editorial gaps to fill. If mental health organizations provide them with well-crafted, sensitive portrayals of the struggles and progress of real people dealing with mental illnesses, those media outlets will sometimes use them.

Key things to remember when talking to the media about mental illness:

- Consider whether or not to participate in the story – does it provide an opportunity to contribute to community understanding of mental health and mental illness?

- Provide expert comment or advice where possible.

- Provide helpline numbers and information about treatment and support options.

- Avoid language that is labeling or stigmatizing and provide alternatives when media professionals use this language.

- Be careful that you don't inadvertently reinforce stereotypes such as those that link mental illness with violence or suggest people with mental illness are unable to work or lead fulfilling lives.

- Consumers and caregivers considering talking to the media should have adequate information to make a decision about participation and have access to appropriate support throughout the process.

(Mindframe-Media www.mindframe-media.info/mentalhealth, 'Suicide and Mental Illness in the Media: A Mindframe resource for the mental health sector')

The Importance of Public Perception

Stigma is commonly defined as the use of stereotypes and labels when defining someone. A narrow set of beliefs that can damage a broad, diverse group of individuals. As a basis for discrimination, stigma robs people of the opportunity to live, work, and thrive in the community.

Stigma represents a major reason that people with mental illnesses do not seek needed treatment. In fact, nearly two-thirds of all people with diagnosable mental disorders do not seek appropriate care. Concerns about stigma appear to vary in different types of communities and cultural backgrounds. Stigma also disproportionately affects certain age groups, including children and older people, as well as those with more severe mental illnesses, such as schizophrenia.

Powerful and pervasive, stigma assumes a variety of forms, both subtle and overt. It appears as prejudice and discrimination, fear, distrust and stereotyping. It prompts many people to avoid working, socializing, and living near people who have a mental disorder. Stigma impedes people from seeking help for fear that the confidentiality of their diagnosis and treatment will be breached and they will experience discrimination in their workplaces, health care providers, communities and families.

Reducing Stigma

Stigma must be overcome. All areas of treatment, recovery and assimilation back into the community will continue to suffer until the discrimination and stigma of those with a mental illness is completely gone.

One key method of countering discrimination and stigma is to replace misinformation with new understanding and knowledge. For change to occur, accurate and positive messages and stories about mental illness and people living with psychiatric diagnoses must become much more frequent, in all areas of the media and public life. Creating programs of advocacy, public education, and contact with persons with mental illness through schools and other societal institutions can clearly help remove the myths and increase awareness of mental illnesses and the people who have them.

How You Can Combat Stigma

1 **Share your experience with mental illness.** Your story can convey to others that having a mental illness is nothing to be embarrassed about.

2 **Help people with mental illness reenter society.** Support their efforts to obtain housing and jobs.

3 **Respond to false statements about mental illness or people with mental illnesses.** Many people have wrong and damaging ideas on the subject. Accurate facts and information may help change both their ideas and actions.

When understanding becomes widespread people will be empowered to act to protect mental health and to restore it when illness strikes, once they realize that proper care can generally relieve most mental distress and symptoms and that most people with mental illnesses can live full lives.

Fresh approaches to inform the public about the true nature of mental illnesses (which can help counter stigma) need to be developed and evaluated. As stigma abates, a major shift in public attitudes should occur. People should become eager to seek care. They should become more willing to absorb its cost. And, most importantly, they should become far more aware of and comfortable with the idea that mental health and mental illness fall within the mainstream of health and should matter greatly to *everyone.*

Suicide Contagion

Suicide Contagion is a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to attempt or complete suicide, or where one suicide becomes a compelling model for successive suicides.

Suicide contagion has occurred all throughout history, from ancient times through the present, in all cultures and nations. Concern about suicide contagion (also known as suicide clusters or imitative suicide) has grown due to several highly publicized suicide outbreaks among young people in recent years. Adding to the concern is the mounting evidence that a significant number of suicides appear to be linked to suicide stories in the mass media (see section on Suicide in the Media).

the Reduction of Suicidal contagion[1]

General Concerns and Recommendations

The following concerns and recommendations should be reviewed and understood by health professionals, suicidologists, public officials, and others who provide information for reporting of suicide:

- Suicide is often newsworthy, and it will probably be reported. The mission of a news organization is to report to the public information on events in the community. If a suicide is considered newsworthy, it will probably be reported. Health-care providers should realize that efforts to prevent news coverage may not be effective, and their goal should be to assist news professionals in their efforts toward responsible and accurate reporting.

- “No comment” is not a productive response to media representatives who are covering a suicide story. Refusing to speak with the media does not prevent coverage of a suicide; rather, it precludes an opportunity to influence what will be contained in the report. Nevertheless, public officials should not feel obligated to provide an immediate answer to difficult questions. They should, however, be prepared to provide a reasonable timetable for giving such answers or be able to direct the media to someone who can provide the answers.

- All parties should understand that a scientific basis exists for concern that news coverage of suicide may contribute to the causation of suicide. Efforts by persons trying to minimize suicide contagion are easily misinterpreted. Health officials must take the time to explain the carefully established, scientific basis for their concern about suicide contagion and how responsible reporting can reduce the potential for contagion.

- Some characteristics of news coverage of suicide may contribute to contagion, and other characteristics may help prevent suicide. Clinicians and researchers acknowledge that it is not news coverage of suicide per se, but certain types of news coverage, that promote contagion. Persons concerned with preventing

suicide contagion should be aware that certain characteristics of news coverage, rather than news coverage itself, should be avoided.

- Health professionals or other public officials should not try to tell reporters what to report or how to write the news regarding suicide. If the nature and apparent mechanisms of suicide contagion are understood, the news media are more likely to present the news in a manner that minimizes the likelihood of such contagion. Instead of dictating what should be reported, public officials should explain the potential for suicide contagion associated with certain types of reports and should suggest ways to minimize the risk for contagion.
- Public officials and the news media should carefully consider what is to be said and reported regarding suicide. Reporters generally present the information that they are given. Impromptu comments about a suicide by a public official can result in harmful news coverage. Given the potential risks, public officials and the media should seek to minimize these risks by carefully considering what is to be said and reported regarding suicide.

Reference:
1General Concerns and Recommendations, Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop, MMWR 43(RR-6);9-18 http://www.cdc.gov/mmwr/preview/mmwrhtml/00031539.htm

Media guidelines for responsible coverage

In addition to reducing the risk of suicide contagions, the media is in a prime position for active suicide prevention. Research has shown that responsible media coverage can help with suicide prevention efforts. It is important for journalists to have a detailed understanding of the difference between responsible and irresponsible coverage.

One approach has been to develop guidelines that provide practical advice and information to educate and support the work of media professionals. Numerous sets of guidelines have been produced by international, national, and professional organizations, often in collaboration with media professionals. There is evidence from a few studies that modification of suicide reporting by the media is both feasible and effective (Hawton & Williams, 2001; Hawton, 2001; Turley, 1998).

Language

Whenever possible, it is preferable to avoid referring to suicide in the headline. Research has shown that the likelihood of contagion rises when headlines include the word “suicide” or refer to the cause of death as self-inflicted. Unless the suicide occurred in public, the cause of death should be reported in the body of the story and not in the headline.

In deaths that will be covered nationally, such as of celebrities, or those apt to be covered locally, such as persons living in small towns, consider phrasing for headlines such as: “Marilyn Monroe dead at 36,” or “John Smith dead at 48.” Consideration of how they died could be reported in the body of the article.

In the body of the story, it is preferable to describe the deceased as “having died by suicide,” rather than as “a suicide,” or having “committed suicide.” The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.

CULTURAL AND RELIGIOUS ISSUES INFLUENCING SUICIDE & MENTAL ILLNESS

Culture is an all-embracing term that defines the relationship between an individual and his environment. In these days of globalization, the environment includes, in a ripple effect, the family (of birth and of marriage), the community, the nation, the region, the world. Within any country, there may be several different cultural and ethnic groupings and within these there usually exist marked differences in social class, wealth, education, political and economic outlook, childrearing and other practices, standards of behavior, religious persuasion and values. These factors influence behavior, including suicidal behavior.

Much of our knowledge and understanding of the sociology of suicide rests on the work of the great 19th century French sociologist Emil Durkheim. He indicated that close social inter-relationships were protective of suicide, while social isolation was not. He also suggested a typology of suicide that looked at the results of one's connectedness to society and one's satisfaction with this society. Egoistic, anomic, altruistic and fatalistic suicides reflect this. Egoistc suicide, for example, occurs in situations where the individual is not adequately integrated into society. He or she acts based on their inner impulses and not by the social rules or norms. In the altruistic type, by contrast, the individual is almost entirely governed by the society and suicide is a sacrifice of self for the supposed benefit of that society.

Issues relating to culture and suicide clearly cut across the life span. It is thus important to consider among different societies and ethnic groups:

Knowledge, attitudes, values and practices including those concerning:

- Childrearing,
- Discipline,
- Acceptable adolescent behavior,
- Marriage,
- Aging and
- The aged in the family and society

Legal issues. There are a number of relevant issues to consider – for example, how is suicide viewed by the society? Is suicide illegal so that failed attempters may face fines or imprisonment? Has suicide been decriminalised but does it's former illegality still a source of stigmatization?

Religion. There are many religions in the world. The main ones are Christianity, Buddhism, Hinduism, Islam, and Judaism. Among the major religions, suicide, while generally proscribed, may be acceptable in certain specific situations.

Islam is generally against suicide. It is Allah's will to determine a person's destiny and time of death. However, when a people sacrifice their lives for a holy cause, this is considered to be martyredom, rather than a suicide.

In Judaism there is condemnation of suicide in orthodox commentaries, although suicide is not forbidden in the Old Testament.

Hinduism accepts "suttee" – the ritual suicide of a widow, as away to cancel out his sins and gain favour for the children. Suttee is currently banned in India, but there are still rare instances of its practice.

Buddhists claim detachment from their body. As such, they condemn suicide on two counts:
The act of suicide implies insufficient detachment from and indifference to their body and
As a violation of the requirement that people should live their allotted time and not try to short-circuit/prevent pain and suffering which is their lot from a previous life.

Concepts of Health and of Illness

- What is illness?
- Is psychiatric illness different from other illnesses?
- What makes people seek help?
- From whom do they seek help?
- When do they seek help?
- Can race, age, gender, class, sexual orientation, religion, social status affect the approach to illness and to treatment?

East vs. West

Values- family, the aged, individual focus vs. Community/collective focus
Traditions - priests as healers
History – aggression & acquisition vs. assimilation & coexistence.

Traditionally, countries in Asia and also Africa, upheld family values, raised their children communally, and had specific rituals or rites of passage from one stage of life to the next, respected the aged and acknowledged the value of older persons. Many of the inhabitants of these countries also used the services of religious persons as healers, or tried folk remedies, before seeking help from physicians. The whole person is considered and remedies are holistic. Eastern methods such as acupuncture valued and used.

The Western countries, conversely, were more individualistic, less bound by tradition, had a culture that placed a high value on youth and tended not to place a high value on older members of the community. Members of such societies would visit the physician first, rather than a traditional healer.

Alcohol and other Drug Use and Abuse: The use of alcohol is accepted in most societies in the world. Each society seems to tolerate a certain level of use, beyond which there are negative consequences. Notable exceptions are the Islamic societies and certain denominations of the Christian faith where alcohol is totally banned.

Certain plants – Coca leaves, poppies and cannabis – are endemic to particular regions of the world and are used in particular, usually socially accepted ways by the natives of those regions (e.g. chewing coca leaves for energy, or drinking ganja tea to prevent colds). However, it has been seen that when use extends beyond the traditional and socially acceptable and becomes abuse and dependence, then difficulties arise of a psychological, social, occupational and domestic nature, which may have serious repercussions. Researchers have long noted the link between suicide and drug abuse/dependence.

Social Deviance: Deviance is defined differently in different societies. In many cultures, mentally ill persons are seen as weak, dangerous or depraved. Persons with serious mental disorders such as depression and schizophrenia, may not only become suicidal because of the illness, but may also do this because of the impact of society's ostracism. Persons with HIV also suffer much ostracism.

Dominance and Power: The male/female relationship has different power differentials across cultures. Murder of the female partner, followed by suicide of the male, is a recognized phenomenon. The male for a variety of reasons, including major depression, primary and secondary psychosis and jealousy, seeks to destroy those persons he loves most. Power differentials also exist across nations where lack of affluence and lack of political clout may be operative in creating suicide bombing as the only way to focus attention on a national plight. Japanese Kamikaze bombers and today's Palestinian and Iraqi suicide bombers are examples of this altruistic suicide.

Death concept: The cultural belief about death as well as the individual's beliefs may be important in considerations of suicide. What happens to the soul after death/ is death a transition to a better place? Quite apart from religious concerns, should suicide be a method to help persons if they are in intolerable situations medically? Euthanasia is currently legal in the Netherlands and Belgium and assisted suicide is legal in the US state of Oregon and permitted in Switzerland.

Distance: This may be emotional or geographical distance. In particular, migration and its attendant stresses e.g. of being a minority in a majority culture vastly different from one's own, may be associated with increased suicidal risk.

Discrimination: Discrimination may be multi-factorial (e.g., racial, ethnic, because of illness, and/or occupation and poverty). Historical discrimination and dismantling of many indigenous cultures' traditions and language are considered an erosion of many protective factors against suicide. Hopelessness and stigmatization may overwhelm the coping style of the person subjected to such discrimination, with suicidal behaviour as a final solution.

Culture-bound syndromes. There are some culture bound syndromes that are linked to suicidal behaviour in the sufferer. They have been well described in the literature and include 'amok' in Indonesia, 'tabanca' in Trinidad and 'Hi Wa Itck' in Mojave Desert Indians. (Hari Maharajh)

In any person, the decision to die by suicide implies that a stage has been reached where the protective factors-cultural barriers, religious proscription, sense of guilt or shame at the thought of killing oneself is obliterated by the need for immediate relief from intolerable emotional and / or physical pain. The availability of a method that the person can manage to use, again a cultural factor, will further tip the balance to suicide. Our task is always to strengthen the protective cultural factors, to offer a human hand, voice and mind in that minute of need.