MENTAL HEALTH PROMOTION AND SUICIDE PREVENTION

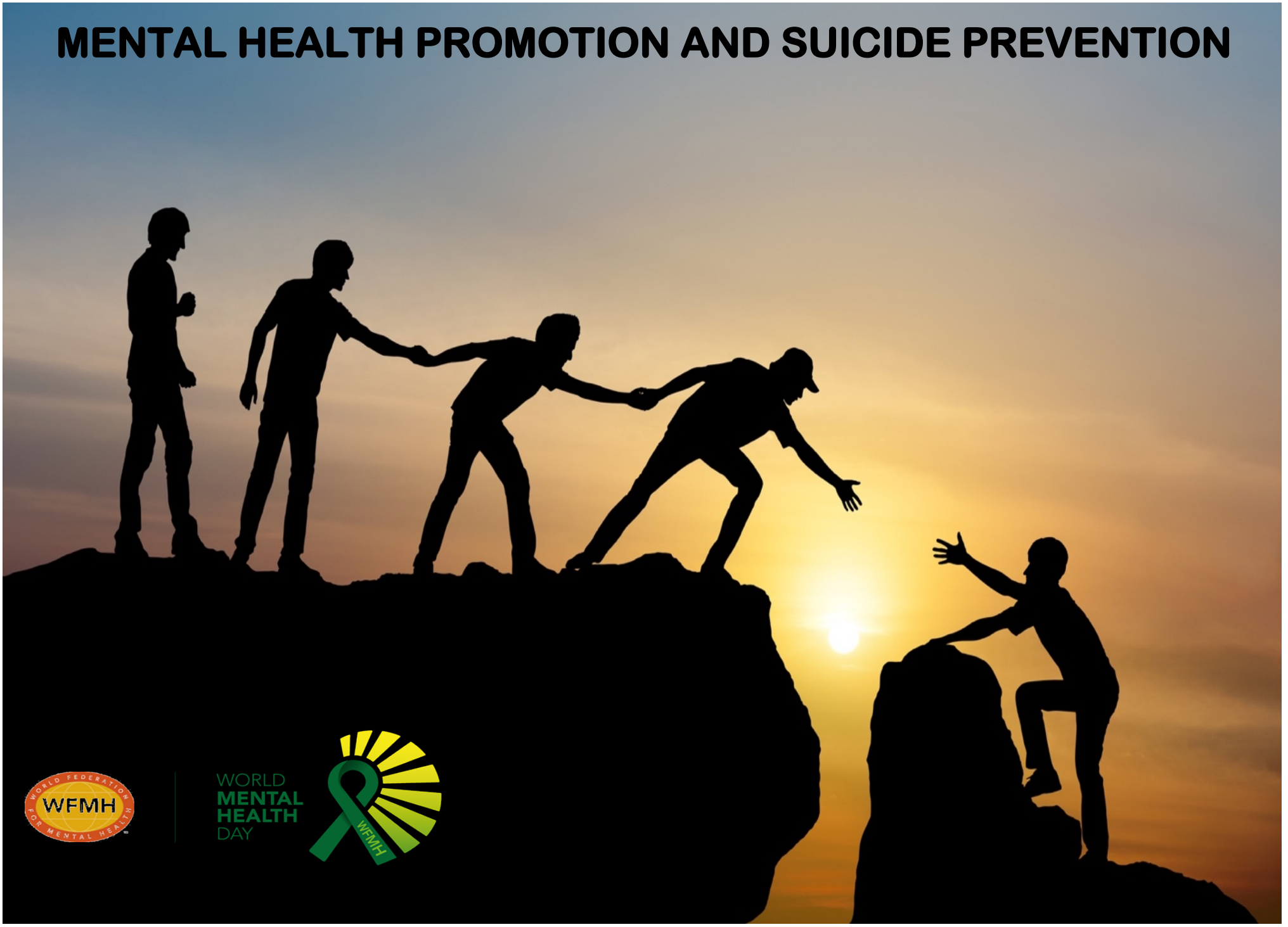

TABLE OF CONTENTS

MESSAGE FROM THE PRESIDENT

Dear Friends:

This year, the World Federation for Mental Health (WFMH) has decided to make “suicide prevention” the main theme of World Mental Health Day.

While suicidal behavior has existed throughout human history, it has increased gradually in all parts of the world and, in the past few decades, has reached alarming statistical levels.

While the World Health Organization (WHO) has made suicide a priority issue for a number of years, it is important to emphasize that it is a topic that has attracted the interest of most fields of study for centuries; thus, it has been explored by philosophy, religion, medicine, sociology, bioethics, law, and psychology, among other fields.

According to the WHO, more than 800,000 people die by suicide a year, making it the principal cause of death among people fifteen to twenty-nine years old. It is often believed that it is only adults who exhibit suicidal behaviors, but it should be stressed that many children and young people also engage in this kind of behavior as a result of violence, sexual abuse, bullying and cyberbullying.

Suicide is a global public health problem that deserves the attention of all the actors in the field of mental health, including scientific and professional organizations, organizations for mental health users and their families, and universities. It is particularly important to have the attention of national health authorities since it is their responsibility to craft policies and directives aimed at establishing strategies to prevent suicide and promote the public’s mental health. The role of both print and audiovisual communication media and of social media is no less important, since their participation can have positive as well as negative effects, depending on how they address this subject.

There are numerous complex factors that contribute to a suicide, but it is most important is that our actions be geared toward prevention.

Suicide is confusing, painful and mysterious, but it is preventable. The WFMH is concerned about the increase in numbers of suicides while resources, education, crisis lines and action plans for prevention aren’t keeping up. This is the reason we chose to focus our 2019 campaign on this topic.

We hope this material will give you information to educate yourself and your community. We hope the information will inspire you to do more to help others, to recognize the signs and hopefully save more lives. We must keep the fight going, together, to bring people back from the darkness and into the light!

Join us this year as we focus on suicide prevention. We are partnering and collaborating with many groups around the world to make this an amazing year of positive change. We hope you will support our efforts and keep the spotlight on suicide prevention!

Thank you for your ongoing support of World Mental Health Day!

Alberto Trimboli

WFMH Board President

MENTAL ILLNESS AND SUICIDE PREVENTION

Gabriel Ivbijaro, Lucja Kolkiewicz, Sir David Goldberg KBE, Michelle Riba, Isatou N'jie, Jeffrey Geller

World Mental Health Day 2019 focuses on the major public concern of mental health promotion and suicide prevention.

According to the World Health Organization, over 800,000 people die by suicide every year. While suicide is considered a serious problem in high income countries and the tenth leading cause of death in the US (American Foundation for Suicide Prevention 2017), it is also the fifth leading cause of death in China and 79% of suicide occurs in low and medium income countries (WHO 2018).

Suicide rates vary between and within nations. The UK suicide rate is 10.1 suicides per 100,000 population with the highest rate in Scotland (13.9 suicides per 100,000 population) and the lowest in England (9.2 deaths per 100,000 population) (Office for National Statistics 2017).

The highest rates of suicide worldwide are currently Lithuania (31.9 suicides per 100 000 population), Russia (31 per 100 000 population), Guyana (29.2 per 100 000 population), South Korea (26.9 per 100 000 population) and Belarus (26.2 per 100 000 population). The lowest rates are reported in the Caribbean in Barbados (0.8 suicides per 100 000 population) and Barbuda (0.5 suicides per 100 000 population) (World Population Review 2019).

In contrast with many other countries, most of the people who die of suicide in China are women—most likely because of strain and stress, poverty and stigma associated with mental illness. In Japan, it's the leading cause of death among men aged 20-44 and women aged 15-34, which has reached crisis level with the Government intervening to decrease the risk among vulnerable populations (World Population Review 2019).

A key objective of the 2019 World Mental Health Day campaign is to reduce the rate of suicide throughout the world.

To achieve this goal, the following goals are essential: prevention of mental illness, promotion of good health, reduction in the stigma associated with mental illness and improved access to evidence based mental health care.

The story described below illustrates some of the issues and suffering that can occur when people are in distress and believe that suicide is the only way out.

Sarah was a petite 22- year old who moved from a small town to a midsize city where she got a factory job. She knew no one in her new locale and kept to herself as she always had done. She dreaded others would learn she had grown up in poverty raised by her grandparents. She became depressed and self-medicated with alcohol. Her drinking impaired her work performance and she was fired. Unable to pay her rent, she was relegated to living on the streets. One night she went into a bar, ordered a drink, and told the bartender she'd be right back. Sarah never returned to the bar. She was found dead, hanging from a bathroom stall door with her bra around her neck. There was a note pinned to her blouse: "Tell my Grandma I'm sorry."

This requires each of us to play our part.

Suicide and Mental Illness—What Do We Know?

Somebody somewhere in the world dies of suicide every forty seconds. Ninety percent of these individuals have a clinically diagnosable mental illness (Hawton et al. 2001). Depression and alcohol addiction are major risk factors (Nock 2009). One third of suicides occur in young people and is the leading cause of death in those aged between 15 years and 29 years old, and the second most common cause of death in women between 15 and 19 years old.

Screening and identification of suicide risk in healthcare settings is important because many people present to healthcare settings in the months prior to completed suicide (King CA et al. 2017) and current evidence suggests that many suicides due to a diagnosable mental disorder are preventable (Strathdee et al. 2012). Screening for suicide in healthcare settings is possible and can identify those at increased risk so that appropriate actions can be taken (Boudreux et al. 2016; King et al. 2009).

The incidence of suicide in adolescents is rising despite the implementation of suicide prevention programmes targeting young people who are particularly vulnerable; suicide continues to be the leading cause of death in adolescents. This age group has difficulty navigating access to care and making a disclosure, especially when they are experiencing psychological stress or symptoms of mental illness (Cauce et al. 2002; Srebnik et al. 1996; Klimes-Dougan et al. 2013; Chen et al. 2012).

Adolescents at increased risk of suicide have increased suicidal ideation, anxiety, agitation and sleep disturbance, difficulty with adapting to new situations, associated alcohol and drug use, peer victimization and increased prevalence of sexual and physical trauma (King et al. in press). This highlights the need for collaboration among policy makers, schools, housing and healthcare providers to develop a holistic approach to identify and respond to suicidal ideation in the adolescent population. Education about the safe use of social media and protection of the young from cyberbullying and exposure to inappropriate and inaccurate advice is of increasing importance.

Older adults are also vulnerable to suicide and the proportion of older adults in the general population is increasing (de Mendoça Lima & Ivbijaro 2019). Older adults often experience comorbid mental and physical disorder including dementia.

A 2011 expert consensus panel noted that not enough was being done to address suicidality in older adults and recommended that special efforts need to be in place to identify mental illness and frailty in older adults earlier, including suicide risk, so that management plans addressing suicidal ideation can be implemented (Erlangsen et al. 2011; Rockwood K 2005).

Universal actions suggested to better identify mental illness in older adults include administration of self-administered depression screening tools, tackling disability and social isolation including family, friends and carers as much as possible whilst respecting their wishes, and recognising the specific role of family practitioners and social services staff.

Suicide and Contact with the Family Doctor/General Practitioner

According to Goldberg & Huxley (1992), the majority of people with a diagnosable mental disorder presenting to their General Practitioner (GP) do not have their mental illness identified. In the restricted time available, doctors understandably give high priority to the exclusion of physical causes for the patient’s symptoms. Most episodes of what turns out to be psychological distress will present with somatic symptoms, and the possibility of an emotional disorder may be delayed until a later stage.

More than 40 global studies show that 75% of patients who complete suicide have contact with their GPs in the previous 12 months (Luoma et al. 2002). Over 81% of the UK adult working population have contact with their GPs within any 12 month period, and evidence suggests that suicide prevention training for GPs working in this type of system is effective at reducing the risk of future suicide by 50%, particularly in those people with a diagnosis of depression because they are then referred for psychological therapies such as Cognitive Behaviour Therapy (CBT) (Bermingham S et al. 2010).

Suicide prevention strategies aimed at general practice can be effective and can lead to healing for the individual and family concerned and have economic benefits for the state (McDaid et al. 2011).

Suicide and Mental Health In-Patient Admission

Many people, who require hospital admission for the treatment of mental illness, as well as their relatives, believe that hospital is a safe place that promotes healing. This is not always the case.

Sometimes people who are mental health in-patients harm themselves and the first few weeks after discharge from an in-patient mental health unit are also a period of high risk for suicide.

An English national survey of people who completed suicide between 1996 and 2000 (Meehan et al. 2006) showed that 16% of those people who had been in contact with mental health services died whilst they were in-patients in a mental health unit, approximately 20% died within seven days of admission and 23% died within three months of discharge.

People who are mental health in-patients and who die as a result of suicide have a variety of diagnoses. One third have a diagnosis of schizophrenia, one third a diagnosis of depressive disorder and the remainder have a variety of diagnoses including bipolar affective disorder, personality disorder, anxiety disorder, alcohol dependence and drug dependence.

Preventing Suicide in In-Patient Units

Level of observation and staffing are very important in the prevention of suicide on in-patient wards, and there is a correlation between level of observation and completed suicide.

Seventy-two percent of those who die as a result of suicide on in-patient mental health wards are being nursed on low level observations and are being checked every 30 minutes or longer. Twenty-three percent of people who complete suicide on an in-patient mental health ward are on medium level observations and are being checked every 5 to 25 minutes and 3% of people on high level one to one observations complete suicide (Meehan 2006).

Medical staff believe that over 30% of in-patient suicides are preventable by taking the following measures:

- Good observations
- Adherence to treatment to more effectively treat symptoms of mental illness
- Higher staffing levels
- Better staff training

Future Developments in Mental Illness and Suicide Prevention

Research into suicide and the prevention of suicide does not get the attention it deserves, partly because it is associated with many different psychiatric diagnoses and, in some countries, it is considered a crime.

Funding for suicide prevention is disproportionately low when compared to prevention of other problems that affect a high proportion of the younger population such as road traffic accidents.

Between 2002–2006 and 2013–2017, the Scottish suicide rate fell by 20%. Over much of the last 30 years the suicide rate in Scotland has been consistently lower than the average across the 53 countries of the WHO European Region. Key ingredients of success include restricting access to means (pesticides, firearms); influencing the media to modify the way in which mental disorders are covered; enhancing young people's problem-solving, coping and life skills; and early identification, assessment and follow up so that people at risk of suicide. Of course, it is not known which, if any, of these measures was effective in bringing down the suicide rate.

The WHO produced three key publications that help us to understand how to prevent suicide. The first of these three publications drew attention to a number of possible factors that might be responsible for lowering the suicide rate, and these included medical interventions such as treatment with lithium or neuroleptics, as well as interventions in the community, such as school based preventive programs, multifaceted suicide prevention programmes and restricting access to lethal methods such as firearms and toxic chemicals (WHO 2012).

The second key publication clarified the model used, as well as emphasising the fact that suicide in LAMI countries has a peak for young adults, in contrast to the greater age in high income countries (WHO 2014).

The third key publication introduces a five point plan for interventions: first, to restrict access to methods of suicide; secondly, to interact with the news media to modify the way in which mental disorders are presented to the public; third, to influence young people's problem solving skills, coping and life skills; fourth, early identification of those who are at high risk of suicide, such as patients discharged from psychiatric care. This paper draws attention to the need for staff training and a budget to support continuing activities (WHO 2018).

As a result of these papers many countries have produced national policies for the prevention of suicide and detailed description of their success should be available over the next few years and we would recommend that people review their approach to suicide prevention when the results are available.

There is a problem in that training possible gatekeepers to mental health care may not persist after initial enthusiasm has died down. Gatekeeper training has been implemented and studied in many populations, including military personnel; public school staff, peer helpers, clinicians, and Aboriginal people (Isaac et al. 2009).

This type of training has been shown to positively affect the knowledge, skills, and attitudes of trainees regarding suicide prevention. Large-scale cohort studies in military personnel and physicians have reported promising results with a significant reduction in suicidal ideation, suicide attempts, and deaths by suicide. Extensive follow up reduced the risk of suicide (Inagki et al. 2005).

The prevention training developed by WHO is called 'brief intervention and contact' (BIC) and consists of a one-hour interview as soon as possible after the person was discharged from hospital, followed by regular checks over the next 18 months. Riblet and her colleagues (2017) have succeeded

in identifying 8,647 citations, including 72 RCTs and 6 pooled analyses about the prevention of suicide and concluded that the World Health Organization's 'brief intervention and contact' works (Fleishman et al. 2008).

Recommendations

- To improve mental health literacy in the community so that people can identify mental distress and mental illness earlier ensuring people get more effective help.
- To improve the skills of community and primary care health professionals in the recognition of signs of mental illness and suicidality at first contact.
- To ensure that general hospital and secondary mental health care staff have enough training and manpower to identify those people at increased risk of suicide so that an appropriate prevention plan can be put in place, particularly during the first two weeks of admission and the first two weeks following discharge when suicide risk is at its highest.
- Governments to increase their funding into suicide research and public health measures to improve prevention.
- Policy makers, WHO and international professional colleges to work collaboratively to develop better tools for rating suicide risk and for developing effective management plans for suicide prevention.
- Psychological first aid to be included in all first aid training courses in order to raise awareness of mental health problems and provide the general public with increased confidence and skills to identify mental health crisis and problems and obtain early help.
- Collaborative working between those involved in developing and influencing mental health classification systems in order to consider suicide more explicitly in mental health diagnosis to enabling early identification of those at increased risk and the development of treatment plans to support preventive action.
- Regulators to include suicide prevention indicators and suicide rates as part of mental health key performance indicators.
- Develop a global agenda and consensus on tackling mental health stigma in suicide prevention strategies.
- Brief intervention and contact (BIC) works.

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THE WARNING SIGNS OF SUICIDE

Befrienders

Suicide is rarely a spur of the moment decision. In the days and hours before people kill themselves, there are usually clues and warning signs.

The strongest and most disturbing signs are verbal—"I can't go on," "Nothing matters any more" or even "I'm thinking of ending it all." Such remarks should always be taken seriously.

Other common warning signs include:

- Becoming depressed or withdrawn
- Behaving recklessly
- Getting affairs in order and giving away valued possessions
- Showing a marked change in behavior, attitudes or appearance
- Abusing drugs or alcohol
- Suffering a major loss or life change

The following list gives more examples, all of which can be signs that somebody is contemplating suicide. Of course, in most cases these situations do not lead to suicide. But, generally, the more signs a person displays, the higher the risk of suicide.

Situations

- Family history of suicide or violence
- Sexual or physical abuse
- Death of a close friend or family member
- Divorce or separation, ending a relationship
- Failing academic performance, impending exams, exam results
- Job loss, problems at work
- Impending legal action
- Recent imprisonment or upcoming release

Behaviors

- Crying
- Fighting
- Breaking the law
- Impulsiveness
- Self-mutilation

- Writing about death and suicide
- Previous suicidal behavior
- Extremes of behavior
- Changes in behavior

Physical Changes

- Lack of energy
- Disturbed sleep patterns—sleeping too much or too little
- Loss of appetite
- Sudden weight gain or loss
- Increase in minor illnesses
- Change of sexual interest
- Sudden change in appearance
- Lack of interest in appearance

Thoughts and Emotions

- Thoughts of suicide
- Loneliness—lack of support from family and friends
- Rejection, feeling marginalized
- Deep sadness or guilt
- Unable to see beyond a narrow focus
- Daydreaming
- Anxiety and stress
- Helplessness
- Loss of self-worth

This factsheet is available in 16 different languages on the Befrienders Worldwide website: www.befrienders.org

SUICIDE AND OLDER ADULTS

C.A. de Monedoca Lima, D. De Leo and U. Arnautovska

This article is adapted from the chapter titled “Suicidal Behaviour in Older Adults,” by D. De Leo and U. Arnautovska, in the book *Primary Care Mental Health in Older People: A Global Perspective*, edited by Carlos Augusta de Mendonça Lima and Gabriel Ivbijaro. Springer, 2019.

According to the World Health Organization (WHO), “suicide is the result of an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome.”[1] It is a major public mental health problem. Suicide is a human phenomenon found in all cultures, in both sexes, in all ages and throughout history. It has different meanings according to the context of the person’s life, but the common feature in all cases of suicide is the presence of a suffering behind the decision to choose death over the uncertainty of a future perceived as unbearable. Commonly considered as “survivors of their own generation,” older adults may commit suicide for different reasons than younger adults. These differences are important to be identified because they may help to develop specific strategies to prevent suicide later in life.

Although declining in many parts of the world for the past thirty years[2], suicide rates among individuals aged 65 years and older are still the highest for both men and women in almost all regions of the world[3]. In addition, increase in life expectancy and decrease in mortality due to causes of death other than suicide created expectations that the absolute number of older adults’ suicide might be growing further. Suicide rates continue to grow up to extreme ages[4], with a curve of the trend line steeper in men than in women. However, older adults seem to have benefitted more than other age groups from the improvements in general health assistance and quality of life which have been witnessed in many countries in recent years[3], as testified by the fact that their rates have declined more than in younger individuals[2, 3].

Compared to suicide rates, non-fatal suicidal behaviour decreases proportionally with increasing age[5]. Compared to younger individuals, the ratio between fatal and non-fatal suicidal behaviour can become very small in old age, varying from 1 to 2[6] (in youth, if we consider non-suicidal self-injury episodes, it can reach 1 to 5,000[7]). While non-fatal behaviour is particularly frequent in women of younger age groups, the prevalence tends to be equal in advanced age[8]. The gender paradox in suicide rates is often explained by the more frequent help-seeking behaviour in females and the use of more violent methods in males[9, 10, 11].

Contrary to common beliefs, approaching the natural end of life is not accompanied by an increased frequency of suicide ideation or death wishes: both types of thoughts are more prevalent in youth and young adults[12].

A note of caution should be expressed in relation to the validity of suicide mortality data in old age as well as in the general population[13, 14]. In fact, mortality data for suicide in older adults are often under-reported: ‘accidents’, refusal to take life-sustaining medication or overdosing with drugs such as insulin or opioids, can all be recorded as non-suicide cases[15].

Suicide in old age may be considered as the result of a rational decision. Lack of positive expectations, frailty, dependency from others, loss of spouse and solitude are frequently considered motivations that could ‘explain’ cases of suicide. Aggregation of different factors, for example bereaving the death of partner in a dependent and frail individual, may reinforce the paradigm of rational choices. Similarly, suicide can be interpreted as a ‘legitimate exit’ from life when loss of reputation, dignity, or dramatic change in social status is experienced.

Depression is an important risk factor for suicidal behaviour in all ages[16], but it is possible that its role has been overemphasized. Sadness, disillusionment, disappointment, disengagement, and lack of positive expectations are frequent travel mates in the life journey of every individual and not necessarily symptoms of depression [17, 18].

In old age suicide methods vary from country to country and gender but the increased lethality of methods chosen by older adults is seen around the world. Greater determination to die and more attention to avoid being rescued by third parties concur with this phenomenon[6, 9, 19, 20, 21, 22].

Among the risk factors, those represented by mental disorders, psychosocial context and the physical illness are the most studied:

Mental Disorders

A psychiatric diagnosis has been reported as present between 71% and 95% of suicide cases of older adults. The most common diagnosis is affective disorder, which is present from 54% to 87% of these cases[23, 24], and is associated with the highest population attributable risk for suicide in late life[25]. Depression—both as chronic depressive symptoms and as first episode in old age—has been identified as the most powerful independent risk factor for suicide in old age[26].

Several age-related medical conditions (e.g., cardiovascular disorders, stroke, chronic pain, etc.) are often concomitant to depression[27]. These co-morbidities sometimes make the identification of depression difficult, or delay its recognition and treatment; thus, depression might end by being regarded as irrelevant or secondary to a somatic condition.

Also, depression in older adults is often accompanied by symptoms of anxiety or a full-blown anxiety disorder. These conditions may frequently increase the risk of suicide[28, 29].

Alcohol abuse represents a less common risk factor for suicide in older adults compared to what is found in young adults[30], but it remains an important indicator of risk for both sexes. Similar considerations apply to the association between suicide and psychotic disorders, which are much less represented in suicide cases of people of advanced age than in those of younger individuals[25, 31].

Even personality disorders appear to be less frequently associated with cases of suicide in older adults compared to younger persons[32]. As for the presence of specific personality traits in suicidal older adults, cognitive rigidity, apprehensiveness and anankastic traits seem to be particularly common among suicides in older adults [25, 33].

Despite the high prevalence of dementia diagnosis in advanced age, this condition does not seem to be significantly associated with an increased risk of suicide[34, 35].

Psychosocial Factors

The presence of many psychosocial factors (such as impoverishment, isolation, relocation to a nursing home, and bereavement) may increase susceptibility to depression[36]. However, even in the absence of an affective disorder, these factors can markedly upset the life of an individual, often creating living conditions too poor to be accepted, and increasing the risk of suicide at very advanced age. Men, particularly when single, widowed or divorced, are often reported to be at increased risk of suicide[37]. Financial problems, low level of education, lack of social and/or religious support networks[38], and feelings of loneliness[39] may increase the risk of suicide. In particular, isolation and a lack of social interactions are important risk

factors for suicide in older adults, even after accounting for the influence of mood disorders. The existence of relationship problems in the family or the presence of a very tense climate or discord may also represent important stressors by increasing the sense of emotional isolation, then being associated with suicidal behaviours[22]. In fact, loneliness may result from the loss of an important intimate relationship or a social role that previously helped to preserve a person's sense of self-esteem and dignity. Early traumatic experiences can have consequences in later life and be associated with increased likelihood of suicidal behavior[33, 40].

Usually, a death represents a significantly stressful event, especially if it involves the loss of a child or close relative[41]. For the older old (80+ years), the loss of a partner increases the risk of suicide especially during the first year after the death, with men being affected more strongly by this stressful life event than women[38]. Loneliness is also reflected in the solitary nature of suicides among older adults, which are more often performed at home[31]. Even the loss of a pet can be a significant trigger for a suicidal crisis[41].

Retirement is an event related to the ageing process with potentially negative effects on the mental health of an older adult. The risk of suicide is particularly high in the first 2-3 years after the termination of the employment[17]. Of key relevance in this context are changes in income, social status, and social and family roles interactions. These changes can lead to feelings of worthlessness and loss of self-esteem and purpose in life[22].

Precipitating factors for suicidal behaviour among older adults are also represented by forced relocation, a recent placement in a nursing home or the anticipation of such an event[42, 43].

Although murder-suicide is a relatively rare phenomenon, older adults are disproportionately represented among both perpetrators and victims of domestic homicide-suicide[45, 46, 47]. The vast majority of cases of murder-suicide are committed by men against a female spouse with a firearm[46, 47]. As many as 40% of the actors were involved in providing assistance to a spouse with a long-term illness or with a disability[46].

Physical Illness

Somatic and functional-impairment conditions significantly increase the risk of suicide during the entire life span[48]. Serious physical illnesses were independently associated with suicide among males[49, 50].

Hospitalisation can be a risk factor for suicide in older adults[44]. Interestingly, approximately 80% of diagnoses given during the hospitalization were non-psychiatric.

Abuse or inappropriate use of prescription medications, particularly painkillers and those used to treat psychiatric disorders, can also place older adults at increased at risk of suicide.

Co-morbidity of psychiatric disorders with physical disabilities appears to particularly increase the risk of suicide in older adults[51], with loneliness adding to that risk[38].

Protective Factors

Protective factors may include high levels of education and socioeconomic status, engagement in valuable activities, and religious involvement[52]. Intensity of faith and participation in social activities connected to the religious practice seem to be the most important explanations for this effect[53].

Furthermore, the presence of significant levels of social support, either represented by intimate friends or relatives, can constitute an important protective factor. Marriage seems to constitute a protective factor, particularly for older adult males[10, 54].

Interventions and Assessment

Interventions to treat suicidal behaviour need to balance risk and protective factors, bearing in mind that these will be of different significance depending on the cultural and social context[55].

Risk of suicide is often not recognized in older patients[22]. In fact, many older adults who take their life have consulted their General Practitioner (GP) shortly before their death. Persons who died by suicide had significantly more frequent contacts with mental health professionals than those who die suddenly from other causes. Primary care physicians would be less willing to treat suicidal older adults compared to younger patients and would be more likely to believe that suicidal ideation in an older individual is frequently 'rational'[56, 57].

As a matter of fact, communication of suicidal thoughts tends to be less common among men and older adults who die by suicide than it is among women and younger people who do it[58]. In addition, older people tend to minimize their psychological problems and consider them to be related to physical illness. As a result, family and friends can be the first to note that an older adult is at risk of suicide[59, 60].

Assessment of suicide in older adults should not overlook the impact of chronic stress factors such as loneliness, complicated pain and severe disability. These might trigger suicidal tendencies, especially in the absence of social support[22].

An older person may present a greater determination to die than their younger counterparts. Indeed, the presence of previous attempts of suicide in older adults strongly indicates the risk of repeated suicide attempts and fatal suicidal behaviour[61].

Hopelessness, considered as the most important psychological condition that may be seen in patients with a variety of different psychiatric conditions, has been associated with suicide ideation and behaviour. It was also identified as a moderator between cognitive functioning in dementia and suicidal behaviour in the few cases of suicide observed in patients diagnosed with dementia.

The majority of studies on empirical assessment of a suicide prevention program focused on reducing risk factors and they seemed to reduce the risk of suicide more successfully in women than in men[62]. This group proposed a set of recommendations to address senior citizens at risk of suicide[63]. They stressed the need for multi-component approaches, to be based on available scientific evidence and having an organized system of distribution of resources while monitoring the effectiveness of each intervention that could support the efforts through various levels.

At the level of general prevention, limiting access to means of suicide is one of the most effective universal strategies to reduce suicide rates in the world[64]. However, there is no convincing evidence that access restriction may be effective with populations of older adults.

Older adults seem more likely to approach their GP for help, rather than specialist mental health services[23]. Social services and communities can represent potential gatekeepers[25]. The training of gatekeepers at community level was proposed as a potentially useful method to identify older individuals at risk for suicide[25]. It is clear, however, that every effort needs to be done to promote the integration of older people in social groups and communities (religious and non-religious). By providing a social support network, connectedness can help to moderate isolation and loneliness, and to promote feelings of belonging and self-esteem[65].

The evidence on the effectiveness of suicide prevention interventions for older adults remains limited. There is consensus that a multi-factorial approach and multiple levels of suicide prevention could reduce suicide in older adults[63]. On the other hand, elements of national prevention strategies that could be of relevance also for late life suicide are: 1) awareness of suicide and its public health dimension; 2) recognizing suicide risk factors and controlling those that are modifiable; 3) coordination of mental health and substance abuse control programs; 4) development and implementation of strategies to reduce the stigma associated with mental illness and suicidal behaviour; and, 5) creating programs to improve help-seeking behaviour, particularly among males[3].

Strategies aimed individuals aged 65 years and over[3] generally promote mental health, with particular emphasis on the early recognition and treatment of depression. To achieve these objectives, access to integrated mental health services and adequate treatment and support for older adults and their carers are often provided[15].

Conclusion

In conclusion, even if they remain the highest, suicide rates among older adults are falling in most western countries[2, 3]. It is possible that older adults have particularly benefitted from improvements in overall levels of health care and quality of life, more than any other age group. Having been the most disadvantaged demographic segment, improvements in older adults have shown a proportionately greater size compared to the others[2]. Hopefully, this phenomenon might continue with the same pace, but targeted action would be required to achieve a steeper decrease in the trend line.

The improvement of social support and the detection and early treatment of affective disorders are key interventions to reduce risk of suicide in old age[62]. Prevention based on community actions and training of gatekeepers seems to be important strategies. In particular, community programs that promote a sense of usefulness and belonging and preserve social integration and social status should be pushed vigorously. Governments must continue to pay attention to improving retirement programs, facilitating access to general health and mental health services and developing support systems. Testing the validity of actions undertaken and verify their applicability to different cultural contexts remain imperative.

Combating stigma and ageistic perspectives must be done with great determination. Meanwhile, actively promoting a culture of adaptation to different stages of life and to the changes imposed by the advancing of age should form the essential part of a process bringing to better successful aging avenues.

Suicide prevention in older adults should broaden its focus and pay attention to the many socio-environmental conditions that may be relevant in older age, especially social isolation, financial security and physical health. This would certainly help to better counteract suicide ideation and behaviours in this difficult part of life.

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THE ROLE OF THE MEDIA IN PROMOTING AND PREVENTING SUICIDE

International Association for Suicide Prevention

The media—in all its forms—is extremely influential. Journalists and editors know this, advertisers and campaigners know this, and bloggers and influencers know this. Many suicide prevention experts also know this. They are acutely aware of the media's impact on the community's attitudes towards suicide and on the way vulnerable individuals think about suicide as a course of action.

Early work on suicide and the media tended to focus on traditional media like newspapers and television and concentrated on its potential for harm. Numerous studies conducted from the 1960s onwards have shown that when stories about suicide appear in the news, there are 'spikes' in suicide rates.[1] This is particularly the case when media reports on suicide are prominent or repetitious,[2,3] feature celebrities who have taken their own lives,[4] or describe methods of suicide in explicit detail.[2,3,5,6] Fortunately, there are also certain types of reports that are associated with drops in suicide rates as well.[1] In particular, reports that describe people who have overcome suicidal crises can have a beneficial effect.[7]

More recent work has begun to examine the role of social media in promoting and preventing suicide. It makes sense that any effect of traditional media might be magnified in the case of social media because of its wide reach and speed of transmission, and because individuals are both recipients and contributors of social media content.[8,9] Studies of the influence of social media on suicide have yielded mixed findings. Some have indicated that social media can heighten risk for those who may already be struggling by, for example, enabling them to access information on lethal methods and by introducing them to others who may encourage them to end their lives.[10] Other studies have identified more positive effects, mostly to do with individuals finding sources of help and supportive virtual communities of people who have come through similar crises.[8]

Some suicide prevention experts have also begun to think about interventions that can increase the potential for the media to do good, rather than harm. The most established of these interventions target print and broadcast media professionals, offering recommendations about ways to report on suicide. The International Association for Suicide Prevention and the World Health Organization have produced and updated guidelines for journalists and editors,[11] and governments and non-governmental organisations in many countries have done the same,[12] often giving them a local flavour. The essence of these guidelines is similar; none are about censorship, but all are about careful, considered reporting. They all recommend minimising the prominence of reporting, taking care with suicide-related language, avoiding discussion of suicide methods and locations, and providing information about where people can seek help.[13] Evaluations of these guidelines have shown that they can have a positive impact on journalistic practices.[14]

Attention has now turned to interventions that might be useful in the context of social media. In recognition of the fact that adolescents and young adults are the heaviest users of social media and perhaps also more susceptible to its influence, guidelines have been developed to equip young people to talk safely about suicide if they are doing so online.[15] Other novel interventions that capitalise on the architecture of social media are also being developed, including some that allow for real-time identification of and responses to posts that indicate that an individual is at heightened or imminent risk.[16] These newer sorts of interventions show promise but have yet to be formally evaluated.

The above interventions are largely about preventing harm, but there are also interventions that are being developed and implemented that are about using the media as a force for good in suicide prevention. In particular, suicide prevention media campaigns have been created that target suicidal individuals themselves or people who are concerned that someone close to them may be at risk.[17,18] Usually these campaigns have some sort of brief public service announcement at their core, often with a catchy tag-line.[19] They vary, however, in terms of their precise messaging and in terms of the

different media they use to get the message out. Often they use a mix of print and broadcast formats, and increasingly they use both traditional and digital channels.[19] Variations on this intervention include longer formats, like documentaries.[20] The evaluative evidence surrounding these sorts of interventions is mixed, but some have been shown to be effective in encouraging help-seeking, changing attitudes towards suicide, and even reducing suicide rates.[17,18]

Suicide is complex and has multiple causes, and the media has a significant role to play in its promotion and its prevention. Suicide prevention experts must partner with media professionals and others who have a role in creating and disseminating media content if we are to make inroads into reducing suicide rates.

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International Association of Suicide Prevention: www.iasp.info

OPENING MINDS, OPENING DOORS—MEDIA GUIDELINES

World Federation for Mental Health

"There is tremendous potential for journalists to improve the public's understanding of mental health issues and to play a critical role in reducing stigma and discrimination against people with mental illnesses."—Former U.S. First Lady Rosalynn Carter

The World Federation for Mental Health is dedicated to educating the public and empowering change. This document will help journalists and reporters form a better understanding of mental health and those with mental illness. It can serve to enhance the ability of those reporting on situations relating to mental health and mental illnesses that arise in their community and to encourage fair and accurate reporting on the subject.

Issues to Consider When Reporting on Mental Health and Mental Illnesses

- Know, and use, the facts. Mental health problems and mental illnesses can impact all aspects of people's lives, including family, work, school and social life. A community that doesn't understand these disorders will make it more difficult for individuals to get help and lead productive and satisfying lives**.**
- Your reporting impacts lives. Promoting understanding in your community can encourage results in more people with mental health problems to be accepted and supported by their peers and neighbors.
- Media guidelines and codes of ethics provide for the right to privacy. Consider how your story may affect the individual's life. Follow your media outlet's code of conduct on interviewing people with disabilities.
- There is more to a person with a mental illness than their condition. If it's not relevant to your story, don't mention it.
- Use appropriate, non-judgmental language and terminology that is respectful to the person.

Appropriate Terminology and Use of Language

The use of degrading and unfair terms promotes misunderstanding, discrimination and false portrayals of people with mental disabilities. Following is some preferred terminology to promote equality and understanding. Consider this language in your speech, your writing, and your descriptions.

Use "*person with a mental illness"* OR "*person diagnosed with schizophrenia"* and "*person who has a psychiatric disability"* instead of "the mentally ill" or "psychotic person" or the "schizophrenic." Words such as "crazy," "lunatic," "psycho" are very offensive and should never be used to describe a person with a mental health problem.

Whenever possible, use "*discrimination"* instead of "stigma." Over the years, the term 'stigma' has sometimes ended up causing more separation and mistreatment. The word "discrimination" shows the differences in the ways people are treated.

Say the "*person has depression"* instead of "burdened with," "afflicted with," "victim of." Using the latter terms promotes a sense of weakness; in reality, people with mental health problems are usually no "weaker" than are people who experience other serious health problems such as diabetes, heart disease, and cancer.

Say “*person who has died from suicide”* instead of *“committed suicide.”* ‘Committed’ leads people to think of being incarcerated or put somewhere against their will. Suicide is a very important health concern and should not be viewed as a sinful or criminal behavior.

Say “*person with a disability”* instead of *“the disabled*.” The total being of an individual with an illness or injury is not usually affected by the condition. There is much more to a person with a disability—their personality, their work, and their family. Labeling an individual with a disability, as “a disabled person” is somewhat like describing a person with red hair—you would not say “the red-hair person.” but rather “the person with red hair.”

RECOMMENDATIONS FOR REPORTING ON SUICIDE©

Developed in collaboration with: American Association of Suicidology, American Foundation for Suicide Prevention, Annenberg Public Policy Center, Associated Press Managing Editors, Canterbury Suicide Project—University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry, ConnectSafely.org, Emotion Technology, International Association for Suicide Prevention Task Force on Media and Suicide, Medical University of Vienna, National Alliance on Mental Illness, National Institute of Mental Health, National Press Photographers Association, New York State Psychiatric Institute, SAMHSA, Suicide Awareness Voices of Education, Suicide Prevention Resource Center, The Centers for Disease Control and Prevention (CDC) and UCLA School of Public Health, Community Health Sciences.

Important Points for Covering Suicide

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.
- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/ graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

Instead of This	**Do This**
Big or sensationalistic headlines, or prominent placement (e.g., “Kurt Cobain Used Shotgun to Commit Suicide”).	Inform the audience without sensationalizing the suicide and minimize prominence (e.g., “Kurt Cobain Dead at 27”).
Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.	Use school/work or family photo; include hotline logo or local crisis phone numbers.
Describing recent suicides as an “epidemic,” “skyrocketing,” or other strong terms.	Carefully investigate the most recent CDC data and use non-sensational words like “rise” or “higher.”
Describing a suicide as inexplicable or “without warning.”	Most, but not all, people who die by suicide exhibit warning signs. Include the “Warning Signs” and “What to Do” sidebar (from p. 2) in your article if possible.
“John Doe left a suicide note saying…”	“A note from the deceased was found and is being reviewed by the medical examiner.”
Investigating and reporting on suicide in a way similar to reporting on crimes.	Report on suicide as a public health issue.
Quoting/interviewing police or first responders about the causes of suicide.	Seek advice from suicide prevention experts.
Referring to suicide as “successful,” “unsuccessful” or a “failed attempt.”	Describe as “died by suicide” or “completed” or “killed him/herself.”

Avoid Misinformation and Offer Hope

- Suicide is complex. There are almost always multiple causes, including psychiatric illnesses that may not have been recognized or treated. However, these illnesses are treatable.
- Refer to research findings that mental disorders and/or substance abuse have been found in 90% of people who have died by suicide.
- Avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce or bad grades.
- Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide.
- Consider quoting a suicide prevention expert on causes and treatments. Avoid putting expert opinions in a sensationalistic context.
- Use your story to inform readers about the causes of suicide, its warning signs, trends in rates and recent treatment advances.
- Add statement(s) about the many treatment options available, stories of those who overcame a suicidal crisis and resources for help.
- Include up-to-date local/national resources where readers/viewers can find treatment, information and advice that promotes help-seeking.

Suggestions for Online Media, Message Boards, Bloggers & Citizen Journalists

- Bloggers, citizen journalists and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs and suicide hotlines.
- Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- The potential for online reports, photos/videos and stories to go viral makes it vital that online coverage of suicide follow site or industry safety recommendations.
- Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies and procedures could support removal of inappropriate and/or insensitive posts.

Helpful Side-Bar for Stories	
Warning Signs of Suicide	What To Do if someone you know exhibits warning signs of suicide
• Talking about wanting to die • Looking for a way to kill oneself • Talking about feeling hopeless or having no purpose • Talking about feeling trapped or in unbearable pain • Talking about being a burden to others • Increasing the use of alcohol or drugs • Acting anxious, agitated or recklessly • Sleeping too little or too much • Withdrawing or feeling isolated • Showing rage or talking about seeking revenge • Displaying extreme mood swings The more of these signs a person shows, the greater the risk. Warning signs are associated with suicide but may not be what causes a suicide.	• Do not leave the person alone • Remove any firearms, alcohol, drugs or sharp objects that could be used in a suicide attempt • Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK (8255) • Take the person to an emergency room or seek help from a medical or mental health professional

http://reportingonsuicide.org/recommendations/

THE IMPACT OF SUICIDE

Susan Weinstein

It used to be said that a suicide death affected six people. That number reflected the immediate family and closest friends of the person who took their life, suggesting that suicide impacts only those who had been most directly in contact with and emotionally connected to the person who died. The prevailing wisdom was that a person's spouse, children, parents, and close friends would be significantly affected by their loved one's death but that the impact on others—neighbors, work colleagues, school mates, teachers, etc.—would not make enough of a difference in their lives to warrant intervention. As is often the case with conventional wisdom, the number 6 was not based on empirical evidence, yet has been widely repeated since the 1970s. People crave certainty and the number 6 provided assurance (however inaccurately) that a suicide death affected only a small circle of people.

Researchers now look at the effects of suicide in a different way. A death by suicide has different impacts on loss survivors that, with some exceptions due to personality, emotional, and mental health characteristics, roughly correspond with the relationship between the person who died and the person who survived them. Though the language describing loss survivors continues to evolve, there is a common view that suicide results in a much broader impact than previously recognized.

"Exposed" is the lightest effect, occurring to those who personally knew the one who died by suicide. People in this category each process the death in their own way but generally do not feel a need for professional intervention, such as mental health counseling. Recent studies have concluded that one suicide death results in exposure to nearly 150 people. In the U.S., that means that more than 6.9 million people are exposed to suicide loss each year, while worldwide (if the same model applies to different societies and cultures) the exposure reaches more than 117.5 million people. In the U.S., about 40% to 50% of people are exposed to a suicide death in their lifetime.

The next level of impact is "affected." People who are categorized as "affected" by suicide loss may experience grief, guilt, disbelief, anger, shame, and other emotions associated with suicide loss. The loss has some level of impact on the person, who may lose sleep, have difficulty concentrating, experience a change in eating patterns, or manifest other symptoms reminiscent of signs of stress. People in this category may well benefit from mental health support or intervention, along with self-care.

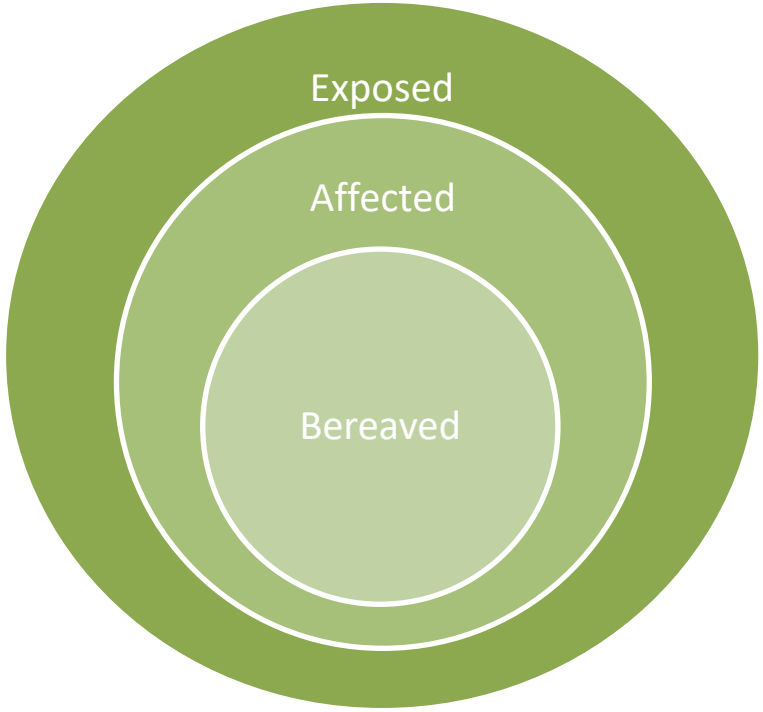
"Bereaved" is the most intense level of impact. People in this category of suicide loss survivors often suffer great distress, major life disruption, and a loss of functioning. Researchers have determined that more than 6 people experience this level of emotional impact for each suicide death. That means that more than 282,000 people in the U.S. are bereaved due to a suicide, many of whom would benefit from receiving mental health care, developing coping skills and self-care practices, and being able to rely on support from family and friends.

It's important that we not assume that, just because someone did not have a close, personal relationship with a person who ended their life, they are not affected by the loss. Some deaths hit harder than one might expect. Consider, for example, the aftermath of a celebrity's suicide.

Reactions to a celebrity's death by suicide often defy neat categorization, tending to have an impact more like losing a friend than losing someone they don't know. In the U.S., for example, think about the shock, disbelief, and despair that followed the deaths of Robin Williams, Kurt Cobain, Kate Spade, and Anthony Bourdain. Why did people feel these losses so acutely?

It may be that people feel like they “know” a particular celebrity because they like, identify with, idolize, or respect them so much. They envision the loss to society or culture or sport or intellectual pursuits, whatever the celebrity’s particular talent. People also have difficulty understanding how a celebrity who “has so much” cannot get the support and care they need to manage their mental health condition.

Is the discussion about exposure, affect, and bereavement merely a matter of language choice, or is there a deeper reason why this information is important? These distinctions are important not only for encouraging empathy and for increasing availability of mental health support, but also because exposure to suicide increases the risk of another suicide. When we recognize the broad impact of suicide on the people in places that we live, work, play, and pray, we can better equip ourselves and others to be effective caregivers (carers) to those who have lost someone to suicide and, in turn, prevent additional suicides.



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BEYOND THE WHY

Natasha Müller

This is an honesty of experience to honour those lives lost, those who matter too much for me to stay silent.

I used to ask myself:

When?

When would I feel better?

When would I be a “happy,” stable, “normal” person—whatever “normal” means. When would I just be over “it”?

I also asked myself, and others continue to ask me, the very question I stopped asking myself long ago, “Why did they do this?”—a question I find is only asked in relation to suicide. There is something about suicide that begs this senseless question.

A life changing moment of realisation for me—having lived for 17 years with my father’s death by suicide, three other suicides in my lifetime thus far, and personal demons of depression and anxiety—is that there is no such turning point in life. There is no magic moment when things are just better—when you are suddenly “at peace.”

And that is OK.

There is a particular kind of permanence that exists when you live with the experience of suicide, as the scars that it leaves behind cannot be undone.

This is why I share: To let others who are struggling with depression, who are having suicidal thoughts, who are living with the trauma of suicide like me, to know that there is hope.

The ‘invisible hand of depression’ that sometimes holds your head down so tight will lift again.

This is my story:

When I was 17 years old my father died by suicide. It was three days before my first A level exam; my mum had left a few days before to go to the US to attend an important family gathering. My younger brother and I were home alone. During my evening study break, I suddenly realised that I had not seen or heard from my father for the last couple of hours. Under normal circumstances this would not have been abnormal, but we were not living in normal times.

My father had Bipolar Disorder Type 1 and was a former alcoholic. He had been going through a particularly tough time: he had been very sick physically with severe kidney stones and was bed ridden. The combination of his own concerns for his health and interaction with his lithium medication sent him spiraling into a dark place. This time his “inner child” (as he called it) or a deep tormented depression fully consumed him. Not hearing from him for a few hours therefore sent warning bells through my mind.

Together with my brother, we started searching the house and eventually realised that the door to the large storage room on the bottom floor was locked from the inside, with the key inside the keyhole. For some reason I knew instinctively what was going on behind the locked door. I started banging on it demanding to be let in—to no avail. We eventually managed to pry our way in. It was, unfortunately, too late and our father's spirit had already left him.

That was the day I felt true pain. The unbearable pain of realising my father had chosen to leave us, having succumbed to his own pain. For a long while I felt broken—unknowing and unable to find ways to put myself back together again.

However, bit by bit, day by day, with the endless support and love of my family and friends, we endured the pain. We soldiered on. To do otherwise would be to dismiss my father's pain—to reject the one thing that I and my loved ones had left of him: our memories.

It is in his honour and with his presence always in my mind and in my heart, that I choose to live and continue to fight my own battles. Every battle won makes me more confident that I can overcome the next one.

Even when I experienced two more deaths by suicide during my university years, and very recently the death of one of my closest and dearest friends earlier this year—someone full of life and love—I knew I could endure.

They say that time can heal anything. Now I know that there are some hurts and some wounds that cannot be covered up regardless of how much time has passed.

Living with the trauma of having experienced a death by suicide is one of those wounds.

Someone recently told me that depression is a form of total inner contraction—where your field of vision becomes so small you feel totally isolated.

I know that I want to be expansive.

So, rather than asking why? Why did they do this? Why did they leave me? I *choose* to think instead about how fortunate I am to have had them in my life for as long as I did. Depression and anxiety in life will always come in waves, and we must ride the waves—the ups and the downs. When we pull ourselves up from the downs, we are stronger for it, and we are stronger if we do it together.

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A CARING CONVERSATION: WHAT SUICIDE PREVENTION CAN LOOK LIKE

Robert Olson, Centre for Suicide Prevention

"I was officially diagnosed bipolar when I was thirty years old. It was at that breakdown, when I was thirty and ended up in the hospital that I truly felt so disconnected and in so much pain like looking out the window and seeing the life out there and not feeling that, just feeling empty. I didn't want to be here anymore, I thought it would be better somewhere else. And I've always heard people saying that people who take their own life are selfish and that's so not true. Unless you've been in the moment where you can feel that absolute darkness, hopelessness, pain it has nothing to do with anyone else, it's just wanting to like remove myself from a situation and stop that pain."

"Yeah, I honestly thought my life was over, like if this was the new normal for me, I didn't want it thank-you-very-much. I'm checking out, like I'd rather do something else than suffer and not know what's happening every minute. And because I had already been predisposed for thirteen years of thinking about suicidal ideation, this was like "oh this is the opportune time" because this was pretty bad, this was a good reason to say I had enough. So, it just goes to show how difficult it can be to understand what's happening with someone and the fear is so great, obviously just recently with one other celebrity, the fear of figuring out the struggle is so great that they are willing to die."

The idea of killing oneself is baffling and abhorrent to most of us. We cannot fathom what goes through the mind of someone who decides to end it all. Some may wonder how much pain and anguish people must feel to push themselves to that extreme. Others may think that they are selfish and only thinking of themselves. And many more don't want to know what is going on at all, believing matters like suicide—and what drives people to it—are better left unsaid. As a society, most of us just don't get it.

The above italicized quotations are recollections of 'attempt survivors', people who have attempted suicide and lived, relating how they felt when they were on the verge of killing themselves. I spoke with a group of people who had attempted suicide and lived, and they described that point where their decision to die had been made or was closely approaching. The above quotes belong to two of those individuals. Of course, their words cannot even begin to fully relate how horrible that point was for them, but they give us a retrospective glimpse into what they were thinking at the time of acute crisis.

The overwhelming majority of people who die by suicide do not want to die, nor do they kill themselves on a whim. Suicide is rarely an act of impulsivity: rather, it has been mulled over for a long time. People considering suicide are in extreme psychological pain and they want that pain to end. This pain causes their vision to become so narrow that the only way out of it they can see is killing themselves. This process is gradual—people rarely come to a point of suicidal crisis over one awful experience. What can "seem" impulsive to an observer, however, is the decision to carry out the act of suicide at a particular moment in time. Why now, someone may ask of another, whose suicide appears like a rash act coming out of nowhere?

On the contrary, often the decision to die by suicide happens when a negative circumstance becomes the tipping point, the proverbial "camel straw." A precipitating factor, such as a marital breakup or a job loss, combines with other existing but perhaps not as apparent or obvious risk factors directing that person to suicidal action. This is a time where any one of us—those who do "get it"—can make a huge difference. Our humanity and empathy can go a long way to helping someone at risk. By providing a compassionate ear, a sounding board, or a simple, caring presence, we can help avert a death by suicide.

Suicidal Behaviours

Anyone can experience thoughts of suicide, in fact most people do though typically fleetingly. Also, the vast majority of people at risk of suicide are not experiencing a high acuity of a comorbid mental illness, outside of depression. 4% of the adult population in the United States will have thoughts of suicide in any given year. 1.1% will make plans to die by suicide, and 0.6% of those people will attempt suicide. These numbers are so small because, though tragic, it is very difficult for a person to take their own life. In fact, it may be the most difficult thing that someone can ever undertake (Centers for Disease Control and Prevention, 2015).

Joiner's Interpersonal theory of suicidality posits that to attempt suicide a person must feel a strong sense of "(perceived) burdensomeness", that they are of no use to anybody and better off dead. They must also experience "thwarted belongingness", an extreme lack of connection to anyone or society in general. Last and most crucial, they must have "acquired capability", a habituation to the fear and pain of self-injury through repeated exposure, which enables them to overcome the powerful instinct for self-preservation. All three elements must be present for someone to die by suicide. As Joiner says, "Killing is hard to do", especially to kill oneself, as we are biologically hard-wired to live (Joiner, 2005).

Therefore, at the point of suicidal crisis, the individual has typically lost all hope and sees no other alternative than to end their life.

"The Caring Conversation"

So, how do we help someone who is in crisis? A person who appears suicidal? The answer may surprise you. It may be as fundamental as a thoughtful conversation.

You, as helper, can aid the person at risk to gain sufficient perspective and insight that they themselves can identify reasons for living. I know this may seem simplistic, but its effects are powerful.

Having a caring conversation with the person at-risk can provide basic, life-saving assistance in their moment of need. With the proper knowledge and training, the ability to actively listen, and—above all—the desire to really help someone, any one of us can bring someone back from the precipice of a final, fateful decision. Simple in concept, a caring conversation, for most of us, is difficult to achieve. We must be willing to enter and sit in the person's discomfort with them, and truly listen.

A seminal study by Seiden (1978) looked at suicide attempters at the Golden Gate Bridge in San Francisco from its opening in 1938 up to 1971. He found that 90% of attempters who were thwarted in their intentions—either by passersby, bridge patrols, or police—to die by suicide did not go on to attempt again, either at the Golden Gate, another bridge, or by some other means. The intervention of just one person was enough to snap them out of their constricted time and space mindset and out of their stasis of acute crisis. This caring intervention can refute deep-seated feelings of thwarted belongingness and can provide a lasting anchor for the person at risk in future*: they are not alone and others do care if they live or die.*

Another story involving a Golden Gate suicide was mentioned in a 2003 *New Yorker* article, *Jumpers: The fatal grandeur of the Golden Gate Bridge*, documenting suicides in the San Francisco Bay area (itself the inspiration for the documentary film, *The Bridge*). A San Francisco psychiatrist recounts a suicide note of a young male who died by jumping from the bridge. It stated, "If one person smiles at me, I will not jump" (Friend, 2003, p.6). Evidently, the man sought human connection so desperately. Unfortunately, no one acknowledged his presence on the bridge and no one smiled either. He jumped to his death.

A trial conducted by Motto and Bostrom looked at how "caring letters" sent to discharged psychiatric inpatients affects future suicide attempts. One group received a letter of encouragement once a month for 5 years, while a control group received none. The letters were concise but supportive. They found fewer

suicide attempts for those receiving regular “caring texts” than those in the control group (Motto & Bostrom, 2001). The study has been replicated in Australia using postcards (with even fewer words of encouragement than the previous study) which saw similar positive outcomes. Currently, the U.S. military is sending these messages via electronic mail, and preliminary results also show a marked reduction in attempts among email recipients (Joiner, personal communication, May 3, 2018). These cases powerfully illustrate how even the smallest gestures to connect can generate profound therapeutic effects.

Active listening invites opportunity for a person at-risk to divulge how they are truly feeling within a safe setting of trust. Such conversation can allow a person to reflect on why they might want to die, but also to see their own strengths and why living would be the better alternative to dying. This encouragement of autonomy is often the next step towards recovery.

This opportunity for the person at risk to tell their story serves more than just a release and relief. Yes, importantly, it lets the individual vent how they have been feeling and serves as a cathartic release. But it also provides an opportunity to recount, self-consciously or not, elements of their life (what we may call protective factors) which they and the helper may identify as reasons to live. It is a back-and-forth where the helper and suicidal person can discover, together, those all-important reasons to live and for that person to be “safe for now”.

Attitudes Toward Suicide

So, what is holding us back? Why are we so often not able to intervene with people in suicidal crisis or even prevent people from going down that road? A significant barrier to suicide prevention is perpetuated by us directly: stigma (International Association for Suicide Prevention & World Health Organization, 2013).

There are widespread beliefs that someone at risk and their desire to die cannot be stopped, that it is inevitable. Or some feel that they have no business interfering in the choices that people make, including the decision to die. Or, most disturbing of all, some may just not care whether someone chooses to die by their own hand. I think that these feelings and beliefs are more often than not the result of stigma.

The casual conversation will not ever effectively help someone at risk if the helper does not truly believe that the person-at-risk can even be helped. Our attitudes toward suicide and our personal feelings toward it are influenced by stigma. It can prevent our being of any help to someone on the verge of killing themselves. How can someone effectively help someone else at risk for suicide, if they have an inherent bias which may impede a successful intervention?

We, as would-be helpers, must be cognizant of our possible (probable?) “unhelpful” attitudes and biases at the outset. We must address the issue of suicide stigma and how it affects us from the “get-go”.

Exacerbating stigma is our societal value of independence; which stifles our help-seeking and our help-offering; we believe that personal matters should be self-managed. Interdependence, on the other hand, posits that we do not exist in isolation, relationships matter and it is together with other people that we grow, heal and strengthen.

Strengths Over Deficiencies

As mentioned above, most people who consider, attempt, or die by suicide do not actually want to die; they just want the pain of living to end. Given the option, they would choose life. However, when someone is considering suicide they no longer see any other option. Too often, these people suffer alone and die alone.

We must recognize that a suicidal person can be helped and can recover, even if their recovery is non-linear and fraught with setbacks and recurring attempts, as is frequently the case. We must make the effort to hear and help these individuals and try to work with them to emphasize the assets, not the deficits, in their lives.

We must also, clinicians and laypeople alike, encourage an individual's self-empowerment in this process. They should be directly invested in their own recovery, thus giving them the opportunity to evolve from passive to active participants in their own recovery process (Amering & Schmolke, 2009). To acknowledge that someone is not their disease or is not an individual reduced to the action of recurrent suicidality, is the aim.

An assets-based approach is designed to focus on the person's strengths. A therapist or a caring individual can work with the person at risk to incorporate them into a safety plan to offset adverse experiences and prevent outcomes like suicidal behaviour, while emphasizing their unique abilities during their recovery and healing processes (Xie, 2013). It promotes the protective factors in someone's life and champions resilience, strength, and hope.

Connections

Preventing suicide all comes down to working together. The person contemplating suicide and the person presenting a compassionate ear need to work together to avert a pointless death. The isolated suicidal individual needs to feel a strong connection to another human being. The rest of us must acknowledge our potential to help and reach out to them.

Once established, these connections have the potential to expand exponentially throughout society, in our physical lives, and in cyberspace. The conversation surrounding suicide proliferates, the fear and taboo associated with it dissipates, and the stigma slowly erodes.

We will come to realize, as individuals, as communities, as a society, that suicide is preventable and that we, each and every one of us, can make a difference.

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NATIONAL SUICIDE PREVENTION STRATEGIES: PROGRESS AND CHALLENGES AT GLOBAL LEVEL

Ella Arensman and Murad Khan

Suicide and non-fatal suicidal behavior (suicide attempts/self-harm) are major, global public health challenges, with an estimated annual number of 793,000 deaths by suicide worldwide and up to twenty times as many episodes of attempts and self-harm episodes (WHO, 2014). Currently, suicide is the second leading cause of death among young people aged 15-29 years at global level (WHO, 2018b). Although, overall, suicide rates in low- and middle-income countries (LMIC) are lower (11.2 per 100,000 population) than the rates in high income countries (HIC) (12.7 per 100,000 population), the majority of suicide deaths worldwide occur in LMICs (approximately 79%) (WHO, 2018b). However, there are ongoing challenges in relation to the accuracy of suicide figures obtained from many countries (WHO, 2018a).

Over the past decades, there has been a progressive development of prioritising suicide prevention at a global level, in particular by IASP, WHO and the UN, and by national governments. Global developments have accelerated over the past two decades, with major initiatives, such as the initiation of World Suicide Prevention Day (WSPD) on September 10th 2003, which has continued as an annual event that has contributed to increased awareness of suicide and suicide prevention across the globe. WPSD has been fundamental in stimulating the debate about a national suicide prevention strategy among government representatives and other stakeholders in suicide prevention in countries where suicide prevention activities and infrastructural support is limited, including Guyana, Namibia, and Afghanistan (Arensman, 2017).

Ten years after the introduction of WSPD, the WHO Global Mental Health Action Plan, 2013-2020, was a major step forward in prioritising the global agenda of suicide prevention (Saxena et al, 2013; WHO, 2013). This plan was adopted by Health Ministers in all 194 WHO member states to formally recognise the importance of mental health, which was a remarkable achievement. The action plan covers specified actions to improve mental health and to contribute to the attainment of a set of agreed global targets, in particular to aim for 1) a 20% increase in service coverage for severe mental disorders, and 2) a 10% reduction of the suicide rate in countries by 2020.

The subsequent publication of the WHO Report: *Preventing Suicide: A Global Imperative (WHO, 2014),* in 2014, was strategically a major and timely next step to increase the commitment of national governments and Health Ministers to reinforce action in relation to suicide prevention. This report provided guidance on developing a national suicide prevention strategy and information on the evidence base of specific interventions.

At the 29th IASP World Congress in Malaysia, the IASP Special Interest Group (SIG) was launched to support the development and implementation of national suicide prevention programmes at global level (Platt et al, 2019). This SIG aims to establish an active forum of international experts which will collaborate with relevant organizations, ministries and NGOs in the development of suicide prevention strategies in countries (especially LMICs) where, historically, there has been little or no suicide prevention activity. It is tasked with developing guidance for establishing, implementing and evaluating community-level suicide prevention activities in countries where a national strategy is not currently feasible. Since 2017, this SIG has organised many workshops and seminars facilitating professionals and volunteers working in suicide prevention to develop and implement national suicide prevention programmes. In addition, annually, both IASP and WHO underline the importance of national suicide prevention programmes on World Suicide Prevention Day.

The ongoing global priority of suicide prevention is highlighted by the UN's Sustainable Development Goals (SDGs) for 2030, which include a target of reducing by one third premature mortality from non-communicable diseases, with suicide mortality rate identified as an indicator for this target (Votruba & Thornicroft, 2015). SDG target 3.4 calls for a reduction in premature mortality from non-communicable diseases through prevention and treatment and promotion of mental health and wellbeing (WHO, 2015). The suicide rate is an indicator (3.4.2) within target 3.4. In this historic step, the UN acknowledged the societal impact of mental illness, and defined mental health as a priority for global development for the next 15 years (Votruba et al, 2016).

Currently, approximately 40 countries at all income levels have adopted a national suicide prevention strategy, with some countries already developing or implementing further revision(s) of their national strategy (WHO, 2018). However, among low- and middle-income countries only few have adopted a national suicide prevention strategy, even though 79% of suicides occur in these settings (WHO, 2018). The available national suicide prevention strategies vary in terms of outcome indicators as well as approaches to evaluation.

In conclusion, despite the progress in suicide prevention globally, we still face numerous challenges. The accuracy and reliability of suicide statistics is an ongoing issue of concern in a considerable number of countries. In addition, it would be important for a national suicide prevention programme to address real-time developments, such as emerging suicide contagion and clustering, emerging methods of suicide, and 'new' vulnerable and high-risk groups, such as responding to migrants and refugees, e.g. from Eastern Mediterranean countries, with increased risk of suicide and self-harm.

In terms of implementing national suicide prevention programmes and the sustainability of interventions, on-going challenges are insufficient resources, ineffective co-ordination, lack of enforcement of guidelines, limited access to surveillance data on suicide and attempted suicide or self-harm, and lack of independent and systematic evaluations.

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PREVENTING SUICIDE: A COMMUNITY ENGAGEMENT TOOLKIT

World Health Organization and Mental Health Commission of Canada

Introduction

Communities play a crucial role in suicide prevention. This toolkit follows on from the World Health Organization (WHO) report Preventing suicide: a global imperative (WHO, 2014) by providing practical steps for engaging communities in suicide prevention activities.

Community engagement is an active and participatory bottom-up process by which communities can influence and shape policy and services (McLeroy et al., 2003). Communities can accomplish this by initiating activities that are important and appropriate to their local context. However, although increasingly gaining recognition as innovative approaches to both public health and mental health, community engagement techniques often lack clear evidence and guidelines for their successful execution and design (Mendel et al., 2011). When implemented adequately, community engagement projects can be very effective in tackling mental health challenges in general and preventing suicide in particular. Such approaches are often relatively cost-effective and are therefore particularly appealing to low- and middle-income countries where stigma and taboo often limit access to quality care for suicidal behaviours.

When dealing with sensitive issues such as suicide prevention, it may be difficult to know where or how to initiate action. This toolkit therefore provides some practical suggestions that can be used by communities worldwide, regardless of the resources at their disposal or their current state of progress in suicide prevention efforts.

Understanding Suicide

Globally, over 800 000 people die of suicide every year and it is the second leading cause of death in 15-29-year-olds (WHO, 2014). However, since suicide is a sensitive issue, it is very likely that it is under-reported because of stigma, criminalization in some countries and weak surveillance systems.

Some 75% of all cases of suicide globally occur in low- and middle-income countries. In high-income countries, three times as many men die by suicide than women, but in low- and middle-income countries the male-to-female ratio is much lower at 1.5 men to each woman. Suicide rates are highest in persons aged 70 years or older for both men and women in almost all regions of the world. In some regions, suicide rates increase steadily with age, while in others there is a peak in suicide rates among young adults. In low- and middle-income countries, young adults and elderly women have much higher suicide rates than their counterparts in high-income countries, while middle-aged men in high-income countries have much higher suicide rates than those in low- and middle-income countries. Globally, suicides account for 50% of all violent deaths (i.e. from interpersonal violence, armed conflict and suicide) in men, and 71% of such deaths in women (WHO, 2014).

Social, psychological, cultural and other factors can interact to increase the risk of suicidal behaviour. Risk factors for suicide include, for instance, previous suicide attempt(s), mental health problems and disorders, problematic substance use, job loss or financial loss, trauma or abuse, and chronic pain or illness, including cancer, diabetes and HIV/AIDS. Unfortunately, suicide prevention is too often a low priority for governments and policy-makers.

Suicide prevention needs to be prioritized on the global public health and public policy agendas. Awareness of suicide as a public health issue needs to be raised through a multidimensional approach that takes account of the social, psychological and cultural impacts. It is important to understand the local context in each community in order to determine which groups may be most vulnerable to suicide. This allows community suicide prevention activities to be targeted at those who are most at risk of suicide (Wasserman, 2016).

Why It Is Important to Prevent Suicide

In 2013, the Mental Health Action Plan 2013-2020 was adopted by the World Health Assembly (WHO, 2013). This action plan outlines suicide prevention as a priority, with the global target of reducing the rate of suicide in countries by 10% by 2020. In the Sustainable Development Goals (SDGs) for 2030, suicide is a proposed indicator for health target 3.4 which is to reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.

Suicides are preventable. Comprehensive multisectoral strategies for the prevention of suicide are essential to achieving suicide reduction worldwide, and community-level approaches should be employed as part of an effective strategy. The prevention of suicide is not only important for individuals and families but also benefits the well-being of communities, the health-care system and society at large.

Preventing suicide can have a positive impact on communities by:

- promoting health and well-being of community members;
- empowering communities to identify and facilitate interventions;
- building capacity of local health-care providers and other gatekeepers.

Why Communities Play an Important Role in Preventing Suicide

Governments need to take a lead in suicide prevention in order to develop and implement comprehensive multisectoral national suicide prevention strategies. In some countries, multilevel community suicide prevention programmes are being implemented and it has been noted that synergistic effects can arise when different activities and measures are implemented simultaneously (Harris et al., 2016). However, variations in the suicide rates within countries (e.g. by geographical regions) suggest that top-down suicide prevention must go hand-in-hand with local bottom-up processes. Hence, communities play an essential role in suicide prevention when they provide bridges between community needs, national policies and evidence-based interventions that are adapted to local circumstances.

Suicide is shrouded in stigma, shame and misunderstanding. This means that people often do not or cannot seek adequate help. Prevention of suicide cannot be accomplished by one person, organization or institution alone; it requires support from the whole community. The community contribution is essential to any national suicide prevention strategy. Communities can reduce risk and reinforce protective factors by providing social support to vulnerable individuals, engaging in follow-up care, raising awareness, fighting stigma and supporting those bereaved by suicide. Community members can also raise the issue that registering cases of suicide and suicide attempts is important. In some cases, community members or representatives may take on the so-called "gatekeeper" role of identifying people at risk of suicidal behaviour or noting emerging suicide clusters. Perhaps most importantly, communities can help by giving people a sense of belonging. Social support within communities can help protect vulnerable persons from suicide by building social connectedness and improving skills for coping with difficulties. It is essential to understand that the community itself is best placed to identify local needs and priorities (Coppens et al., 2014; Kral et al., 2009).

A Toolkit for Community Engagement in Suicide Prevention

Community members and stakeholders wishing to engage in suicide prevention often have to identify priorities and strategies themselves. In some cases, they may find useful and sustained resources to support persons who attempted suicide, those bereaved by suicide, and those at risk or in crisis situations. Often, however, this is not the case and communities find themselves inadequately prepared for, or overwhelmed by, the task of establishing successful suicide prevention strategies. Stigma and taboo about suicide may present barriers to sustainable long-term suicide prevention.

Against this background, this toolkit aims to assist with identifying and implementing suicide prevention priorities and directing appropriate community activities towards the whole community, specific groups and/or individuals. The toolkit provides guidance for establishing supportive networks to assist communities in suicide prevention activities or in enhancing activities that may already be in place.

Overview of the community engagement process

The document is a guide for communities to engage in suicide prevention activities; it is not a model for comprehensive community suicide prevention that specifies the core components of a community model, nor is it a blueprint for nations to implement comprehensive community suicide prevention.

Anyone wishing to initiate an activity within their community should be able to use this toolkit. The targeted community could be defined by geography, or by social factors such as age, sex or vulnerability (e.g. indigenous groups, refugees, minorities, military, prisons, workplaces, LGBTI, socially deprived or isolated persons).

The toolkit provides step-by-step guidance according to the following key areas (Figure 1):

1. Initial preparation
2. Begin the conversation at the first meeting
3. Create a community action plan
4. Ongoing mobilization of the media
5. Monitor and evaluate the community action plan
6. Community feedback meeting.

Each section provides advice on how to move forward with community engagement and suggests tools that can be used to further the process of building a suicide prevention action plan that is relevant to the community. This toolkit is not exhaustive, and many other tools can be developed and used. Each community can adapt this material or design its own plan, tools and activities to ensure that these best fit the community and are acceptable and appropriate to the local context.

*This is just one chapter from this important toolkit. PLEASE see the full document for further information and guidance.

Preventing suicide: a community engagement toolkit. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.
https://www.who.int/publications-detail/suicide-prevention-toolkit-for-engaging-communities

WORLD OF THANKS

The theme for 2019—***Mental Health Promotion and Suicide Prevention—***is a message the World Federation for Mental Health believes is crucial to the future of our global mental health movement. The best way to create change is through concerted action and advocacy in each community of the world. Each of us has the power to change, the ability to help, and the dedication to see a different world for mental health care, treatment, and promotion. This year's material is made possible through the work and dedication of mental health supporters, advocates and leaders around the world.

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