

# World Suicide Prevention Day

● Suicide Prevention Across the Globe: Strengthening Protective Factors and Instilling Hope

September 10th, 2012 marks the 10th anniversary of the World Suicide Prevention Day: ten years of research, ten years of prevention, ten years of education and dissemination of information.

The efforts of this decade are founded on research evidence that we can prevent suicide. Indeed, the most important aim of this initiative, organized by the International Association for Suicide Prevention (IASP) in collaboration with the World Health Organisation (WHO), is raising awareness among the scientific community and the general population that suicide is preventable. Hence we must reduce the stigma and silence that still surrounds it.

The theme of World Suicide Prevention Day this year is ***“Suicide Prevention across the Globe: Strengthening Protective Factors and Instilling Hope”***.

Public health awareness and education campaigns have often focused on the role of risk factors in the development of suicidal behaviour. In order to increase effectiveness in preventing suicide we propose to direct our efforts not only towards reducing risk factors but also toward strengthening protective factors, with the aim of preventing vulnerability to suicide and strengthening people’s resilience.

## Suicide: Extent of the Problem and Patterns of Suicidal Behaviour

### *The Magnitude of the Problem*

Suicidal behaviour has become a major public health problem across the world. It is a complex phenomenon that usually occurs along a continuum, progressing from suicidal thoughts, to planning, to attempting suicide, and finally dying by suicide, which represents the final tragic outcome of a morbid process.

Data from the WHO indicate that approximately one million people worldwide die by suicide each year. This corresponds to one death by suicide every 40 seconds. The number of lives lost each year through suicide exceeds the number of deaths due to homicide and war combined.

Suicide attempts and suicidal ideation are far more common; for example, the number of suicide attempts may be up to 20 times the number of deaths by suicide. It is estimated that about 5% of persons attempt suicide at least once in their life and that the lifetime prevalence of suicidal ideation in the general population is between 10 and 14%. Suicide is one of the leading causes of death in the world and over the last years rates have increased by 60% in some countries.

Moreover, suicide statistics may not always be accurate. Many suicides are hidden among other causes of death, such as single car, single driver road traffic accidents, unwitnessed drownings and other undetermined deaths. In addition, suicide is estimated to be under-reported for multiple reasons including stigma, religious concerns and social attitudes. The psychological and social impact of suicide on the family and community is enormous. Furthermore, the economic costs associated with self-inflicted death or injuries are estimated to be in the billions of US dollars a year.

### *Age Differences*

Suicidal behaviour can occur at any age. The frequency of suicidal behaviour escalates steeply from childhood through middle to late adolescence and into adulthood. Suicide ranks as the second cause of death worldwide among 15-19 year olds, with at least 100,000 adolescents dying by suicide every year. Suicide rates are high among middle-aged and older adults and highest among those aged 75 and older. Elderly people are likely to have higher suicidal intent and use more lethal methods than younger people, and they are less likely to survive the physical consequences of an attempt.

### *Gender Differences*

On average, there are about three male suicides for every female suicide. This is more or less consistent across different age groups and in almost every country in the world. Conversely, rates of suicide attempts tend to be 2–3 times higher in women than in men, although the gender gap has narrowed in recent years. The disparity in suicide rates has been partly explained by the use of more lethal means and the experience of more aggression and higher intent to die, when suicidal, in men than women.

## *Country Differences*

Prevalence rates of attempted and completed suicide are significantly different across the world. However, due to the already cited limitations of data collection, these differences should be considered carefully. Documented rates are highest in Eastern European countries, such as Lithuania and the Russian Federation, and lowest in countries of Central and South America, such as Peru, Mexico, Brazil and Colombia. The United States, Western Europe and Asia fall in the middle range. Unfortunately, for many countries in Africa and some countries in South-East Asia suicide statistics are not yet available.

## *Who is at Risk of Suicide?*

**Suicide affects everyone,  
but some groups are at higher risk than others:**

### *People with a History of Suicide Attempts or Self Harm*

A history of previous suicide attempt(s) or self harm is the strongest predictor of future death by suicide, corresponding to a 30-40 times higher suicide rate than the general population. The first days and weeks following psychiatric hospitalization represent the most critical period of suicide risk for patients. This finding highlights the need to attend carefully to continuity of care for psychiatric patients.

### *People with a Psychiatric Disorder and/or Substance-related Disorder*

It has been documented that approximately half of the people who seriously consider taking their lives have been diagnosed with a mental disorder during their life, and that up to 90% of people who die by suicide have at least one psychiatric diagnosis. Among all diagnoses, depressive disorders are most commonly associated with suicidal behaviour, followed by substance-related disorders, schizophrenia and personality disorders. Alcohol and drug abuse and dependence have been identified as important risk factors for suicidal thoughts and behaviours. Current substance use, even in the absence of abuse or dependence, is a significant risk factor for unplanned suicide attempts among those with suicidal thoughts. Comorbidity, namely the presence of two or more psychiatric disorders or a psychiatric disorder and a substance use disorder, significantly increases the risk of suicide.

## *Those who Experience Stressful Life Events*

Stressful life events often act as precipitants of suicide attempts or suicide by those with a diminished capacity to cope with them. Impulsive attempts may follow stressful life events, including family and interpersonal conflicts, relationship breakdowns, other interpersonal difficulties, the presence of legal/disciplinary problems, and financial and job difficulties. Periods of economic crisis and unemployment are associated with greater social vulnerability and often an increase in deaths by suicide. Bereavement, consistently described as one of life's most stressful events, has been shown to elevate the risk of suicide and suicidal behaviour in vulnerable people, particularly if the death is by suicide. The risk of suicide is also greater among patients with severe physical illnesses, such as cancer or HIV infection - in fact, increased suicide risk has been found to be associated with a large number of medical conditions, ranging from asthma to traumatic brain injury. The experience of persistent stress also may explain the elevated risk of suicide in some occupations, such as physicians, military personnel and police officers, as well among people in prison. Moreover distal stressors, e.g. childhood trauma, have consistently been linked to an increased risk of suicidal behaviour in adult life.

## **Strengthening Protective Factors and Instilling Hope**

### *Protective Factors*

Despite the wide experience of the above-cited risk factors in populations, the fact that completed suicide is a relatively rare event indicates that there are a range of protective factors that act to mitigate the effects of exposure to risk factors. Among psychological factors, resilience (the ability to cope with adverse life events and adjust to them), a sense of personal self-worth and self-confidence, effective coping and problem-solving skills, and adaptive help-seeking behaviour are often considered to be protective against the development of suicidal behaviours.

Social and cultural factors such as religious and social integration, social connectedness and maintenance of good relationships with friends, colleagues and neighbours, access to support from relevant others and ready access to health care are associated with a reduced risk of suicide and reduced repetition of attempted suicide. In addition, a healthy lifestyle, with maintenance of good diet and sleep habits, regular physical activity, abstinence from smoking and illicit drug use, is also associated with a reduced risk of suicidal behaviour.

## *Suicide Prevention is Possible*

**S**uicide is a multi-determined phenomenon that occurs against a background of complex interacting biological, social, psychological and environmental risk and protective factors. Despite the complexity of this phenomenon, suicide can be prevented.

**P**rimarily prevention of suicide requires broad modifications of social, economic and biological conditions to prevent members of a population from becoming suicidal. Primary prevention involves population-based interventions, rather than focusing on the individual at risk. Primary preventive interventions include restricting access to lethal methods, promoting physical health and positive mental health, promoting a responsible representation of suicide in social and other media, seeking to reduce stigmatization of mental illness and suicide and encouraging help-seeking behaviour through public awareness and education campaigns.

**S**econdary prevention is aimed at minimising suicide risk in high-risk populations. In this sense, early identification of suicidal individuals, accurate diagnosis and effective treatment of mental health problems, especially mood disorders and substance-related disorders, are crucial. More than half of the patients who die by suicide have seen their primary care physician within the month before their death. Therefore, improving primary care physicians' recognition of psychiatric symptoms and disorders, suicide risk evaluation, treatment interventions and referral skills are key components of suicide prevention. Similarly, providing educational programs for "gatekeepers" (people who regularly come into contact with individuals or families in distress, such as clergy, first responders, pharmacists, teachers and police) can improve recognition of the risk of suicide and self-harm and facilitate referral of vulnerable people to appropriate assessment and treatment facilities.

**F**inally, tertiary prevention is aimed at preventing relapses of suicidal behaviour after a suicide attempt. This also involves the critical work of postvention -- the care, support and treatment of those impacted by suicide.

## *Priorities for Suicide Prevention and a Focus on Protective Factors:*

- We need to continue to research suicide and non-fatal suicidal behaviour, addressing both risk and protective factors
- We need to develop and implement awareness campaigns, with the aim of increasing awareness of suicidal behaviours in the community, incorporating evidence on both risk and protective factors.
- We need to target our efforts not only to reduce risk factors but also to strengthen protective factor, especially in childhood and adolescence.
- We need to train health care professionals to better understand evidence-based risk and protective factors associated with suicidal behaviour.
- We need to combine primary, secondary and tertiary prevention.
- We need to increase use of and adherence to treatments shown to be effective in treating diverse conditions; and to prioritise research into effectiveness of treatments aimed at reducing self-harm and suicide risk.
- We need to increase the availability of mental health resources and to reduce barriers to accessing care.
- We need to disseminate research evidence about suicide prevention to policy makers at international, national and local levels.
- We need to reduce stigma and promote mental health literacy among the general population and health care professionals.
- We need to reach people who don't seek help, and hence don't receive treatment when they are in need of it.
- We need to ensure sustained funding for suicide research and prevention.
- We need to influence governments to develop suicide prevention strategies for all countries and to support the implementation of those strategies that have been demonstrated to save lives.

**September 10, 2012 - World Suicide Prevention Day**  
[www.iasp.info/wspd](http://www.iasp.info/wspd)

**World Suicide Prevention Day Suggested Activities**  
[www.iasp.info/wspd/pdf/2012\\_wspd\\_suggested\\_activities.pdf](http://www.iasp.info/wspd/pdf/2012_wspd_suggested_activities.pdf)

**Official World Suicide Prevention Day 2012 Facebook Event Page** - [www.facebook.com/events/219365821453424/](http://www.facebook.com/events/219365821453424/)

**Light a Candle Near a Window at 8 PM** - [www.iasp.info/wspd/light\\_a\\_candle\\_on\\_wspd\\_at\\_8PM.php](http://www.iasp.info/wspd/light_a_candle_on_wspd_at_8PM.php)

**World Suicide Prevention Day Toolkit** - [www.iasp.info/wspd/pdf/2012\\_wspd\\_toolkit.pdf](http://www.iasp.info/wspd/pdf/2012_wspd_toolkit.pdf)