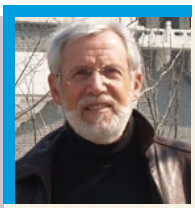
newsbulletin

International Association for Suicide Prevention

OCTOBER/NOVEMBER 2010



FROM THE PRESIDENT

One of the requirements that attends being president of an international organization, such as IASP, is that I am mandated to attend conferences either co-sponsored or officially administered by IASP; this, of course, is not quite the same for the everyday Suicidologist who has freedom of choice of where and when to travel. In this case, the loss of this freedom is both a blessing and a joy. Rome in September for ESSSB13 and Brisbane in November for IASP's 4th Asia-Pacific Regional Conference (and yet ahead, Beijing in September, 2012) – it's a tough life!

Memories of Rome: Sophia Loren, Vittorio DeSica, Marcello Mastroianni, *La Dolce Vita, Spartacus, Roman Holiday* (ah, Audrey Hepburn)… Oops, please forgive my tangent.

Terrific hospitality – thank you Marco; fabulous pasta, great opportunities to network and more informally spend time with colleagues and friends (these are not mutually exclusive); as well, good science. It is rewarding for me, at my advanced age, to still be able to come away from a Suicidology conference convinced that I have much yet to learn and a great deal still to understand. My notes from Rome reflect knowledge gained, as well as musings and challenges.

Here is a sampling:

- A reminder to factor in cultural considerations in cross-applications of international research.
- A reinforced awareness that we still know far too little about preventing suicide among those who have co-occurring substance abuse.
- A question: Do we understand well enough why the (diagnosis-based) medical model seems to apply in the Western world but may not be the model of choice in developing countries?
- Another question: Have we yet developed any viable prevention models that apply to impulsive-aggressive suicides?
- Any yet another: Why do we not focus more on developing interventions with the significant proportion of depressed patients who do not adhere to treatment protocols and recommendations?
- Musing: Will we ever have samples of sufficient size and studies of significant duration to use completed suicides (versus repeat attempts) as the end-point measure of an intervention's success or lack thereof?
- Pie in the sky musing: Will we be able to muster evidence that national suicide prevention strategies, when implemented, actually are effective, i.e. in proximately causing reduced rates of suicide?
- More specifically, with all the emphasis on public education initiatives in these strategies, how can we demonstrate that these approaches are effective and necessary components of a strategy?
- Challenge: If the great majority of adolescent suicide attempters did not reveal having had suicide ideation to anyone before the attempt (this is from David Shaffer's plenary), then why is asking about suicidal ideation the only question most every clinician will ask when doing a risk assessment?

So now we transition some 10,000 miles to Brisbane. Co-chairs Diego De Leo and Michael Dudley, and members of their organizing committee, have put together what promises to be a thought-provoking and exciting program with a number of scheduled presentations of both regional and international focus. Interestingly (to me, at the least), they also have scheduled a debate on one of the questions I brought back from Rome, noted above: Is widespread public awareness and understanding of suicide indispensable to any effective program of suicide prevention? We should have more of these debatable issues at IASP conferences, no?

In the meantime, we continue to receive reports of the success of this year's World Suicide Prevention Day activities across the globe – check out IASP's website for the latest update. We immediately need to begin planning for yet more energy and events to be organized for 2012's WSPD. Stay tuned.

Since returning from Rome, one item of concern to Suicidologists across the globe has come to my attention and is prominently in my agenda for follow-up over the next few weeks. This pertains to a proposed and recommended restructuring of the code structure used for external causes of injury in ICD-11. The proposal is to move the coding for Intent (e.g. suicide, homicide, unintentional…) from its current leading order position to that following after the coding for Mechanism (e.g. drowning) and Object (e.g. in bathtub). It is unclear at this date whether there has been much involvement of the Suicidology community in framing or commenting on this proposal, but many of our colleagues have communicated to me that , by moving the positional coding of Intent from where it now resides to last position, there is the very real danger that this would result in a significant reduction in the number of deaths classified as suicide, simply because coders don't code all the items in the chain of codes – the further down that chain, the less likely it will get coded. This could have significant implications for our field and those impacted by it. If ever we see a reduction in the number of documented cases of suicide, I would hope it is because of our prevention programs and interventions, not because of a failure in their being coded as suicides. I hope to be able to tell you more about this in the near future.

Lanny Berman, Ph.D., ABPP

REPORT FROM A NATIONAL REPRESENTATIVE

COUNTRY REPORT FROM GHANA

Charity S. Akotia

Ghana, one of the low and middle income countries, is in the Western part of Africa. It is bordered on the East by Togo, on the West by Cote D'Ivoire, on the North by Burkina Faso and on the South by the Gulf of Guinea. It has a population estimate of about 22 million, with 51% being female and 49% male. Life expectancy at birth is 56 years (males: 55.04 years; females: 56.99 years). With regard to religion, Ghana has about 69% Christian, 15.6% Muslim, 8.5% Traditionalists and 6.9% others. The labour force in Ghana is predominantly agricultural. On economic indicators, Ghana has a per capita income of US $450. Although there are some private health care facilities, most health care is provided by the government. In 2005, Ghana spent 6.2% of GDP on health care, or $30 per capita.

Although there are no national statistics on the rate of suicide in Ghana, media reports, personal communications and daily encounters at the hospitals indicate an increase in suicidal behavior. However, suicide is a taboo and hardly talked about. Various reasons account for this including cultural and religious factors. Generally, the Ghanaian culture and the religion of the people proscribe suicide. Anyone who therefore engages in suicidal act is frowned upon and stigmatized by society. Suicide also carries legal sanctions in Ghana and to date, many Ghanaians hold the view that a suicide should remain criminalized in the country. Researchers from Norway, Ghana and Uganda are currently conducting a research project: "Suicidal behavior in a cultural context". One of the components of this project is to address attitudes towards suicide and suicide prevention in the three countries.

On April 13th, 2010 some of the researchers (Charity S. Akotia and Joseph Osafo from Ghana and Heidi Hjelmeland and Birthe Loa Knizek from Norway) organized a dissemination workshop for the psychology students of the University of Ghana where some of the results from this study were presented.

About 90 students participated in the workshop. Papers on attitudes towards suicide among students and emergency room nurses, which were generally negative, were presented at the workshop. There were group discussions on, for example, the role of religion in suicide prevention in Ghana. Generally, participants gave very positive evaluations of the workshop and were eager to spread what they had learned to others. It is believed that this workshop will help reduce the stigma and myths associated with suicide among university students in Ghana. We believe that this will facilitate efforts towards the initiation of suicide prevention programs in Ghana.

Dr. Charity S. Akotia is a Senior Lecturer and IASP National Representative for Ghana. She is with the Department of Psychology, University of Ghana. E-mail: sakotia@libr.ug.edu.gh

REPORT FROM A NATIONAL REPRESENTATIVE

SUICIDE PREVENTION IN IRELAND


Geoff Day

Reach Out is the 10 year national strategy for action on suicide prevention in the Republic of Ireland. Agreed by government in 2005, the strategy builds on an earlier report in 1998 which reflected the rapid increase in suicides in Ireland in the 1990s. Suicide was only decriminalised in Ireland in 1993.

Ireland's rate of suicide peaked at 13.9 per 100,000 in 1998 and since then has gradually reduced to a rate of 10.6 in 2007. However provisional rates for 2008 and 2009 indicate that the rate will rise again almost certainly due to the impact of the economic downturn. Youth suicide (15 to 24 years) is the 4th highest in the EU at 14.4 per 100,000.

The National Office for Suicide Prevention (NOSP) was established in 2005 as part of the Population Health Directorate of the Health Service Executive (HSE), to ensure implementation of the 96 actions in *Reach Out*. The HSE has a statutory obligation to report every year to the Houses of the Oireachtas (Irish parliament) on suicide prevention activities. This report is available on www.nosp.ie

Projects to meet many of the actions in *Reach Out*. have been established and funded through the NOSP. These range from pilot projects in early intervention through primary care, mental health awareness programmes, support in emergency departments for those who have self harmed, postvention, support/counselling and research. Some examples of recent activities include:

- The office has used web based initiatives to reach young people including its own www.yourmentalhealth.ie and www.letsomeoneknow.ie as well as supporting other NGO web based initiatives.
- The office funds the National Registry of Deliberate Self Harm operated by the National Suicide Research Foundation (NSRF) and that organisation has also been funded to undertake a pilot project with Coroners to look at ways of improving recording of suicides and supporting people bereaved through suicide.
- *Reach Out* recommends a targeted approach and the office has funded research into suicidal behaviour in the LGBT community. Supporting LGBT lives is the first comprehensive research in this area in Ireland and is available on www.glen.ie. Actions arising from this research will further support the LGBT community.
- A cross border suicide prevention action plan with Northern Ireland has been agreed. This plan sets out actions which are common to both jurisdictions. Partnerships between the statutory and non statutory sectors are critical in continuing to implement the actions in *Reach Out*.

Geoff Day is Director of the HSE National Office for Suicide Prevention and IASP National Representative for Ireland. E-mail: geoff.day1@hse.ie

REPORT FROM AN ORGANIZATIONAL REPRESENTATIVE

SAMARITANS USA - *WORKING TOGETHER*


Alan Ross

Samaritans USA *(SAMS USA)* is the coalition of the nine community-based Samaritans suicide prevention centers in the United States whose mission is:

1) to provide immediate and ongoing emotional support to those who are depressed, in crisis or suicidal;
2) to educate lay and professional care-givers and service providers, academics, those in government, industry and the general public about the keys to effective suicide prevention;
3) to provide support to those who have lost a loved one to suicide.

As with the majority of the hundreds of Samaritans centers throughout the world, the primary means of implementing our mission is through Samaritans volunteer-staffed suicide prevention hotlines which practice a non-judgmental, active listening approach in providing support we call "befriending" which seeks to alleviate a person's despair, isolation and suicidal feelings.

SAMS USA is a collective association that for 25 years has allowed the various branches to share information and materials, program and staff development, advertising and marketing techniques, hotline policies and procedures, etc. The *SAMS USA* Centers' hotline volunteers will respond to approximately 250,000 calls this year from those in crisis; our paid and volunteer staff will train thousands of caregivers in our communities' school systems, social service agencies and government departments; and our Safe Place survivor support programs will provide solace to hundreds of people who have lost a loved one to suicide.

In addition to our core programs, Samaritans centers provide services that are adapted to the needs of our respective communities. Examples include projects in Samaritans Fall River and Cape Cod, Massachusetts branches that focus on outreach to senior citizens living alone who receive weekly calls from Samaritans volunteers and on elder suicide prevention. The Keene, New Hampshire branch's work with veterans groups as well as ensuring hotline volunteers learn how depression and suicide impact veterans and their families. Providence Rhode Island's key role in their community health network is enhancing access through the internet to community resources and referral information. Samaritans in Boston, Massachusetts operates a Samariteens hotline for adolescents, hosts major awareness events for businesses and corporations, is a founding member of the Massachusetts Coalition for Suicide Prevention and works nationally and internationally to prevent railway suicides.

In New York City, Samaritans is the key provider of suicide prevention education for the entire 1,200 site public school system, coordinates the citywide suicide prevention coalition and provides technical support to hundreds of community and government agencies.

Samaritans USA is a member of the National Council for Suicide Prevention (NCSP), which was intrinsic in the development of the US National Strategy for SuicidePrevention, and the IASP.

Alan Ross, SAMS USA Representative, National Council for Suicide Prevention,
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SAMARITANS

TASK FORCE ARTICLE: IASP TASK FORCE ON SUICIDE AND THE WORKPLACE

Dear IASP Members,

Most people who die by suicide around the globe are of working age, but very few suicide prevention programs target the workplace as a venue for suicide prevention. The workplace provides opportunities for suicide prevention that have not been realized. For instance, workplaces offer people in potential distress social connection and a purpose that may help sustain them during difficult times. In many instances workplaces are also already situated to disseminate public health messages, and in some cases even refer people to mental health services such as Employee Assistance Services. Depending on the number of hours worked, co-workers often spend more time with the person involved and may be able to recognize changes in mood and behavior because of this contact.

Finally, suicide affects the social and financial functioning of the workplace. Whether it is ideation, attempts or completion, morale and productivity are impacted significantly. Thus, while often challenging to engage, the workplace offers a unique contribution to a public health approach to suicide, and increased efforts to develop policy, protocols, and programs for this critical sector of society are needed. For these reasons, IASP has recently developed a Workplace Task Force with the following goals:


Sally Spencer-Thomas

Objective #1: Expand the study of suicide and workplace issues.

Objective #2: Develop model policies and protocols for workplaces to adapt.

Objective #3: To share promising suicide prevention programs and training for the workplace.

If you would like to be a part of this Task Force, please contact Sally Spencer-Thomas for more information, e-mail: Sally@CarsonJSpencer.org

Thank you,
Sally Spencer-Thomas, Executive Director, Carson J Spencer Foundation USA
www.WorkingMinds.org

Andrej Marusic Awards 2010

At the 13th European Symposium on Suicide and Suicidal Behaviour in Rome, 1st–4th September 2010, the International Association for Suicide Prevention, the International Academy for Suicide Research and the ESSSB13 organising committee assigned the Andrej Marusic Award to three young researchers in the field of suicidology: Dr Carmel McAuliffe, Dr Marcus Sokolowski, and Dr Holly Wilcox. Family members of Andrej Marusic were present at the award ceremony, which was co-chaired by Professor Marco Sarchiapone (ESSSB13) and Dr Tony Davis (IASP).

Summaries of the research proposals of the successful candidates:

Dr Carmel McAuliffe, National Suicide Research Foundation, Cork, Ireland, e-mail: carmel.nsrf@iol.ie

Identification of suicide risk profiles and emerging suicide clusters: A psychological autopsy study

The classification of suicides, based on demographic and/or clinical characteristics facilitates the identification of individuals at elevated risk of self-harm or suicide (Ovenstone & Kreitman, 1974; Chen et al, 2007). Most classification studies concentrate on non-fatal self harm. The robustness of subgroups derived from classification studies may be compromised by reliance on a single data source (O' Connor et al, 1999). A key outcome of classification studies is the development of suicide risk profiles but these are subject to geographical effects and may also change (WHO, 2000). A related problem is that of suicide clusters (Gould, 1989; 1990).

The aim of the proposed study is to optimise the early identification of individuals at risk of suicide and the development of emerging suicide clusters, using multiple data sources. The proposed study will have a link with a Suicide Support and Information System (SSIS), a psychological autopsy study already piloted in a defined catchment area in Ireland. Over an 18-month period the estimated number of suicide cases for inclusion in the proposed study is 120. Data will be collected after conclusion of the coroners' inquest from multiple sources including coroners' records, police records, interviews with bereaved next-of-kin, and questionnaires completed by healthcare professionals. Cluster analysis (complete and average linkage) will be used to identify the optimal number of subgroups, and to verify homogeneity. Complete linkage will be applied to data followed by average linkage to ascertain whether the clusters remain stable across different algorithms. Stability will be measured in terms of transfer of cluster membership. To identify the quality of the group separation and variables that best describe group membership, discriminant function analysis will be performed. The Knox test will be used to assess the extent of time space clustering.

Carmel McAuliffe and Mrs Marusic

Dr Marcus Sokolowski,
The National Prevention of Suicide and Mental Ill-Health (NASP), Karolinska Institute, S-171 77, Stockholm, Sweden,
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Co-authors: Yair Ben-Efraim, Danuta Wasserman, Jerzy Wasserman

Marcus Sokolowski

Genetic studies of the corticotropin-releasing hormone receptor 1 (crhr1) in suicide attempts

According to the stress diathesis model, genes and environment, as well as possible interactions in-between (GxE), may result in vulnerability towards suicidal behaviors. We wished to investigate this hypothesis for a key regulator of the stress-responsive hypothalamic-pituitary-adrenal (HPA) axis, the CRHR1 gene. Single nucleotide polymorphisms (SNPs), covering 80% of the common variation in CRHR1, were investigated in severe suicide attempters (SA) and their characteristics: method, medical damage, previous attempt, precautions, depression- and anger/aggression-scores. We first investigated main genetic effects, and SNP rs12936511 showed main genetic effect on depression intensity in males proximal to the SA in time. However, result with SNP rs4792887 only appeared in a strata of SA males exposed to low levels of lifetime stressful life events (SLEs), indicating that GxEs might be involved. Thus, we next formally re-tested all SNPs for GxEs involving exposures to rape and/or physical assault (below or over age of 18; U18 and O18) and a lifetime scale with a broad range of SLEs. The index SNP, rs4792887, showed antagonistic GxE with lifetime SLEs (but not rape or physical assault), among male SA with high depression intensity or high medical damage (but not with anger/aggression [AA]). Other AA/impulsive or high medical damage male SA showed synergistic GxE between the 3'-exonic SNP rs16940665 and physical abuse O18 (and not physical abuse U18). AA/impulsive SA further also showed synergistic GxE between another group of 5'-region SNPs (rs7209436 and a "TCA"-haplotype) and physical abuse U18. Among these haplotype-SNPs, particularly rs110402 showed GxE with physical abuse U18 in both male and females in SA with high precautions against discovery.

We conclude that inclusion of environment in analysis revealed novel genetic effects, and that the different combinations of CRHR1 SNPs, age/type of exposure(s) and depression or anger/aggression observed, may represent several possible patterns of SA-risk between individuals.

Dr Holly Wilcox, Department of Psychiatry & Behavioral Sciences, Johns Hopkins University School of Medicine, Johns Hopkins University, Baltimore, MD USA, Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD USA,
e-mail: hwilcox1@jhmi.edu
Co-authors: Janet Kuramoto, Bo Runeson

Holly Wilcox

Biological Parents' Suicidal Behaviors and Environmental Risk: A Population-based Adoption Study in Sweden

Adoption studies provide a method for studying environmental risk (conferred by adoptive, rearing parents) disentangled from genetic risk (conferred by biological parents not involved in rearing their children). The objective of this study was to 1) compare the risk of suicide attempt hospitalization among adoptees whose biological parents engaged in suicidal behavior (suicide or suicide attempt hospitalization) with adoptees whose biological parent had been psychiatrically hospitalized but did not engage in suicidal behavior; 2) examine if risk varied by having an adoptive parent psychiatrically hospitalized during adoptees childhood or adolescence (ages 0-18). This retrospective cohort study used Swedish registry data from 1973-2003 to identify 1,953 adoptees of biological parents with suicidal behaviors, and 5,892 adoptees with biological parents with psychiatric hospitalizations but not suicidal behaviors. Adopted offspring of biological parents with suicidal behaviors were not at increased risk of hospitalizations for suicide attempt, unipolar depression, drug, alcohol, personality disorders or violent criminal convictions, as compared to adopted offspring of biological parents with psychiatric hospitalizations but no suicidal behaviors. However, among adoptees whose adoptive parent was psychiatrically hospitalized during adoptees ages 0-18 years, adoptees whose biological parent had suicidal behavior had increased risk for suicide attempt hospitalization (HR = 6.6, 95% CI 1.9-22.4) and drug use disorders (HR = 3.7, 95% CI 1.2-11.5), as compared to adoptees of a biological parent without suicidal behavior but with a history of psychiatric hospitalization (interaction $p<0.001$ and $p=0.05$, respectively). The relationship between having a biological parent with suicidal behavior on adoptees hospitalization risk for unipolar depression, alcohol use disorders, personality disorder and violent criminal convictions did not vary by adoptive parent's psychiatric hospitalizations. Results suggest that aspects of the child rearing environment increase risk for hospitalizations for suicide attempt and drug dependence over and above genetic vulnerability for suicidal behaviors.

This study was funded by the American Foundation for Suicide Prevention (AFSP).

WORLD SUICIDE PREVENTION DAY 2010

In connection with World Suicide Prevention Day (WSPD) on September 10th this year, 42 countries submitted and carried out a wide range of WSPD activities, such as conferences, general public awareness campaigns, candlelight vigils and theatre plays.

Maurizio Pompili gives a summary of the WSPD activities in Italy:

This year World Suicide Prevention Day was particularly alive in Italy. It started with the historical meeting between me and Pope Benedict XVI. During those moments, I just told him that I was involved in suicide prevention, that I was supporting IASP, WSPD and I asked him to help us. The Pope very charmingly held tightly both my hands for a few seconds, listened to a few words and then blessed the prevention of suicide. I saw this meeting as a symbolic event that put in the Pope's hands the prevention of suicide after so many centuries of stigmatization towards this phenomenon.

Maurizio Pompili meets Pope Benedict XVI

The days preceding WSPD were characterized by huge media coverage with live coverage by main television networks and the most popular newspapers.

Then was the time of our two day-conference. Based at Sant' Andrea Hospital, this event presented the breadth and depth of the state of the art in suicide prevention. Highlights included Prof. Diego De Leo's great presentation entitled "Many faces, many places: suicide prevention across the world" and Prof. Zoltan Rihmer's presentation entitled "Suicide prevention across Europe: pitfalls and future perspectives".

This year also marked the first edition of the Race for Life, a sport event that took place in the magnificent surroundings of the Terme di Caracalla in Rome. For the first time suicide prevention was illuminated by a lovely sunny day, cheerful atmosphere and many people from the community running for our cause (I also ran both the three and six kilometer races). WSPD was also popular in Rome's underground and buses. ATAC, that runs the entire transportation in Rome, allowed us to have ads, and radio and television messages (in the circuit of transports) related to WSPD and our suicide prevention activities. A new cartoon was also developed which depicted a crisis situation that could be solved by asking for help. WSPD was also a success in Genoa where Prof. Maltsberger and Prof. Goldblatt provided insight into the psychodynamics of suicide. What's next? We have begun planning next year's activities.

Maurizio Pompili, M.D., Ph.D. - IASP National Representative for Italy, e-mail: maurizio.pompili@uniroma1.it

Obituary

Vladimir Fedorovich Voitsekh, 1941– 2010

Professor Vladimir Fedorovich Voitsekh was born in 1941. At the age of 32 he completed his Doctor of Philosophy, and in 1990 he successfully obtained a Doctor of Science, based on the subject "Forecast during Depressions". Since 1995 Mr. V.F. Voitsekh was head of the Centre of Suicidology at the Scientific Research Institute of Psychiatry, Moscow, and in 2006 he received the title of Professor.

Vladimir Fedorovich was the author of 120 scientific works and a range of monographs. "Clinical Suicidology", one of his key works, has become one of the most important monographs in Russian suicidology. Vladimir Fedorovich was intensively involved in research: 5 Ph.D. theses were defended under his guidance. He continued the scientific and practical activities of the Suicidological Centre of Moscow Scientific and Research Institute of Psychiatry of the Russian Ministry of Public Health, and essentially strengthened its substantiation, expanded business contacts, and won the respect and favour of colleagues by his numerous works. Professor Voitsekh fearlessly overcame grave illness and continued his work. He was a man of his word and faithful to his friends. The Suicidological Service headed by Professor Vladimir Fedorovich Voitsekh has achieved significant success. "Suicide Prevention in the Army", providing key guidelines for military psychologists, was released in 2008. Vladimir Fedorovich fully devoted himself to work. He was gentle, thoughtful, principled man, who always adhered to principles. He was a reliable and loyal friend. Vladimir Fedorovich Voitsekh died on 2nd May 2010.

Ludmila Arkhangelskaya

44th American Association of Suicidology Annual Conference

Changing the Legacy of Suicide

April 13th - 16th, 2011

Hilton Portland & Executive Towers, Portland, OR, USA

For further information, see www.suicidology.org

American Association of Suicidology (AAS)

4th Asia Pacific Regional Conference of the International Association for Suicide Prevention

17th-20th November, 2010

The 4th Asia Pacific Regional Conference of the International Association for Suicide Prevention (IASP) is to be jointly hosted by Suicide Prevention Australia (SPA) and The Australian Institute for Suicide Research and Prevention (AISRAP).

For further information, see **www.suicideprevention2010brisbane.org**

The Aeschi Working Group

The therapeutic approach to the suicidal patient: New perspectives for health professionals

6th AESCHI CONFERENCE
20.–23. MARCH 2011

Patient-Oriented Concepts of Suicide: Trauma and Suicide

Hotel Aeschi Park, Aeschi, Switzerland

www.aeschiconference.unibe.ch

XXVI IASP World Congress

13-17 September 2011, Beijing, China