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PREVENTING SUICIDE

A RESOURCE FOR PRIMARY HEALTH CARE WORKERS

This document is one of a series of resources addressed to specific social and professional groups particularly relevant to the prevention of suicide.

It has been prepared as part of SUPRE, the WHO worldwide initiative for the prevention of suicide.

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FOREWORD

Suicide is a complex phenomenon that has attracted the attention of philosophers, theologians, physicians, sociologists and artists over the centuries; according to the French philosopher Albert Camus, in *The Myth of Sisyphus*, it is the only serious philosophical problem.

As a serious public health problem it demands our attention, but its prevention and control, unfortunately, are no easy task. State-of-the-art research indicates that the prevention of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and youth, through the effective treatment of mental disorders, to the environmental control of risk factors. Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention programmes.

In 1999 WHO launched SUPRE, its worldwide initiative for the prevention of suicide. This booklet is one of a series of resources prepared as part of SUPRE and addressed to specific social and professional groups that are particularly relevant to the prevention of suicide. It represents a link in a long and diversified chain involving a wide range of people and groups, including health professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families and communities.

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Dr Shutao Zhai, Nanjing Medical University Brain Hospital, Nanjing, China.

The resources are now being widely disseminated, in the hope that they will be translated and adapted to local conditions - a prerequisite for their effectiveness. Comments and requests for permission to translate and adapt them will be welcome.

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SUICIDE - THE SIZE OF THE PROBLEM

- One million people are likely to commit suicide in the year 2000, worldwide.
- Every 40 seconds a person commits suicide somewhere in the world.
- Every 3 seconds a person attempts to die.
- Suicide is among the top three causes of death among young people aged 15 – 35 years.
- Each suicide has a serious impact on at least six other people.
- The psychological, social and financial impact of suicide on the family and community is immeasurable.

Suicide is a complex problem for which there is no single cause, no single reason. It results from a complex interaction of biological, genetic, psychological, social, cultural and environmental factors.

It is difficult to explain why some people decide to commit suicide while others in a similar or even worse situation do not. However, most suicides can be prevented.

Suicide is now a major public health issue in all countries. Empowering primary health care staff to identify, assess, manage and refer the suicidal person in the community is an important step in suicide prevention.

WHY FOCUS ON PRIMARY HEALTH CARE STAFF?

- Primary health care staff have a long and close contact with the community and are well accepted by local people.
- They provide the vital link between the community and the health care system.
- In many developing countries where mental health services are not well developed, they are often the primary source of health care.
- Their knowledge of the community enables them to gather support from family, friends and organizations.
- They are in a position to offer continuity of care.
- They are often the entry point to health services for those in distress.

In short, they are available, accessible, knowledgeable, and committed to providing care.

SUICIDE AND MENTAL DISORDERS

Studies from both developing and developed countries reveal two factors. First, a majority of people who commit suicide have a diagnosable mental disorder. Secondly, suicide and suicidal behaviours are more frequent in psychiatric patients.

The various diagnostic groups, in decreasing order of risk of suicide, are:

- depression (all forms);
- personality disorder (antisocial and borderline personality with traits of impulsivity, aggression and frequent mood changes);

- alcoholism (and/or substance abuse in adolescents);
- schizophrenia;
- organic mental disorder;
- other mental disorders.

Though most of those who commit suicide have a mental disorder, a majority of them do not see a mental health professional, even in developed countries. Hence the role of primary health care staff becomes vital.

Depression

Depression is the most common diagnosis in completed suicide. Everyone feels depressed, sad, lonely and unstable from time to time, but usually those feelings pass. However, when the feelings are persistent and disrupt a person's usual normal life, they cease to be depressive feelings and the condition becomes a depressive illness.

Some of the common symptoms of depression are:

- feeling sad during most of the day, every day;
- losing interest in usual activities;
- losing weight (when not dieting) or gaining weight;
- sleeping too much or too little or waking too early;
- feeling tired and weak all the time;
- feeling worthless, guilty or hopeless;
- feeling irritable and restless all the time;
- having difficulty in concentrating, making decisions or remembering things;
- having repeated thoughts of death and suicide.

Why depression is missed

Although a wide variety of treatments are available for depression, there are several reasons why this illness is often not diagnosed:

- People are often embarrassed to admit that they are depressed, as they see the symptoms as a "sign of weakness".
- People are familiar with the feelings associated with depression and so are not able to recognize it as a disease.
- Depression is more difficult to diagnose when the person has another physical illness.
- Patients with depression may present with a wide variety of vague aches and pains.

Depression is treatable Suicide is preventable

Alcoholism

- About one-third of cases of suicide are found to have been dependent on alcohol;
- 5 – 10% of people who are dependent on alcohol end their life by suicide;
- At the time of the suicidal act many are found to have been under the influence of alcohol.

Characteristically, people with alcohol problems who commit suicide are likely:

- to have started drinking at a very young age;
- to have consumed alcohol over a long period;
- to drink heavily;
- to have poor physical health;
- to feel depressed;
- to have disturbed and chaotic personal lives;
- to have suffered a recent major interpersonal loss, such as separation from spouse and/or family, divorce or bereavement;
- to perform poorly at work.

Alcohol dependent people who commit suicide not only start drinking at an early age and are heavy drinkers, but may also come from alcoholic families.

Substance abuse has been increasingly found in adolescents who engage in suicidal behaviours.

The presence of both alcoholism and depression
in an individual enormously increases the risk of suicide

Schizophrenia

Approximately 10% of schizophrenics ultimately commit suicide. Schizophrenia is characterized by disturbances in speech, thought, hearing or seeing, personal hygiene and social behaviour; in short, by a drastic change in behaviour and/or feelings, or by strange ideas.

Schizophrenics have an increased risk of suicide if they are:

- young, single, unemployed males;
- in the early stage of illness;
- depressed;
- prone to frequent relapses;
- highly educated;
- paranoid (suspicious).

Schizophrenics are more likely to commit suicide at the following times :

- in the early stages of their illness, when they are confused and/or perplexed;
- early in their recovery, when outwardly their symptoms are better but internally they feel vulnerable;

- early in a relapse, when they feel they have overcome the problem, but the symptoms recur;
- soon after discharge from hospital.

PHYSICAL ILLNESS AND SUICIDE

Some types of physical illness are associated with an increased suicide rate.

Neurological disorders

Epilepsy

The increased impulsivity, aggression and chronic disability often seen in persons with epilepsy are the likely reasons for their increased suicidal behaviour. Alcohol and drug abuse contribute to it.

Spinal or head injuries and stroke

The more serious the injuries the greater the risk of suicide.

Cancer

There are indications that terminal illness (e.g. cancer) is associated with increased suicide rates. The risk of suicide is greater in:

- males;
- soon after diagnosis (within the first five years);
- when the patient is undergoing chemotherapy.

HIV / AIDS

The stigma, poor prognosis and nature of the illness increase the suicide risk of HIV-infected people. At the time of diagnosis, when the person has not had post-test counselling, the suicide risk is high.

Chronic conditions

The following chronic medical conditions have a possible association with increased suicide risk:

- diabetes;
- multiple sclerosis;
- chronic renal and liver and other gastrointestinal conditions;
- bone and joint disorders with chronic pain;
- cardiovascular and neurovascular diseases;
- sexual disorders.

Those who have difficulty in walking, seeing and hearing are also at risk.

The suicide risk increases
in painful and chronic conditions

SUICIDE - SOCIODEMOGRAPHIC AND ENVIRONMENTAL FACTORS

Sex

More males commit suicide than females but more females attempt suicide.

Age

The suicide rate has two peaks:

- the young (15 – 35 years);
- the elderly (over 75 years).

Marital status

Divorced, widowed and single people are at a higher risk than married people. Those who live alone or are separated are more vulnerable.

Occupation

Doctors, veterinarians, pharmacists, chemists and farmers have higher than average suicide rates.

Unemployment

Loss of a job, rather than the status of unemployed persons, has been found to be associated with suicide.

Migration

People who have moved from a rural to an urban area or to a different region or country are more vulnerable to suicidal behaviour.

Environmental factors

Life stressors

The majority of those who commit suicide have experienced a number of stressful life events in the three months prior to suicide, such as:

- Interpersonal problems - e.g. quarrels with spouses, family, friends, lovers;
- Rejection - e.g. separation from family and friends;
- Loss events - e.g. financial loss, bereavement;
- Work and financial problems - e.g. job loss, retirement, financial difficulties;
- Changes in society - e.g. rapid political and economic changes;
- Various other stressors such as shame and the threat of being found guilty.

Easy availability

The immediate availability of a method to commit suicide is an important factor in determining whether or not an individual will commit suicide. Reducing access to the means of committing suicide is an effective suicide prevention strategy.

Exposure to suicide

A small portion of suicides consists of vulnerable adolescents who are exposed to suicide in real life or through the media and may be influenced to engage in suicidal behaviour.

THE STATE OF MIND OF SUICIDAL PERSONS

Three features in particular are characteristic of the state of mind of suicidal patients:

1. **Ambivalence:** Most people have mixed feelings about committing suicide. The wish to live and the wish to die wage a see-saw battle in the suicidal individual. There is an urge to get away from the pain of living and an undercurrent of the desire to live. Many suicidal persons do not really want to die - it is just that they are unhappy with life. If support is given and the wish to live is increased, the suicidal risk is decreased.
2. **Impulsivity:** Suicide is also an impulsive act. Like any other impulse, the impulse to commit suicide is transient and lasts for a few minutes or hours. It is usually triggered by negative day-to-day events. By defusing such crises and by playing for time, the health worker can help to reduce the suicide wish.
3. **Rigidity:** When people are suicidal, their thinking, feelings and actions are constricted. They constantly think about suicide and are unable to perceive other ways out of the problem. They think drastically.

A majority of suicidal people communicate their suicidal thoughts and intentions. They often send out signals and make statements about "wanting to die", "feeling useless", and so on. All those pleas for help must not be ignored.

Whatever the problems, the feelings and thoughts of the suicidal person tend to be the same all round the world.

Feelings	Thoughts
Sad, depressed	"I wish I were dead"
Lonely	"I can't do anything"
Helpless	"I can't take it anymore"
Hopeless	"I am a loser and a burden"
Worthless	"Others will be happier without me"

HOW TO REACH OUT TO THE SUICIDAL PERSON

Very often when people say "I am tired of life" or "There is no point in living", they are brushed off, or are given examples of other persons who have been in worse difficulties. Neither of these responses helps the suicidal person.

The initial contact with the suicidal person is very important. Often the contact occurs in a busy clinic, home or public place where it may be difficult to have a private conversation.

1. The first step is to find a suitable place where a quiet conversation can be held in reasonable privacy.
2. The next step is to allocate the necessary time. Suicidal persons usually need more time to unburden themselves and one must be mentally prepared to give them time.
3. The most important task is then to listen to them effectively. "To reach out and listen is itself a major step in reducing the level of suicidal despair".

The aim is to bridge the gap created by mistrust, despair and loss of hope and give the person the hope that things could change for the better.

How to communicate

- Listen attentively, be calm.
- Understand the person's feelings (empathize).
- Give non-verbal messages of acceptance and respect.
- Express respect for the person's opinions and values.
- Talk honestly and genuinely.
- Show your concern, care and warmth.
- Focus on the person's feelings.

How not to communicate

- Interrupt too often.
- Become shocked or emotional.
- Convey that you are busy.
- Be patronizing.
- Make intrusive or unclear remarks.
- Ask loaded questions.

A calm, open, caring, accepting and non-judgemental approach is required to facilitate communication.

<p>Listen with warmth Treat with respect Empathize with emotions Care with confidence</p>

SUICIDE - FICTION AND FACT

Fiction

1. People who talk about suicide do not commit suicide.
2. Suicidal people are absolutely intent on dying.
3. Suicide happens without warning.
4. Improvement after a crisis means that the suicide risk is over.
5. Not all suicides can be prevented.
6. Once a person is suicidal he/she is always suicidal.

Fact

1. Most people who kill themselves have given definite warnings of their intentions.
2. A majority are ambivalent.
3. Suicidal people often give ample indication.
4. Many suicides occur in a period of improvement when the person has the energy and the will to turn despairing thoughts into destructive action.
5. True. But a majority are preventable.
6. Suicidal thoughts may return but they are not permanent and in some people they may never return.

HOW TO IDENTIFY A SUICIDAL PERSON

Signals to look for in the person's behaviour or past history:

1. Withdrawn behaviour, inability to relate to family and friends
2. Psychiatric illness
3. Alcoholism
4. Anxiety or panic
5. Change in personality, showing irritability, pessimism, depression or apathy
6. Change in eating or sleeping habits
7. Earlier suicide attempt
8. Self-hatred, feeling guilty, worthless or ashamed
9. A recent major loss - death, divorce, separation, etc.
10. Family history of suicide
11. Sudden desire to tidy up personal affairs, writing a will, etc.
12. Feeling of loneliness, helplessness, hopelessness
13. Suicide notes
14. Physical ill-health
15. Repeated mention of death or suicide.

HOW TO ASSESS THE RISK OF SUICIDE

When the primary health care staff suspect that suicidal behaviour is a possibility, the following factors need to be assessed:

- current mental state and thoughts about death and suicide;
- current suicide plan - how prepared the person is, and how soon the act is to be done;
- the person's support system (family, friends, etc.).

The best way to find out whether individuals have suicidal thoughts is to ask them. Contrary to popular belief, talking about suicide does not plant the idea in people's heads. In fact, they are very grateful and relieved to be able to talk openly about the issues and questions they are struggling with.

How to ask?

It is not easy to ask a person about his or her suicidal ideas. It is helpful to lead into the topic gradually. Some useful questions are:

- Do you feel sad?
- Do you feel that no one cares about you?
- Do you feel that life is not worth living?
- Do you feel like committing suicide?

When to ask?

- When the person has the feeling of being understood;
- When the person is comfortable talking about his or her feelings;
- When the person is talking about negative feelings of loneliness, helplessness, etc.

What to ask?

1. To find out whether the person has a definite plan to commit suicide:
 - Have you made any plans to end your life?
 - Do you have an idea of how you are going to do it?
2. To find out whether the person has the means (method):
 - Do you have pills, a gun, insecticide, or other means?
 - Is the means readily available to you?
3. To find out whether the person has fixed a time frame:
 - Have you decided when you plan to end your life?
 - When are you planning to do it?

All these questions must be asked with
care, concern and compassion

HOW TO MANAGE A SUICIDAL PERSON

Low risk

The person has had some suicidal thoughts, such as “I can’t go on”, “I wish I were dead”, but has not made any plans.

Action needed

- Offer emotional support.
- Work through the suicidal feelings. The more openly a person talks of loss, isolation and worthlessness, the less his or her emotional turmoil becomes. When the emotional turmoil subsides, the person is likely to be reflective. This process of reflection is crucial, as nobody except that individual can revoke the decision to die and make a decision to live.
- Focus on the person’s positive strengths by getting him or her to talk of how earlier problems have been resolved without resorting to suicide.
- Refer the person to a mental health professional or a doctor.
- Meet at regular intervals and maintain ongoing contact.

Medium risk

The person has suicidal thoughts and plans, but has no plans to commit suicide immediately.

Action needed

- Offer emotional support, work through the person's suicidal feelings and focus on positive strengths. In addition, continue with the steps below.
- Use the ambivalence. The health worker should focus on the ambivalence felt by the suicidal person so that gradually the wish to live is strengthened.
- Explore alternatives to suicide. The health worker should try to explore the various alternatives to suicide even though they may not be ideal solutions, in the hope that the person will consider at least one of them.
- Make a contract. Extract a promise from the suicidal person that he or she will not commit suicide
 - without contacting the health care staff;
 - for a specific period.
- Refer the person to a psychiatrist, counsellor or doctor, and make an appointment as soon as possible.
- Contact the family, friends and colleagues, and enlist their support.

High risk

The person has a definite plan, has the means to do it, and plans to do it immediately.

Action needed

- Stay with the person. Never leave the person alone.
- Gently talk to the person and remove the pills, knife, gun, insecticide, etc. (distance the means of suicide).
- Make a contract.
- Contact a mental health professional or doctor immediately and arrange for an ambulance and hospitalization.
- Inform the family and enlist its support.

REFERRING A SUICIDAL PERSON

When to refer

When the person has:

- psychiatric illness;
- a history of previous suicide attempt;
- a family history of suicide, alcoholism or mental illness;
- physical ill-health;
- no social support.

How to refer

- The primary health worker must take the time to explain to the person the reason for the referral.
- Arrange for the appointment.
- Convey to the person that referral does not mean that the health worker is washing his or her hands of the problem.
- See the person after the consultation.
- Maintain periodic contact.

RESOURCES

The usual sources of support available are:

- family
- friends
- colleagues
- clergy
- crisis centres
- health care professionals.

How to approach the resources?

- Try to get the permission of the suicidal person to enlist the support of the resources, and then contact them.
- Even if permission is not given, try to locate someone who would be particularly sympathetic to the suicidal person.
- Talk to the suicidal person beforehand and explain that it is sometimes easier to talk to a stranger than a loved one, so that he or she does not feel neglected or hurt.
- Talk to the resource people without accusing them or making them feel guilty.
- Enlist their support in the actions to be taken.
- Be aware of their needs also.

THINGS TO DO AND NOT TO DO

Things to do

- Listen, show empathy, and be calm;
- Be supportive and caring;
- Take the situation seriously and assess the degree of risk;
- Ask about previous attempts;
- Explore possibilities other than suicide;
- Ask about suicide plan;
- Buy time - make a contract;
- Identify other supports;

- Remove the means, if possible;
- Take action, tell others, get help;
- If the risk is high, stay with the person.

Things not to do

- Ignore the situation;
- Be shocked or embarrassed and panic;
- Say that everything will be all right;
- Challenge the person to go ahead;
- Make the problem appear trivial;
- Give false assurances;
- Swear to secrecy;
- Leave the person alone.

CONCLUSION

Commitment, sensitivity, knowledge and concern for another human being, a faith that life is worth nurturing - these are the main resources primary health care workers have; backed by that they can help to prevent suicide.