Chapter 1

The Importance of Suicide Awareness and Assessment

Why is it important to know about suicide?

Suicide is a significant public health problem worldwide. Suicide represents 1.4% of the Global Burden of Disease and accounts for nearly half of all violent deaths and almost one million fatalities globally each year. Although these numbers may seem alarming, it is widely believed that they are underestimates of the true global prevalence and global burden of suicide.

For every life lost to suicide there are many more left in the wake of the tragedy – parents, children, siblings, friends and communities.

> 'For every suicide death there are scores of family and friends whose lives are devastated emotionally, socially and economically . . . Suicide is a tragic global public health problem. Worldwide, more people die from suicide than from all homicides and wars combined. There is an urgent need for coordinated and intensified global action to prevent this needless toll.'
>
> Dr Catherine Le Galès-Camus, WHO Assistant-Director General, World Mental Health Day 2006

Suicide Risk Management: A Manual for Health Professionals, Second Edition.
Sonia Chehil and Stan Kutcher.

Challenges to understanding global suicide rates and suicide risk

Estimating suicide prevalence in different countries is problematic. Suicide rates range substantially between countries (WHO, 2009) and the variability of data collection and reporting makes national comparisons difficult if not impossible. Many countries lack a standard surveillance system that accurately captures suicide death. Where surveillance systems exist, data validity can be obscured by variability in the classification of suicide deaths, procedures for recording suicide deaths, procedures for completing death certificates, and the bodies responsible for determining the cause of unexpected death. The stigma associated with suicide is also a significant barrier to estimating true prevalence rates. In many cultures suicide is hidden by affected families to avoid shame, disgrace, ridicule or social exclusion. Worldwide, cultural, religious and social values and beliefs have significantly influenced what has been reported in official death records and are believed to continue to contribute to the misclassification of suicide deaths as accidental or due to unknown causes in many countries. Therefore, 'prevalence estimates' taken from country records globally likely underestimate actual suicide rates.

The pervasive stigma, shame and humiliation associated with a suicide death are perpetuated by legislation that continues to classify suicide as a criminal offence in many developing countries. Although such laws may now rarely, if ever, be enforced in most jurisdictions, in some, persons who survive a suicide attempt may be tried and convicted in court. So too might family members of a suicide victim be charged with stiff penalties or be subject to social humiliation. Not surprisingly, reported prevalence figures in countries where such laws are upheld are consistently reported to be extremely low. Nevertheless, based on available data, globally suicide is believed to account for an average of 10–15 deaths for every 100 000 persons each year, and for each completed suicide there are believed to be up to 20 failed suicide attempts.

Another compounding issue in understanding global and national suicide rates is the large jurisdictional variations in reported suicides even within countries where suicide data are relatively well collected. Suicide rates vary widely across different states in the USA and across provinces and territories in Canada, for example. Historically, suicide rates within jurisdictions, countries and regions have demonstrated

secular trends that are poorly understood. The complexity of factors outside the suicidal individual that may contribute to increased risk is substantial. The underpinnings of suicide are diverse and multifaceted, involving a unique fusion of biological, psychosocial, political, economic and cultural factors for each individual. The significance of each factor or combination of factors in any location at any one time is difficult to deconstruct. For example, in many developed countries, including Canada and the USA, historical prevalence data demonstrate that suicide in young adults and teens started increasing in the 1950s. In the last decade and a half this longstanding trend shifted, with youth suicide rates in many developed countries decreasing or reaching a plateau. This shift has not been strongly correlated with the presence or absence of national suicide prevention strategies and it is not clear what factors have been most important in changing this suicide trend in young people, although considerations have included the more effective identification and treatment of depression and control of lethal means. Nonetheless, in the USA and many other countries (particularly in wealthy or developed states), suicide continues to be one of the three leading causes of death in young people between the ages of 15 and 24.

The majority of studies on risk factors for suicide have been conducted in developed countries using the psychological autopsy methodology. Psychological autopsy studies in the West have consistently demonstrated strong associations between suicide and mental disorder, reporting that 90% of people who die by suicide have one or more diagnosable mental illness. The most common diagnoses found to be associated with suicide death include the affective (mood) disorders, anxiety disorders, substance abuse disorders, personality disorders and schizophrenia. These studies have identified the presence of an untreated mental disorder – particularly depression and substance abuse – as the greatest attributable risk factor for suicide.

Using the same type of psychological autopsy methodology, studies conducted in developing countries have not demonstrated as robust an association between suicide and mental disorder as purported in the West. Undoubtedly there are many factors that may explain this discrepancy. In developing countries, suicide may be less clearly correlated with mental disorder and may be more often influenced by cultural, religious, social, economic and political factors. The dearth

of mental health resources in most developing countries and the lack of accessible and available mental health services may lead to a systematic under-diagnosis of mental illnesses. Stigma, cultural understandings of mental health and mental disorder, and traditional methods for the care and treatment of the mentally ill may also contribute to this difference. Despite the apparent variability between studies conducted in different parts of the world, a strong and consistent association between suicide and mental disorders is undeniable. Thus, the scaling up of mental health services to improve early detection, intervention and management of mental illness – particularly in primary care, where most conditions first present – is recognized as the cornerstone of any suicide prevention strategy.

Not negating the significance of mental disorder to suicide risk, it is important to recognize that the vast majority of people with mental disorders will not die by suicide and that many people who die by suicide do not have a diagnosable mental disorder. Thus, having a mental disorder is neither necessary nor sufficient in itself to account for suicide deaths. Other identified significant risk factors include current or past suicide behaviour, availability of and access to lethal means, exposure to trauma or abuse, severe psychosocial stressors, interpersonal loss, family history of suicide and mental disorder, alcohol and drug misuse, lack of significant relationships and social isolation, chronic physical illness, disabling pain, lack of internal coping abilities, and lack of access to health and social services and supports. Thus, in addition to scaling up mental health services, suicide prevention activities must also address identified modifiable socio-cultural-political-environmental factors that influence suicide risk.

> Suicide prevention is not the purview of health alone. Suicide prevention is everyone's responsibility – individuals, families, community organizations and agencies including faith-based organizations, private business, and all levels of government – and requires a multi-sectoral response to achieve success.

Role of health professionals in suicide risk mgnt

Suicide risk assessment is a necessary core competency required by all health providers. Regardless of location or setting, health providers

are often the first point of contact for individuals and families who may be at risk for suicide. In North America, studies indicate that the majority (up to two-thirds) of those who die by suicide have had contact with a health care professional for various physical and emotional complaints in the month before their death. Unfortunately, many patients who are contemplating suicide do not spontaneously voice suicidal thoughts or plans to their health care provider, and the majority of those at risk are never asked about suicidality during general clinical assessments. Consequently, individuals at risk are often never identified and do not receive needed intervention and support. Failure to identify individuals at risk for suicide may stem from a lack of training in the identification of suicide risk factors, lack of comfort or confidence on the part of the health care professional in addressing suicide risk, time and resource constraints of busy clinical practices, or a combination of these and other factors. Working with patients at risk for suicide is difficult and anxiety-provoking for many health providers. Even among mental health professionals who work with recognized populations at risk for suicide, working with a suicidal patient is considered one of the most stressful and challenging components of their clinical practice. Nonetheless, all health providers must have the knowledge, skills and competencies necessary to identify, assess and manage suicide risk with confidence, care and respect. Once the health care provider has developed necessary suicide risk-assessment competencies she/he can apply them in any setting where individual evaluation occurs.

What are some of the barriers to detection and prevention of suicide?

Several factors can impede the detection and prevention of suicide:

- stigma
- failure to seek help
- lack of suicide knowledge and awareness among health professionals
- suicide is a rare event.

Stigma

Stigma refers to the shame, disgrace or reproach attached to something that is considered socially unacceptable. In many cultures

suicide is seen as shameful, sinful, weak, selfish or manipulative. These beliefs are held both by society as a whole and by those who are contemplating suicide. Stigma acts to reinforce both secrecy and silence and contributes to feelings of isolation, self-contempt and self-deprecation in individuals experiencing thoughts of suicide, and shame and guilt in those with loved ones who have committed suicide.

The social stigma of suicide is compounded by the link between mental disorder and suicide. People with mental disorders continue to be amongst the most marginalized in their society and experience greater misaddress of human rights than any other group of ill people, regardless of their religious affiliation, cultural identity or place of residence. In many parts of the world mental illness fails to be recognized as a legitimate health disorder and people with mental illness continue to be misunderstood as weak, lazy, attention seeking, crazy or stupid. Fear of being thought of or being labelled as mentally ill and fear of the ridicule, discrimination, social exclusion, loss of friends, loss of employment or loss of opportunity that may result likely contributes to the secrecy and silence that keeps people from reaching out and receiving help.

Sadly, the stigma associated with mental illness, as with suicide, is based on misinformation and misunderstanding.

Failure to seek help

As stated above, the stigma attached to suicide and the consequent fear of social sanctions, discrimination, loss of dignity and self-respect can prevent people from seeking help or disclosing suicidal thoughts and plans. For some, contemplating disclosure of suicidality may be associated with such intense feelings of personal shame, humiliation or embarrassment – as well as fear of judgment and ridicule by friends, family, community and health providers – that suffering in silence or ending their life may seem a more acceptable solution. Others may fear that disclosure will result in the forced interruption of a process to which they have committed. Some may fear loss of control over their situation or that disclosure will result in involuntary hospitalization. In jurisdictions in which suicide is considered a criminal offence, individuals may not disclose suicidal thoughts or plans for fear of

Common suicide myths that serve to support and sustain the social stigma of suicide

Myth	Reality
If someone talks about suicide they are unlikely to actually do anything to harm themselves	Many people who die by suicide have communicated their feelings, thoughts or plans before their death
Suicide is always an impulsive act	Many people who commit suicide have experienced suicidal thoughts and have contemplated taking their own life before the act
Suicide is an expected or natural response to stress	Suicide is an abnormal outcome of stress. Everybody experiences stress . . . not everybody attempts suicide
Suicide is caused by stress	Suicide attempts or acts of self-harm may sometimes occur following an acute stressor (such as the breakup of a relationship or following an intense argument) but the event is a **behavioural trigger, not a cause** of suicide
People who are **really** at risk for suicide are not ambivalent about completing the act	The intensity of suicidality waxes and wanes and many people who attempt or commit suicide struggle with their conviction to die
People who commit suicide are selfish and weak	Many people who commit suicide suffer from a mental disorder that may or may not have been recognized
Someone who is smart and successful would never commit suicide	Be careful . . . remember, suicidality is often kept secret. 'Suicide' has no cultural, ethnic, racial or socioeconomic boundaries

(*continued*)

Myth	Reality
Talking about suicide with a depressed person will probably cause them to commit suicide	Many depressed people who have suicidal thoughts or plans are relieved when someone knows about them and is able to help them. Discussing suicidality with a depressed person will not lead them to commit suicide
There is nothing that can be done for a person who is suicidal	Many individuals who attempt suicide may be suffering from a mental disorder that will respond to appropriate and effective treatment. Appropriate treatment of a mental disorder significantly reduces the risk of suicide. For example, suicidality associated with depression usually resolves with effective treatment of the depressive disorder
People who attempt suicide are just looking for attention	In some people a suicide attempt is an event that leads to a first contact with a helping professional. A desperate cry for help is not equivalent to wanting attention

being criminally charged and prosecuted. In cultures in which suicide is prohibited, people may fear facing public humiliation, or social and family sanction.

In some cultures self-inflicted death may be covertly sanctioned in specific sociocultural contexts, for example suicides committed in the name of family honour. In these circumstances, silence, shame and secrecy may be attributed to both the act itself and the circumstances preceding the act. In other situations, religious or secular authorities may overtly sanction suicide that is committed as an act of martyrdom. In these cases, public expression of self-inflicted death may be seen as a declaration of religious devotion, nationalism or political belief.

Regardless of the reasons, many of those who die by suicide do not seek help and do not inform others of their plans. Moreover, some who are contemplating suicide or who are committed to completing suicide may not reveal their thoughts or plans even when directly asked. Thus, asking about suicidal ideation or plan does not ensure that accurate or complete information will be received or that suicide will always be prevented. This, however, does not mean that health professionals should not conduct appropriate suicide assessments when known risk factors are present. Indeed, empathic questioning of high-risk individuals about suicidal thoughts, intents or plans from a knowledgeable and caring health professional will often be seen as an expression of support, interest and professional competency. Such questioning can often encourage the suicidal individual to seek help.

Lack of suicide knowledge and awareness among health professionals

Suicide assessment and intervention are often not components of health professional school training programmes, nor are they a component of most routine general health assessment and evaluation procedures and protocols. Consequently, many health providers do not have the opportunity to develop the skills necessary to feel competent to ask about suicidality or to manage suicidal patients. Further, health providers are not immune to the cultural idioms and stigma associated with suicide.

A common misconception among health professionals is that talking to patients about suicide will increase the likelihood of the patient engaging in suicidal behaviours or dying by suicide. This is not the case. Asking a patient about suicidal thoughts will not plant or nurture these thoughts in the patient's mind. Rather, patients with suicidal thoughts often feel relieved that they have been given 'permission' to talk about them. Many patients who have suicidal ideation feel burdened, ashamed and/or sinful for having such thoughts. Some are frightened by these thoughts. Some interpret these thoughts as reinforcements for their own perceived worthlessness. Opening a dialogue about suicidality in a nonjudgmental and respectful manner can provide the patient with the opportunity to

break their silence, discuss their circumstances, express their thoughts and feelings, and decompress their psychological and emotional pain. In fact, for those patients for whom suicide has become their 'only perceived option', disclosure may provide the opportunity to explore alternative choices that they have been unable to see.

Talking about suicide with a caring and nonjudgemental health provider can help a person choose life rather than choosing death.

Suicide is a rare event

Another issue that interferes with the prevention of completed suicide is the relative rarity of the event itself. As mentioned above, suicide attempts occur much more frequently than completed suicides (up to 20 times more frequently!) and suicidal ideation (having thoughts of wanting to die or of killing oneself) is more common still (up to 6 times more common than suicide attempts and up to 100 times more common than completed suicides!). Hence, most people who have suicidal thoughts and many of those who make a suicide attempt never die from suicide.

Because suicide is a rare event, it is not considered useful to screen entire populations for suicide thoughts or to routinely ask every single patient about suicidal ideas at every health professional contact. A number of risk factors, however, have been identified that can provide clinicians with a risk profile for suicide. Health professionals who are familiar with these risk factors can thereby identify potential 'at-risk' patients for assessment of suicide risk.

Can we always predict who will or who will not die by suicide?

Unfortunately, the answer is 'no'. What we can do is assess individual 'suicide risk' based on identified suicide risk and suicide protective factors that may help identify those who are more or less likely to attempt or complete suicide in the near future. The health professional approaches the issue of suicide in the clinical setting by estimating the burden of risk at a point in time. *How strong is the risk for suicide in the*

near future? This is determined by learning how to identify and weigh both risk and protective factors. A clinical decision is then formulated as to whether suicide risk is high, moderate or low.

Suicide risk evaluation is not an exact science. Each individual's composite 'risk' is estimated based on the presence, relevance and weighting of risk and protective factors for that individual, taking into consideration their psychosocial and cultural context and their life experience at the time of assessment. The relevance and weighting of risk and protective factors are not universal and certain risk factors when present simultaneously may increase risk exponentially in one context but not in another.

While it may be possible to be relatively certain in one's risk prediction for the near future, it is almost impossible to be certain in one's risk prediction outside a window of three to seven days, or thereabouts. That is why for individuals who demonstrate some degree of risk, evaluation of risk potential becomes an ongoing process. Changes in the psychosocial, occupational, health or mental health status of a person at low risk may move that individual into a higher-risk category.

While it is not possible to always predict who will or will not die by suicide, being aware of warning signs for suicide risk and being comfortable and competent in the application of an appropriate suicide risk assessment can assist the health provider in the early detection, assessment and management of patients at risk of suicide and the implementation of appropriate immediate, short-term and ongoing interventions that can assist an individual in choosing life rather than death.

Important definitions

Suicidality Any thoughts or actions associated with an implicit or explicit intent to die. This includes suicide ideation, suicide intent, suicide plans and suicide attempts.

Suicidal ideation Thoughts, images or fantasies of harming or killing oneself.

Suicide attempt A purposeful self-inflicted act that is nonfatal and is associated with implicit or explicit intent to die.

Completed suicide A purposeful self-inflicted act that is fatal and is associated with implicit or explicit intent to die

Self-harm (or self-injurious behaviour) Purposeful self-inflicted acts that are not associated with an implicit or explicit intent to die. The intent of self-harm is often to reduce distress and it is used as a coping strategy, albeit an unhealthy strategy, to manage distressing thoughts and feelings.

Suicide behaviours Any purposeful self-inflicted acts, including suicide attempts, self-harm and self-injury, that may lead to death, regardless of the intent of those behaviours and actions.