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WEEKLY EPIDEMIOLOGICAL REPORT

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Prevention of suicides - The challenge (Part II)

This is the last in a series of three articles on suicides. The first article described the epidemiology of suicides and subsequent two articles are focused on the prevention of suicides.

Role of the Health sector…

Presently there are no focused, specific, targeted programmes for suicide prevention in the region. While no single intervention can yield 100% results, integrated programmes are likely to yield moderate results. There has been progress in the last few decades in the global understanding of the causes of suicides. This understanding has to be utilized to develop prevention programmes in the region.

Suicide is not merely a social, cultural or religious phenomenon. In order to become an active partner in preventing suicides, the health sector needs to expand its role and responsibilities. The health sector should take the lead in promoting and undertaking multisectoral research to understand the problem, risk factors and methods that are effective in prevention of suicides.

In order to effectively address the situation, the health sector should, among other things:

- Start manpower development programmes in suicidology by equipping health functionaries with better knowledge, skills, techniques and strategies to deliver care.
- Improve emergency facilities and services for immediate care of attempted suicides, combined with referral and after-care services.
- Employ, promote and integrate mental health components into primary health care systems.
- Suicide prevention must focus on the four pillars of improving physical, social and mental health; early detection; appropriate management and specific rehabilitation.
- Provide guidance to local media personnel and other sectors to develop a realistic information dissemination policy to shape positive attitudes in the community.
- Develop an intersectoral, integrated, coordinated approach for a suicide prevention programme. Develop a poison centre which can give information and advice on management of poisoning
- Develop and implement pilot demonstration projects in all SEAR Member Countries. The lessons learnt from international or local experiences should be implemented with local culture-specific interventions.
- An act of suicide is often reported/witnessed by some near family member, neighbour, relative or friend. The immediate reaction is to call for medical help at the site or shift the patient to a nearby health centre. In many cities, a 24-hour hotline emergency telephone service is available. The immediate management depends on the age and gender, physiological status, method of suicide, type and amount of poisonous substance consumed or extent of burns or management of other methods of attempted suicide. What is essential is a prompt response.
- Hospitals should be equipped to handle suicides more effectively. Specifically, immediate acceptance of the patient and treatment should be the first duty of hospitals. A few hospitals in some countries do not accept patients with a history of attempted suicide. A non-accepting attitude of the hospital staff, considering suicide emergencies as increasing their workload, thinking that patients are just seeking attention, and medico-legal fears are some of the common reasons for refusing registration and admission. The unsympathetic attitude of some hospital staff might discourage people from seeking help.
- Wide publicity should be given about minimal and safe first-aid measures and emergency help centres, especially for handling poisoning and burn injuries. Many common household first-aid practices can, in fact, be dangerous. However, there should be no delay in taking the affected person to a hospital.
- The detoxification of domestic gas in some countries, such as Japan, Switzerland and the United Kingdom, resulted in a decrease in suicide rates as well as a reduction in the use of domestic gas to commit suicide. Health advocacy in these areas has shown an example of intersectoral approach.

Need for partnerships…

The health sector is a partner in socio-economic development and health promotion. For suicide prevention to be a reality, an intersectoral approach is

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the key. Sensitization of teachers, doctors, media personnel, lawyers and product manufacturers can be effectively undertaken by the health sector as it has access to first-hand information. Coordination between health and related sectors is an essential element for achieving success.

- Minimum facilities to handle emergencies must be available at the community level in each country. Considerable time is spent in transporting patients from rural to urban areas.
- Doctors and nurses should be provided with training in the management of patients who have attempted suicide, especially in rural areas, as transfer to urban hospitals can delay treatment. Apart from providing skills, facilities and resources for treatment, such medical centres should be strengthened by improving emergency care services.
- Along with immediate management, medical personnel should be trained to initiate after-care services. At the time of discharge, the health status of the person should be reviewed. Future help in terms of referral, counselling and other interventions should be strongly recommended to family members.
- Referral to local mental health professionals such as psychiatrists, psychologists and social workers should form an integral part of after-care to ensure that suicide attempts are not repeated.

The role of health professionals….

In every country, health professionals at primary, secondary or tertiary levels can play an effective role in preventing, managing or rehabilitating persons with suicidal tendencies, those who have committed a suicidal act or families of such persons. Usually (after a family member), it is the health sector that first comes in contact with the person, who has attempted suicide. On the other hand, due to the stigmatizing attitudes of several societies, health professionals may also be the last persons to come in contact with possible attempters, after every possible option has been tried. Unfortunately, in a majority of countries, attempting suicide is not considered a serious health problem and some health workers believe that suicide is more of a social/religious/cultural problem. Thus, the health professionals need to reorient their thinking to effectively meet this challenge.

Health professionals should be in close touch with the community in order to know the people better, and be able to intervene in a variety of action-oriented programmes. Due to their involvement in health matters and their unique and respected stature, health professionals can offer and deliver a wide range of services to people with suicidal thoughts and behaviour, and to those families with a history of suicide among its members.

Health professionals should

- Equip themselves with knowledge and skills about managing and preventing suicides along with counselling techniques. They should identify the resources required and attempt to obtain them from local or national agencies
- Learn and adopt simple mental health assessment methods in their practice to identify persons with potential social and psychiatric problems
- Promote mental health in their area and within their institution. The assessment procedures and treatment plans for those at risk of suicide need to take into account the frequent presence of co-morbid conditions
- Pay special attention and care to individuals or families with a member suffering from depression, alcoholism, schizophrenia and personality problems (mood disorders and behaviour disorders). Since these are high-risk people, they should be observed, monitored and provided care. Other individuals, such as those with a history of HIV/AIDS, paralysis, epilepsy, chronic terminal illness and disability, need counselling, diagnostic services and continued support.
- Not make abrupt discontinuation, change or alteration in medications without a reason.
- As a first step, establish contact with the affected person, listen carefully, and not pass judgement after the first sentence. The patient should be offered non-judgemental hearing and allowed to talk. Exploring the situation and understanding his/her feelings, will provide confidence, hope and direction for the person and the family. The family and friends must be involved.
- Depending on the individual patient and his state, prescribe simple medication along with counselling. The patient must be observed over a period of time to see his/her response .
- Establish a referral and after-care programme with the nearest social and mental health agency in the area. If it is a high-risk geographical area, this is important, as the majority of those who cannot be managed at the local level need help at the tertiary level. Many patients might refuse referral and there is a need to persuade them to contact tertiary-level hospitals.

A training programme for general practitioners on the identification of depression and suicide prevention in the Dutch island of Gotland in Sweden resulted in a decline in suicide rates the following year. A repetition of this experiment in Hungary also showed a reduction in suicide rates. Many studies have shown a decline in the number of suicides among depressed persons after proper management.

The role of Media…

The media (visual and print) has a profound impact on the lives of people. A responsible way of presenting the problem of suicide would be in describing what led to the act and the consequences of such an action. While the media has the freedom to report, media personnel need to be aware of the consequences of such reporting. Across the world, a number of novels, television shows, films, soap operas, serials, magazines and newspapers have reported suicide as a heroic act, resulting in "copy cat suicides". Research has clearly demonstrated that reporting of self-inflicted or intentional (suicide and homicide) injuries, especially celebrity acts, definitely result in an increase in suicides over a period of time.

Reporting and publicity about suicides is often determined by who commits the act, place of committing the act, motive and lethality of the act, method employed and whether it was justified. This leaves a lasting image on the person viewing, reading or listening to this event and also to his/her state of vulnerability. The media can play a positive role in shaping people's thoughts and can show the direction, avenue or option to a distressed person.

Summary

Suicide is a serious problem causing nearly one million deaths a year globally. Suicide is estimated to represent 1.8% of the total global burden of disease in 1998 and estimated to be rising with time. Sri Lanka had very high suicide rates in the 90s and the suicide rate is still high in the country. Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing. Mental disorders (particularly depression and alcohol use disorders) are a major risk factor for suicide in Europe and North America; however, in Asian countries impulsiveness plays an important role. Suicide is complex with involvement of psychological, social, biological, cultural and environmental factors. Suicides are common in certain people, families and certain communities. Suicide prevention is a challenging task but can be done by anybody. Family members, community, health sector, media should all collaborate together to prevent suicides.

Sources :

Sources Suicide prevention, available from

http://www.searo.who.int/en/Section1174/Section1199/Section1567/Section1824_8087.htm,

http://www.searo.who.int/en/Section1174/Section1199/Section1567/Section1824_8088.htm

Compiled by Dr. Madhava Gunasekera of the Epidemiology Unit

Table 1: Vaccine-preventable Diseases & AFP

02nd – 09th September 2011 (36th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	00	00	00	00	00	00	00	00	00	02	62	65	+ 04.6 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	00	00	00	00	00	00	00	00	00	00	03	104	73	+ 42.5 %
Tetanus	00	00	00	00	00	00	01	00	00	01	00	17	18	- 05.5 %
Whooping Cough	00	01	00	00	00	00	01	01	00	03	01	25	22	+ 13.6 %
Tuberculosis	120	04	73	07	22	13	00	00	05	244	82	6401	6612	+ 03.2 %

Table 2: Newly Introduced Notifiable Disease

02nd – 09th September 2011 (36th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	06	05	03	00	03	00	03	05	01	26	47	3042	2390	+ 27.28 %
Meningitis	03 CB=1 KL=2	00	01 GL=1	00	00	05 KN=4 PU=1	02 AP=2	01 BD=1	00	12	11	615	1224	- 49.7 %
Mumps	02	00	05	03	11	02	03	04	04	34	21	2237	830	+ 169.5 %
Leishmaniasis	00	00	03 HB=3	00	00	02 KN=2	06 AP=6	00	00	11	08	524	243	+ 115.6 %

Key to Table 1 & 2

Provinces: **W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.

DPDHS Divisions: **CB**: Colombo, **GM**: Gampaha, **KL**: Kalutara, **KD**: Kandy, **ML**: Matale, **NE**: Nuwara Eliya, **GL**: Galle, **HB**: Hambantota, **MT**: Matara, **JF**: Jaffna, **KN**: Killinochchi, **MN**: Mannar, **VA**: Vavuniya, **MU**: Mullaitivu, **BT**: Batticaloa, **AM**: Ampara, **TR**: Trincomalee, **KM**: Kalmunai, **KR**: Kurunegala, **PU**: Puttalam, **AP**: Anuradhapura, **PO**: Polonnaruwa, **BD**: Badulla, **MO**: Moneragala, **RP**: Ratnapura, **KG**: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008. .

Dengue Prevention and Control Health Messages

Check the roof gutters regularly for water collection where dengue mosquitoes could breed.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

02nd – 09th September 2011 (36th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	25	6950	2	152	0	6	1	138	0	48	6	304	0	7	3	56	0	2	**85**
Gampaha	28	2723	1	102	0	15	1	54	0	27	0	393	0	21	5	205	0	6	**60**
Kalutara	5	939	2	112	0	4	0	47	0	21	6	223	0	2	0	6	0	1	**75**
Kandy	32	672	2	316	0	7	1	25	0	38	0	137	3	88	0	44	0	0	**100**
Matale	1	250	1	129	0	3	1	27	0	18	0	149	0	14	1	7	0	0	**100**
Nuwara	3	146	0	291	0	4	0	46	0	89	1	42	0	55	0	18	0	1	**77**
Galle	10	603	1	74	0	6	0	15	0	6	11	140	0	32	0	9	0	5	**74**
Hambantota	2	329	0	44	0	4	0	3	3	28	6	452	0	52	0	10	0	1	**100**
Matara	12	355	2	63	0	2	1	12	0	28	12	233	1	60	0	15	0	1	**82**
Jaffna	3	249	5	183	0	3	2	198	0	71	0	2	0	193	0	23	0	1	**91**
Kilinochchi	0	45	0	16	0	3	0	9	0	12	0	2	0	8	0	3	0	0	**25**
Mannar	0	26	0	17	0	0	2	29	4	82	0	13	0	32	0	2	0	0	**100**
Vavuniya	0	65	0	24	1	12	0	8	0	47	0	44	0	2	0	1	0	0	**100**
Mullaitivu	0	15	1	43	0	1	1	4	0	9	0	5	0	1	0	2	0	0	**75**
Batticaloa	0	689	1	530	0	5	0	5	0	25	0	26	0	3	0	2	0	6	**79**
Ampara	18	123	1	99	0	1	1	10	0	28	0	56	0	1	0	7	0	0	**86**
Trincomalee	0	139	0	567	0	2	0	5	0	9	0	87	0	7	0	7	0	0	**75**
Kurunegala	12	689	6	265	0	12	0	80	0	69	2	1406	0	66	0	30	0	4	**91**
Puttalam	2	379	0	153	0	1	0	25	0	9	1	100	0	17	0	6	0	2	**75**
Anuradhapu	1	214	0	104	0	1	0	3	0	33	0	237	0	16	0	15	0	1	**74**
Polonnaruw	2	238	1	97	0	1	0	9	0	22	0	78	0	1	0	15	0	0	**71**
Badulla	6	465	1	270	0	5	0	48	0	9	1	65	1	68	1	53	0	0	**82**
Monaragala	1	179	3	77	0	4	0	30	0	10	0	170	0	57	1	55	0	0	**82**
Ratnapura	3	666	2	411	0	5	0	43	0	17	1	407	0	26	1	34	0	2	**67**
Kegalle	8	534	0	91	0	12	2	62	0	23	2	268	0	27	4	150	0	0	**82**
Kalmune	0	28	0	500	0	0	0	1	0	25	0	5	0	2	0	3	0	1	**77**
SRI LANKA	**174**	**17710**	**32**	**4730**	**01**	**119**	**13**	**936**	**07**	**803**	**49**	**5044**	**05**	**858**	**16**	**778**	**00**	**34**	**81**

Source: Weekly Returns of Communicable Diseases WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 09th September, 2011 Total number of reporting units =327. Number of reporting units data provided for the current week: 266
A = Cases reported during the current week. **B** = Cumulative cases for the year.

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to **chepid@sltnet.lk.**

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