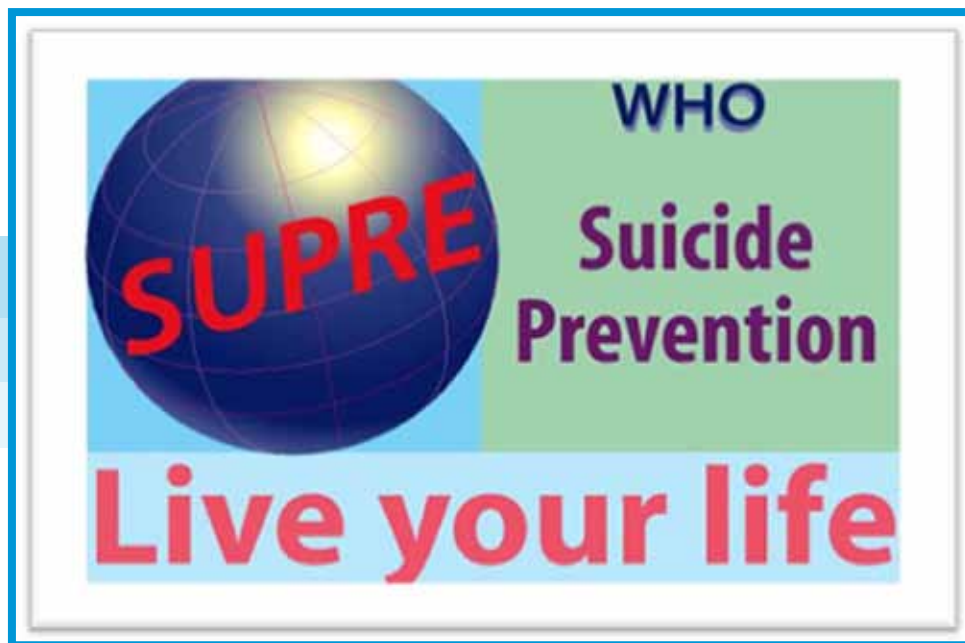


## Seoul Forum on Suicide Prevention in the Western Pacific Region



13–14 September 2012  
Seoul, Republic of Korea



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## **REPORT**

### **SEOUL FORUM ON SUICIDE PREVENTION IN THE WESTERN PACIFIC REGION**

Convened by:

**WORLD HEALTH ORGANIZATION**

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## NOTE

The views expressed in this report are those of the participants in the Seoul Forum on Suicide Prevention in the Western Pacific Region and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Seoul Forum on Suicide Prevention in the Western Pacific Region, held in Seoul, Republic of Korea from 13 to 14 September 2012.

## SUMMARY

The Seoul Forum on Suicide Prevention was held in Seoul, Republic of Korea from 13 to 14 September 2012. It was attended by more than 200 participants from 19 countries and areas in the Western Pacific Region, including representatives from WHO Collaborating Centres, academic institutions and nongovernmental organizations.

The objectives of the meeting were:

- (1) to present current situation, trends and risk factors of suicide behaviour in the Region;
- (2) to share good practices, lessons learnt and emerging evidence in suicide prevention;
- (3) to identify next steps in the development and implementation of regional and national initiatives for suicide prevention; and
- (4) to discuss networking and partnerships for suicide prevention in the Region.

The suicide situation and the status of suicide prevention programmes in Member States were shared by participants in the workshop including during breakout groups.

Among the key areas in suicide prevention reviewed and discussed were the public health approach, interventions for adolescents, young people and the elderly, available evidence and knowledge gaps, reducing access to lethal means of self-harm, common components of strategies, crisis intervention through national hotlines, the harmful use of alcohol, screening and treatment of depression, and the role of the media.

Two sets of recommendations were presented—one for the Member States and another for WHO. Specific recommendations were made to address the key areas and issues identified during the course of the meeting.

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Keywords:

Suicide – prevention and control / Western Pacific / Evidence-based practice
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## 1. INTRODUCTION

The Seoul Forum on Suicide Prevention was held in Seoul, Republic of Korea from 13 to 14 September 2012. It was attended by more than 200 participants from 19 countries and areas in the Western Pacific Region, including representatives from WHO Collaborating Centres, academic institutions and nongovernmental organizations (Annex 1).

### 1.1 Background

Every year, almost 800 000 people die from suicide globally. In some countries, suicide is among the three leading causes of death among those aged 15 to 44 and the second leading cause of death among those 10 to 24 years old. These figures do not include suicide attempts and deliberate self-harm which are up to 20 times more than completed suicide.

Suicide is currently among the top ten causes of death in some countries and areas of the Western Pacific Region. In 2008, there were approximately 225 000 suicides in the Region. In recent years, a number of countries in the Region have experienced a significant increase in suicide rates. While suicide rates have been traditionally highest among the elderly males, suicide behaviour among young people is now a major concern in many places, particularly in some Pacific island countries and areas.

Suicide is a tragic global public health problem but is largely preventable through concerted efforts by stakeholders and the community at large. WHO has made continuous efforts in suicide prevention. These efforts include global surveillance and monitoring of suicidal behaviours. WHO collaborated with the International Association for Suicide Prevention (IASP) to hold the first World Suicide Prevention Day on 10 September 2003. With the assistance of experts from around the world, WHO has produced a series of resource documents, available in different languages to guide those with a critical role in suicide prevention, including health-care workers, teachers, prison officers, media professionals and survivors of suicide.

The WHO Regional Office for the Western Pacific held its first regional meeting on suicide prevention in August 2005 in Manila, Philippines with the participation of representatives from 22 countries and areas. Following the meeting, the WHO START project (Suicide Trends in At-Risk Territories) was launched in March 2006 with support from the Australian Institute for Suicide Research and Prevention (AISRAP), a WHO Collaborating Centre for research and training in suicide prevention. With participation of 15 countries and areas, the project is playing an important role in helping establish and strengthen surveillance systems for suicidal behaviour and providing support to the development and implementation of national strategies for the effective management and prevention of suicidal behaviour. Based on a systematic review on the impact of media on suicide and the effect of media-centred interventions on suicide prevention, a series of consultations were held in high-burden countries to engage media professionals and other stakeholders in suicide prevention efforts.

The Seoul Forum on Suicide Prevention was convened to bring together representatives of Member States, the media industry, professional and volunteer organizations and other stakeholders to address the over-represented burden of suicidal behaviours in the Region.

## 1.2 Objectives

The objectives of the meeting were:

- (1) to present current situation, trend and risk factors of suicide behaviour in the Region;
- (2) to share good practices, lessons learnt and emerging evidence in suicide prevention;
- (3) to identify next steps in the development and implementation of regional and national initiatives for suicide prevention; and
- (4) to discuss networking and partnerships for suicide prevention in the Region.

## 1.3 Welcome remarks

In his welcome remarks (Annex 2), Sohn Gunn-Yik, Vice Minister of Health and Welfare of the Republic of Korea, welcomed and thanked the participants for attending the Seoul Forum on Suicide Prevention. He said that the Republic of Korea had the highest suicide rate among the countries of the Organisation for Economic Co-operation and Development (OECD).

He also pointed out the factors responsible for suicide in the country, from personal issues such as depression and physical illness to larger societal issues, including poverty among the elderly and the breakdown of the conventional family structure.

Finally, the Vice Minister affirmed the Republic of Korea's commitment to take the lead in suicide prevention given the severity of the problem. He added that the meeting was an opportune time to discuss solutions to create a "pro-life" culture to save precious lives.

## 1.4 Opening remarks

In his opening remarks, Dr Shin Young-soo, WHO Regional Director for the Western Pacific, pointed out that of the 800 000 people who die by suicide globally every year, one in four are from the Western Pacific Region. This translates to about 600 suicide deaths in the Region per day. He also pointed out that suicide is among the top five causes of death among young people and adolescents in many countries.

Despite many myths and misconceptions about suicide, it is preventable, using different means and approaches. These include treating people with mental disorders and alcohol and substance use problems that may lead to suicide, training health-care providers to recognize mental health triggers which may lead to suicide, and diagnosing and managing at-risk cases.

Dr Shin also emphasized the importance of addressing the shame and stigma related to suicide and mental disorders, which sometimes may prevent people at-risk for suicide from seeking help and care. He also urged Member States to invest more in mental health services in the Region, so that these services are available to people who need them.

Dr Shin reminded participants that suicide prevention is everybody's responsibility, with governments needing to lead to coordinate joint efforts (Annex 3).



## 2. PROCEEDINGS

### 2.1 Global and regional overview of suicide

Approximately 800 000 people commit suicide every year. Over 50% of these occur in the age group 15 to 44 years with the vast majority (85%) in low- and middle-income countries. Suicide is among the top three causes of death for young people (15 to 34 years old) worldwide.

In most countries, suicide rates tend to be two to three times higher among males than among females. However, in China and India the male to female ratio is closer to one, and suicide rates among women in rural China are higher than among men. Non-fatal suicidal acts are becoming far more frequent. Estimates suggest that there are some 10 to 20 attempted suicides for every completed suicide.

Forum participants were divided into three groups to share their countries' and/or territories' suicide situation. Several key and common concerns and challenges emerged from the group discussions (Annex 5). These included:

(1) Cultural concerns. In countries like Australia, Cambodia, China, Japan, Mongolia and Viet Nam, cultural transition, the difference between "Western" values and predominant cultures, and intergenerational complications, may have an impact on the suicide phenomenon.

It was pointed out that some countries may tend to individuate and select which values they are going to keep and which they are going to throw out. This may mean wholesale adoption of new values when they might not be appropriate or desirable for a specific country. Having a cultural identity that is contemporary and meaningful may not come from changing values on a mass scale.

(2) Risk and protective factors. One risk factor highlighted was the stress being experienced by young people in several countries and areas in the Region. These include pressure from family, pressures from societal demands and expectations, poverty and financial restraints. In some countries, since alcohol and drugs are very accessible and cheap, abuse of these substances have been linked with suicide.

Spiritual and psycho-emotional connections and communities were cited as protective factors. In the Pacific island countries and areas, the role of the church in the lives of individuals, families and communities is very strong. Churches can have some very positive effects on how communities behave. However, religious beliefs may reinforce stigma against mental illness. In some Christian communities in Pacific island countries and areas, mental illness symptoms are associated with being possessed by evil spirits. There is therefore a need to educate and increase public knowledge and awareness of mental health.

Strong family support is another protective factor. An example cited by a participant was the *Aiga* (family) system in Samoa which has a very strong effect on young people in terms of keeping them with their families teaching them the basics of life, cultural beliefs and values. *Aiga* promotes family support even in times of deep trouble.

The occurrence of natural disasters and adverse events may affect the mental health and suicide situation of some countries and/or areas in the Region. In this context, there is a need for a whole community response.

(3) Media portrayals of suicide. Participants said media has to ensure that covering and reporting about suicide does not cause vulnerable individuals to commit suicide in imitation. Vulnerable individuals may suffer from cognitive restriction and may have limited problem-solving abilities, and certain types of reporting may only worsen their mental states.

(4) Stigma and discrimination. A concern raised was the stigma around suicide and discrimination even by health-care and medical practitioners. According to a participant, there are doctors and nurses who think that mental illness should not be treated at hospitals or among those who have physical illness.

## 2.2 Suicide prevention in the Western Pacific Region

In terms of suicide prevention initiatives and programmes, participants cited a number of factors, issues and concerns related to programme implementation. These included:

(1) Data collection and surveillance system issues. There is a need to arrive at a common definition across countries of when a death can be considered suicide. For example, a motor vehicle death might be considered an accidental death. Factors affecting data collection are access to data and adequacy of recording systems. In one country, the source of suicide data was reports by the media.

The Suicide Trends in At-Risk Territories (START) project is a positive initiative that must be strengthened. In Guam, a law dictates that those involved in the suicide prevention programme work with the office of the medical examiner to help investigate questionable deaths.

(2) Suicide prevention strategies and policies. In some cases, effectiveness of these policies are not known since they have not been adequately evaluated. A number of participants realized that good policies and strategies are those that they have tailored to their country's circumstances and not necessarily those in use in other countries.

Strong political leadership is a prerequisite for crafting and implementing the right strategies and policies. In a number of countries, mental health and suicide are not considered very important and are therefore not provided with adequate resources.

(3) Multistakeholder and multisystem collaboration to expand the reach and coverage of mental health programmes and services. Coordination is essential at all levels in and among the mental health care system, the suicide prevention programme and other related institutions and groups including the legal system, forensic system, community system, nongovernmental organizations and churches. Those involved in implementing suicide prevention programmes must be able to acknowledge difficulties and solicit ideas and suggestions from partners.

There are various means to extend the reach of suicide prevention and mental health programmes that should be considered. For example, communication technologies such as Skype can cover urban areas as well as hard-to-reach areas including isolated rural areas or island communities.

Another approach is to teach primary health-care workers (whether in a rural or urban or isolated area) the basics of mental health and thereby increase their understanding of the relevant risk and protective factors, as defined by the *mental health Gap Action Programme* (mhGAP).

In the Republic of Korea, a nongovernmental organization is working with the Government to carry out suicide prevention programmes. In Malaysia, nongovernmental

organizations are also involved as is the Ministry of Health which has committed to participate in a special programme for suicide prevention.

Since most of the Pacific island countries and areas are far apart and many have no resources, there is the potential to decentralize services by taking mental health and other services out into the community. Another potential solution is to educate lay people on the signs and symptoms of anxiety and depression and where they can avail of mental health and suicide prevention services if needed.

In China, the approach is to develop and strengthen the mental health care system especially in small cities and local governments to better generate resources and serve people. While the central government is important, it is the local government that pays for the system. An important task is to educate the local government to set up the mental health care system to provide essential or basic mental health service to the people, after which the system can be gradually improved.

(4) Capacity building, education and training of health human resources. The process could be inter-disciplinary or inter-professional and include community representatives (learning together and working better together).

In Hong Kong (China), the Lao People's Democratic Republic, Malaysia, the Philippines, the Republic of Korea and Singapore, there were varying degrees of achievement in programme implementation. Some countries have specific suicide prevention plans. In Malaysia, while the national action plan for suicide prevention was recently endorsed and amendments to the law to regulate access to pesticides were passed, suicide is still criminalized.

One barrier to implementation is the lack of psychiatrists and other related health-care personnel. In Tonga, there is only one medical officer in the psychiatric unit; in the Lao People's Democratic Republic there are only two psychiatrists; and in Samoa, the whole mental health service is managed by nurses only.

In the Philippines, a potential solution to address the lack of psychiatrists in non-urban areas is to train non-psychiatric doctors to help manage the patient at their local hospital before transfer to tertiary hospitals.

## 2.3 Public health approach to suicide prevention

### 2.3.1 Introduction to the public health approach

The public health approach focuses on identifying the patterns of suicide and suicidal behaviours of a group or population. It aims to manage the environment to protect people against diseases as well as change the behaviours that put people at risk. The public health approach is not limited to preventing epidemic diseases and can also be applied to preventing suicide.

It consists of four components. First, surveillance identifies suicide patterns and the different suicide rates according to age, geographical location, etc. It may also include information on the characteristics of individuals who die by suicide. This helps to identify and define the problem. Second, identification of risk and protective factors focuses on the chain of causes leading to suicide. Risk factors may be those leading to or associated with suicide. Protective factors are those that may reduce the likelihood of such incidents, and the interaction between these factors.

The third component, prevention/intervention, is classified into three levels: universal (targeting the entire population), selective (targeting subgroups with risk factors) and indicated (for high-risk individuals). *Hope&Faith* is the last component and measures the effectiveness of interventions in preventing suicide. An evidence-based approach helps determine the best and most cost-effective intervention or programme for the current situation.

### 2.3.2 Common components of strategies and plans for suicide prevention

Effective and efficient suicide prevention strategies are those that are tailored to specific populations or systems.

#### 2.3.2.1 Suicide prevention strategies targeting the general population

Suicide prevention programmes targeting the general population aim to: (1) improve suicide risk recognition; (2) promote help-seeking behaviour for those at risk for suicide; and (3) reduce the stigma around suicide and mental illness. Common strategies and actions include public education, crisis intervention, training of gatekeepers, and improving media reporting on suicide. Literature reviews reveal that the effectiveness of these programmes is difficult to measure. However, targeting the general population is still an important component of suicide prevention programmes.

#### 2.3.2.2 Suicide prevention strategies targeting high-risk groups

Patients with mental disorders, particularly depression and schizophrenia, and those who have previously attempted suicide are high-risk groups for suicide. Individuals experiencing intense stress, those with chronic, terminal and painful somatic diseases and the elderly are also considered high-risk. Effective responses based on evidence include psychosocial intervention, systematic antipsychotic and antidepressant treatment, and case management. A few studies attempted to screen individuals at risk of suicide and depression, but did not generate enough evidence to demonstrate screening as an effective suicide prevention strategy.

#### 2.3.2.3 Suicide prevention strategies targeting the health care system

The health care system, including both general and mental health care, plays an important role in suicide prevention. Strategies and approaches include training primary health care providers to identify and refer patients at risk, improving emergency service for those who attempt suicide, providing intensive crisis intervention and psychosocial support as needed, improving access to mental health care, preventing suicide within institutions, and increasing adherence to treatment.

#### 2.3.2.4 Suicide prevention strategies to restrict access to suicide means

Some of the strategies that have proven effective in suicide prevention include restricting use or sale of pesticides, restricting the prescription and sale of barbiturates, packaging analgesics in blister packets only and reducing the number of tablets per package, detoxifying domestic gas, requiring the use of catalytic converters in motor vehicles, constructing barriers at potential jumping sites, using new, lower-toxicity pesticides and medicines, and controlling firearms.

Over the past three decades, studies identified suicide prevention strategies. To implement these strategies effectively, it is essential to involve various stakeholders and to systematically evaluate these strategies. Multi-level and integrated suicide prevention strategies are recommended in the future.

### 2.3.3 Interventions for suicide prevention among adolescents and youth

Up to 90% of young people who attempt suicide meet the Diagnostic and Statistical Manual (DSM) III criteria for a psychiatric disorder. Suicidal youth are six times more likely to have a psychiatric disorder compared with non-suicidal youth. Most common disorders are related to depression and anxiety, with between 60% and 80% of suicidal young people having a diagnosis of depression at the time of a suicide attempt. Psychiatric issues present as early as eight years of age can be predictive of future suicidal behavior. Past suicide attempts is the strongest risk factor.

A review of the international literature on suicide prevention, postvention and early intervention in school settings revealed that such programmes lead to increased knowledge and promoting help-seeking attitudes. However, until there is clear evidence on negative effects, general mental health promotion as a universal approach is recommended.

In terms of selective approaches, a review of gatekeeper training programmes showed they were effective in improving knowledge, attitudes and confidence and in some cases, led to self-reported improvements in practice. A review of screening programmes showed these were successful in identifying students at risk who would not have sought help otherwise and referring them to either school- or community-based services. No iatrogenic effects were reported.

To date, suicide prevention interventions that have proven effective for young people and adolescents are gatekeeper training, screening programmes and cognitive behaviour therapy (CBT). Factors and approaches worth further investigation are the roles and effects of media (including social media) in suicide risk, iatrogenic effects of whole-school programmes, online interventions, and postvention approaches.

### 2.3.4 Interventions for suicide prevention in old people

Rates of suicide in later life exceed those of other age groups in many regions of the world, and are typically higher among men than women. In addition to depression and great personal distress, older people who commit suicide often suffer significant co-morbid medical illnesses associated with marked functional decline and related disruption of important life rhythms and interpersonal interactions. Fundamental social and economic changes in many countries may exacerbate these difficulties.

Until recently, suicide was viewed in the United States of America and many other developed countries primarily from the point of view of psychopathology, or as an individual problem reflecting unique life circumstances. In other nations, it has been regarded largely as a societal problem. An emerging public health view promotes multi-layered approaches to suicide prevention that combine social and policy changes with group-focused and individually-focused interventions. It is built upon a continuous cycle of problem identification, research and establishment of "best evidence," dissemination, and reassessment of continuing needs.

Integrated responses to suicide prevention, which consider individual, family, community, and societal components as part of a multilayered programmatic strategy, will be necessary for reducing suicide rates among older people, who are especially vulnerable to both major social transformations as well as the individual frailty that is part of the ageing process.

## 2.4 Evidence-based interventions

### 2.4.1 Reducing access to lethal means

Restriction of means is a method to prevent suicide by controlling access to instruments or materials that may be used to commit suicide. A growing body of research suggests that this approach is one of the most effective ways to reduce suicide rates. The success of these methods is largely due to the fact that people attempting suicide (whether planned or unplanned) choose methods that are most readily available to them. In many cases, removing the method appears to delay suicidal action enough for the suicidal impulse to pass without fatal effect.

Some successful examples of means restriction to reduce suicide rates are the banning of pesticides in Sri Lanka; removal of charcoal bags from open shelves in grocery stores in Hong Kong (China); and the installation of platform safety doors in train stations.

### 2.4.2 Screening and treatment of depression

By 2020, depression will be a leading cause of disability. Common presentations of depression include: low energy, fatigue, sleep or appetite problems, persistent sad or anxious mood, irritability, low interest or pleasure in previously enjoyed activities, and difficulty carrying out usual work, school, domestic or social activities. Depression and its associated symptoms are associated with the risk of suicide. A significant minority of suicide victims contact their primary care providers in the month of their suicide.

In screening for depression, the evidence for screening in primary care is mixed. Some studies reported improved detection and treatment of depression through programmes aimed at educating primary care physicians, while others showed no improvement. Particular focus for screening includes high-risk individuals as well as groups. High-risk individuals are those with a first degree relative with a history of depression, with two or more chronic diseases, with chronic pain, under financial strain, undergoing a major life change, pregnant or just given birth, socially isolated, or with a substance use disorder. High-risk groups include adolescents and older persons.

Screening alone does not result in positive outcomes. Appropriate, effective treatment, relapse prevention and follow-up are essential. While the at-risk individual must be willing to commit to treatment, there is also the need for the broader community to foster a help-seeking culture.

Treating mood and other psychiatric disorders is a central component of suicide prevention, since these disorders are exhibited (but usually untreated) by a large number of those who die by suicide. In treating depression, the following principles of care apply: communication with people seeking care and their carers and families (information, support and consent), respect for human rights, attention to overall well-being, and rendering of competent care.

Treatment of mild depression consists of psychosocial interventions (i.e. psycho education, addressing current psycho-social stressors, reactivation of social networks, structured physical activity, among others) while for more severe depression, psycho-education for the individual and family, anti-depressant medication, and psychotherapy may be necessary. Pharmacotherapy, another treatment option for severe depression, requires precaution in special populations such as adolescents, older people and people with cardiovascular disease.

One of the initiatives to treat depression in countries in the Asia Pacific is developing treatment guidelines and programmes to educate physicians. This however has met resource and

population-related barriers such as the urban-rural divide and the availability of mental health services.

Finally, health promotion is a key component in treating depression, especially addressing risk and resilience factors both at population and individual levels (i.e. biological, psychological, socio-cultural).

#### 2.4.3 Control of harmful use of alcohol

The majority of studies on alcohol and suicidal behaviours were conducted in a limited number of countries, mainly high-income countries. These studies show quite consistently a significant association between alcohol consumption and suicidal behaviour. The evidence of effectiveness of alcohol prevention programmes is also restricted to a limited number of countries, mainly English-speaking and northern European countries. It is not known to what extent these studies/programmes to limit alcohol to prevent suicide are applicable to different countries or cultures.

Given the available evidence however, there may be significant potential to decrease alcohol-related suicidal behaviours by implementing effective strategies. According to the available scientific literature, it seems that alcohol control policies have the potential to curb alcohol-related suicides. These include taxation, limitation of availability and enforcement of a minimum legal drinking age. It also seems that participation in self-help groups may contribute to reducing alcohol-related suicidal behaviours.

#### 2.4.4 Crisis intervention

Telephone and internet-based services to respond to anonymous individuals in the midst of distressing or suicidal crises are common around the world. Such programmes appear to be valid since they offer individuals an opportunity to quickly find a sympathetic listener, and potentially provide communities with a method of connecting desperate persons with appropriate resources. However, they have yet to prove that they lower rates of suicide or attempted suicide.

It is uncertain whether individuals who are most intent on suicide indeed choose to avail of telephone/internet crisis counselling services. It is also unclear whether operators and workers staffing such hotlines actually implement effective suicide counselling methods. Available data suggest that many crisis operators or counsellors fail to adequately assess suicidal risk. Furthermore, it remains to be determined whether callers are effectively connected to the appropriate local agencies which can provide continued or follow-up service.

Given the rapid development of the internet, mobile phones, smart phones, and other personal communication devices, there are new opportunities to reach potentially suicidal individuals through carefully designed and assessed efforts, make a positive difference and save lives.

#### 2.4.5 Role of media in suicide prevention

Those in media may feel that their role in suicide prevention is limited. Media acts as a window through which the world learns about the suicide incidents. However, suicide prevention is a social responsibility. Studies have shown that media's influence in suicide prevention tends to be more negative rather than positive as a result of reckless reporting which may encourage copycat suicide or impulsive suicide.

Media in the Republic of Korea have tended to feature suicide in the headlines and report the method of suicide in detail. In order for media to play a positive role, it is important for them to practice care in reporting suicides while also informing the public of suicide prevention programmes and alternatives to suicide.

From the WHO perspective, there is a need to promote sensitive coverage of suicide and develop and disseminate reporting guidelines for media professionals.

Media may also make a positive contribution by helping increase suicide issues in the public health agenda, normalize help-seeking behaviour, increase mental health literacy and remove the stigma from mental illness and suicide.

Through its media and the prevention of suicide (MAPS) initiative, WHO hopes that media professionals and organizations may play an active role in promoting mental health and suicide prevention through consultative and participatory approaches. The MAPS initiative covers the systematic review of all published studies evaluating media-centred suicide prevention interventions, identification and forging of links with partner organizations and technical advisers in the media, government and nongovernment sectors, development of resources to facilitate consultations and discussions, and the holding of country-level consultations in priority countries.

### 3. CONCLUSIONS

At the end of the Seoul Forum on Suicide Prevention, the following conclusions were put forth:

- (1) Suicide rates vary greatly in countries across the Western Pacific Region, ranging from three to more than 30 deaths per 100 000 people. While there is a significant decrease in the overall estimated number of suicide deaths in the Region largely due to the decline in China, suicide remains a public challenge. Suicide rates in some countries remain high, some witness further increase, particularly among vulnerable populations such as young people and the elderly.
- (2) Well-documented suicide trends over the last two decades in several high-income countries indicate a complicated relationship between suicide and economic growth. It is therefore important for countries undergoing rapid and dramatic social economic changes to monitor the suicide situation closely and make every effort to enhance protective factors and reduce risk factors for suicide.
- (3) While some countries report significant progress in the endorsement of relevant laws and development of national suicide prevention strategies, plans and programmes, the urgency of the issue is severely underestimated by the public and by policy makers.
- (4) Most low- and middle-income countries share common challenges and barriers to suicide prevention including, among others, the absence of essential information about current trends in suicide and attempted suicide; the lack of expertise and trained personnel to analyze the suicide situation and initiate suicide prevention programmes at national and local levels; and poor access to health care and especially in mental health care.



(5) The stigma around and discrimination against mental illness, victims and survivors of suicide, including among health-care providers represents a major barrier to development and implementation of suicide prevention programmes across the Region.

(6) Reduction of suicide requires strong political leadership and commitment, partnership among all stakeholders and a multisectoral approach. Both mental health and general medical services need to be provided in a variety of different settings tailored to the needs of different at-risk individuals or groups.

#### 4. RECOMMENDATIONS

##### 4.1 Recommendations to Member States

(1) Strengthen data collection and management to understand the magnitude, pattern, and trend of suicide, and to identify protective and risk factors for suicide within a national context so that well-targeted suicide prevention programmes can be developed and implemented.

(2) Integrate suicide prevention into existing programmes and projects (for example, mental health promotion activities, school programmes, workplace safety, primary health care, drug and alcohol abuse programmes, and others).

(3) Develop national strategies and plans, where appropriate, with involvement of all stakeholders and sectors such as education, agricultural, housing, the community, the religious bodies, and law enforcement agencies.

(4) Engage and create partnerships with media and other partners and stakeholders to promote suicide prevention efforts.

(5) Improve mental health services and enhance access to quality mental health services for early detection and treatment of depression and other mental disorders.

##### 4.2 Recommendations to WHO

(1) Support and sustain a formal network within the Western Pacific Region, and where appropriate, in sub-groups of countries.

(2) Support countries in their efforts to develop and implement national strategies for effective management and prevention of suicidal behaviours.

(3) Coordinate with and assist Member States in improving monitoring and surveillance of suicide in the Region.

(4) Generate and disseminate evidence and good practices to address the unique challenges of Member States in the Region.

(5) Engage and create partnerships with media and other partners to promote suicide prevention efforts.

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WELCOME REMARKS  
BY THE HONORABLE SOHN, GUNN-YIK  
VICE-MINISTER OF HEALTH AND WELFARE  
REPUBLIC OF KOREA  
AT THE SEOUL FORUM ON SUICIDE PREVENTION IN THE WESTERN PACIFIC REGION  
13-14 SEPTEMBER 2012  
SEOUL, REPUBLIC OF KOREA

Dr Shin Young-soo, WHO Regional Director,  
Distinguished guests, ladies and gentlemen,

Thank you for joining us at the Seoul Forum today and tomorrow. I would like to express my warm welcome to all of you, who are gathered together to prevent suicide and to save lives.

Suicide is a serious issue and it disturbs almost everyone in the world. In this context, it is encouraging that the World Health Organization has decided to get involved in this grave concern of our time. Moreover, it is also meaningful that the forum is taking place in South Korea, in which the suicide rate is shamefully highest among OECD member countries.

There are numerous factors that are responsible for suicide, ranging from personal issues, such as depression and physical illness, to larger societal issues, such as poverty among the elderly and the breakdown of the conventional family structure, which are all the more heart-wrenching.

We need to keep sparing no efforts to find solution for this troubling issue. As the causes are varied, the issue requires an approach of the society as a whole as well as international cooperation. Korea is more than willing to take the lead in this matter given its severity of the problem. Also I have high hopes for this forum as an opportune time to discuss solution to create pro-life culture and save precious lives.

Thank you, all, once again, for your unflinching endeavour and active participation.

## ANNEX 3

OPENING REMARKS BY DR SHIN YOUNG-SOO  
WHO REGIONAL DIRECTOR FOR THE WESTERN PACIFIC  
AT THE SEOUL FORUM ON SUICIDE PREVENTION IN THE WESTERN PACIFIC REGION  
13-14 SEPTEMBER 2012  
SEOUL, REPUBLIC OF KOREA

Every year about 800 000 people die by their own hand. Almost one in four of these suicides happen in the Western Pacific Region. That means about 600 lives are needlessly lost every day in the Region.

Suicide is among the top five causes of death — and the number one cause among adolescents and young adults — in some countries. Worldwide, six out of 10 suicide victims are younger than 45 years of age.

The overall trend in the Region may be decreasing, but some countries are experiencing an alarming increase in suicide rates.

Most people never give suicide a second thought until it touches them directly. We are prepared for the death of elderly parents, or the deaths of people we know with serious diseases. But suicide catches us by surprise.

There are many myths and misconceptions about suicide. These falsehoods — such as the one that suicide is not preventable — can hinder addressing the issue effectively.

The reality is most suicides can be prevented.

One method of prevention is to treat people with mental disorders that may lead to suicide. These conditions include depression, schizophrenia and alcohol or substance abuse.

There are many ways to stop suicide... provided we use of the wealth of evidence and good practices we have regarding suicide prevention. Among the most effective interventions is training health-care providers to spot the mental health triggers for suicide. Primary health-care providers must be trained to diagnose and manage at-risk cases before they turn into tragic suicides. This training is even more important in places where specialized mental health services and facilities are not readily available. Training would allow community health workers to identify those at-risk for suicide so that they can refer them for more appropriate care.

Shame and discrimination about suicide are tough obstacles to overcome. We can help dispel harmful misconceptions with accurate and readily available information, so that people seek help without worrying about being stigmatized.

But even for those seeking care, mental health services are not always available. In many parts of the Region, hundreds of thousands of people with mental health disorders remain untreated. This happens because the majority of low- and middle-income countries spend less than two percent of health budgets on mental health.

We must invest more in mental health services in the Region.

Suicide prevention is the responsibility of the entire society — from community groups to international organizations — but governments must take the lead in

coordinating efforts. Indeed, all of us must work together to address this shared concern and achieve our common goal—SAVING LIVES.

I wish you a productive meeting. THANK YOU.



## PROGRAMME OF ACTIVITIES

Thursday, 13 September 2012

08:00 – 08:30	Registration	
08:30 – 09:00	Opening ceremony	Moderator: Inhyang Kim, Seoul National Hospital
	Welcome speech	Sohn, Gunn-Yik, Vice Minister of Health and Welfare
	Welcome speech	Shin Young-soo, Regional Director, WHO WPRO
	Introduction of Seoul Forum	Dr Wang Xiangdong, Responsible Officer, Mental Health and Injury Prevention, WHO WPRO
	Photo opportunity	
09:00 – 09:15	Coffee break	
09:15 – 10:50	Overview of suicide and suicide prevention	Chair: Dr Xiao Shuiyuan, Dean, School of Public Health, Central South University
	Overview of global trends in suicide	Ms Alexandra Fleischmann, Scientist, Management of Substance Abuse, WHO / HQ
	Public health approach to suicide prevention	Professor Paul Yip, Director, The Hong Kong Jockey Club Centre for Suicide Research and Prevention
	Overview of interventions for suicide prevention in adolescents and youth	Ms Jo Robinson, Research Fellow, The University of Melbourne, Centre for Youth Mental Health
	Overview of interventions for suicide prevention in old people	Dr Eric D Caine, University of Rochester Medical Centre
10:50 – 12:20	Question and answer	
	Suicide and suicide prevention in the Western Pacific Region	Chair: Professor Paul Yip, Director, The Hong Kong Jockey Club Centre for Suicide Research and Prevention
	Presentation of country reports and discussion	Country participants in three (3) groups
	Group A: Cook Islands, Fiji, French Polynesia, Guam, Samoa, Tonga, Vanuatu	
	Group B: Australia, Cambodia, China, Japan, Mongolia, Vietnam	
	Group C: Hong Kong, Republic of Korea, Laos, Malaysia, Philippines, Singapore	
	Summary of working group discussions	
12:20 – 14:00	Lunch break	
14:00 – 14:30	Plenary: Presentation of group reports (Groups A, B, C)	
14:30 – 16:20	Suicide and suicide prevention in the Republic of Korea	Chair: Emeritus Professor Kang-E Hong, Chairman, Korea Association for Suicide Prevention (KASP)
	Hot issues related to rising suicide and suicide prevention	Professor Jong-Ik Park, Director, Korea Suicide Prevention Center (KSPC)

	Suicide prevention law and national policy in the Republic of Korea	Dr Jungkyu Lee, Director, Division of Mental Health Policy, Ministry of Health and Welfare
	Evidence-based approach to suicide attempters in the Republic of Korea Panel discussion and advise (by temporary advisers)	Professor Kyooseob Ha, President, KASP Professor Paul Yip, Dr Eric D Caine, Dr Xiao Shuiyuan, Ms Alexandra Fleischmann, Dr Hiroki Ozawa
16:20 – 16:35	Coffee break	
16:35 – 17:30	Suicide prevention: available evidence and knowledge gap (Part 1)	Chair: Dr Ros Montague, Head, WHO Collaborating Centre for Mental Health and Substance Abuse, The New South Wales Institute of Psychiatry
	Common components of strategies and plans for suicide prevention	Dr Xiao Shuiyuan, Dean, School of Public Health Central South University
	Reducing access to lethal means of self-harm	Professor Paul Yip, Director, The Hong Kong Jockey Club Centre for Suicide Research and Prevention
	Discussion	

Friday, 14 September 2012

09:00 – 10:15	Suicide prevention: available evidence and knowledge gaps (Part 2)	Chair: Dr Hiroki Ozawa, Professor, Division of Neuropsychiatry, Nagasaki University, Graduate School of Biomedical Sciences Dr Eric D Caine
	Crisis intervention and effects of national hotlines	
	Harmful use of alcohol and suicide	Ms Alexandra Fleischmann
	Screening and treatment of depression	Dr Ros Montague
	Discussion	
10:15 – 10:30	Coffee break	
10:30 – 11:45	Role of media in suicide prevention	Chair: Mr Chong-Ryul Park, President, Journalist Association of Korea
	Overview of media and suicide prevention	Dr Wang Xiangdong, Team Leader, Mental Health and Injury Prevention, WHO / WPRO
	Role of media in suicide prevention: perspectives of a journalist	Mr Young Chul Kwon, Senior Reporter, Christian Broadcasting System
	Role of media in suicide prevention: interim report of findings from consultations with media	Dr Hyun-Chung Kim, Department of Psychiatry, National Medical Centre
	Panel discussion (media resource persons and temporary advisers)	Mr Chong-Ryul Park Ms Jin Yonghong, Director, Public Affairs, Health News
11:45 – 12:00	Closing of the Forum	Dr Wang Xiangdong

## Country Summaries

**Cambodia** (Dr Khuon Eng Mony, deputy director, Preventive Medicine Department, Ministry of Health)

Suicide is a tragic global public health problem with a number of underlying causes. The causes may include loss of loved ones, breakdown in relationships, poverty, unemployment and legal problems. Physical and mental illness and disabling pain can also increase suicide risks. In developed countries, suicide prevention is receiving increased attention but in a developing country like Cambodia there is still low attention, aggravated by a number of factors such funding and burden of many other public health problems, which impedes implementation of suicide prevention and control programs.

The actual trend of suicide in Cambodia cannot be defined due to the lack of registration of cause of death. There is no baseline data on suicide. In the Hospitals there are cases of suicide by drug and pesticide poisoning, and injury by cutting.

Cambodia is a Buddhist country where it is believed that if one commits suicide, s/he will reincarnate and commit suicide for 500 years as part of the Karmic cycle. Suicide in Cambodia frequently highlights interpersonal relationships, domestic disputes, financial problems, poverty, and abuse. Depression is also recognized as one common cause of suicide.

Selected health problems are reported to the Ministry of Health through the health information system (HIS), where the reporting formats do not yet include suicide. An injury surveillance system is implemented to collect information on injury and road traffic accidents and their causes. In the injury form, suicide has been included as a cause. So far, however, this is not reported due to the misunderstanding that poisoning is not injury and fatal cases of drug poisoning are first admitted in emergency services and, after recovery, are discharged at ED. Fatal cases outside of hospitals are registered at the commune level under the Ministry of the Interior.

Cases of suicide are known through the media. In August 2012 there were 23 cases reported as completed (11 cases) and attempted suicides. Methods used included hanging, drowning, and herbicide and pesticide ingestion.

There were 584 registered cases of depression at the Khmer Soviet Friendship Hospital, of which 30% attempted suicide. Of these, 174 are male and 410 are female.

Since the cases of suicide appear to increase annually, the Preventive Medicine Department will collaborate with the mental health programme to implement prevention measures and monitor cases. Discussions will be conducted with the Ministry of the Interior for improving reporting of cause of death so that in the future, cases of suicide can be monitored and prevented.

**China** (Xiao Shuiyuan, Dean, School of Public Health)

Suicide research has only developed in the past two decades. Rigorous statistics on suicide have not been available until recently. Existing epidemiological data of suicide in mainland China reveals that there was a relatively high suicide rate in the 1980s (over 20 / 100 000). Since the late 1990s, the suicide rate in China significantly decreased, mainly due to dramatic reductions in suicides by rural young women.

The recently released Report on Injury Prevention in China (Disease Prevention and Control Bureau of MOH, 2007) reported the number of suicide deaths to be 226 000, 224 000, 221 000, 193 000 and 193 000 in 1995, 1998, 2000, 2003 and 2005 respectively. A recent study indicates an even more

astonishing decrease of suicide rate (13.14/100 000 in 1996 to 7.17/100 000 in 2009), with the suicide rate of rural residents has decreased from 27.75/100 000 in 1987 to 9.1/100 000 in 2009.

Determinants of these trends may include: the rapid socioeconomic transitions in rural areas, the rapid epidemiological transition of the population, improved emergency and mental health system, the increased public awareness of suicide and suicide prevention, and the reduced production, sale and use of highly lethal pesticides, among others.

China is the only country with statistics showing an equal amount or more of female suicides; about one-third of the persons who commit suicide have no diagnosis of mental illness; the suicide rate among rural residents is three to four times higher than that of urban residents (but the gap was reduced recently). The higher suicide rates among rural residents are strongly linked to the most frequent suicide method (about two thirds of suicide used toxic substances).

Suicide was a culturally and politically sensitive topic in China before the late 1980s. Since 1990s, suicide has been gradually recognized to be an important public health issue in China. A few centers and hotline services dedicated to crisis intervention and suicide prevention have recently been opened in large cities such as Nanjing, Beijing, Shanghai, Shenzhen, Dalian, and Changsha. Suicide prevention programs were initiated in some local areas and almost all universities developed some suicide prevention programs.

However, there is still no national plan, guideline or program of suicide prevention. China should not be too pessimistic for the recent decreasing of suicide, and be prepared for the possible increasing of suicide rate in specific groups, such as the elderly, the left-behind rural children, the migrant population, and the urban youth.

**Japan** (Hiroki Ozawa, MD, PhD, Director of the Nagasaki WHO Collaborating Center, and Yuko Kusumoto, MD, Professor, Division of Neuropsychiatry, Unit of Translational Medicine, Nagasaki University Graduate School of Biomedical Sciences, Nagasaki University)

The Reports of Cabinet Office and National Police Agency reveal that 30 651 people committed suicide in 2011 in Japan. When the suicide rate had marked the peak at 31 755 in 1998, the rate remained higher than 30 000 per year. However the rate in 2011 was the lowest since 1998. The socio-economical background is thought to be associated with the suicide trends in Japan.

The Basic Law on Suicide Countermeasures came into force in 2006, ordering the comprehensive nation-wide suicide prevention measures and the expansive support system for the families of those who have died by suicide. The initiatives were based on the success of community-based suicide-prevention programs in local prefectures, e.g. Akita (Motohashi, 2011).

In Nagasaki Prefecture where our center resides, there are also unique measures which, I think, is worth to introduce. We have developed the Everyone, Everywhere, Gatekeeper Operation, which addresses: 1) education and promotion of appropriate knowledge on suicide and the related mental illness such as depression and dementia; 2) education and training of local mental health gatekeepers as liaisons between the community and the specialists; 3) free counseling campaign for multiple debtors; 4) trilateral collaboration among lawyers, public health nurses and clinical psychologists; 5) collaboration with bereaved family members of the suicide; and, 5) social and psychological case work on emergency hospitals without psychiatrists.

There are also geographical and socially-specific mental health gaps in disaster areas, as in the Nagasaki Prefecture which holds many small islands, and among Japanese expatriates.

As a WHO Collaborating Center, we are undertaking the project for the translated version of mhGAP in Japanese to implement in the disaster area, Nagasaki prefecture, Japanese expatriates and anywhere the mental health gaps exist. In addition, we will continue to give lectures on cinema psychiatry and supply telemedicine services to educate and raise interest and commitment of civil society groups with the collaboration with community, medical facilities and companies. Through these, we aim to contribute to the reduction of total number of suicide in our community and globally.

**Mongolia** (Dr Ganchuluun Ochir, National Centre of Mental Health)

Mongolia faces the same social problems caused by suicide and suicide attempts. Historically, before 1990, it was taboo among researchers and specialists. There were no available statistical data, aggravated by efforts of the then socialist state to deliberately keep it in secret. Therefore the problem itself was out of any national health policy and programs of those times.

Data provided by the National Poison Centre shows that 415 suicide cases were registered in 2001 compared to 17 cases in 1990 in capital city. Rapid social changes and challenges that have been experienced in the past 20 years of the so-called transitional period from socialist state to market related (capitalist) economy may have contributed to the increase of suicide numbers temporarily.

Suicide prevention still largely remains out of state health policy and programs although the country is implementing its 2<sup>nd</sup> health program (2010-2019).

Based on data gathered by the WHO-supported START project (2003-2008), 6357 cases of suicide and suicide attempts were registered during 2003-2008, of which 51% (3352) were completed suicide and 49% (3195) were suicide attempts. Males outnumbered females three to one and this was prevalent in all age groups. Age-wise, those in the 18 to 29 year age group accounted for 47% of total cases.

Suicide numbers were higher in the season of spring (30%) while 55% of total suicides were committed at home, while the means used was commonly suffocation.

Mongolia also ranks high in terms of alcohol use compared to other regional nations. Adequate prevention and treatment of alcohol and substance abuse tops the agenda of the national mental health service.

Meanwhile, the top priorities for suicide prevention for the next three to five years are: conduct of a nationwide study of suicide and the setting up of a database at national level; an in depth study of social, psychological and biological risk factors that contribute to suicide; setting up of a counseling center, telephone help line services for suicide attempters, their family members, people with mental health problems; collaboration with support organizations to help suicide attempters; training of physicians including primary doctors on suicidology; public education about health and public training on appropriate use of medication is needed; and a public information campaign on suicide prevention by disseminating notes, brochures.

**Viet Nam** (Dr Truong Le Van Ngoc, Department of Medical Service Administration, Ministry of Health)

Mental health has long been marginal to global health initiatives. The population prevalence of all mental disorders in Vietnam is 14.9% (National Survey 2002). This is approximately similar to the prevalence in other low and middle-income countries.

Suicide is a growing public health problem in Vietnam. A research on suicide attempts was conducted in rural area of Gia Luong in Bacninh, Vietnam in 2008 . The mean population during the study period was 204 000 persons. There were 104 suicide attempters (0.05%), of which 54 were male (52%) and 50 Female (48%). The yearly incidence of attempted suicide was 10.2 per 100 000 person-years, 10.6 per 100 000 in males, 9.8 per 100 000 in females.

Poisoning was the method used in 99% of attempted suicide cases. The most common method of poisoning was by pesticides (62.6%) and by pharmaceutical drugs (36.3%).

The Survey Assessment of Vietnamese Youth Round 1 (SAVY 1) and SAVY 2 were conducted in 2003 and 2008 by the Ministry of Health, General Statistic Office, WHO and the United Nations Children's Fund. SAVY 1 found that 4.1% of those 14-25 years old had ever thought of suicide, with 5.9% of young women, 2.3% of males having done so. SAVY 2 found that 3.4 % of those 14-25 years

old had ever thought of suicide. The number of youth who reported suicide attempt had double since SAVI 1 (0.55%) and SAVI 2 (1.02%).

The government of Vietnam has been active in recent years in strengthening treatment and social support services for people with severe mental disorders. There are three Central Psychiatric hospitals at central level (National Hospitals I and II and the Mental Health Institute), 33 provincial mental hospitals, 25 Psychiatric Departments in provincial General Hospitals, and six Mental Health Centers. There are no inpatient beds at provincial level. There are also 24 Mental Health Units in Social Diseases Prevention and Control Centers belonging to Ministry of Labor Impairment Social Affair.

The national program on community mental health was established in 1998. In 13 years of program implementation, it provided treatment for people with schizophrenia and epilepsy in 70% of communes, covering 100% of provinces. However, the program focuses more on schizophrenia and epilepsy, depression. Suicide is not a priority in the program, despite the rising rates.

Suicide prevention is integrated into National Mental Health Program and general examination and treatment activities in health facilities. Suicide surveillance, monitoring are not implemented completely.

In the near future, Vietnam aims to learn from other countries to start developing a program and model on suicide prevention.

#### **Hong Kong** (Mr Paul Yip, Center for Suicide Prevention, The University of Hong Kong)

Suicide is now a major public health issue in all countries and is the sixth leading cause of death in Hong Kong. In each year, closed to an average of three suicides occurred per day. Since the Asian financial crisis in 1997, Hong Kong suicide rate had increased from 12.0 to 18.6 for the period of 1997-2003 and then decreased and leveled off to about 13.6 in 2010. Elderly suicide is about 2-3 times that of the general population and suicide is the leading cause of death amongst 15-24 age groups.

In Hong Kong, the most common methods of suicide used are jumping from height followed by hanging. However, charcoal burning (carbon monoxide poisoning by burning charcoal in a closed space) as a mean of suicide has become the third most common suicide method since the economic recession in 1997, especially among the middle-aged group.

There is also a more reliable procedure for certifying suicide cases, in which all reported or suspected cases need to be examined by a coroner, forensic pathologist and with a police investigation report.

According to one study (Chen et al., 2012), the profiles of risk factors are somewhat different from those in Western countries. Acute life events such as job loss and work-related issues are key precipitants in Asian men and family conflicts and relationship issues are salient risk factors amongst Asian women. However, there is a lower male-to-female suicide gender ratio and higher elderly-to-general population suicide ratios found in Asian countries as compared to Western countries.

Social support and family ties have been identified as important protective factors for preventing suicide in Hong Kong.

A public health approach towards suicide prevention has been adopted and in recent years, a concerted effort was exerted to develop community-based suicide prevention models with other important stakeholders in the community including government, social welfare department, front-line service organizations, and media. The goal is to use community resources to enhance and empower the connectivity of individuals in the community.

Means restriction has been shown to be one of the most effective ways to prevent suicide. Tuen Mun, Hong Kong was one of the successful examples in reducing suicide rate by limiting access to charcoal by relocating charcoal pack to closed shelf. Media also plays an important role in suicide prevention by improving the reporting accuracy suicide cases.

Besides the community-based suicide prevention programs, CSRP has invested in youth mental health education and internet-based intervention as one of the most important platform for communicating and obtaining information. The Little Prince is Depressed ([www.depression.edu.hk](http://www.depression.edu.hk)) created in 2004 aims to promote public mental health literacy and help-seeking behavior online. There is another ongoing web-based program, GOOLEY targeted at students aged 12-13 and their parents aimed at enhancing adolescent mental wellbeing and enabling mutual communication between parent and child.

Although the suicide rate in Hong Kong has decreased and leveled off in recent years, efforts are still undertaken to develop some evidence-based and promising effective programs at reducing the number of suicides and its associated outcomes.

**Republic of Korea** (Sang Jun Moon, MD, Deputy Director, Division of Mental Health Policy, Ministry of Health and Welfare)

The suicide rate of the Republic of Korea (hereafter, Korea) has skyrocketed over the past two decades and today ranks the highest among OECD countries. In 2010, the rate amounted to 31.2 deaths per 100 000 persons, which translates to 15 566 total deaths by suicide in just one year. This recent increase is reflected across all adult age groups, with the sharpest rise among the elderly population. Although there are more female suicide attempters, the male suicide mortality rate exceeds the female rate. Finally, rates vary according to geographical regions.

In 2010, suicide as a cause of death surpassed traffic accidents as the fourth most prevalent cause of death. Possibilities for the alarming increase include rapid social and economic changes in modern Korean history, changes in cultural values, rapid growth of the elderly population, heavy stress of the achievement-oriented society, increase in mental disorders, weakened ego strength of individuals and weakened support systems. In addition, the numerous celebrity suicides in recent history have most likely contributed to the rise by triggering the Werther Effect.

To this end, both the private and governmental sectors of Korea have given greater attention to suicide prevention. Among the challenges are: heightened stigma against suicide; lack of understanding regarding the relationship between suicide and mental health; the limited budget for suicide prevention programs; and, the lack of comprehensive suicide prevention programs, standardized education programs and experts.

Fortunately, 2012 could mark the turning point for suicide prevention in Korea. In March 2011, the government legislated the Suicide Prevention Law, which calls for the establishment of additional suicide prevention centers, the installation of emergency phones and the renewal of a national-level suicide prevention plan every five years. Earlier this year, the government set up the Korean Suicide Prevention Center to serve as the national center for suicide prevention organizations scattered around the country. Through these measures, we aim to create an effective network of suicide prevention organizations and multidimensional, culturally appropriate suicide prevention programs to combat the current suicide epidemic.

**Lao People's Democratic Republic** (Dr Bouavanh Southivong, Senior Officer Substance Abuse and Mental Health Division, Health Care Department, Ministry of Health)

Lao PDR's first mental health policy was implemented in 2007 and include the following components; (1) developing a mental health component in primary health care, (2) involvement of users and families, (3) advocacy and promotion, (4) human right protection of users, and (5) equity of access to mental health services across different groups. A national mental health strategy and action plan is in the process of development by the mental health strategy development committees assigned by the Ministry of Health. It is expected to be completed and approved by the Ministry of Health at the end of this year.

There are only two in-patient and three out-patient mental health treatment facilities in the country including a NGO-run outpatient service which provides outreach community based treatment and

training to local people and staff at district hospitals. The two outpatient facilities reported 3 381 users were treated in 2010. The only available inpatient mental health services in the country are the 15 beds psychiatric unit in Mahosot hospital and the 20 beds at the 103 Military hospital in Vientiane. The in-patient units had 988 admissions in 2010. The patients admitted to the inpatient facilities had a diagnosis of mood disorders (38%), schizophrenia and related disorders (18%), substance use disorders (16%). However, suicide data is not available in the record of the two hospitals.

There are only 42 personnel are working in mental health facilities in the country, providing mental health services to the 6 million populations; two psychiatrists, one neurologist, 10 general practitioners, 18 nurses, and 11 others health workers. There are no psychiatric nurses, clinical psychologists, social workers, or occupational therapists working in the country. One psychiatrist works for government administered facility and the other work for NGO.

Suicide is still taboo among Lao citizens. The reported suicidal cases are taken from the record book of the out-patient of the emergency care unit and the inpatient of the Mental Health Unit (MHU) of Mahosot hospital. In 2010, there were 29 persons (16 women/13 men) and 44 (16 women/28 men) in 2011 who attempted suicide admitted at the Mahosot hospital MHU. At the emergency care unit of Mahosot hospital, 80 persons (58 women/22 men) who attempted suicide were admitted in 2010 and 115 persons (93 women/22 men) in 2011. The number of suicidal cases might be higher than this figure as we did not collect data in all hospitals.

Currently, there is no suicide prevention program in Laos. At the same time, barriers to such a program include: lack of an effective mental health system in place; lack of research data; stigma of mental illness because of the sensitivity of the issue; and, lack of funding.

To address these, a number of next steps are being currently considered: nationwide data collection on suicidal behaviours (integrating this investigation into mental disorders survey); initiating multisectoral cooperation on promotion and advocacy on mental health including suicide prevention.

**Malaysia** (Dr Rosnah Binti Ramly, Sector for Mental Health, Substance Abuse, Violence and Injury Prevention, Ministry of Health)

In Malaysia, the real magnitude of suicide is not known. Available suicide data is an underestimate. Several local researches indicate that under-reporting of suicide in Malaysia could be attributed to religious, cultural and legal factors. Attempting suicide is illegal under section 309 of The Penal Code (Act 574).

In 2007, The National Suicide Registry Malaysia (NSRM) was established to register data on suicides through the Forensic Services of the Ministry of Health. A total of 1156 suicide cases were registered between mid July 2007-2010. Most cases commonly occurred at home and hanging was the commonest method used. Main contributing factors were life events prior to suicide history followed by substance abuse and history of mental disorders particularly depression and schizophrenia.

The National Health and Morbidity Survey conducted by the Ministry of Health in 2011 revealed the prevalence for suicidal ideation per 100 000 populations was 1.7%; prevalence for suicide plan was 0.9%; and, prevalence for suicide attempts was 0.5%. Younger people (16-24 years) had higher risk of suicidal behaviour. Females and Indians also had higher risk. Depressive disorders were noted to be significantly associated with suicidality.

Efforts to address the problem of suicide in Malaysia have been instituted as early as in the 70's. Befrienders Malaysia, a voluntary non-government organization began providing services to the depressed, distressed or suicidal since 1970s through face to face and tele-counseling. Their activities are available in large cities i.e. Johor Bahru, Seremban, Kuala Lumpur, Ipoh, Penang, Malacca and Kota Kinabalu. Among the activities conducted by the organization are outreach programs to youth and their caregivers, public forums and workshops and seminars on suicide prevention and coping skills to public groups such as schools and colleges. At present, the services are being run by more than 300 volunteers who are trained in emotional support skills.



In the Ministry of Health, suicide prevention activities are coordinated by the Community Mental Health Programme which is under the organization of the Public Health Department. Suicide prevention activities carried out under the health sector mainly comprises of mental health promotion, conducted in the form of health talks, public forums, exhibitions, articles in the media during the World Mental Health Day and World Suicide Prevention Day. Among the activities were exhibitions that highlighted negative and sensational media reports on suicide. A workshop on formulating guidelines for media reporting on suicide was also conducted, attended by 68 media representatives and the Guidelines for Media Reporting on Suicide was launched by the Minister of Health in 2005. Information, Education and Communication (IEC) materials on suicide prevention were also produced.

In response to the resolution adopted by the 49th World Health Assembly and in line with the National Mental Health Policy, an initiative was taken to formulate a National Strategic and Action Plan for Suicide Prevention to address the growing concern over the increasing trend in suicidal behavior in Malaysia. This effort obtained the support from the International Association of Suicide Prevention (IASP) and WHO. The National Strategy and Action Plan for Suicide Prevention which has recently been approved by the higher authorities of Ministry of Health in January 2012.

**Philippines** (Ditas Purisima T. Raymundo, Senior Health Program Officer, Department of Health)

The Philippines, with a population of approximately 90 million, is one of the most populous countries in the Western Pacific, yet very little is known about the epidemiology of suicide and suicidal behavior in the country. Official suicide rates are lower in the Philippines than in many other countries in the Western Pacific region, although there is likely to be under-reporting because of its non-acceptance by the Catholic Church and the associated disgrace and stigma to the family. As in other Catholic countries, a high proportion of suicide deaths are likely to be misclassified as injury of undetermined intent or accidents. To date, no studies of national trends in the incidence of suicide or the national epidemiology of suicidal behavior have been undertaken using Philippine mortality data.

The Philippines is cited to have one of the lowest male (3.59) and female suicide rates (1.09 per 100 000) in the Western Pacific Region. Based on the review of case records, greatest proportion of suicide are from 20 to 29 years. The mean age of non-fatal suicide cases (33.85) was similar to the mean age of fatal suicide (33.16). Sex ratio is 4:1 for fatal and 1.7:1 for non-fatal suicide. Overall, the mean age of female who exhibited suicide behavior (30.5 years) is lower than that of males (34.0) particularly among the fatal suicide group.

A great majority of the suicide behaviors (86%) are carried out in the home. The leading method for fatal suicide is intentional self-harm by hanging, strangulation and suffocation. For non-fatal suicide, the leading method is intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances. In most cases, there is no statement of suicide intent. When present, direct expression of intent was mostly through suicide notes. However, indirect suicide intent was mostly through previous suicide attempt.

Currently, there is no suicide prevention program in Philippines. Major barriers to the development / implementation of national suicide prevention plan include 1) lack of factual data to cite magnitude of the problem, hence, lack of evidence to support need and fund for program; 2) competing interests within the health system where budget is limited; and 3) cultural factors and stigma on suicide that discourage families from reporting.

A plethora of suicide prevention activities are being conducted by different sectors in the country, such as: Community Mental Health Course offered by the University of the Philippines Open University; workshops on institutionalizing suicide prevention as part of guidance and counseling services; training on identification of suicide warning signs and symptoms in communities; and, crisis hotlines, among others.

Recently, a Delphi consensus study included the Philippines which resulted in the formulation of guidelines for how a member of the public should provide first aid to a person who is suicidal, i.e. has

expressed suicidal thoughts or intent or has made a suicide attempt. The guidelines were produced for three Asian countries: Japan, Philippines and India.

### **Pacific Island Countries**

#### **Cook Islands (Dr Rangi Fariu, Director, Public Health and Psychiatry, Ministry of Health)**

Suicide was rare before 1970, if it did happen at all. One thing for certain, it was not discussed openly, even among the medical fraternity. The first suicide was recorded in 1996, followed by three years of inactivity. Suddenly in 2000, five cases were reported. No one looked if these were cluster suicides. At about the same period, on an outer island, six cases of attempted suicide was reported informally, anecdotally in fact. All were under 25 years old, the youngest being 11 years. Alcohol was involved in the older boys. All were attempted following an altercation with their parents.

Thirty suicides recorded since 1996. Except for the spike in 2000, the annual rate hovers around 1-3 cases. Males outstrip females by 2:1. It would appear more suicides happened in the last 5 years (2005-2012) compared to previous years. Of interest, all were from reasonably well-off homes; employed (full or part-time); belonged to sporting, religious or social groups. The commonest cause was inter-relationship issues, either with partners, friends or parents. The only case of mental illness was mentally stable and well controlled. He had been yearning for his family overseas for two years, but could not visit for immigration reasons.

It is difficult to gauge the part played by alcohol. Anecdotally, alcohol may have given them the added courage to act.

Hanging was the commonest method used, followed by self-poisoning with paracetamol. Attempted cases peaked in 2002, and again in 2005. Since 2009 and 2011, it stayed at 2 per annum. The annual figure sits around 2-3 in some years, none in others. Females are three times more common to attempt, than males. Self-poisoning with paracetamol featured in three quarters of cases. Hanging was a distant second.

Several sectors are involved in preventing suicide. Whether by design or by default, the effect had been positive. While the Health Ministry is the lead agency, others ran their programs their own way. Both civil societies and various government ministries had programs suited for their own clientele. As such, all age groups, from young adults to the elderly, were more or less covered.

Health works right across all ages.

A country can never rid itself free of suicide, despite all its best intentions. The Cook Islands has gone through one or two years without. It had focused on the numbers of suicide deaths alone, unknowingly, ignoring positive gains made elsewhere, which were equally acceptable or better indicators, for example, reduced suicide attempts; increased mental health literacy and help seeking behaviour; increased life-skill resilience, increased positive factors.

The Cook Islands are faced with challenges common throughout small nations such as, depopulation, ageing workforce, loss of health professionals, government's competing priority and lack of funds. The best way forward is to do the best one can with what one has.

#### **Fiji (Dr Kiran Gaikwad, Medical Officer in charge of Stress Management Unit)**

Fiji is the island country comprising of about 350 islands and population of around 900,000. Three main islands are Viti Levu, Vanua Levu and Taveuni. Health care services are divided in Cent-eastern, western and Northern divisions. There are three Divisional Hospitals and 16 sub divisional hospitals and one psychiatry hospital in the country. Major ethnic groups are Indo-Fijian and indigenous Fijian.

Majority of the population reside in the central division. However, the suicide rates are comparatively high in the western and northern divisions.

Suicide in Fiji has been recognized as a "chronic epidemic" – a death that outnumbered deaths by drowning and other injury related accidents yet hidden by stigma, myth and shame. What's distinctive in Fiji is that a significant majority of suicides are in the Indo-Fijian and Hindu groups (perhaps 75-80%).

It needs to be highlighted the fact that in Fiji ratio of male to female is closer to 1 to 1 (while worldwide usual ratio of male to females is from 4 to 1 and in some places to as high as 10 to 1), suggesting unique problem among the female population, particularly in young Indo-Fijian female group.

A high percentage of victims are youth. There is data back to 1971-72 showing large numbers of victims in the "youth" age range. These have exceeded road traffic accidents and HIV in most of the past years.

Available data from 2001-2007 suggests that most suicides are committed by hanging. However data in 2011 has shown more suicide and suicide attempts by drinking poison. The commonest poison used is pesticide (Paraquat, which is lethal even in small quantity) followed by herbicides (Rambo), Bleach (Janola), kerosene.

On a global basis suicides are 22% underreported and this is assumed to be true for Fiji as well.

Shame and stigma related to suicide and, in general, to all forms of mental illness, result in suicides often being misreported (e.g. accidental ingestion of chemical). The most common method for attempted suicides is pills and other less-toxic chemicals. They are less lethal.

Rates and causes of suicide and suicide attempt are fluctuating and not always truly apparent. What has come up over the years is that usually the apparent reasons are family conflicts, marital conflicts, relationship issues, or poverty. The data does not always reflect true reasons of suicide and attempted suicides as it is kept secret by the victims due to shame, religious burden and family or cultural concerns.

The report submitted to ICERD (International Committee to Eradicate Racial Discrimination) by NCOPS (National committee on prevention of suicide) has stated that cultural issues among the Indo-Fijian population have been identified as: financial stresses in Indo-Fijian population; isolation of females within the Indo-Fijian culture and a general lack of emotional support; low status of the woman in the culture with little sense of personal identity, worth or hope; excessive availability and inadequate control of pesticides within the farming community; and, extreme pressure to succeed as a way to deal with financial hardship and cultural despair.

There are ongoing though slow moving efforts for suicide prevention in Fiji. The country has a National Committee for the Prevention of Suicides (NCOPS) since 2001. This committee is made up of members from various government departments and agencies, NGOs, civil society, individual, religious organisations and community groups.

The mental health and suicide prevention strategic plan 2007-2011 had been launched. However the achievement of its goals and objectives has been limited. NCOPS drafted a National Suicide Prevention Policy which has been submitted to the Health Ministry in 2008.

The current Ministry has actively taken steps to improve mental health services all over the country. This has been effectively done by implementation of Mental Health decree in July 2011, decentralising mental health services. The Ministry is also committed to work on component one of START (Strategic Trends in At-Risk Territories) with police and a professional counselling service provider, Pacific Counselling Services (PCSS), to do more accurate data collection. PCSS - which provides services free of charge – operates in the three divisions.

From past experiences it is evident that mental health services need to reach out to peripheries and should be part of primary care settings. The country now has stress management wards in all three divisional hospitals and has extended mental health services to remote areas. Outreach clinics

conducted in subdivisional hospitals and health centres improved the accessibility of mental health services to the rural population. There are ongoing efforts to integrate mental health care in primary care settings.

The Ministry of Agriculture has made headway in controlling the use of Paraquat by farmers and this seems to have had an effect in the Vanua Levu area. Better control over Paraquat is perhaps the most significant progress so far.

In terms of awareness raising, the Ministry is pursuing Divisional workshops to increase awareness and to begin to develop Divisional committees (which can increase local control and take advantage of local personnel) for suicide prevention. Awareness-based workshops were conducted last year in divisions. That process continues.

**French Polynesia** (Dr Stephane Amadeo, psychiatrist and coordinator, programme of suicide prevention, Department of Psychiatry, Centre Hospitalier de la Polynesie Francaise, CHPF)

Suicide is a growing public health problem in French Polynesia. Suicide rates increased slowly from the 1990s (13/100 000) and strongly in 2008 and 2009 (18/100 000), becoming the first cause of mortality in the age group 15 to 44 years old (mean age 30 years). There were three males for one female and the most frequent method used for suicide was hanging (90%).

Suicide attempts are not systematically registered in French Polynesia, but the START WHO survey conducted from 2008 to 2010 gives a rate of 70 per 100 000 for suicide attempters, with a same mean age as suicides (32 years) but an inverse sex ratio (two females/one male).

Although at the clinical individual level, causal factors seem to be broken or troubled relationships for couples, associated with depression, the increasing number of suicides may be related to the current severe economic, political and social crisis, according to Durkheim's concepts.

Suicide prevention actions were initially operated by the Association SOS suicide (NGO) since 2001. It consists of a crisis phone line and different initiatives to make the general public and professionals more aware of the problem.

Since 2005, suicide prevention programs launched in French Polynesia received grants from the local Ministry of Health through EPAP (public financial body for prevention) for the implementation of:

- The WHO SUPRE (since 2006) program based on the delivery of resources booklets, adapted to the oral tradition of Polynesians, i. e. given during public meetings and professional workshops.
- The French National Strategy Against Suicide program (since 2007), with one part of this plan, training of a large panel of professionals and voluntary workers in suicidal crisis intervention (3 day course) including evaluation of suicidal potential by the < Risk-Emergency-Dangerosity> method. This training session took on an academic form with a "University Diploma" in 2009 and 2010 (3 weeks course).
- The WHO START study from 2008 to 2010 (epidemiological study with brief intervention and contacts and psychological autopsy).

An international congress on suicide prevention held in Tahiti in May 2011, with the support of Ministry of Health, France "Fonds Pacifique"(Pacific Fund) and WHO-ROWP, helped us establish a novel plan for suicide prevention strategy in French Polynesia. It is being implemented, with the creation of a suicide prevention centre and culturally based interventions (aromatherapy, religious network, among others)

**Guam** (Dr Annette M. David, Health Partners LLC, technical consultant to the Guam DMHSA)

Suicide remains prevalent on Guam, with an average of 1 suicide death occurring every 2 weeks. The crude death rate from suicide has remained unchanged at ~18-19 deaths per 100,000 inhabitants over the past years.

- Suicide deaths are highest among youth and young adults, with about 60% of all suicide deaths occurring in those under the age of 30 years.
- Micronesian Islanders, particularly Chuukese and Chamorros are significantly over-represented in suicide deaths.
- Suicide deaths occur predominantly among males. This likely reflects the difference in choice of suicide method, with a higher proportion of males preferring hanging.
- Nineteen percent (19%) of those who died of suicide from 2008-2011 left direct evidence (suicide note) of intention to commit suicide. Twelve percent left indirect evidence of intent. Altogether, about one on three (31%) of suicides from 2008 to 2011 left evidence of their intent. If community members were better trained to pick up on intention to commit suicide, it may be possible to intervene before a suicide death occurs.
- Alcohol is implicated in almost one-fourth of all suicide deaths from 2008 to 2011. Other drugs of abuse are involved in 7% of suicide deaths.
- Youth in Guam appear to have a higher likelihood of thinking about suicide, making a suicide plan and actually attempting suicide as compared to youth in the US mainland.
- Correlates of youth suicidal ideation and suicide attempts include sexual violence, depression, identifying oneself as gay or bisexual, and substance abuse.
- Five attributes linked to higher suicide risk --- (1) being hit by a boyfriend/girlfriend in the past year, (2) forced to have sex, (3) felt sad for at least 2 weeks over the past year, (4) current daily smoking and (5) current marijuana use---have prevalence rates among Guam youth that are statistically higher on Guam than the US.

These findings provide justification for integrated suicide prevention approaches that also address skills in developing healthy relationships, physical and sexual violence prevention, tobacco and substance abuse prevention and control and aggressive screening and treatment for depressive symptoms.

The data have implications for suicide prevention approaches, such as:

- Youth and young adults are a valid target for suicide prevention efforts.
- Micronesian Islanders, especially Chuukese, and Chamorros constitute critical target groups for prevention intervention.
- Strategies that may be important for suicide prevention include: preventing and controlling alcohol and other drug abuse; aggressively screening to recognize and treat mental illness and depression; building community capacity to recognize the signs of impending or possible suicide and training community members and first responders to effectively intervene to bring individuals at risk of suicide to professional attention; training emergency room personnel and other hospital personnel to do brief interventions and referral to DMHSA and other mental health treatment providers for all cases of attempted suicide; and, skills training in developing healthy relationships and physical and sexual violence prevention.

**Samoa** (Pisaina Tago-Snyder, clinical nurse consultant, Mental Health Unit)

Suicide is not a new phenomenon, but it is one of the major mental health problems in Samoa.

Depressed clients may certainly be suicidal but many suicidal clients are not depressed. It is either an individual retaliatory behaviour that have resulted from internalizing anger or seeking attention to manipulate someone with suicidal behaviour. Clients may view suicide as an escape from extreme despair or from a perceived intolerable life situation such as living with a chronic painful medical conditions or terminal illnesses.

From 2001- 2011, there were 167 completed suicides (we would expect 220 on our population and an annual rate of 1:10,000). The highest number of these recorded were among the age groups of 20-39 and the majority were male. The two commonly used methods were hanging and Paraquat poisoning (weed killer).

There were 212 cases of attempted suicide in the same period with the majority of those recorded as the highest number were among the age groups of 10 - 39. More females attempted suicide than males. The two commonly used methods were paraquat poisoning and detergents. More males used paraquat poisoning and hanging than any other methods.

The major causal factor was situational and/or relationship crisis within the family, arguments between couples, parents and their children, relationships which their children are engaged in, and other social factors that have impacted the family stability. Cultural factors have played a role in instigating suicide among different age groups such as village decisions imposed among men resulting in disputes in families and other people of the village. Recent legislation and the global financial crisis have affected the living conditions and morale of many families, contributing to economic hardship. Socially derived financial obligations add to these stresses.

In terms of suicide prevention, one of the recommendations that came from the Mental Health Symposium of 2003 was the crafting of a suicide strategy and program to raise public awareness on prevention of suicide, collect and maintain health sector suicide data; support and treat populations at risk - adolescents, elderly, those with depression; support survivors of suicide - self help groups; reduce availability of the means of suicide (especially Paraquat); and, wider availability of counselling agencies for people in distress.

Fa'ataua Le Ola (FLO) a non-governmental organization was established to focus programs in the community on suicide prevention, working in partnership with Mental Health Unit.

Major barriers are lack of funding and lack of political awareness.

**Tonga** (Dr Mapa Ha'ano Puloka, authorised psychiatrist i/c Psychiatric Unit, Vaiola Hospital)

Tongans are no different from any other races in the world as far as self-destruction is concerned. But on the other hand our legends reveal not much stories about individual suicide as it is now common in Tonga (in a sense is the Anomic Suicide according to Durkheim's type of suicide).

There was no specific word for individual suicide (anomic-type) in ancient Tonga. The current Tongan word specifically coined to translate the English word "suicide" into Tongan is 'taonakita'. In fact it was a recently coined word sometime in the late 1970s or early 1980s.

Suicide in Tonga and still many people in the community believe that the act of suicide is familial due to a curse that runs in the family from generation to generation. Thus a nemesis of that family wrong doing in the past. Suicide is usually a forbidden issue to talk openly about. Such is the strong stigma associated with suicide.

Since 1903 suicide has been criminalized according to the Law of Tonga and is currently stated in the 1988 volume # 1 of the Law of Tonga.

In the 1970s and 1980s suicide incidence seem to gradually emerge, attracting the attention of the mass media and the public. Also health personnel started to do retrospective study on suicide.

In 1891 Basil Thomson estimated that the suicide rate in Tonga was about 0.6 per 100 000 of the population. Between 1971 - 1982 an annual crude rate of 1.5/100 000/year was mentioned. In 1983 - 1993 an annual crude rate of 3.2/100 000/year was also mentioned. A current estimation (1978-2011) of crude suicide rate reveals a range of 5-to-7/100 000/year. Thus an average increase of ten times of the rate of suicide from 1891 to the 2000s. Also an increase of 400% of suicide rate in the 1970s in comparison to the 2000s.

The commonest method of suicide in ancient Tonga was strangulation. So someone else had to assist the victim to commit the act of suicide. There were other methods such as, adrift in a leaky canoe, jumping from a coconut tree, and drowning in water (weighed down by a stone). Hanging was uncommonly practiced (was regarded as more European rather than Tongan) but now the method of hanging is the most common method of fatal suicide.

In 1996 a proposal came from the newly formed organization at the time, The Australian Institute for Suicide Research and Prevention (AISRAP) to assist Tonga and other Pacific Islands in suicide research. A half day workshop was held in the Ministry of Health, Vaiola Hospital attended by health personnel and others from related sectors. Research and preventive programs for suicide were discussed.

In 2005 Rev. Fili Lilo from the Life-Line Tonga discussed the issue of suicide in Tonga. He was not only a person from the community and working in the community but he has a passion for such matter. Since then Rev. Lilo became the National Focal Point for Suicide in Tonga coordinating the research part of the activities and the program for suicide prevention in the community.

A formal partnership has now been established between the MOH (psychiatric unit) and Life-line Tonga in the running of the START project and the implementation of preventive program for suicide in the community.

The START project is currently under the umbrella of the Mental Health Advisory Committee (MHAC) chaired by the Director of Health. Currently the working committee core members include the National Focal Point for Suicide, Solicitor General, Deputy Commander of Police, authorized psychiatrist and the secretary. It is in the process of submitting a document of agreement for a Cabinet endorsement on the Collection, Analysis and Publication of National Data Bank on Fatal and Non-Fatal Suicides. The endorsed agreement is to be made available for relevant Government Ministries and NGOs for possible signing.

Schizophrenia, psychotic disorder NOS and major depressive disorder were the top three diagnoses (causes) of fatal suicide among known psychiatric cases since 1985 up to the present (August 2012) according to the psychiatric unit's record, Vaiola Hospital.

Fatal suicide among males always far exceed the number of female fatal suicide. The most common finding world wide. Hanging was uncommonly practiced (was regarded as more European rather than Tongan) but now the method of hanging is the most common method of fatal suicide.

The increasing number of fatal suicide among youths are associated with increasing conflicts in families and the abuse of drugs.

Problems concerning suicide work in Tonga still persist such as:

- There is limited knowledge about suicide and non fatal suicide behavior in Tonga due to difference in the quality of examination of cases and recording practices among stakeholders (especially among Ministry of Police, Ministry of Health and Mental Health Unit).
- The existing Law for the investigation of the cause of death, The Inquests Act (#17, 1903- last review #14 1988) is out of date and therefore needs amendment. In other words Tonga has no proper coronership system for the investigation of unnatural death.
- Tonga has no specific government policy for suicidal behavior (the Inquest Act needs amending).
- There is a need further improvement in the treatment options for persons who have engaged in non-fatal suicidal behaviors as well as improvement in the co-ordinated interventions and treatments of fatal and non-fatal suicidal behaviors.
- There are insufficient systems for capturing data on fatal and non-fatal suicidal behaviors.
- There is limited attention from government bodies.
- There is a lack of systematic research.

Tongans are now gradually developing some kind of immunity or acclimatization to the consequences of suicide; as an analogical comparison, it is just like substances related problem and early death among Tongans due to non-communicable disease.

**Vanuatu** (Mr Peter Kaloris, national mental health coordinator)

Vanuatu is a tiny nation in the South Pacific with a population of 234 000 people and of that 20% are youth due to a continuing high birth rate. Vanuatu is facing a rapid increase in population especially in urban areas where there is increasing social problems. Today there is existence of the double burden of morbidity / mortality with communicable and non communicable diseases.

Life expectancy is 67 years and infant mortality rate is 25 / 1 000. A majority (85%) of the population have access to clean water, 63% to good sanitation, five hospitals, 38 health centers and 89 dispensaries but 25% are non-functional. There are large gaps in human resources for health.

The country regularly suffers from volcanic eruptions, cyclones, earthquakes, droughts and floods, some of which are increasing in frequency and variability, as well as extreme events due to climatic variability and sea-level rise associated with human-induced climate changes. Increasing population, uncontrolled growth of urban centers and spontaneous peri-urban settlements are contributing to increased levels of vulnerability.

There are no clear statistics on suicide, data collected by Non-Ministry of Health sources show that relationship and family problems as a major cause of suicide in Vanuatu and personal stories indicate that suicide is often hidden in Vanuatu. Due to lack of proper implementation of the START Study we continue to experience poor collection of data on the number of fatal and non-fatal cases of suicidal behaviour and lack of proper recording using the same method.

Although some efforts are done around suicide prevention interventions no government departments have developed a suicide prevention policy.



