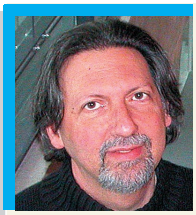
newsbulletin

International Association for Suicide Prevention

JULY 2008



FROM THE PRESIDENT

Considerations on linking suicide with violence and other topics

Suicide is often associated with or subsumed under other seemingly "more general" topics, such as Injury Prevention or Mental Health. The basic assumption is that suicide is a specialized sub-set of a more general overriding domain. Killing oneself can be seen as just one of many ways one can sustain injuries; suicidal behaviours may be viewed as one of many consequences of living with a mental disorder. Sometimes suicide prevention is considered as part of what some may consider strange bedfellows. For example, WHO considered suicide in the unit that dealt with Brain Disorders; anti-abortion campaigners in the United States have embraced suicide prevention workers as brethren working for the same cause; and in some schools suicide prevention is assumed by nurses as part of their "personal hygiene" classes.

Sometimes the desire to place suicide within a "larger" phenomenon is motivated by a theoretical position that can be well defended. However, it is often the case that where suicide is "housed" reflects a political reality with financial consequences. Suicide prevention money may be spent very differently if it is handled by medically oriented mental health planners or by public health workers who favour primary prevention over interventions when the risk is already high. It is sometimes quite a challenge to sort out the motivations and implications of placing suicide in one or another camp.

I was inspired to write this column in the midst of teaching at the "5th Francophone Summer University on Public Health" in Besançon, France. In past years there was a course on suicide. However, this year the wisdom of the organizers, in collaboration with the Francophone International Network on Safely Promotion and Trauma Prevention, decided that they would merge suicide in a course on "Prevention of violence and suicide in youth." Freud would probably have been content. As Menninger and other followers elaborated, externally focussed violent acts can be viewed as alternatives to self directed suicidal impulses. In the most simplistic analysis, increased violence should be related to decreased suicide, and vice-versa. Although the data tend to support the opposite view, that increased violence is associated with increased suicidal behaviours, the linking of suicide with violence seems to make some sense. Some violence researchers point out that suicide is just one of many violent acts. But, are all suicides truly violent? Are there advantages to viewing suicide as a special form of violence?

Perhaps a closer association between suicide and violence would bring more attention (and funding?) to suicide prevention. Although more people worldwide die by suicide each year than die in all wars, terrorist acts and murders combined, our media focuses by and large on people killing others. "Self-murder" is of much less concern than wars, terrorism and homicides. Perhaps this is a hold-over from condemnations of suicide and the feelings of shame associated with suicidal behaviours. Perhaps it is the association with mental illness that leads to minimizing the importance of suicide. Enough Hollywood films tell us that "normal" people commit other acts of violence and murders by Hollywood heroes are often glorified. It is only the murders by the "bad guys" that we need to prevent.

I still feel uncomfortable whenever suicide is subsumed under another topic, be it mental health, injury prevention or the prevention of violence. A defining characteristic of suicidal behaviours is the multiplicity of influences. Suicide has many dimensions and limiting the focus to one perspective ignores the complexity of suicide and results in a myopic view of the many opportunities for suicide prevention. The IASP membership and the interdisciplinary content of our scientific programmes at IASP congresses exemplify the wide range of opportunities for understanding and preventing suicide. Biology, genetics, anthropology, sociology, public health, and a vast range of psycho-social perspectives have complementary implications for treatment and prevention. Still, I am a realist. I know that there can be practical advantages to housing suicide prevention in mental health or other "general" areas. Teaching a course on suicide and violence is also a fascinating exercise. But at heart, I know that there are important limitations whenever the complex phenomenon of suicide is reduced to "just a sub-category" of whatever topic. The rich complexity of suicidal behaviours is generally compromised whenever this occurs.

Brian L. Mishara, Ph.D.
mishara.brian@uqam.ca

Dear IASP Colleagues,

I am writing to introduce myself as the newly elected Chair of the Council of Organizational Representatives to the Board of the International Association for Suicide Prevention. I hold a Master of Social Work degree in Aging Administration and recently completed my Doctor of Philosophy in Health Related Sciences with an emphasis in Gerontology focusing on older adult suicide. I have been active in the field of suicide prevention in the United States for the past eleven years.

As Chair of the Council, it is my intention to build a working relationship with current organizational representatives during my tenure on the board, encourage other organizations to join IASP, and to listen to your comments and suggestions for our association and represent them well to the board and full membership. I believe that as organizational members of IASP we are uniquely positioned to inform our international suicide prevention colleagues by sharing what we do from an organizational perspective by actively participating in planned trainings, symposia, conferences and through publication in our newsletter and journal. As a result, we would all benefit from learning from others doing similar work in other nations.

To facilitate our dialogue, I would like to provide my contact information so we can communicate via email. My email address is jreed330@comcast.net . I would be pleased to hear from you on how you believe the association can be of value to organizations as we engage in our work around the world dedicated to preventing suicide. I would also like to hear what you would like to see on the program at our 2009 World Congress in Montevideo. I hope many of us will submit abstracts that highlight the work of organizations as the call for abstracts is released.

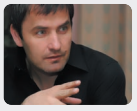
There are many exciting opportunities being planned to come together as colleagues in the months and years to come. Our first opportunity will be in Glasgow, Scotland at the 12th European Symposium on Suicide and Suicidal Behaviour being held 27-30 August 2008. For more information visit the conference website at http://www. esssb12.org/ . Following this event will be the 3rd Asia Pacific Regional Conference of the International Association for Suicide Prevention to be held in Hong Kong between the period 31 October – 3 November 2008. For more details visit the conference website at http://csrp.hku.hk/ iasp2008/. And of course planning is well underway for the XXV IASP World Congress being held in Montevideo, Uruguay during the period 27-31 October 2009. Having attended my first World Congress in Killarney, Ireland, I am very much looking forward to attending and spending time with suicide prevention colleagues from around the world. It provides a great sense of "community" giving us each strength and encouragement as we return to our home nation to continue our important work. I plan to attend all three gatherings and hope we can meet in person at the events you are planning to attend. I will arrange an opportunity at each venue listed above for organizational members and prospective members to meet and provide input that can inform the future work of IASP. I will advise you in due course of the dates, times and venues of these meetings.

As organizational members of IASP I hope we can work closely in the days to come to advance our collective capacity to reduce the burden of suicide and suicidal behaviour around the world. I look forward to the opportunity of working with each of you during my tenure as Chair of the Council of Organizational Representatives.

Best,

Jerry Reed, Ph.D., MSW
Chair, Council of Organizational Representatives
International Association for Suicide Prevention

Prof. Andrej Marusic Trust



ANDREJ MARUSIC, 1965-2008

Thank you! Prof. Andrej Marusic's colleagues would like to thank everyone for the kind messages they received in the weeks after he died. Many people asked that their condolences be passed on Prof. Marusic's family. His colleagues have prepared a book of condolences, which is to be sent to Andrej's wife, children, mother and brothers. Andrej's family members would also like to thank everyone for their sincere condolences and they and Andrej's colleagues want you to know that the support and warmth they have received is giving them all the strength to go on.

The "Prof. Andrej Marusic Trust" has been established to continue research in suicidal behaviour and mental health. Details of the trust follow:

"Prof. Andrej Marusic Trust", Zavod Celjenje, Vojke Smuc 12, 6000 Koper, Slovenia, EU
Bank: Unicredit Bank, Smartinska 140, 1000 Ljubljana, Slovenia, EU
IBAN: SI56290000055337678 SWIFT: BACXSI22

From: Andrej's researchers and colleagues

COUNTRY REPORT: **HONG KONG**

Epidemiological profile

Encouragingly, suicide rates in Hong Kong have been substantially reducing from a peak in 2003, 18.6 per 100,000 people, to less than 14.0 per 100,000 in 2007. However, suicide is still one of the leading causes of death, particularly among people aged 15-24. Charcoal burning as a newly emerged suicide method in the late 90s has swiftly proliferated to become the second most common means of suicide in Hong Kong since 2001. The total number of suicides by this method increased from 16 (2%) in 1998 to its highest level at 325 (25%) in 2003, and now this issue has become a major public health concern in the Asia-Pacific region.

Together with other NGOs, stakeholders and government departments, the HKJC Centre for Suicide Research and Prevention, The University of Hong Kong (CSRP) has been working diligently in tackling the suicide problems from a multi-layered approach in the community including conducting research, providing training for front-line professionals, and producing educational materials for the community. Two of the CSRP's programs integrated, multi-layered approaches to suicide prevention in Hong Kong include:

Postvention research and intervention for survivors of suicide

Since 2006, a three-year pilot multi-disciplinary project, which aims to develop, study, and evaluate evidence-based quality care, and to understand and identify best practice to help people bereaved by suicide in Hong Kong has been developed, funded by a local entrepreneur, Mr. Peter Lee.

This program is based on local and international experiences that not all suicide survivors develop complicated grief or suicid risk, but those who are at risk do not generally seek professional help. Thus, we established a program that cares for people bereaved by suicide at all level of needs. With support from the Department of Health, informational support, and immediate help are provided at public mortuaries. Structured psycho-educational groups, telephone follow-up and brief-psychotherapy are also offered to survivors with various levels of needs.

Community-based suicide prevention project

A community-based, multi-agency suicide prevention alliance was formed within a community with a population of 600,000 in 2006, with representatives from CSRP, Hong Kong Police Force, Social Welfare Department, Housing Department, and the Pamela Youde Nethersole Eastern Hospital. The Working Group is chaired by the Eastern District Police Commander, and has developed a series of strategic suicide prevention initiatives and includes systematic evaluation of their effectiveness. Multi-level strategies include training for all front-line police officers by medical, psychological and social work professionals; development of a "First Responder Kit" for police officers, an information card and poster for public which contains help line numbers; establishment of a new Police-Social Welfare Department referral mechanism for attempters and families of suicide; training for GP and teachers about early identification of suicidal behaviours; and development of professional-led psycho-educational groups for bereaved families.

The 3rd Asia Pacific Regional Conference of the IASP

To raise the importance of suicide prevention and to share our experience in suicide prevention with others in the Region, we have organized the 3rd Asia Pacific Regional Conference of IASP The theme is "Suicide Research and Prevention in Times of Rapid Change in Asia: Opportunities and Challenges". It is the wisdom of Chinese saying that crisis always comes with opportunity. Experts in all aspects of suicidology, from those bereaved through suicide to those foremost in the field of research, will attend. Mrs. Selina Tsang, wife of the Chief Executive of Hong Kong SAR Government, has also kindly agreed to become the Conference Patron.

We have received very good responses to call for abstracts: 150 abstracts of presentations representing 19 countries and cities / regions have been selected. Topics vary from scientific knowledge to practical skills, with all enhancing the effectiveness of suicide prevention in the Asia Pacific region.

Early bird registration will close on July 31, 2008. For more details, please visit the conference website http://csrp.hku.hk/iasp2008/

I am looking forward to seeing you in Hong Kong.

Dr Paul S.F. Yip
IASP National Representative
Hong Kong
sfpyip@hku.hk

COUNTRY REPORT: **HUNGARY**

Decreased suicide rates in Hungary: The paradox of suicide reduction without prevention

Hungary's suicide rate between 1968 and 1987 was the highest in the world but decreased markedly from 1987 to 1988 (from 45.1 to 41.3 per 100 000) and has continued to decline steadily since then, reaching 24.4 in 2006. The origin of this decline is not clear, but it may have multiple causes.

- First, the decline cannot be explained by the increased use of SSRI antidepressants since commercial sales of SSRIs in Hungary began to increase in 1995, while the decline in the suicide rate began much earlier.
- Second, the sudden decline in suicide rates in 1988 points to the possibility that a significant improvement in the political climate, and the hope associated with liberation from an oppressive political regime, may have influenced the suicide rate.
- Third, drug-related deaths emerged during the 1990s and there are approximately 80-100 of these each year. Most of these deaths are probably not accidental, but, rather, voluntary overdoses (the term used is "golden shots"). "True"suicide cases are very difficult to verify as such, but only those cases "beyond reasonable doubt" are registered officially as suicides.

Distinct regional differences remain an intriguing phenomenon in Hungary: For 160 years the Southeastern part of the country (The Great Hungarian Plane) has had a suicide rate which is 2 to 2.5 times higher than in the Northwestern part of the country. This difference persists to this day.

It is a pity that because of the political and economic situation in Hungary the problem of suicide prevention is of no more than marginal interest to the government. The "official" work of our Hungarian Association for Suicide Prevention is virtually negligible: we assist in the preventive work of the civil organisations and the churches. We have written the Hungarian Suicide Prevention Plan, but it has not been implemented. Neverthless, and paradoxically, the suicide rate has halved in the last 20 years! I am not sure what this indicates about the need for suicide prevention programmes!

Tamás Zonda, MD PhD
Hungarian Association for Suicide Prevention
National Representative of IASP (Hungary)

SYMPOSIUM AND CONFERENCES