What can be done? (contd.2)

Legal reforms...laws and impact

All SEAR Member Countries have their own legal systems and procedures with regard to suicides. Many countries have a discriminatory attitude and suicides are considered an offence. As per Section 174 of the Indian Code of Criminal Procedures, every intentional death has to be investigated unless otherwise directed. Sections 305, 306 and 309 of the Indian Penal Code consider "abetment of suicide of a child" and "attempt to suicide" as an offence punishable under the code. The punishments under such acts vary from one to 10 years of imprisonment and heavy fines. During 1994, this was declared as unconstitutional, only to be reverted to the original two years later. Rigorous punishments for suicide existed in Sri Lanka until 1998, after which it is no longer considered a crime. Significant progress has been made recently by modifying the law whereby survivors of suicide attempts are no longer prosecuted. Thailand does not have any law but is strengthening mental health through parliamentary procedures. The Bangladesh Penal Code specifies that completed or attempted suicide is a punishable act, while Indonesia does not have any such law. There may be a few countries still practising laws which impose severe punishment.

While the legal status with regard to suicide in every country is debated extensively for its merits and demerits, the law makes it mandatory for suicides to be investigated by police authorities and for judgement to be delivered by courts. This leads to a situation where hospitals refuse to admit persons who have attempted suicide and even if such patients are admitted, it is for unrelated reasons. This leads to gross underreporting, refusal to help the affected person, increased stigma due to police visits, and concealment of the facts, all of which result in the affected person not receiving proper medical or psychiatric help.

Every SEAR Member Country needs to re-examine such laws. Attempts should be made to remove stigma, remove offences and punishments and make systems people friendly. Legal authorities need to be made aware of the consequences of such laws and their role in making services easily available, decreasing harassment and the burden on individuals, and eliminating stigma. A greater interaction between law-makers, enforcing agencies and health professionals is required for smooth transition towards a new phase.

Did you know that the majority of developed countries have decriminalized suicide laws?

Germany	1751
France	1791
Netherlands	1810
Austria	1852
Sweden	1864
Denmark	1868
Finland	1910
England	1961
Hong Kong	1967
Ireland	1993

Spiritual leaders and faith healers...wisdom to action

Spiritual leaders and faith healers occupy a unique position in South-East Asian societies owing to their stature, position, wisdom and their capability to influence people's beliefs and values. While the spiritual and religious dimensions of suicides are debatable, it is essential to realize that "human life is precious". Since people have enormous faith, respect and confidence in spiritual leaders, they should emphasize the fact that suicide is preventable and individuals can be helped by counselling, medication and supportive services. Spiritual leaders can emphasize the importance of life and its meaning by promoting positive beliefs and values.

Faith healers should be involved in suicide prevention activities at the community level as they are the first level of contact for many health problems. If they can play a positive role in identifying suicidal thoughts, behaviour, depressive states and offer emotional support to people, it will be a step in the right direction. Several non-pharmacological methods of management are gaining popularity in SEAR Member Countries. Some of these are yoga, meditation, acupuncture and reiki. While no established randomized controlled trials are available to prove their efficacy and effectiveness in the management of certain psychological problems, their acceptance in the community has been growing. It is vital to develop a better understanding about the role of these systems to incorporate positive, harmless and culturally- accepted methods. The involvement of spiritual leaders (*imams* in Bangladesh, monks in Sri Lanka and Thailand, religious leaders in India) in community decision-making activities will be of help in promoting solidarity in the community.

Digital Creativity

Nongovernmental organizations (NGOs)...pillars of strength

NGOs in every country are involved in a number of health and developmental programmes. Their knowledge of the community, family and individuals is vast due to their close rapport with the people. Many NGOs in developmental and mental health care have suicide prevention as a major agenda (directly or indirectly). Such NGO initiatives should be expanded in terms of their geographical coverage and their range of services. Governments and communities should encourage and support their activities, especially those related to welfare activities of children and women.

What NGOs can do...

NGOs can offer direct intervention efforts and related supportive services. The **Samaritan's Movement** has branches in Hyderabad and Chennai in India and has become an international movement with over 1000 centres in several countries. **Sneha** in Chennai, India, has a wide range of activities by committed volunteers, available and accepted by society. **Vimochana** in Bangalore, India, offers supportive services to women and has taken up the issues of investigation, legal matters, recording and reporting people's rights, and helping families to cope with a suicide/attempted suicide. **Sanjivini** in New Delhi, India, has teams of committed volunteers to provide timely help. **Sumithrayo**in Sri Lanka, with 11 branches across the country, has "untrained volunteers" capable of providing a sympathetic ear to distressed people. **Slavs**, another NGO in Sri Lanka, has initiated peer counselling services for youth by training them in basic counselling techniques. **Befrienders** (Samaritans) in Thailand has established hotline services in Bangkok and Chiang Mai with partial funding from the government. The **Bersama**, hotline service in Indonesia, offers timely assistance. Individual, family and group therapies are offered by a number of hospitals and NGOs in their day-to-day practice. Several NGOs have also taken up a greater role with regard to laws, stigma removal, rehabilitation of people attempting suicides, counselling for children, supportive services for women, public awareness programmes among the public and doctors, improving the life of the elderly, and basic social and welfare reforms. There is a need to expand these movements within countries to increase the availability and accessibility of such services and to share the successes and failures.

Due to the vision and mission of Reverend Chad Varah, a small movement began in the early 1980s in the south-western part of London. It was basically a telephone befriending service for suicidal people. Following the death of a young man due to loneliness in a crisis situation, the priest realized there had been no one to lend a sympathetic ear to this man. Subsequently, he displayed a small note saying that anybody who wanted to talk about his problems could contact him. Innumerable calls flowed in from people from all walks of life. Since he was alone and unable to handle the large volume of calls, he invited a group of like-minded, friendly people to join him. This voluntary service by non-professional volunteers has developed into a 24-hour telephone service. It encourages people to visit their centre and even despatches flying squads. Confidentiality, immediate service, referral network, non-judgmental approach and public awareness-building are the hallmarks of this movement. The staff provide a voluntary, sympathetic, and listening human ear to persons in distress. The guiding principles of work are "no advice", "no patronage", "no money", and "do not hang up upon the caller." In totality, the services are available, acceptable and affordable.

This small movement, begun 20 years ago has nearly 1000 centres across countries. The Indian movement, started in 1992, already has 10 branches in major cities. Branches in South-East Asian countries, such as Sri Lanka, Thailand and Indonesia are accepted for their human services.

Ma Thiri Nanda Shwe War Phone

National governments...time to act

With limited information on the problem and limited preventive programmes in SEAR, suicide is an unrecognized, silent and hidden epidemic. With nearly 200000 officially reported deaths,

2000000 attempted suicides and millions with suicidal thoughts, the problem has not received due attention from national governments. While the debate continues on causes and issues among professionals and the public, there is an urgent need to prevent suicides. Countries of the Region have to assume greater responsibility for reducing the problem through coordinated and integrated approaches. No country in the Region has a focused "suicide prevention policy" except Sri Lanka. Even in Sri Lanka, strategies have been made but not implemented.

Figure 10:An intersectoral approach

Fill in the blank boxes for your country
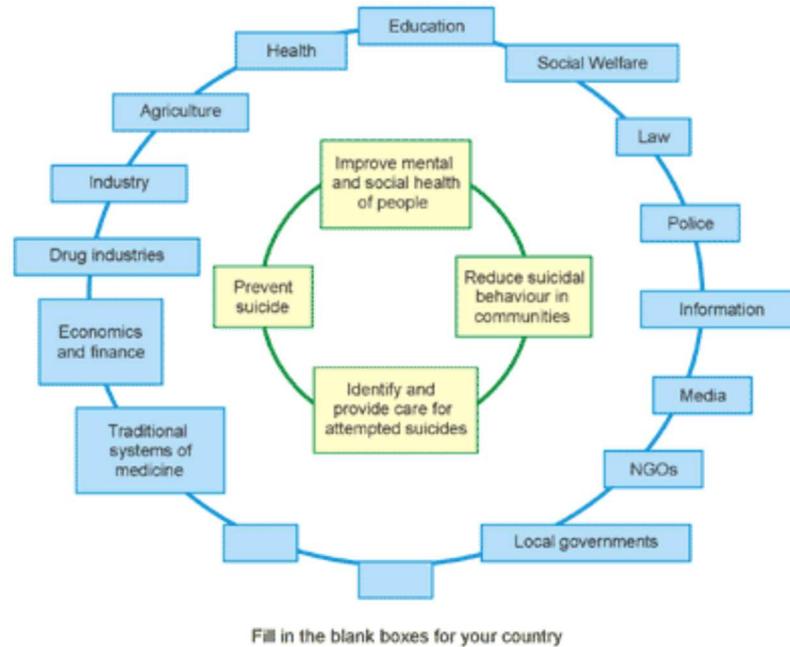
Health Education Social Welfare Law Information NGOs Police Media Local governments Economics and finance Traditional systems of medicine Agriculture Industry Drug industries Improve mental and social health of people Reduce suicidal behaviour in communities Prevent suicide Identify and provide care for attempted suicides

Fill in the blank boxes for your country

In Sri Lanka ...

A presidential committee examined the problem of suicides in 1998 and suggested :

:: reducing easy access to pesticides;
:: introducing measures to reduce lethality by presenting dilute formulations and promoting non-lethal forms of pesticides and poisons;
:: formulating strategies to improve medical management by improving facilities in district hospitals and setting up poison treatment centres;
:: ensuring appropriate treatment of depressed and alcoholic people;
:: changing the present law to decriminalize suicide (implemented by an Act of Parliament since May 1998), and
:: developing media policies on the reporting of suicides.

Every SEAR Member Country must develop a National Suicide Prevention Policy. Implementation should be through an intersectoral approach with participation and inputs from all sectors. Only when there is a policy can there be a programme and resources for implementation (Figure 10).

Yogeeta

What Member Countries can do...

Member Countries should also consider the following steps to strengthen suicide prevention mechanisms:

:: Countries must establish and strengthen "suicide surveillance" at local and national levels to understand the problem and identify risk groups as well as the causes and preventive methods. A trend over a period of time should be used to monitor the impact of interventions. Health departments must be encouraged to report both completed and attempted suicides on a regular basis. Simultaneously, police personnel must be sensitized to the importance of accurate reporting to initiate preventive measures.
:: National centres should be identified in all countries to undertake research, policy support, programme development and evaluation. It is obvious that the lack of research is one of the contributing factors for the lack of suitable programmes. Funding should be available to examine specific research issues, implement interventions and evaluate programmes.
:: Every country must identify cities and towns with high suicide rates within their countries for priority interventions on a culture-specific and cost-effective basis.
:: Components of mental health care must be strengthened to identify at-risk subjects. Mental health must be integrated into primary health care under the respective national mental health programmes. There is an urgent need to focus upon small-scale training programmes at all levels to identify and manage depression and alcohol dependence along with other mental health problems.
:: Removal of stigma should receive the highest priority. As long as it remains, suicide will be a hidden and undisclosed phenomenon. Public awareness programmes, elimination of punishable laws, friendly attitude of enforcing agencies and open discussions with community leaders are essential prerequisites in this direction.
:: Immediate measures should be taken to restrict public access to pesticides and other organophosphorus compounds. As agriculture is the predominant occupation in this Region, a total ban on such products may not be possible. However, control of supply and distribution of pesticides may save many lives.

Examples from the West The reduction in the availability of a toxic product is one of the best means for reducing suicides. In Samoa, suicide rates were around 5 per 100 000 till 1974. "Paraquat", a pesticide, was introduced around 1975 in the country. Suicide rates continued to rise, reaching a peak around the 1980s to the level of 50 per 100 000. During 1982, access to this toxic product was severely curtailed by public health measures. In the next few years, the rates drastically fell to about 10 per 100 000.

Restricting the availability of handguns in USA, Canada and other countries resulted in a significant reduction in suicides and homicides. During 1985, "Perestroika" in former Russia brought in a strict anti-alcohol policy. Later, it was observed that suicide rates declined by one-third. However, "Perestroika" could not be sustained due to several economic, political and social reasons.

:: Advertising in the media provides information about the contents and the poisonous effects of pesticides on weeds and pests infesting crops. This information may suggest means of committing suicide to vulnerable people. Realizing the implications, pesticides manufacturers should resort to responsible advertising.
:: Similarly, drugs such as sedatives, hypnotics and anxiolytics should not be sold over the counter. Better coordination among the ministries of agriculture, industries, health, economics and law is required in this direction.
:: Though many interventions are beginning to be considered useful, their universal applicability remains doubtful. Therefore, culture-specific, cost-effective and sustainable strategies must be developed with people's involvement. This process must have targeted interventions for the youth, adults and women.
:: Supportive mechanisms for care for the elderly, HIV/AIDS prevention, cancer prevention and rehabilitation components must be strengthened. It is felt that with the entry of the private sector, the cost of health care will be beyond the reach of the ordinary man. Unless specific efforts are made by governments and local agencies, unaffordable health care might result in increased suicide rates.
:: Major sociocultural reforms are required in a number of areas. Poverty alleviation, removing gender discrimination and bias, encouraging a greater role for women in employment and decision-making, alcohol prevention programmes, reforms in the education sector with an emphasis on skills and values, promoting life-skills education, and better employment opportunities for youth should be implemented urgently to prevent this avoidable, man-made tragedy. Large-scale public awareness programmes are required in each country to move their respective populations from a state of despair to a state of hope and optimism. An investment in these areas will improve the life and social status of the marginalized and underprivileged sections of the society.

Most SEAR Member Countries have begun implementing country-specific mental health programmes. The various components must be strengthened with the inclusion of suicide

prevention as a thrust area for action. Related components of detection and management of mental health problems must be given adequate emphasis to prevent suicides.

Research...towards understanding

Developing and implementing suicide prevention programmes requires a basic understanding of the problem, risk groups, pattern, methods and causes at the national and local levels. However, research in this area has been very limited. As SEAR countries are in different stages of transition, methods and causes as delineated in the West may not be applicable. A general review of available (though extremely limited) literature from SEAR Member Countries reveals distinct differences in age and gender ratio, methods and specific causes leading to suicide.

There is an urgent need to develop suicide surveillance programmes in SEAR countries. The specific questions to be addressed are:

:: How big is the problem in its various sociodemographic dimensions?
:: What are the causes of suicides in general, and specifically among adults and the middle-aged groups?
:: What is the role of social, economic, family and health problems in the context of suicide?
:: What specific interventions are likely to yield results?
:: What is the impact of rapid societal changes on suicides?
:: What are the specific issues related to suicide among women from a sociocultural point of view?
:: What will be the socioeconomic impact on survivors, families and society at large?
:: What is the burden of suicides on SEAR Member Countries and facilities to be augmented for prevention and management?
:: How can after-care services for a large number of survivors be developed, and
:: What societal and governmental reforms are required in this direction?

In order to specifically address these questions, there is a need for four supportive mechanisms. Firstly, centres of excellence (health care institutions) capable of coordinating with national and local agencies having adequate infrastructural facilities should be designated in all SEAR Member Countries. Secondly, manpower within and outside these institutions (through short-term programmes) should be developed within countries. Thirdly, the most important aspect is related to the development of culture-specific, acceptable and standardized tools and methodologies for suicide surveillance with optional variables depending on unique local situations. Fourthly, the required funding should be made available from national and international agencies for undertaking and evaluating research.

The type of research required to be undertaken deserves special mention. Epidemiological research (descriptive, analytical, case control designs, interventional research) is required to understand the who? what? when? where? and why? of the suicide phenomenon in the Region. Also there is immediate need for social and behaviourial research to understand people's perceptions for identifying specific areas for interventions. Clinical research to support causation and management are crucial to save lives. Research into legal issues is also required to identify the merits and demerits of existing laws for future strengthening. The need for evaluatory research to learn "What works?" and "What does not work?" is crucial for learning from experiences. More importantly, policy-oriented research to initiate, strengthen and establish culture-specific programmes is vital.

Yarathaya Chinaprapath