Evidence to Action – Implementing the mental health sustainable development goals through suicide prevention

Date - 13th October 2017

Venue – Hilton Colombo

Session 1: Introduction

This workshop was organised by the University of Bristol, in collaboration with the THEME institute, SACTRC and the Mental Health Directorate at the Ministry of Health. The main aims of the policy workshop were to share the research findings of the largest suicide research project study in Sri Lanka (n=54,000 households), and to draw on the expertise of attendees in refining the recommendations that have been drawn together from previously conducted community stakeholder workshops. The workshop was moderated by Dr Shaluka Jayamanne, a representative from SACTRC.

Session 2: Suicide Overview

Part 1 – Suicide: a global perspective (Prof Nav Kapur, University of Manchester)

- WHO statistics of suicide rate in Sri Lanka seems to be an overestimation of suicide rates [1]. Evidence has shown that Sri Lanka has reduced its suicide rate by 70% [2].
- Statistics in the WHO report are incorrect for Sri Lanka [3].
- True figure world wide – close to a million. This number is hidden because of the stigma associated with suicide; the fact that it is still illegal in 25 countries [4]; and the variability in which suicide deaths are recorded between countries (e.g. some countries require a suicide note to be recorded as a suicide death).
- There is a difference in suicide rates between low/middle and high-income countries, with the burden being highest in low and middle-income countries (76% of deaths) – with 40% of deaths occurring in low and middle-income countries in South and South-East Asia. So, if we want to make a difference in numbers, this is the part of the world where we should be focusing
- The highest number of deaths occur in the youngest age group (10-20 year olds).
- Worldwide, males have highest rate of suicide. 3 times more than women. Same as in Sri Lanka. Why? Men have more of the risk factors for suicide (e.g. alcohol addiction); use more lethal methods; and help seeking behaviour is less common in men.

- What causes suicide? It is important to remember that no 2 people are the same. Risk factors include: genetic predisposition; early childhood experiences; problems in adulthood (financial issues); relationship problems; psychological problems; impulsivity; and hopelessness. In the west 90% of people suffer from a mental illness at the time of death. However, in South and South-East Asia the evidence is less clear. It maybe we haven't identified this issue correctly (a measurement error), because when studies have defined mental distress (as opposed to mental illness) the prevalence of psychological distress is higher.

Important to recognise that suicide and self-harm (sometimes called suicide attempts) are related behaviours. At least half of those in UK who have died by suicide have engaged in self harm. Life expectancy in the male general population is 80 years of age, compared to a life expectancy of 40 years of age for those who have self-harmed.

Part 2 – Suicide: a national perspective (Dr Rohan Ratnayake, Mental Health Directorate Sri Lanka)

- Nearly 3000 deaths due to suicide in Sri Lanka
- Sri Lanka has 1 death every 4 hours
- The current rate of suicide is 14 per 100,000, and there have been dramatic changes to the suicide rate in Sri Lanka, primarily as a result in the introduction of pesticide bans. Whilst suicide deaths have declined there has been an increase in self-poisoning with medicinal products (hospital data 1994-2013)
- Suicide is more common in males, whereas deliberate self-harm is more common in females. Three quarters of suicide deaths occur in people who are married and the most common method is hanging.
- Presidential task force – former president Chandrika Bandaranayke formed a Presidential Task Force in 1997 – to look into the increased number of suicides (possibly we will need this to go forward)
- Directorate has prioritised suicide prevention - School children and adolescents have been prioritised
- Current programmatic actions can be split into two sectors: preventative and curative.
    - Preventative: Anger management, study techniques, coping with stress; good parenting programmes; and school based life skill enhancing programme
    - Curative: Promotion of mental wellbeing at institutional level; support for people who have attempted suicide; and de-criminalisation of suicide (1998)

- There are several challenges for suicide prevention in Sri Lanka. This include:

    - Reaching target groups
    - Counteracting adverse media publicity
    - Competitive education system increasing stress among children
    - Influence of social media
    - Changes in social system (i.e. change to the household structure) with a reduction in social support via family relationships

A strategic multi-stakeholder approach is needed and the Presidential secretariat should take this initiative because the majority of suicide prevention opportunities lie outside the health sector.

Part 3 – Suicide: a rural perspective (Dr Duleeka Knipe, University of Bristol)

- Data collected as part of a large randomised control trial (54,000 households) was used to look at the suicide and suicide attempt epidemiology of rural Sri Lanka [5]. Evidence from this trial suggests that locking away pesticides is not an effective suicide prevention strategy.
- The main research question was to investigate whether there was an association between socioeconomic position and suicidal behaviour in rural Sri Lanka using a longitudinal cohort design where exposure variables were measured at baseline and then these individuals were followed up over a 3-5 year period of hospital/coroner presentations of self-harm/suicide.
- The socioeconomic factors investigated included a measure of wealth, education, occupation, left-behind family members as consequence of temporary foreign migration and young female headed households.
- In rural Sri Lanka the risk of suicide mirrors that of the national population, with a higher rate of suicide being observed in men and an increased rate of suicide in young women.
- The rate of suicide attempts was higher in young people that in older individuals.
- There was a high risk of suicide in those with lower levels of education and assets. In addition, farmers, daily wage labourers, female headed households and temporary foreign migrant households are at an increased risk of attempted suicide. These last four groups are the focus of the workshop.

Discussion

- Sri Lanka currently does not have a surveillance system of suicide attempts. The current hospital morbidity and mortality datasets do not record self-harm. Dr Amila Chandrasiri is carrying out a project in a particular area in Sri Lanka to explore this, and the Health Promotion section of the Ministry are looking at piloting an island wide surveillance system. Prof Kapur highlights the importance of data, as this will help inform prevention efforts.
- Whilst female headed households have a higher risk of attempted suicide, this population is small. It would not be advisable to target suicide prevention just at this group, but instead universal interventions should be developed which will inherently benefit this group of individuals.

Session 3

Part 1 – Opportunities for Suicide Prevention: Community Recommendations (Dr. Duleeka Knipe)

The findings from nine stakeholder groups (69 individuals) were presented. The stakeholder groups were conducted to give a voice to the individuals in the four high risk groups. The stakeholder groups were:

1. Presented with the findings
2. Asked to individually list what they thought were the reasons for increased risk of suicidal behaviour
3. What they thought would be the best approach to tackle these problems

Several problems were highlighted. The problems which were universal to all vulnerable groups included: 1) Income problems; 2) Debts; 3) Alcohol addiction – not just to the person who is drinking but also to others around them; 4) Poor problem solving – not knowing how to deal with their problems; and 5) Interpersonal problems, this included, unmet expectations between husbands and wives. Community mebers particularlly highlighted sexual problems – e.g. wives seeing sex only as a reproductive act, this often leads to extra marital relationships/marital rape

Recommendations were put forward which were common to all groups but also specific to particular ones. For the workshop we focused on those recommendations which were suggested to have universal benefit (see accompanying slides for more information).

Part 2 - Opportunities for Suicide Prevention: Effective suicide prevention – global evidence (Prof. Nav Kapur)

The suicide prevention strategy in the UK focuses on several aspects. These include:

- Reduce risk in high risk groups. Evidence from the UK suggest that safer care in mental health services, and guidelines can help reduce the risk of self-harm/suicide.
- Promoting mental health
- Reducing availability of means → MOST evidence globally. The final act is quite impulsive, in that moment if you remove the access to lethal methods, you buy time.
- Improving care for the bereaved
- Improve media reporting. Very strong evidence that media can help but also promote suicide. Imitative suicide has been shown to be linked to fictional reporting of suicide [6], as does news reporting [7]. Most countries have media guidelines (see presentations)

There are also other approaches to suicide prevention which might also be worth considering. The evidence of these interventions is perhaps less developed but show promise. These additional approaches are community based (see slides for further details):

- School approaches (mental health and life skills).
- Debt and financial service support

Community mobilisation to reduce violence

Community approaches to mental health (psychological treatments/talking treatments delivered by non specialist/alcohol interventions/mhGAP)

Discussions

Ananda Galapatti was called upon to share his experiences on using evidence/tools developed in a different context for implementation in Sri Lanka: WHO has recommended 2 methods for non-specialists to provide psychological help. Manual was developed by WHO in 2011. Took those guidelines and adapted it to Sri Lanka. It is possible to utilise evidence based interventions – but the process of adaptation should be done carefully and tracked how it is implemented. Need people who are bilingual and bi-cultural to help do this.

Panel discussion was open with Dr. Duleeka, Prof Nav and Mr Ananda

1. The point was raised that when considering women who migrate we need to be cautious about potentially blaming the woman and restricting her migration. Women migrate for many reasons, some might be economic but others might do so to escape abusive husbands. The recommendations for suicide prevention should be mindful of this and should be aimed at not restricting the possibilities for these families but for providing options. If they want to migrate due to financial issues, then give them options which allow them to stay in the country of origin, but on the other hand if they are migrating to escape husbands, then let them.
2. The ILO have been working to provide solutions for farmers and market pricing. Linking farmers with cooperative formal structure. Gives farmers financial stability. Builds a community of cooperative members, so farmers are not isolated. Further details are available from the ILO representatives (see contact details)
3. When trying to solve one problem the solution itself creates a new problem. Problems are complex. In order to address this, we need to understand that the complex problem will: 1) Keep changing; 2) Some factors are more important than others; and 3) there is a constant need for monitoring. Track what the impact of the policies are. All policies can be positive and negative.
4. Dr Yakandawala – Family Planning Association Sri Lanka → FPA call centre gets a lot of suicide cases. Many problems are due to sexual problems. Children also do not get good sex education. Finally ending up with problems they can't resolve.
5. There is a big problem with the lack of a link between the mental health department and counsellors. Every Ministry/Department has its own set of counsellors, therefore a very large workforce. Worthwhile thinking about the human resources we have and thinking how we can use it effectively. The huge amount of services

available (sometimes essentially the same sort of support but from different organisations) are making community members confused about what is available to them.

6. Important to upstream – think about prevention rather than addresses the issue at a point of crisis (e.g. when a woman wants to migrate due to abuse).
7. The recommendations made by Sri Lanka are very macro level – at a grass root level these policies are never implemented. Sri Lanka takes a highly medicalised approached where only doctors' voices are heard. Dominated by doctors. We need a multi factorial approach.
8. Another major issue is that the service providers are not trained to deal with the issues of the community.
9. Suggested that we might also need to help communities to move away from the mentality of always looking externally for solutions to community problems. We need to empower communities to mobilise themselves and talk to each other. For example, within a community there will be people who have good budgeting skills – utilise these people to teach others. A much more sustainable approach.
10. Dr Amila – only 32% admitted for deliberate self-harm are getting psychiatric help. This means most are getting general medical help. 68% leave hospitals without any psychiatric assessment. NICE says every self-harm person need not be seen by a mental health professional. Dr Duleeka - Provision of support for those who have self-harmed is important but we must not lose sight of the fact that only 2-3% of people who self-harm and present to hospital repeat self-harm. The NICE guidelines are based on the fact that in the UK the repetition rate is much higher (20% +). In Sri Lanka, the suicide prevention focus should therefore be on pre-event. Newer house officers, latest medical graduates take psychiatry in their last exam – therefore now they refer people to psychiatric services more due to more awareness. The medical management of those who self-harm is improving.

Session 4: Small group discussions

Questions

1. What are the priority recommendations (select 2)
2. What needs to be done before implementation?

You might want to consider:

A. Do they need modifying in any way?
B. In what setting should it be delivered?
C. Who should deliver it?
D. Are there any existing resources you could use?

Output:

Select the most feasible intervention. Report back to the group what this intervention looks like, who will take the lead, and the steps for implementation.

Group Discussion Results

Group 1 – A life course approach to relationship and conflict resolution skills

Things to consider:

- Multi sectoral involvement and advocacy
- Strengthen the operational aspect of the system and policy of the country, with monitoring

Stage	Approach
Early Childhood	Early childhood care and development programs need to be imporved so that staff have the technical competency
Pre-school	Improve competency of teachers, link with PHS, and PMS. Also include parents in this skills development.
School	Integrate life skills into the whole education system Every teacher should be a life skill teacher Should be a monitoring and appraising method (possible linked to financial benefits?)
School-leavers	Social media based approaches Community interventions Restrict and control negative impact spreading through media
Elderly	(ran out of time)

Group 2 – A content approach (Educational awareness and Economic empowerment)

1. Education awareness

Entering suicide awareness into school curriculum**.** Train teachers in skills which allow them to deal with mental health issues. Encourage a more positive role for social media. Community leaders should take on an active role in promoting mental health and communicate to the community on how to deal with suicidal thoughts. (this will require training of community leaders). Who should these leaders be? Religious leaders may not play an important role in people's day to day lives (though this will depend on the setting). Funeral service society providers identified as a good entry point in rural areas because at least 1 member in the family is a part of this service. More than 90% of the society gather within societies such as the funeral society. Important to use exisiting structures rather than trying to develop new ones which don't have a strong standing within the community.

2. Economic empowerment

Increase welfare safety nets, but also imporve vocational training oppportunities.

Training on house management eg: use money on education rather than alcohol

Improve the quality of exisiting data to help us better monitor the problem.

Group 3 – A content and systems approach (Media and Existing systems)

1. Media and social media

- Need to include some sort of formalised training program for jounralists so that they are aware of the things they need to consider when reporting on suicide. Currently guidelines are not given unless they ask for it.
- Suggest to build a national guideline for reporting. Previous guidelines did not cover social media influence Problems – turn over and accountability. There are no consequences for not following guidelines. Sumithrayo representative said they write to the press if any reporting violates guidelines but media does not respond. Need to carefully consider what approach is the best way forward here.
- Encourage student based – vigilant groups for social media. Develop guidelines and train the groups to look at media reporting – teach them what is bad and what is good reporting. → creates alternative thinking – like media literacy.

2. Strengthening exisiting services

Support services for people → focus on individuals and family affected by suicide. In Sri Lanka should be based on family because in Sri Lanka, family ties are very important.

Already there are services available – government, community level as well as NGO. Problem is barriers to approaching these services – eg; not knowing about the services, financial problems.

There is enough man power in the DS's – but no awareness about the services available. The services are in place. If we can get all the community services to link up → that's the best.

Volunteers → very important. Volunteers in the community know the community well and have easy access to the families. But now willingness for voluntary services are decreasing.

The underlying problem → how do we work together? → Identify what is working (eg: in the public health sector) and come up with a sustainable method.

The meeting was conlucded with Dr Duleeka thanking particpants and saying that the recommendations from this workshop would be fed into the policy document to be later circulated.

Group for suicide prevention in Sri Lanka

http://bit.ly/SL_Suicide (resources from this workshop will be uploaded to this site)

REFS:

1. World Health Organisation, *Preventing suicide - A global imperative*. 2014, WHO: Geneva.
2. Knipe, D.W., D. Gunnell, and M. Eddleston, *Preventing deaths from pesticide self-poisoning: learning from Sri Lanka's success.* The Lancet Global Health. **5**(7): p. e651-e652.
3. Knipe, D.W., C. Metcalfe, and D. Gunnell, *WHO suicide statistics – a cautionary tale. .* Ceylon Medical Journal, 2015. **60**(1): p. 35.
4. Mishara, B.L. and D.N. Weisstub, *The legal status of suicide: A global review.* Int J Law Psychiatry, 2016. **44**: p. 54-74.
5. Pearson, M., et al., *Effectiveness of household lockable pesticide storage to reduce pesticide self-poisoning in rural Asia: a community-based, cluster-randomised controlled trial.* Lancet, 2017.
6. Hawton, K., et al., *Effects of a drug overdose in a television drama on presentations to hospital for self poisoning: time series and questionnaire study.* BMJ, 1999. **318**(7189): p. 972-7.
7. Chen, Y.Y., et al., *The impact of a celebrity's suicide on the introduction and establishment of a new method of suicide in South Korea.* Arch Suicide Res, 2014. **18**(2): p. 221-6.