PUBLIC HEALTH

Suicide: the hidden epidemic

Epidemiology: During the past 15 years, more than 52 500 Canadians committed suicide.[1] Despite this toll, which is almost 20% higher than Canada's total number of battle deaths during World War II, suicide remains a hidden epidemic. People kill themselves for many complex and intangible reasons, but society is far less willing to talk openly about the issue.

French sociologist Emile Durkheim was the first academic to throw back the curtain on these private acts and reveal their social patterns. He identified associations between rates of suicide and levels of social integration in certain populations and concluded that increased community involvement reduces suicidal risk. One hundred years later that observation continues to influence and inform effective suicide-prevention and community-intervention programs.

Despite gains in insight and methodology, since the 1970s there has been an almost universal upward trend in suicide rates, particularly among young men. In 1996 the World Health Organization and the United Nations urged member nations to address the growing problem of suicide and provided guidelines for the formulation and implementation of national prevention strategies.[2] In 1997 a 15-nation survey identified only 5 countries (Australia, Finland, New Zealand, Norway and Sweden) that had comprehensive national strategies. At the time, the United States had a limited program and Canada fell alongside Austria, Denmark, Germany and Japan as countries that were not taking action nationally.[3]

The US Surgeon General recently announced a comprehensive national strategy for suicide prevention, identifying suicide as a critical public health priority.[4] Canadians might do well to pay heed. In the 1970s Canadian suicide rates overtook US rates, and they have remained consistently higher.[4] In 1997 the Canadian suicide rate was 12.3 per 100 000 population,[5] but it jumped to about 30 per 100 000 among young men aged 20–29 and elderly men aged 75 and over. Among Canada's First Nations, suicide rates are 3 to 4 times higher than the rate in the general population.[6,7] Suicide follows motor vehicle accidents as the second leading cause of death among Canadian youths aged 10–19, accounting for 19.5% of deaths in this group.

Clinical management: The Canadian Task Force on Preventive Health Care recommends that physicians evaluate suicide risk in patients in high-risk groups.[8] Populations of special concern include Aboriginal people, certain age groups (youths and elderly people), prisoners, homosexual people and people who have previously attempted suicide. Mental illness, substance abuse, stressful life events, terminal illness and a family history of suicide are risk factors.[9] Studies over the last decade have shown that about 40% of suicide victims, particularly elderly victims, consulted a physician in the month before their death, which suggests that opportunities for suicide prevention were missed.[10]

Even the most gifted clinician can find it difficult to distinguish ominous from benign suicidal gestures. Direct questions such as whether and how often a patient thinks about suicide and whether he or she has ever attempted suicide can help ascertain his or her risk, as can information provided by third parties such as family members, caregivers or teachers.

If suicidal ideation or recent suicidal behaviour is evident, clinicians should be prepared to admit the patient to hospital for further assessment. Studies suggest that about 90% of those who attempt suicide have psychiatric disorders;[11] therefore, the diagnosis of any acute or chronic comorbid psychiatric illness needs to be established.

The circumstances and motivations that promote deliberate self-harm should be investigated, as should access to lethal means such as firearms or medications. Interpersonal conflicts seem to be an important precipitating factor for about 50% of patients who commit self-harm.[11] Treatment plans need to be individualized, but they should include medication to treat psychiatric problems, practical help to cope with immediate precipitating factors, and rapid and systematic follow-up.[11,12]

Prevention: Components of a national strategy for suicide prevention[13] include promoting awareness of suicide as an important, preventable public health problem and developing strategies to reduce the stigma associated with seeking psychiatric help or substance-abuse and suicide-prevention services. It means increasing the number of evidence-based suicide-prevention programs in schools, work sites and correctional institutions, and improving the training and availability of health care professionals and community gatekeepers to recognize and respond to patients at risk. A coordinated approach involves ensuring that people treated for sexual assault, trauma, abuse or depression in the emergency department also receive mental health services. It also includes strategies to reduce access to lethal means such as firearms and large quantities of potentially toxic medications, to support the evaluation of suicide-prevention programs and to foster media consideration of the impact that their representations of suicide and mental illness have on the viewing public. — *Erica Weir*, CMAJ; *Tamara Wallington*, PGY-5, Community Medicine, McMaster University

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