Management of the Problem of Suicide
(Happiness in the mind leads to no suicide)

The situation

1. Suicide and attempted suicide are key problems of public health and are a social problem in every country. The World health Organization estimates that each year successful suicides number more than 1 million people, or every 40 seconds a successful suicide occurs, meaning an average of 16 suicides per 100,000 of the population. This also results in psychological harm to the families and those close to suicide victims, such groups numbering 5-10 million people. The economic damage is also immense. Moreover, the number of attempted and unsuccessful suicides stands about 20 times the number of successful ones.(1)

2. For Thailand the year 1999 was the year with the highest number of suicides, that is 5,290 people, or constituting 8.59 per 100,000 of the population or an average of 14.5 persons per day. These figures resulted in the Department of Mental Health for the first time receiving a budget for a project on prevention of suicide, which continues to this day, leading to a reduction to an extent of the suicide rate. That is, the suicide rate during 1999-2010 dropped from 8.59 per 100,000 population to 5.90 in 2010. (2) In 2010 successful suicides numbered 3,761 persons, or about 10 a day. But suicides in some areas of Thailand are still higher than the global average. Looking to the future, economic, political, social, and cultural change, not to mention natural disasters, all are trending upwards, putting enormous pressure on people, increasing risk events in the daily lives of people.

3. The rate of suicide varies greatly between areas of the country. In 2010, Lampoon Province had the highest rate of suicide—at 20.02 per 100,000 population, whereas Pattani had the lowest i.e 0.77 per 100,000 population.(3) Areas with the highest suicide rates are to be found concentrated in the upper northern region, and in coastal areas of the East. The top 10 provinces in terms of suicide rates for 1999-2010 are shown the appendix attached to this paper. (NHA 4/ main 6/ appendix A)

4. Successful suicides are more in the male group than in the female group. During 2006-2010, successful suicides among men was between 9.24-9.48 of 100,000 people, where as for females the rate was 2.38-2.72, which works out to a male to female ratio of 3.5 to 1. The age bracket in which the highest number of suicides occurred was 31-40 years old, followed by those in the range of 21-30 years old. Most of them were of working age.(4) This pattern is different from in foreign countries where suicides occur more among the elderly and teen-age group, with incidents among the latter group tending to increase.

The causes of suicide

5. Suicide is the end result of many influencing factors, namely, biological, psychological, social, cultural, environmental, economic, family, and community factors. The WHO assessed that mental illness, especially depression and drinking problems are important risk factors in suicide in Europe and North America, but in the Asian region, it is believed that impulsive acts and cultural factors are more important co-factors.

6. The research on epidemiology of suicides-- both attempted and successful--l in Thailand, done between 2004-2010 (5) concluded as that these are the key risk factors: depression, chronic illness, mental problems, drinking, relationship problems with persons close to them, arguments and fights, being the object of gossips and slander, attacked physically, living with alcoholics and drug addicts, hearing of self-harm and suicides among people in the community, being prone to physically harm oneself. Also, it was found that lack of employment is a key reason for stress among the working age group.

Effects of suicide

7. *Economic*: In 2005, the Kasikorn Bank Economic Research Centre (6) assessed the economic losses from suicide at about 16,000 million Baht, Boonchai Navamongkolwatana and colleagues in 2003 (7) studied the expenses of suicide patients receiving treatment in 12 psychiatric hospitals and found their economic losses due to these attempted suicides amounted to 37,793 Baht per patient.

8. *Effects on the family*. Suicide affects the mental and psychological state of the family. From studies of family of those committing suicide, it was found that guilt feelings, feelings of sorrow, depression, anxiety, and embarrassment occur. Some took to drinking and smoking, even after having stopped for many years. They became unable to work and live normally, thus undermining their capability to carry on in life, especially if relations with the suicide victim was not good prior to the suicide. In the case of the father or mother committing suicide, the child would feel unsafe, which might impede his/her development, or even stunt their growth. If the child is a teen ager, problems of negative emotional expression might happen, and this they tend to interpret new situations more negatively that ordinary teenagers. Mental scars resulting from a suicide would be extremely painful for the living who are close to the victim.

9. *Social and community effects*. Suicide in the community not only creates shock and unhappiness in its members but also provides an unhealthy model of solving problems, inducing negative behavior on the part of family members of the victim, which in turn leads to social and community problems especially among those facing similar problems to the suicide victim. If it happens on a recurrent basis, the fear is that replication will follow.

Factors preventing suicide

10. Manoj Lohtrakul (8) concluded, after studying foreign reports, that preventive factors consists of:

o There are children/grandchildren in the house o A sense of family responsibility o Has faith in religion o Is pregnant o Is satisfied with life o Able to acknowledge truths/realities	o Confidence in one's efficacy o Mental resiliency o Has good adjustment skills o Has good problem solving skills o Social support is given o Able to maintain relationships

Suicide, happiness, and quality of life of the people (9)

11. Results of a study on happiness of Thai people during 2008-2010 found these risk factors associated with less happiness: low education, low income, no job security, the family members do not have time for each other and do not engage in activities together, divorce or separated, in debt in the informal money market, not have their own land (for farmers), not practicing religion, not involved in community activities, self-doubt about their health, and living in a high income province.

12. Risk factors of unhappiness and risk factors of suicide are expressions that a person's condition of life has problems, whether it is relations within the family, security in maintaining a living, problems of living in harmony in the community, lack of assistance, and health problems. Suicide is an indicator of the quality of life of people, that they face many problems. At the social level, suicide reflects a lack of some kind of mechanism of mutual help within a community. At the systematic level, incidences of suicide indicates the need for the state, community, and other relevant organizations to act together to arrange and provide for better mental health services.

The law relating to mental health and access to services

13. Thailand has a law called the Mental Health Act of 2008, in force on 20 February 2008, dealing with the organization of services and care of mental health patients. The intent of the Act is the provide protection, improve quality of life and mental health of the people, protect the human rights of people that are abnormal mentally, and prevent danger to the mentally ill. It is specified in the Act that patients have the right to received treatment and cure in accordance with medical standards, in full consideration of their dignity as human beings, and also have the right to receive protection from the health and social security system, and also from other state schemes in equality with other people.

14. The Mental Health Act of 2008 determines that a national mental health board be established, to consist of (1) the Prime Minister or deputy Prime Minister who is designated by the Prime Minister, as Chairperson. (2) The Minister of Public Health is to be the Vice-Chairperson. (3) the Permanent Secretaries of the Ministry of Social Development and Human Security, Interior, Justice, Labour, Education, Public Health, the Attorney-General, the Commissioner-General of the Royal Thai Police and the Secretary-General of the National Human Rights Commission, as members. (4) Representatives of the non-governmental organizations which are juristic persons having objectives in providing protection and care for person with mental disorder as elected among themselves to be four in number, as members. (5) six qualified persons six qualified persons appointed by the Minister from experts having apparent experience and works in psychiatry, clinical psychology, medical social work, psychiatric mental health nursing, occupational therapy and law; one from each field, as members. The Director-General shall be member and secretary. (10)

15. The Board shall have the powers and duties as follows:

(1) to lay down policy and measure in relation to the protection of rights of a person with mental disorder and to the access of mental health service as well as social cohabitation;

(2) to prescribe rules and procedure for the provision of consultation and advice and for the coordinated conduct with the government and private agencies in relation to the protection of rights of a person with mental disorder and the access of mental health services as well as social cohabitation;

(3) to inspect and monitor the performance of the infirmary board;

(4) to prescribe the form of consent for treatment under section 21;

(5) to notify the assistance and welfare agency under section 40 (2);

(6) to prescribe rules or notifications for the execution of this Act;

(7) to carry out any duty as prescribed by this Act or by other laws or as entrusted by the Council of Ministers.

16. The National Mental Health Board is an important national level mechanism that in the past has helped the National Health Security Office set up a 200 million Baht mental health fund in2009 and also helped the Social Security Office expand coverage for the self-insured, from originally reimbursing medical expenses only those with emergency mental illnesses and who are in-patients and only for 15 days, to covering cure and treatment for every case of in and out mental health patients.

17. The Department of Mental Health in co-operation with the Health and Technology Assessment Programme or HITAP has assessed that there are about 10 million substantive[®]

[®] The definition of mental health problems in the research literature and by the WHO covers 8 types of illnesses/situations: mental disorder, depression, Alzheimer's disease, epilepsy, psychiatric disorder from consuming alcohol and addictive substances, abnormal development and behavior of the child, self-harm and suicide.

mental health patients that need help, but that only about 800,000 or 8% of all the mentally ill have access to mental health services.(11)

18. When considering the access to services of those having mental health problems, it can be said that the present health insurance system still need much further development, in order that the patients are looked after in an equal manner. For example, at present, the Social Security Office still does not cover patients who inflict harm on themselves, in spite of the fact that in academic terms self-infliction is a way of crying out for help from people who have mental health problems and do not see a way out. It is also found that society in general still has prejudice towards mental illness, which creates psychological and other obstacles for the mentally ill in accessing services and for them to live with others in the society.

Measures to prevent suicide and experience of work in this area in Thailand

19. The WHO has proposed key suicide prevention measures for member countries, namely: development access to health care and social services; prevention and cure of depression, drinking and use of drugs; control of access to suicide techniques and implements such as guns, pesticides; providing quality care for those attempting suicide; appropriate and responsible reporting by the media; developing life skills among youth, especially on how to handle emotional and other problems. It is suggested that these measures can help lower the suicide rate but the work needs engagement by many sections of the society.

20. The successful Thai experience in suicide preventive work can be found in work at the level of community, district, and province, as described below:

21. Development of access to mental health services

The Mental Health Department has set up a project: to search and select depression patients who are at risk in committing suicide; to specify that public health facilities in cooperation with community leaders do the selection and seek out and treat depression patients; to determine standards for the help of those trying to commit suicide. This can be seen in the example of Ban Hong District in Lamphun Province; the district has worked in an integrated way by setting up a committee to develop the mental health service system at the district level. What the committee does is to: analyze data, assess the situation, present the data, build understanding, develop capacity of various organizations, and engage all parts of the community to help in selecting and searching for those suffering from depression and those who are prone to suicide. It was found that these efforts helped to decrease the attempted suicide rate from 67.54 per 100,000 of population in 2007 to 48.69 per 100,000 in 2010, and the successful suicide rate from 28.10 per 100,000 in 2007 to 18.54 per 100,000 people.

22. Control of drinking liquor

Looking at the experience of Pa Sang District of Lamphun (12), it was found that 20 % of successful suicides were addicted to alcoholic drinks. After disseminating knowledge and arranging for a consensus to arise in the community, a project to decrease access to alcohol and lessen the problem of suicide was instituted, with campaigns to stop drinking at funerals, to stop drinking during the Buddhist Lent, to care for alcohol addicts in the community, and to have joint agreements concerning sale of liquor in the villages. The areas covered by the project are Nam Dib and Sob Tha villages. No association was then found between successful suicides and drinking.

23. Control of agricultural toxic substances

In the past Mae Tha District in Lamphun was the area with the highest successful suicide rate the country. Mainly used in the attempt was eating or drinking toxic substances, Thus, the district community hospital worked together with agencies in the district, namely, district agricultural officials, community development officials, vendors and the community in general, to control the distribution of these agricultural substances, by limiting its sale only in agricultural working seasons, by not holding stocks, by campaigning for discontinuance of chemicals, for consuming safe foods, and invoking the adoption of the principle of sufficiency economy Subsequently, it was found that suicides decreased.

24. Developing life skills of youth in schools

555 schools from educational administrative zones all over the country distributed learning media titled "Top Up for Spiritual Strength", which was developed by the Work Plan on Improving Mental Health. The aim is to support teachers to organize participatory learning activities. It was subsequently found that students understood themselves and others more, learnt problem solving thinking, de-stressed correctly, had lesser behavioral problems (e.g. fights and arguments, coming to school late). Moreover, the teacher was able to coordinate more with parents, and teachers had concepts to guide them in teaching life skills in schools. More than 50 educational administrative zones have adopted and extended such work plan in their schools.

25. Integrated services and community mutual help

Saraphi District in Chiang Mai (14) has the highest successful suicide rate i.e. 26.64 cases per 100,000 population. In 2008 from a community interview it was found that key factors in the decision to suicide were chronic illness, alcoholic drinks addiction, and economic problems. Thus, afterwards, representatives from hospitals, the Senior Citizens Club, local organization leaders, and Buddhist monks met. They then jointly acted to: disseminate knowledge, instituted mutual care, trained masseuses, organized training in praying, in practicing the dharma, and training in advisory skills. Then, there are activities for example wandering dharma teaching, visits to the home of ill people, visiting to impart knowledge in schools, guiding people on how to look after their mental and physical health. It was found that after these activities, the rate of suicides fell the following year from 20 cases to 11, and then to 5.

26. Promotion of religion, art, and culture

The community of Baan Puang village in Thung Hua Chang in Lamphun province (15) used Buddhist teachings to prevent suicides by setting up an activity called "robe offerings to monks on Buddhist holy days for alleviation of suffering". That is, whoever has suffering, stress and cannot solve it themselves or find someone to help them, can write down their problem and put the note in the donations facility. A committee will look at them and meet to find ways to help such persons. The result is no patient with depression or attempted suicide was found in the village during 2010-2011, after this activity started.

27. Integration at the provincial level

Chiang Rai was in 2009 the province with the highest suicide rate in the country. This resulted in heightened discussion and activity in health forums. Prior to the findings, a successful suicide case involving a student disappointed by his failure to pass the university entrance examinations in 2007 had induced a group consisting of family members named "candlelight to enlighten the mind club" to be set up, engaging in activities to disseminate experiences in overcoming life obstacles to neighbours and the community. The result was a positive thinking trend emerged, a lessening of guilt feelings about psychiatric problems people have, and the community gained understanding and joined the club to spearhead such activities. This was an important step in growing to become a wider network. The further result was that these efforts elevated the issue to public policy level and led to the insertion of an agenda specifically on suicide in the 2011 National Health Assembly (16).

Mass media and presentation of news on suicide

28. The WHO has proposed guidelines in presenting news on suicides:

- Avoid presenting news in ways which make people feel suicide is interesting
- Avoid describing in detail the techniques of suicide and death letters
- Imparting knowledge on suicides and advice on assistance to head off suicides and sources of help
- Be considerate of impacts on relatives and persons close to the deceased
- Understand that the way news is presented might lead to replication, if the deceased was a star or someone famous

The above guidelines would differ from the normal principles of presenting news by the media, which aims for news that "sell", it being a difference between news that help the society in some way and news that is profitable. The Department of Mental Health had organized meetings with news editors during a time when a lot of suicides occurred, and found that the meetings helped much in steering presentation of news in the direction cited above, but this change was found to only to be in place for a short term; because of lack of mechanism for self regulation in the media and lack of social interest in long lasting social control.

29. During the great flood of the end of 2011, the mass media played a creative role in helping society, both in the sense of presenting news in a way as to raise morale to fight against problems e.g. presenting news on community efforts to solve the problems; recording problems and referring them and disseminating news so as to mobilize people to go and help areas in crisis; and arranging people's forums to reflect opinions and perspectives towards the problems. The roles they played were beneficial, helping to care for the hearts and mind of people and building the community's strength in time of crisis.

30. In summary, suicide is the end result of many undesirable factors. It is a loss that is preventable. It is also a reflection of the state of the health insurance system, the state of access to mental health services, and of living together in the community with a sense of mutual help. The WHO has determined for member countries guidelines and measures to prevent suicide. In the case of Thailand, the key issues are: helping those with mental illnesses receive guaranteed access to quality services; control of how the mass media presents news on suicides; dissemination of news that help people to lead a happy life; building up correct understanding of mental illness; and strengthening the local community so as to develop a mechanism for mutual help within the community, especially of those with risk factors and the disadvantaged.

Issues to be considered by the National Health Assembly

The National Health Assembly is requested to consider NHA document 4/ draft resolution 6.

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