DOI: http://doi.org/10.4038/sljma.v23i1.5395
Volume 23, Issue I, November 2022

Suicide prevention strategies: Is Sri Lanka on the right track?

Deerasinghe KD[1], Sabhapathige R[1]
[1]Center for Health Services Studies, University of Kent, United Kingdom.

ABSTRACT

Suicide is a severe, yet avoidable, public health issue that affects people all around the world, including Sri Lanka. Despite many initial measures to address the issue, Sri Lanka's suicide rate remains high, keeping it in second place in the region. As a result, it is time to revisit them and assess their contribution to the country's suicide prevention efforts. This perspective paper examines current Sri Lankan suicide prevention strategies and compares them to available standard approaches in order to provide authors' perspectives on how to improve the situation using available theoretical standard approaches and practical evidence from England.

INTRODUCTION

According to global epidemiological data, suicide is considered a serious international public health issue among the twenty-leading causes of death. That is above the deaths due to war and homicides, malaria, or breast cancer, where we usually pay more attention[1]. More importantly, suicide has become one of the three leading causes of death among the 14–15 age group and the second leading cause of death among the 15–19 age group[2]. The global average age-standardized suicide rate in 2016 was 10.5 per 100 000 population[1]. In 2019, it was 72.4 and 40.3 in Lesotho and Guyana respectively, where they recorded the peak values. It was 7.9 and 14 per 100 000 population in the UK and Sri Lanka respectively[3].

Worldwide, the majority (79%) of suicide deaths are reported from low and middle-income countries attributed to the fact that they occupy 84% of the world population[1]. However, developing countries are less prepared, except in a few pockets, than developed countries to address the issue[4]. Sri Lanka can be proud of being the first developing country to have a national suicide plan as early as 1997, as a response to its early peak in suicide rates during the early and mid-nineties[5]. In 1995, Sri Lanka became the top of suicides in the world[6]. The situation in the country improved as a result of this plan, and the ending of the conflict situation. However, Sri Lanka's suicide rate remains higher than the average of low and middle-income countries, ranking second among the SEARO countries, having India ahead with a rate of 16.3[3]. It indicates the need for close attention by relevant authorities as a major public health issue.

Approaches to address the problem

WHO has established suicide prevention as a global target recognizing it as a priority issue. As a result, the reduction of suicides is used as an indicator in the United Nations' SDG; reduction of premature mortality due to non-communicable diseases under target 3.4[7].

In 2005, experts from 15 countries conducted a systematic review and identified the following areas for suicide prevention[8].

1. Education and awareness for the general public and professionals
2. Introducing and use of tools to identify individuals at risk
3. Treatment for psychiatric disorders
4. Restriction of access to lethal means
5. Responsible media reporting

WHO introduced the following strategies to manage suicides at different levels[1].

Strategies to address the population level are:

1. Restrict access to means of self-harm and suicide
2. Develop policies to reduce the harmful use of alcohol
3. Assist and encourage the media to follow responsible reporting practices of suicide

Strategies for vulnerable sub-population at risk:

1. Gatekeeping training
2. Mobilizing community
3. Using trained survivors as champions

Strategies for the prevention of suicide at an individual level:

1. Identification and treatment of mental disorders
2. Management of persons who attempted suicide or who are at risk
3. Improving case registration and conducting research
4. Monitoring and evaluation of the ongoing program

PERSPECTIVE

How far has the country progressed?

Sri Lanka as the first country in the developing world to have a national plan to prevent suicide has taken policy decisions and initiated strategies to reduce suicides in the country. In 1997, a presidential committee was appointed to address the issue. With the recommendations of the committee, a national plan for suicide prevention was developed and operationalized. The plan addresses the problem at the population level as well as the high-risk group level.

The population-level strategies include creating a culture that discourages suicide, changing laws that act as a barrier to suicide prevention efforts such as criminalizing suicide, and initiating life skills programs in schools. Attempts of suicide were decriminalized in 1998. High-risk pesticides were banned.

As strategies that address high-risk groups, improving the mental health of young and elderly populations, establishing mechanisms to intervene and assist those individuals and families who are in need, and enabling non-governmental organizations like "Sumithrayo", can be stated[5]. However, with the conclusion of the presidential committee in late 2000, the functional

capacity of the plan and the attention of authorities seemed to diminish raising concerns about the sustainability of the planned actions[4,5].

In 2005, Sri Lanka unveiled its mental health policy. The objectives of the policy were to improve the mental health and psychological well-being of the citizens of Sri Lanka and to treat mental disorders in an efficient and holistic manner[9]. In 2015, Sri Lanka declare a national policy and strategy on the health of young persons. Promotion of psychosocial and mental well-being: preventing and managing psychosocial issues and mental illnesses, preventing suicide and self-harm, and providing counseling and support services for affected young people were considered major activities under the first strategy[10].

Later, in 2016, Sri Lanka introduced the national policy on alcohol control, which focuses on direct risks for users of alcohol and indirect risks for families and society due to its effects on household income, child abuse, and violence. Under priority policy area 4, it is clearly mentioned that protecting all populations from the consequences of alcohol use is a priority. The Director of Mental Health, under the guidance of DGHS, coordinates the implementation of the policy actions[11].

In 2016, experts in the mental health field developed a culturally appropriate guideline on providing first aid to a person at risk of suicide based on a study carried out in Sri Lanka. These guidelines are freely accessible. They can be used in suicide prevention activities as a basis for training gatekeepers[12]. Gatekeepers can be close family members or friends of at-risk individuals. Professionals like PHIs, midwives, schoolteachers, prison and military officers; prominent and reputed community members such as religious leaders, leaders of village committees, or charity organizations who are in frequent contact with at-risk individuals can also act as gatekeepers[8,13]. Recognizing pesticide vendors as gatekeepers, training was carried out for them to cover some pockets[14].

Sri Lanka recently declared (2022) a new mental health policy to be implemented from 2020 to 2030. It focuses on strengthening leadership and research, expanding mental health services, human resource development, and community empowerment[15].

How far do suicide prevention and management activities still have to go?

As previously stated, suicide claims more lives than some other public health issues in Sri Lanka and therefore Sri Lanka has initiated substantial measures to reduce suicides. However, the functional sustainability of existing programs is uncertain. The necessary modifications, amendments, and improvements are in doubt. To fill the gaps in the approaches to prevent suicides, Sri Lanka needs to expand its services.

When it comes to early detection and care of at-risk individuals the community level needs to be expanded and improved. There is currently no formal way to assist victim families in Sri Lanka. Authorities must prioritize the establishment of this service because they are more likely to experience mental health issues and suicidal thoughts[16]. When the recently reported incidents are considered, developing a protocol to guide and encourage ethical and responsible media reporting of suicide-related incidents is critical. The accuracy and timeliness of data collection, as well as research on suicide-related topics, should be encouraged. Above all, monitoring and evaluating the ongoing program will help to improve its performance and outcomes.

In Sri Lanka, many policies have been enacted to address the prevention of suicide and associated risk factors. It is high time to revisit and reflect on those policies to see how far the objectives have been met after many years of implementation or whether they are making the expected contribution to reducing suicides in the country. The debate over the national alcohol control policy and the contradictory government activities is an example.

It is time to appoint a national and regional body to deal with the national suicide problem. It shall comprise all relevant stakeholders such as health authorities, representatives from the agriculture field, social service department, home affairs, education, police department, and volunteer organizations. Although some areas are covered by mental health programs, numerous other risk factors can lead to suicidal behavior such as socio-economic and cultural effects. Therefore, effective management necessitates multifaceted collaboration. The ongoing economic crisis and political unrest can influence the suicide rate. Thus, Sri Lanka must get prepared and equipped to deal with the impending threats.

Evidence of successful adaptation of the standard approach

In England, suicide is considered a major issue for society leading to life years lost. It is considered to have a significant impact on families and communities[17]. England published their national suicide prevention strategy in 2012, focusing on preventing suicide through a public health approach. By 2017, England's suicide rate had dropped significantly after a few years of its implementation[15].

The National Suicide Prevention Strategy Advisory Group (NSPSAG) which is advisory to the Department of Health and Social Care provides leadership and support to ensure the successful implementation of the strategy. Members of the body represent all relevant stakeholders, including politicians, professionals, and the general public. The National Suicide Prevention Strategy Delivery Group (NSPSDG) ensures consistent and coherent implementation of commitments to suicide and self-harm prevention programs through continuous monitoring[16].

The National Suicide Prevention Alliance (NSPA) works to unite all stakeholders to support those who have been bereaved by suicide. It receives funding from the Department of Health and Social Care to support its 115 organizational members and 129 individual supporters[16]. The NHS Long Term Plan (LTP) and the Five Year Forward View for Mental Health (FYFVMH) set the national target to reduce suicides in England.

The regional suicide prevention strategies establish six priorities as listed below. They are aligned with the national strategic priorities[18].

1. Reduce the risk of suicide in key high-risk groups

2. Tailor approaches to improve mental health and well-being in Kent and Medway

3. Reduce access to the means of suicide

4. Provide better information and support to those bereaved or affected by suicide

5. Support the media in delivering sensitive approaches to suicide and suicidal behavior

6. Support research, data collection, and monitoring

Every local area has its own ongoing or developing a multi-agency suicide prevention plan. For an instance, the following services are supposed to be provided by the Medway authorities: a 24/7 helpline, the Stay Alive App (for assisting the safety of oneself or others), a crisis text service "Shout", a free community suicide awareness training program, mental health first aid training including suicide prevention, local workplace suicide prevention program, a council funded by HUB recruits, training and developing of community mental health champions, appointing a council project officer to work on self-harm and a strategic plan for adolescents[18].

The respective Clinical Commissioning Group oversees the commissioning of mental health treatment services. Among many others, Crisis and Home Treatment teams, psychiatric hospital in-patient facilities, Accident and Emergency (A&E) Psychiatric Liaison services, talking therapies for people with low-intensity suicidal thoughts, and Safe Haven which provides a place for reassurance and emotional support for people, are some of the services available. Through the memoranda of understanding the respective statutory organizations in collaboration with voluntary organizations provide vital services for people within the volunteer community sector frameworks[18].

Sri Lanka attempts to address many identified gaps through its new mental health policy 2020-2030[15]. However, while implementing this new policy, attention should be drawn to successful practices adopted by other countries. Among many others, supporting bereaved families, training and developing community mental

health champions, developing a system to obtain community support, and developing a platform to obtain collaborative support from other government, non-governmental, and volunteer organizations, are some of them.

CONCLUSION

Suicide is a serious, continuing global public health issue that affects Sri Lanka as well. Despite numerous measures to address the problem, Sri Lanka's suicide rate remains high, keeping the country in second place in the region. Therefore, it is high time to revisit those measures and evaluate their impact on the country's suicide prevention efforts.

To improve the situation, monitoring and evaluating already implemented strategies, amending and modifying Sri Lanka's existing strategies based on standard theoretical approaches, and learning from the success stories of other countries can be recommended. Nevertheless, Sri Lanka can expect to have a high suicide rate due to the country's economic and political turbulence. Therefore, the formation of national and regional task forces to address the issue in a multisectoral approach would aid us in getting prepared and equipping ourselves to deal with the impending threats.

REFERENCES

1. World Health Organization. Public health action for the prevention of suicide. Who. 2012;Retrieved on 12 Dec 2013 From http://www.who.int/m.

2. Patton GC, Coffey C, Sawyer SM, Viner RM et al. Global patterns of mortality in young people: a systematic analysis of population health data. Lancet. 2009;374:88192.

3. World Bank. Suicide mortality rate (per 100,000 population) - World Bank Gender Data Portal [Internet]. 2019 [cited 2022 Apr 29]. Available from: https://genderdata.worldbank.org/indicators/sh-sta-suic-p5/

4. Vijayakumar L, Pirkis J, Whiteford H. Suicide in developing countries (3): Prevention efforts. Crisis. 2005;26(3):1204.

5. de Silva D. Suicide prevention strategies in Sri Lanka: the role of socio-cultural factors and health services. Vol. 48, The Ceylon medical journal. 2003. p. 6870.

6. Gunnell D, Eddleston M, Phillips MR KF (2007). The global distribution of fatal pesticide self-poisoning: systematic review. BMC Public Heal 7 357. 2007;7(357).

7. United Nations. Goal 3 | Sustainable development goal report [Internet]. UN. 2017 [cited 2022 Apr 29]. Available from: https://sdgs.un.org/goals/goal3

8. Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, et al. Suicide prevention strategies: A systematic

review. J Am Med Assoc. 2005;294(16):206474.

9. Lanka M of H and N-S. The Mental Health Policy of Sri Lanka. J Chem Inf Model. 2005;53(9):168999.

10. Ministry of health SL. National poilicy and strategy on health of young persons, Sri Lanka.pdf. 2015.

11. Ministry of health SL. National policy on Alcohol control. 2016.

12. De Silva SA, Colucci E, Mendis J, Kelly CM, Jorm AF, Minas H. Suicide first aid guidelines for Sri Lanka: A Delphi consensus study. Int J Ment Health Syst. 2016;10(1):19.

13. Sareen J, Isaak C, Bolton SL, Enns MW, Elias B, Deane F, Munro G, Stein MB, Chateau D, Gould M et al. Gatekeeper training for suicide prevention in First Nations community members: a randomized controlled trial. Depress Anxiety. 2013;30(10):10219.

14. Weerasinghe M, Pearson M, Turner N, Metcalfe C, Gunnell DJ, Agampodi S, et al. Gatekeeper training for vendors to reduce pesticide self-poisoning in rural South Asia: a study protocol for a stepped-wedge cluster randomised controlled trial. BMJ Open. 2022;12(4):e054061.

15. Ministry Of Health SL. National Mental Health policy of Sri Lanka 2020-2030 [Internet]. Sri Lanka; 2021. Available from: ww.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/2022/National Mental Health Policy 2020-2030.pdf

16. Department of Health. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. Public Heal Engl [Internet]. 2017;(January):38. Available from: www.nationalarchives.gov.uk/doc/open-government-licence/

17. HM goverment. Preventing suicide in. 2012;2:59. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf18. Medway council, Kent E. Medways Joint Strategic Needs Assessment Suicide Prevention. 2021.