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 Émile Durkheim was the first academic to throw back the curtain on these private acts and reveal the impact that their representations have on the formulation and implementation of national prevention strategies.2 In 1997 the United Nations urged member countries to address the growing problem of suicide and provided guidelines for the formulation and implementation of national prevention strategies.3 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 that was 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 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

References
9. Suicide in Canada: update of the report of the Task
Force on Suicide in Canada. Ottawa: Mental Health Division, Health Services Directorate, Health Programs and Services Branch, Health Canada; 1994.


