SUICIDE IN CHINA

Michael R. Phillips
Beijing Suicide Research and Prevention Center

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Outline of talk:

A. Overview of mental health services in China
B. Overview of suicide and attempted suicide in China
C. Preventing suicide in China
D. Engaging Chinese students on American campuses
A. Overview of mental health services in China
## Proportion of Total Disease Burden (using DALYs) for 6 Major Categories of Diseases and Injuries in China (2002)

<table>
<thead>
<tr>
<th>Category</th>
<th>males and females</th>
<th>males</th>
<th>females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>rank</td>
<td>% of all burden</td>
<td>rank</td>
</tr>
<tr>
<td>Neuropsychiatric Conditions and Suicide</td>
<td>1</td>
<td>20.3</td>
<td>1</td>
</tr>
<tr>
<td>Cardiovascular Diseases</td>
<td>2</td>
<td>12.61</td>
<td>3</td>
</tr>
<tr>
<td>Unintentional Injuries</td>
<td>3</td>
<td>11.51</td>
<td>2</td>
</tr>
<tr>
<td>Malignant Neoplasms</td>
<td>4</td>
<td>9.72</td>
<td>4</td>
</tr>
<tr>
<td>Infectious/Parasitic Diseases</td>
<td>5</td>
<td>7.38</td>
<td>5</td>
</tr>
<tr>
<td>Sense Organ Diseases</td>
<td>6</td>
<td>7.15</td>
<td>6</td>
</tr>
</tbody>
</table>

From: National Burden of Illness Summary Tables, WHO, 2004
### Relative Importance (as % of all DALYs) of Psychiatric Disorders in China (2002)

<table>
<thead>
<tr>
<th>rank</th>
<th>condition</th>
<th>% of all burden</th>
<th>rank</th>
<th>condition</th>
<th>% of all burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>cerebrovascular disease</td>
<td>7.6</td>
<td>1</td>
<td>depressive disorders</td>
<td>7.8</td>
</tr>
<tr>
<td>2</td>
<td>depressive disorders</td>
<td>5.1</td>
<td>2</td>
<td>cerebrovascular disease</td>
<td>6.9</td>
</tr>
<tr>
<td>3</td>
<td>motor vehicle accidents</td>
<td>4.8</td>
<td>3</td>
<td>COPD</td>
<td>4.4</td>
</tr>
<tr>
<td>4</td>
<td>COPD</td>
<td>4.7</td>
<td>4</td>
<td>lower respiratory infection</td>
<td>3.8</td>
</tr>
<tr>
<td>5</td>
<td>other accidental injuries</td>
<td>4.0</td>
<td>5</td>
<td>suicide</td>
<td>3.2</td>
</tr>
<tr>
<td>6</td>
<td>alcohol use disorders</td>
<td>4.0</td>
<td>13</td>
<td>suicide</td>
<td>2.4</td>
</tr>
<tr>
<td>20</td>
<td>schizophrenia</td>
<td>1.8</td>
<td>18</td>
<td>schizophrenia</td>
<td>1.8</td>
</tr>
<tr>
<td>23</td>
<td>bipolar disorder</td>
<td>1.5</td>
<td>20</td>
<td>bipolar disorder</td>
<td>1.6</td>
</tr>
<tr>
<td>40</td>
<td>dementias</td>
<td>0.8</td>
<td>25</td>
<td>dementias</td>
<td>1.3</td>
</tr>
</tbody>
</table>

From: National Burden of Illness Summary Tables, WHO, 2004  
Only conditions that account for > 1% of total burden (in males or females) are included.
Macro measures that underlie the availability of services in China

- 2.23% of total health budget is allocated to mental health
- Less than 15% of population have health insurance that covers mental health
- About 1 psychiatrist per 100,000 population
- About 1 psychiatric bed per 10,000 population
- Average time spent in 5-year medical school on mental health topics: 40 hours
- Average time spent in nursing schools: none
Mental Health Challenges for China: (A)

- There are almost no psychiatric services in China's vast countryside, so 70% of all persons with chronic mental illnesses receive no treatment.

- In most urban areas services that are available are primarily provided in the inpatient and outpatient settings of specialty psychiatric hospitals.

- In large urban areas an increasing proportion of mental health services are provided at general hospitals, but the quality of services provided is usually quite poor.
Mental Health Challenges for China (B)

• Lack of knowledge about mental illness and negative attitudes about the mentally ill prevent many sufferers from seeking needed care.

• General physicians have little or no training in mental health so they are unable (and often unwilling) to provide basic psychiatric services.
Mental Health Challenges for China (C)

- Social changes are leading to the need for new types of mental health services that the current mental health care system is unable to provide: services for children and the elderly, community-based counseling services for depression and other less-severe psychological problems, substance abuse services, and so forth.
Mental Health Challenges for China (D)

- Several problems such as suicide and substance abuse require inter-sectoral strategies; these are extremely difficult to coordinate in China.
- The overall quality of mental health research is poor and the research funding mechanisms are not based on merit, so researchers are unable to provide policy-makers with useful information.
Goals of the 2002-2010 National Mental Health Plan

1. Increase awareness of mental health problems
2. Prevent mental illness in high-risk groups
3. Increase quality and comprehensiveness of mental health services
4. Improve coordination of mental health services
5. Improve quality and increase numbers of professionals who provide services
6. Improve scientific knowledge about mental illnesses
Excerpts from circular issued by the State Council on 20 September 2004 entitled “Opinions on how to strengthen mental health work” (A)

• Mental health is already an important public health problem and pressing social problem

• Psychological and behavioral problems in children and adolescents, dementia in the elderly, depression, drug abuse, suicide and psychological crisis following natural disasters are becoming more and more prominent.

• Establish a collaborative system between departments; incorporate mental health work into economic and social development plans, and to government agendas.

- Resources
- Technical skills
- Political will
B. Overview of suicide and attempted in China

<table>
<thead>
<tr>
<th>rank</th>
<th>cause</th>
<th>rate (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>ALL AGES</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Cerebrovascular disease</td>
<td>110.41</td>
</tr>
<tr>
<td>2</td>
<td>Bronchitis &amp; chronic emphysema</td>
<td>107.15</td>
</tr>
<tr>
<td>3</td>
<td>Liver cancer</td>
<td>24.78</td>
</tr>
<tr>
<td>4</td>
<td>Pneumonia</td>
<td>24.66</td>
</tr>
<tr>
<td>5</td>
<td>Suicide</td>
<td>23.23</td>
</tr>
<tr>
<td></td>
<td><strong>PERSONS 15-34</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Suicide</td>
<td>26.04</td>
</tr>
<tr>
<td>2</td>
<td>Motor vehicle accidents</td>
<td>20.61</td>
</tr>
<tr>
<td>3</td>
<td>Accidental drowning</td>
<td>6.87</td>
</tr>
<tr>
<td>4</td>
<td>Liver cancer</td>
<td>4.72</td>
</tr>
<tr>
<td>5</td>
<td>Homicide</td>
<td>4.26</td>
</tr>
</tbody>
</table>
Proportion of Total Deaths Due to Suicide: China 1995-1999

- Rural female
- Urban female
- Rural male
- Urban male
Method of suicide among 454 male and 441 female completed suicides from the national psychological autopsy study.
Psychiatric diagnosis in 454 male and 441 female completed suicides from the national psychological autopsy study.

- **No Diagnosis**: 33% male, 42% female
- **Affective Disorders**: 36% male, 34% female
- **Alcohol Disorders**: 15% male
- **Psychotic Disorders**: 6% male, 13% female
- **Organic Disorders**: 6% male, 6% female
- **Other Disorders**: 4% male, 6% female

Percent of cases.
Type of psychological treatment received by 895 persons who died by suicide

- <1% shaman
- 1% TCM doctor
- 8% Western MD
- 9% psychiatrist
- 82% never treated
Characteristics of completed suicide in China (Based on 895 suicides in the national autopsy study)

- 49% were female
- the mean age at death was 46.5 years
- 58% die by ingesting pesticides or rat poison (among these 62% received medical resuscitation, but it failed)
- 79% live in rural villages
- 28% never attended school
- 47% had relatives or associates who have had suicidal behaviour
- 63% had a mental illness at the time of death
- 27% had made a prior suicide attempt
- only 9% had ever seen a mental-health professional.
| Age of child | Rural children | | | | Urban children | | | | All children |
|-------------|----------------|----------------|----------------|----------------|----------------|----------------|---|
| | mother | father | parent | | mother | father | parent | | |
| under 2     | 8,261 | 2,226 | 10,487 | | 155 | 0 | 155 | | 10,642 |
| 2-4         | 14,948 | 5,407 | 20,355 | | 618 | 136 | 754 | | 21,109 |
| 5-9         | 37,764 | 14,311 | 52,075 | | 1,545 | 1,086 | 2,631 | | 54,706 |
| 10-14       | 28,323 | 17,492 | 45,815 | | 1,854 | 1,222 | 3,076 | | 48,891 |
| 15-17       | 15,735 | 10,177 | 25,912 | | 773 | 543 | 1,316 | | 27,228 |
| under 18    | 105,031 | 49,613 | 154,644 | | 4,945 | 2,987 | 7,932 | | 162,576 |

**estimated suicides**  

| | 146,335 | 119,580 | 10,487 | 10,506 | 10,592 | 21,098 | 287,013 |
INDEPENDENT RISK FACTORS FOR COMPLETED SUICIDE
(in order of importance)

- High level of depressive symptoms in 2 weeks before death
- Made a prior suicide attempt
- Acute stress at time of death due to negative life events
- Low quality of life in month prior to death
- Experienced acute interpersonal crisis in two days prior to death
- Chronic stress due of negative life events over year prior to death
- Had friends or associates who had history of suicidal behavior
- Had blood relative who had history of suicidal behavior
- Agricultural laborer or other non-income employment status
- Decreased participation of social activities in month prior to death
ESTIMATED PATTERN OF ATTEMPTED SUICIDES IN CHINA, 2000

[Assuming total of 2 million attempted suicides, urban/rural proportions same as for completed suicides (7.3% urban, 92.7% rural) and an age by gender distribution that is the same as in the 4,628 urban and 9,710 rural attempted suicide cases treated in 25 general hospitals.]

More than 50% of all attempted suicides are in rural women under 40
### METHOD OF SUICIDE ATTEMPT

Retrospective Data from 24 General Hospitals
Emergency Room Records, 1990-2003

<table>
<thead>
<tr>
<th>TYPE OF HOSPITAL</th>
<th>ALL</th>
<th>URBAN</th>
<th>SEMI-RURAL</th>
<th>RURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N=14,334)</td>
<td>(N=4,627)</td>
<td>(N=4,190)</td>
<td>(N=5,517)</td>
</tr>
<tr>
<td>SELF-POISONING</td>
<td>90.8 %</td>
<td>85.3 %</td>
<td>87.5 %</td>
<td>97.8 %</td>
</tr>
<tr>
<td>agricultural poisons</td>
<td>23.3 %</td>
<td>8.9 %</td>
<td>22.9 %</td>
<td>35.7 %</td>
</tr>
<tr>
<td>rat poison</td>
<td>3.8 %</td>
<td>1.0 %</td>
<td>3.6 %</td>
<td>6.2 %</td>
</tr>
<tr>
<td>medications</td>
<td>54.3 %</td>
<td>54.5 %</td>
<td>56.3 %</td>
<td>52.5 %</td>
</tr>
<tr>
<td>other toxins</td>
<td>7.8 %</td>
<td>18.9 %</td>
<td>2.6 %</td>
<td>2.4 %</td>
</tr>
<tr>
<td>unknown poisons</td>
<td>1.7 %</td>
<td>2.1 %</td>
<td>2.0 %</td>
<td>1.0 %</td>
</tr>
<tr>
<td>OTHER METHODS</td>
<td>9.2 %</td>
<td>14.7 %</td>
<td>12.5 %</td>
<td>2.2 %</td>
</tr>
</tbody>
</table>
PSYCHIATRIC DIAGNOSES IN 161 MALE AND 456 FEMALE ATTEMPTED SUICIDES
Type of help sought for psychological problems by 617 serious suicide attempters

- <1% shaman
- 1% TCM doctor
- 2% Western MD
- 11% psychiatrist
- 86% no treatment
Risk factors for medically serious attempted suicide (identified from 2 case-controlled studies)

- acute life stressor
- depression or other mental illness
- prior suicide attempt
- suicidal behavior in family member or associate
- poor family adaptability or cohesion
- low educational level
- low quality of life in prior month
- impulsive or aggressive personality traits
PREMEDITATION IN ATTEMPTED SUICIDE

Time from FIRST considering suicide to making the suicide attempt in 590 individuals who made serious suicide attempts:

- 5 minutes or less: 37%
- 10 minutes or less: 46%
- 2 hours or less: 60%
### Relative Importance of Different Classes of Causes of Suicide as Assessed by Interviewers and Researchers After Detailed Evaluation of Each Case

<table>
<thead>
<tr>
<th>Type of Cause</th>
<th>Serious Suicide Attempts N=617</th>
<th>Completed Suicide N=895</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychological problems:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood disorder</td>
<td>20.7%</td>
<td>29.3%</td>
</tr>
<tr>
<td>Alcohol disorders</td>
<td>2.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Other mental disorders</td>
<td>7.1%</td>
<td>14.2%</td>
</tr>
<tr>
<td><strong>Social problems:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family conflict</td>
<td>54.8%</td>
<td>26.3%</td>
</tr>
<tr>
<td>Economic difficulties</td>
<td>2.7%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Physical illness</td>
<td>2.4%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Other social problems</td>
<td>9.8%</td>
<td>6.4%</td>
</tr>
<tr>
<td>TYPE OF CAUSE</td>
<td>SERIOUS SUICIDE ATTEMPTS N=79</td>
<td>COMPLETED SUICIDE N=40</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Psychological problems:</td>
<td>26.0%</td>
<td>41.5%</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>16.9%</td>
<td>20.6%</td>
</tr>
<tr>
<td>Alcohol disorders</td>
<td>0.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other mental disorders</td>
<td>8.8%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Social problems:</td>
<td>74.0%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Family conflict</td>
<td>56.3%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Economic difficulties</td>
<td>1.0%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Physical illness</td>
<td>1.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Academic problems</td>
<td>15.4%</td>
<td>14.7%</td>
</tr>
</tbody>
</table>
MULTI-FACTOR MODEL OF SUICIDE

NATIONAL AND GLOBAL FACTORS

EXTERNAL INFLUENCES
- globalization of Western values
- regional and global economic integration

CULTURAL FACTORS
- beliefs about suicide and the afterlife
- traditional norms of interpersonal relationships, of defining status

MACRO ENVIRONMENT OF THE COMMUNITY

SOCIOPOLITICAL FACTORS
- means of production, distribution of wealth
- political structure, influence of the media
- community-level suicide prevention campaigns

LOCAL WORLD OF THE INDIVIDUAL

INTERPERSONAL NETWORKS
- relationships with family, friends, associates
- beliefs about suicide of intimate associates

SOCIOECONOMIC ENVIRONMENT
- access to social resources such as education, work, housing, health care, social welfare, etc.
- access to and effectiveness of suicide prevention and treatment services
- availability and lethality of means of suicide

INDIVIDUAL CHARACTERISTICS

SOCIAL IDENTITY
- negotiated social status and social roles
- intersubjective legitimation/delegitimation

PERSONAL RESOURCES AND STRESSORS
- educational level, economic status
- life events, coping skills

BIOLOGICAL AND PSYCHOLOGICAL STATUS
- genetic factors, gender, age
- personality, level of life satisfaction
- physical and mental illness

ATTEMPTED AND COMPLETED SUICIDE
Explanation for China’s unique pattern of suicide

There are no strong religious or legal prohibitions against suicide in China, so persons with serious mental disorders or chronic life stressors (such as incurable illness) may consider suicide an acceptable method of relieving their misery or of reducing the financial and emotional burden they cause their family.

In this generally permissive environment, acute stressors (such as family conflicts) in persons who do not have an underlying mental illness can also result in impulsive suicidal behavior, particularly among young rural women who have very limited social support networks.
Like in other countries, suicide attempts (with a low intent to die) in China are more common in women than men (2.5:1), but in China, particularly in rural China, a much higher proportion of suicide attempters use methods that are quite lethal and the ability of the rural health care system to successfully resuscitate these patients is poor.

Thus it is likely that more suicide 'attempts' die in China than in countries in which less lethal methods are used or where resuscitation services are better. This results in an overall increase in suicide rates and a relative increase in female suicide rates, particularly in rural areas.
# M:F Gender Ratios Of Deaths By Suicide In Different Age Groups In Different Regions Of The World For 1990*

<table>
<thead>
<tr>
<th>Region</th>
<th>ALL AGES</th>
<th>5-14</th>
<th>15-44</th>
<th>45-59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WORLD</strong></td>
<td>1.37</td>
<td>1.74</td>
<td>1.19</td>
<td>1.85</td>
<td>1.69</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>4.64</td>
<td>NA</td>
<td>4.29</td>
<td>3.53</td>
<td>9.11</td>
</tr>
<tr>
<td>Former Socialist Economies of Europe</td>
<td>3.63</td>
<td>4.75</td>
<td>5.53</td>
<td>4.22</td>
<td>2.66</td>
</tr>
<tr>
<td>Established Market Economies</td>
<td>2.69</td>
<td>3.50</td>
<td>3.32</td>
<td>2.50</td>
<td>2.61</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>2.37</td>
<td>1.29</td>
<td>2.09</td>
<td>3.32</td>
<td>4.15</td>
</tr>
<tr>
<td>Middle Eastern Crescent</td>
<td>2.16</td>
<td>2.12</td>
<td>2.33</td>
<td>2.75</td>
<td>1.56</td>
</tr>
<tr>
<td>Other Asia and Islands</td>
<td>1.48</td>
<td>1.64</td>
<td>1.30</td>
<td>2.51</td>
<td>2.31</td>
</tr>
<tr>
<td>India</td>
<td>1.10</td>
<td>0.97</td>
<td>0.86</td>
<td>2.24</td>
<td>3.18</td>
</tr>
<tr>
<td><strong>China</strong></td>
<td><strong>0.81</strong></td>
<td><strong>1.32</strong></td>
<td><strong>0.67</strong></td>
<td><strong>0.93</strong></td>
<td><strong>1.12</strong></td>
</tr>
</tbody>
</table>

International M:F Suicide Ratios for 1990*

C. Preventing suicide in China
Promoting the suicide prevention effort in China

• Develop model research and service delivery centers around the country

• Conduct a National Suicide Prevention Research Project

• Develop, implement and monitor a National Suicide Prevention Plan
Goals of the Beijing Suicide Research and Prevention Center

Our short-term goal is to develop a model center that:

1) conducts high-quality research about suicide;
2) provides high-quality clinical services for suicidal individuals and persons experiencing other types of psychological crises;
3) provides clinical and technical support for clinicians and researchers in other institutions;
4) that trains non-professionals in the recognition and management of suicidal behavior; and
5) actively promotes public awareness of the importance of suicide.

Our long-term goal is to develop a coordinated network of such centers around the country that can effectively reduce the high rates of suicide and attempted suicide.
Center’s Official Opening December 3, 2002
FIRST FREE NATIONAL CRISIS HOTLINE SERVICE
Operator Using Computer System for Hotline Service
Development of Beijing Suicide Research and Prevention Hotline Service

Dec 2002--April 2005
- Calls received: 190,562
- Calls answered: 51,752

- Free national 800 number
- Upgrade computer system
- 24 hours/day, 7 days/week all calls recorded and computerized data entry
- 8-hours/day, 5 days/week

Number of calls per month

Calls answered: blue
Calls not answered: red

2003
2004
2005
Beijing Suicide Research and Prevention Center Hotline Service

ORIGIN OF 51,752 CALLS ANSWERED (2002.2-2005.4)

- Beijing: 18.6%
- Shanghai: 1.1%
- Ningxia: 0.4%
- Hainan: 0.8%
- Foreign: 0.1%
- Tianjin: 1.5%
- Other areas: 2.2%, 0.3%, 0.1%, etc.
Age distribution of 11,035 hotline calls

% of calls

Age group

<20 20-29 30-39 40-49 50-59 60-69 >70

19.4 41.2 24.9 9.5 3.5 1.1 0.4
Work status of 11,145 callers

- 27.9% of callers are students
- 16.8% of callers are unemployed
- 48.8% of callers are wage earners
- 6.5% of callers fall into other categories
<table>
<thead>
<tr>
<th>Problem</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict over spouse choice</td>
<td>5.9%</td>
<td></td>
</tr>
<tr>
<td>Relationship breakup</td>
<td>4.1%</td>
<td>Work pressure</td>
</tr>
<tr>
<td>Dissatisfied with studies</td>
<td>3.2%</td>
<td>Other work/school problem</td>
</tr>
<tr>
<td>School pressure</td>
<td>3.1%</td>
<td>Spouse has affair</td>
</tr>
<tr>
<td>Marital conflict</td>
<td>3.0%</td>
<td>Divorce</td>
</tr>
<tr>
<td>Dissatisfied with work</td>
<td>2.6%</td>
<td>Conflict with leader</td>
</tr>
<tr>
<td>Serious illness</td>
<td>2.6%</td>
<td>Unable to find work</td>
</tr>
<tr>
<td>Conflict with parents</td>
<td>2.4%</td>
<td>Conflict with children</td>
</tr>
</tbody>
</table>
Hotline Training in Other Parts of the Country: Hangzhou
National Training Course for Managers of Crisis Hotlines
December 2004
Role-playing to Train Managers of Crisis Hotlines
International Experts Conduct Formal Evaluation of our Hotline Services
OTHER SERVICES
Crisis Intervention Outpatient Department
自杀一个太多，预防自杀是每一个人的责任

使命
通过开展研究、提供临床服务、培训专业人员、提高公众对自杀的认识水平以及协调制定地区性和全国性自杀预防计划并协调监测其效果来降低中国高的自杀率。

目的
· 不断提高中心的临床服务质量和范围
· 提高人们对自杀的公共卫生重要性的认识水平
· 开展研究以了解自杀行为的特征和危险因素
· 根据可靠的科学研究结果建立有效的城市和农村自杀预防模式，并大力宣传以获得公众和政府的支持以便在全国范围内推广这些模式
· 推动建立地区性和全国性自杀预防计划的政府和非政府机构提供其所需的技术支持
· 在未来8年内将中国的自杀率降低20%，从而每年挽救5至6万人的生命并预防40万人自杀未遂
Activities of the Family Survivors Group Run by the Center
Develop and Distribute Public Education Pamphlets
Conduct National meetings on Suicide Research, Intervention and Training
Hold Training Courses for Researchers from Around China
Quarterly Newsletter About Suicide Prevention in China
PROMOTING ADOPTION OF A NATIONAL SUICIDE PREVENTION PLAN FOR CHINA
OVERALL GOALS OF PROPOSED NATIONAL PLAN

GOAL 1: Promote psychological well-being, resilience and community ‘connectedness’
GOAL 2: Promote broad-based support for suicide prevention
GOAL 3: Decrease access to and lethality of different means for suicide, particularly pesticides
GOAL 4: Enhance social support networks for high-risk groups
GOAL 5: Promote community-based screening programs to identify high-risk individuals
GOAL 6: Increase awareness and change attitudes about mental health problems and suicide
GOAL 7: Improve availability and quality of mental health services
GOAL 8: Develop specific services for high-risk individuals and others affected by suicide
GOAL 9: Expand scientific evidence base for the prevention and management of suicide
GOAL 10: Improve and expand surveillance of suicidal behavior
GOAL 11: Develop sources of sustained funding for suicide-related services and research
Prevention measures that need to be tested as part of China’s national suicide prevention plan

1) restrict access to means, particularly pesticides and toxic drugs
2) expand social support networks for high-risk groups
3) implement promotion campaigns about mental health and suicide
4) improve health providers’ ability to recognize and manage the psychiatric problems associated with suicide
5) institute screening programs to identify high-risk individuals
6) expand crisis support services and targeted mental health services for high-risk individuals
7) increase the ability of primary care facilities to manage the medical complications of suicide attempts
PUBLIC PROMOTION ACTIVITIES
Promotion Meeting on First World Suicide Prevention Day,
10 September 2003
Two of Our Most Famous Volunteers

Da Shan  Qian Yong Fu
Activities During Beijing 2004 Science Week
2004 World Suicide Prevention Day Activities at Ditan Park
Distribution of Information Booklets to the Public
TARGET GROUP FOR 2004:
UNIVERSITY STUDENTS
Promotion Activities at University Campuses
Our new celebrity supporter: Guan Ling
Role-play to Train University Student Gatekeepers for Suicide Prevention
Opening Ceremony of Training Course for Depression and Suicide in University Students: November 2004
WHO Representative Gives Presentation at Meeting
Mother of University Student Who Died by Suicide Describes Her Experience
Training Course for Counselors in Psychological Clinics at Universities Around the Country
Lecture by Professor Judd
President American Association of Suicidology
Discussion with Foreign Experts in University Counseling
D. Engaging Chinese students on American Campuses
Type of prior mental health treatment received by 103 suicides 18-24 years old

- 1% witchdoctor
- 5% western MD
- 11% psychiatrist
- 83% never treated

Type of prior mental health treatment received by 118 suicide attempters 18-24 years old

- 1% western MD
- 7% psychiatrist
- 92% never treated
Outreach to Chinese Students on American Campuses

Identify potential stakeholders/supporters in the target ‘community’:

- Chinese student organization leaders
- Chinese faculty/administrators
- Chinese students in psychology departments
- Potential on-campus and off-campus Chinese ‘celebrity’ supporters

Hold meetings with stakeholders to outline the problem, encourage and assist them to develop a plan to enhance the mental health of Chinese students, and identify a core group of actors invested in the plan:

The plan should consider community-specific educational activities and materials both for new students and continuing students, gatekeeper training, an early warning referral system, liaison with university counseling services and with services outside of university, hotline and web-based services, postvention activities, and so forth.
Outreach to Chinese Students on American Campuses (cont’d)

Publicize the plan among Chinese students and encourage all interested students to participate in relevant activities:

Main goal is to increase early identification of students with problems and the rate of self-referral for professional services. Fear of effect care-seeking has on the academic record is of paramount importance so this issue must be explicitly addressed in promotion efforts.

Periodic re-assessment and revision of the plan:

Turn-over of the core group. Improve methods of promulgation. Identify new target activities, etc.

Counseling staff and university leaders should encourage the Chinese campus community to develop a plan, but remain as consultants to the core group that actually develops and implements the plan.

Make core-group liaison persons affiliates of the counseling center
Notes on treating Chinese students

Socio-cultural factors to assess in all cases:

- first or second generation Chinese
- from mainland or elsewhere (Taiwan, Hong Kong)
- rural or urban upbringing
- time in US, pathway to US
- attitude, expectations about academic success
- family and social network in US
- continuing contact with family in China, sense of responsibility to the family
- level of acculturation, intimate and/or social relationships with non-Chinese Americans
Issues to address:

• source and method of referral
• discuss confidentiality issues early
• If there is extreme fear about confidentiality of on-campus treatment, do they have funds to pay for off-campus treatment?
• benefits & disadvantages of same-sex therapist
• willingness to involve Chinese social network and/or members of Chinese campus community
• Is a Chinese-speaking therapist needed? If so, is there one available?
Notes on treating Chinese students (cont’d)

Therapeutic interventions:

• for psychotic patients get core-group liaison to help contact peers and family to develop a management plan

• encourage non-psychotic patients to utilize the liaison to help mobilize a supportive social network

• assess factors affecting patient’s ‘face’ (self-esteem)

• CBT versus other psychotherapies

• family/couples therapy

• psychopharmacology in Chinese

• provide realistic expectations about therapy/medications

• consider home-leave as an option if patient non-functional

• referral back to China when returning home
THANK YOU FOR LISTENING!

Preventing suicide is everyone`s responsibility