to a survey,[13] which is completely at variance with the Government's philosophy of early intervention.

So, first, there needs to be a major reappraisal of priorities at every level. In the UK this needs to start with the Department of Health, and then local commissioners should fulfil their obligation by 2014 to provide IAPT therapy for 15% of all patients with depression and anxiety disorders. But more will be needed after that. Half of all patients referred for a first consultant appointment at two large acute hospitals in London had medically unexplained symptoms.[14] Only a further expansion of IAPT and evidence-based psychological therapies can provide help for many of these patients, and for the millions of patients with chronic physical diseases whose condition is made worse by depression or anxiety.

Alongside increased provision of care, improvement in diagnosis is also needed. In the UK, this depends largely on the mental-health competence of general practitioners (GPs); at present most trainee GPs do not do a mental-health placement within their 3-year training. Since at least a quarter of visits to the GP are explicitly about mental health,[1] this is quite wrong and a placement in IAPT or other adult or child mental health services should be automatic. It is also vital to tackle the recruitment problems in psychiatry by making late entry much easier. The medical case for better mental health care is straightforward and strongly evidence-based, as is the economic case. And the humanitarian case is overwhelming.

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Suicide affects all of us

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Astute readers of obituaries know that "died unexpectedly" is a common euphemism for "died by suicide". The family and friends of suicide victims are often reluctant to openly discuss the cause of death because of profound sadness, sense of privacy, embarrassment, or cultural taboos. Public discourse on suicide is also limited, perhaps because of unease with the topic of self-destruction or cultural bias against suicide. The news media generally pay scant attention to suicide other than celebrity suicides[1] and suicide clusters.[2] Yet, we are all affected by suicide. There are few among us who have not been touched by the loss of a loved one, friend, colleague, or patient who has chosen to end their life by suicide. It occurs in all countries and

all cultures. It can happen in any family, including your own. Suicide has been reported in children as young as 6 years old,[3] the very old,[4] and all ages between. For the victim of suicide, it is a life needlessly lost. For the survivors of suicide victims, the family and friends, there is an enormous toll in terms of grief, guilt, and a lifetime of unanswered questions.[5] Suicide is an act that is contrary to what is perhaps the strongest of human instincts—survival. To voluntarily end one's own life is incomprehensible for most of us.

In *The Lancet*, three reviews help us to better understand the incomprehensible, each with the aim of contributing to strategies to reduce the risk of self-destructive behaviour. Keith Hawton and colleagues[6] review the current state of knowledge for self-harm and suicide in adolescents; Alexandra Pitman and colleagues[7] do the same for suicide in young men. The third article by Paul S F Yip and colleagues[8] is devoted to prevention of suicide by means restriction—ie, the limiting of access to highly lethal methods of suicide. The articles are informative for health-care providers and provide a context for the development and modification of suicide prevention strategies. Although each article addresses different aspects of suicide, there are some common themes, either implied or explicitly stated, that are worthy of further elaboration. These include the complexity of factors that lead to suicidal behaviour, pain as a unifying feature in the framework of suicide, and means restriction to prevent suicides.

Among the many risk factors for suicide are mental illness, physical illness, previous suicide attempt, substance abuse, family history of suicide, impulsiveness, hopelessness, isolation, and loss (relationship, social, work, financial).[9] Most of us who encounter such challenges learn to cope with them or find ways to overcome them, going on to survive and sometimes flourish. However, an individual with limited psychological reserves who faces the same challenges might come to feel that suicide, however undesirable, is preferable to living. Although there is no simple explanation for such counter-intuitive human behaviour, social and cultural factors, media exposure, and availability of lethal means are woven in a complex web with other risk factors that can lead to suicide.[6-8] The complexity of risk factors for suicide suggests that many approaches to suicide prevention should be considered and customised to accommodate local circumstances.

Jamie Pesotine/AP/Press Association Images

Memory wall dedicated to those lost to suicide, Hazleton, PA, USA

Suicide and pain are closely linked.[10] Suicide might be chosen as the ultimate solution to end psychological pain (eg, from depression or bullying) or chronic physical pain when there is a perception that no other option for relieving the pain is available. Pain is also a consequence of suicide. The family and friends of suicide victims suffer from psychological pain in ways that are mostly silent but nevertheless profound, and they themselves are at high risk for suicide due to the loss they have experienced.[11] Pain management is good medical care for these people and might reduce the risk of suicide.[12]

There is strong empirical evidence that restriction of access to lethal means reduces suicides.[13] The benefit of this approach is predicated on the impulsivity of suicide. It is commonly a very short time, often minutes to hours, between the decision to attempt suicide and the act of suicide, with the urge to die by suicide rapidly dissipating if not completed. Many who die by suicide do not provide advance warning and do not seek help from others.[14] When a common and highly lethal means of suicide (eg, handguns in the USA, pesticides in Asian countries) is easily available, a suicide attempt is likely to result in death. When access to highly lethal means is thwarted (eg, waiting period for purchasing a handgun in the USA, restricted access to pesticides in Asian countries), another chosen means (eg, drug overdose) might be less likely to result in death. Of those who survive a suicidal impulse or a suicide attempt, many go

on to live long and productive lives. Means restriction is an effective population-based approach that should be considered for inclusion in all comprehensive suicide prevention strategies.

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The changing global face of suicide

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On the basis of WHO estimates for 2004, India and China account for 49% of global suicides, and all low-income and middle-income countries (LAMICs) combined account for 84% of all suicides.[1] However, high-quality research on suicide in LAMICs is very restricted, so the Article in *The Lancet* by Vikram Patel and colleagues,[2] the first nationally representative study to estimate suicide rates in India, is an important contribution to available knowledge. The high estimated overall suicide rates in India of 18·6 per 100 000 boys and men (upper bound 15·7, lower bound 19·8) and 12·7 per 100 000 girls and women (10·7, 13·0), and the fact that suicide is the second most important cause of death in young adults aged 15–29 years, parallel findings from China[3] and confirm what has been suspected for decades—suicide is a major public health problem in LAMICs that has not received the attention it deserves. Their data suggest that India's National Crime Records Bureau underestimates suicides in men by at least 25% and suicides in women by at least 36%, showing that treating suicide as a criminal offence, as is done in India and many Islamic countries, can result in the frequent misclassification of suicide deaths and, thus, undermine prevention efforts.

GMB Akash/Panos

As better information about suicide in LAMICs emerges it is starting to challenge conventional beliefs about suicide that, up until the past decade, have been almost completely based on research from high-income countries—countries that account for only 16% of worldwide suicides.[1] Largely based on epidemiological research from high-income countries, most international experts and the WHO Division of Mental Health report that global suicide rates are more than three times higher in men than in women;[4] but the male-to-female ratio reported for India was 1·5 to 1 and the ratio in China is