ASSESSMENT OF SUICIDE RISKS AND FACTORS IN A REFUGEE CAMP IN THAILAND

International Organization for Migration (IOM)

The UN Migration Agency

INTRODUCTION

Background[1]

Suicide is the act of intentionally causing one's own death, and constitutes a major public health issue globally. Almost 1 million people lose their life through suicide on an annual basis, in addition to many more that attempt suicide. Therefore, many millions of people are affected or experience suicide bereavement every year.

Suicide is a behaviour and not a mental disorder; neither is suicide always the result of a mental disorder. Suicide can result from a range of factors, including, for example, negative life events, psychological upheaval, alcohol and drug abuse, mental disorders, physical illness, exposure to suicidal behavior of others, including a family history of suicide. Multiple factors are usually involved in any individual case.

Suicide is a complex human behavior that encompasses psychosocial, health, cultural, economic, and environmental factors. Furthermore, as these factors are intricately connected, it is often hard to disentangle the causes and effects.

Research is inconclusive as to whether refugees are at higher risk of suicide than other migrant and non-refugee populations (Silove et al. 2007). Certainly, distressing life events, difficult living conditions, restrictions on movements and isolation, uprooting, lack of social networks and traditional support mechanisms, and uncertain future prospects can all contribute to both vulnerabilities to mental disorders and to higher suicide rates.

The refugee experience can also bring challenges to the self-concept and to individual and group identities due to legal constraints, the necessity to re-adapt to different social, economic, cultural and symbolic structures, and to the concurrent deprivation of original social support and relational systems and traditional coping networks. Refugees are therefore usually considered at higher risk of mental disorders than non-refugee populations (Lindert et al. 2008, Marshal et al. 2005). This notwithstanding, research aimed at substantiating this assumption has been inconclusive (Silove et al. 2007), mainly due to the fact that samples are not representative. For example, the 112/100,000 annual rate of suicides among detained asylum seekers in the UK in 1998/2007 is frequently reported in literature, but this figure is misleading. Whilst it is nine times higher than the rate in the general population, it is quite close to the suicide rate among the detained British population, and therefore more likely to be related to detention as opposed to refugee-specific vulnerabilities. Regardless of whether refugees are more at risk of suicide than the general population, they are subject to specific suicide risk factors, including lack of help-seeking behaviour, stigma, social isolation and separation from ethno-cultural communities (Cohen 2008), and prior history of unmet mental health problems.[2]

The interplay between distant and proximal factors constitutes a crucial factor for suicidal behavior. The distant causes, such as underlying mental disturbances, genetic predisposition, and chronic stressors, give fertile ground for recent triggers such as acute distress, interpersonal conflict, and financial crisis to

[1] The assessment was undertaken at the largest refugee camp along the Thai-Myanmar border. The Ministry of Thailand's Office for the Coordination of Displaced Persons has requested that the name of the camp be withheld.

[2] IOM Migration Health Division, Mental Health, Psychosocial Response and Intercultural Communication Section and Mission in Nepal, 2013. 'Who Am I? Assessment of Psychosocial Needs and Suicide Risk Factors Among Bhutanese Refugees in Nepal and After the Third Country Resettlement'.

precipitate self-harming acts. It is therefore essential to understand and recognize this fatal combination in order to devise preventive measures.

Context of the Refugee Camps in Thailand

The Republic of the Union of Myanmar, also known as Burma, is a sovereign state in Southeast Asia bordered by Bangladesh, India, China, Laos and Thailand.

Decades-long conflict in the country resulted in the displacement of hundreds of thousands of civilians and forced many to flee their homes to seek shelter in Thailand. Although Thailand is not a signatory to the 1951 Refugee Convention, it has adopted an open-door policy allowing refugees from Myanmar to stay in the country. Thailand currently hosts over 100,000 refugees from Myanmar in nine refugee camps along the Thai-Myanmar border. Taking into account that refugees first arrived in Thailand in the early 1980s after fleeing ethnic conflict in south-eastern Myanmar, this constitutes one of Asia's most protracted refugee situations.

The formation of a civilian-led government in Myanmar in 2011, extensive political and economic reforms, and a dramatic reduction of armed conflict in the south-east of the country have had significant implications for both the local population in general and for some of the refugees who reside in temporary shelters in Thailand.

A series of bilateral discussions between the Government of the Union of Myanmar and the ethnic armed groups resulted in a Nationwide Ceasefire Agreement that was signed in October 2015, which opened a path towards a political settlement in the country.

At the same time, discussions amongst refugees on the possibility of voluntary repatriation have increased. There have been some spontaneous returns to areas of origin by internally displaced persons, and to a lesser extent, by refugees. The establishment of a new government in Thailand in May 2014 has triggered a renewed focus on the refugee situation and durable solutions. Both the Royal Thai Government and the Government of the Union of Myanmar have reiterated their commitment supporting the voluntary repatriation of refugees in line with international standards and humanitarian principles.

According to UNHCR, thousands of refugees in Thailand have already returned to Myanmar spontaneously and several hundreds have approached them for return assistance. In view of recent social, political and economic reforms taking in place in Myanmar, including the Nationwide Cease Agreement, UNHCR together with the Royal Thai Government, the refugees and the humanitarian community in Thailand have engaged in preparedness activities to facilitate the voluntary repatriation of refugees.

Since resettlement commenced in 2005, more than 80,000 refugees from Myanmar have been resettled from Thailand. The United States, Canada and Australia committed to accept large numbers of refugees from Thailand. Other resettlement countries are Finland, Great Britain, Ireland, the Netherlands, New Zealand, Norway and Sweden. Departures for resettlement have been declining on an annual basis since 2008, principally because the majority of those who were able to register in 2004 and 2005 have already left.

Reason, Aims and Limits of the Assessment

The issue of suicides in the camps along the Thai-Myanmar has been raised by international and non-governmental agencies operating at the camps, and has recently come to the attention of the media, with

an article on suicides being published on the BBC website in January 2017[3] and on the Live Science website in February 2017[4]. Taking into account the experience of the IOM in providing mental health and psychosocial support services to serve migrant, host, displaced, mobile and crisis-affected populations, IOM undertook a rapid assessment to identify risk categories and factors, as well as possible cultural explanatory factors for the recent spike in suicides in the biggest refugee camp along the Thai-Myanmar border.

The specific objectives of the rapid assessment, conducted between the 11th and 26th of May 2017, were to:

1) Confirm the magnitude of suicides among Myanmar refugees in absolute terms and in comparison with other populations and analyze statistical correlations and chronological trends, in order to identify risk categories and factors.

2) Investigate possible cultural explanatory systems for suicide and if a specific "culture" of suicide exists in the camp.

3) Investigate if general levels of distress in the camp could create an environment for suicide, possible causes of and responses to distress and possible co-existence of mental health problems in the ones who attempted or committed suicide.

4) Identify recommendations and strategies to enhance measures to prevent suicides in the camp.

The study experienced several limitations. First, the direct assessment took place in one camp only, although this camp was chosen because it has by far the highest number of residents. Secondarily, data and information was not available concerning the incidence rate of suicides amongst the population in Myanmar, so the incidence rate was compared with incidence rate of Tak Province, Thailand and WHO global incidence rates. Most importantly, not all the cases of committed and attempted suicides registered by camp and health authorities could be certainly identified in the UNHCR registration database, therefore statistical correlations were done between a sample of the population and only 71 cases of suicidality. Likewise, post mortem interviews were conducted in relation to 41 cases of committed and attempted suicides and not the entire suicidal population. As a consequence, findings should be considered partial and indicative.

[3] http://www.bbc.com/news/magazine-38423451

[4] https://www.livescience.com/57867-couples-suicide-case-highlights-refugee-mental-health.html

ASSESSMENT METHODOLOGY

The assessment required a multi-pronged approach to facilitate triangulation and determination of possible explanatory systems for suicide within particular communities in the camps. IOM therefore conducted a comprehensive assessment that encompassed statistical analysis; stakeholder (sector) focus group discussions; in-depth interviews with key stakeholders, including service providers; and a comprehensive psychological autopsy (postmortem) of both completed and attempted suicide cases. An overview of the approach adopted for the data collection and statistical analysis, psychological autopsy, stakeholder interviews, and focus group discussions is presented below[5]:

Data Collection and Statistical Analysis

Data of refugee suicides and attempted suicides in the camp was extracted, and only certified completed and attempted cases from 2014-2017 were considered for the study. The analyzed socio-demographic profile included gender, registration status, age group, ethnicity, religion, camp zone, and presence of any persons with specific needs (PSN) criteria. The analysis encompassed the following elements:

- Incidence rate of suicide cases (both completed and attempted) in the period 2014 – 2017;
- Chi square correlation of basic demographic characteristics with suicidality;
- Identification of risk factors through logistic regression;
- Multivariate logistic regression analysis to eliminate potential confounders.

The incidence rates were computed based on all cases of attempted and committed suicide and the total population of the camps, with a cutoff point of June each year for the suicidality case and in January each year for the total general population. The correlations were analyzed between 71 cases of committed and attempted suicides between June 2014 and May 2017 (on a total of 125), that could be with certainty identified within the UNHCR registration database, and a sample of 1,092 randomly selected files of non-suicidal individuals in the same registration database. The internal proportion of the group of 1,092 files, with minimal backward fitting, corresponded to the proportions of the population in the camps in terms of age, gender, sector of residence, and refugee status.

Psychological Autopsy (Postmortem)

The psychological autopsy involved collecting all relevant available information on completed suicide cases through structured interviews with family members, relatives or those with close contact, with the aim of reconstructing the mental state, behavior and actions prior to the suicide.

The list of bio-data of almost all completed and attempted suicide cases was obtained from the authorized health agency, namely the primary health care provider in the camp. In order to preserve confidentiality, the name and other relevant details were obscured. The assessment team decided to conduct psychological postmortem on all 29 completed suicide cases (via close family contact), and on 20 (19%) of the total 96 attempted cases. However, interviews were conducted with only 21 informants (completed cases), as some families have resettled or moved out of the camp. The attempted cases were included randomly as per the list provided by the primary health care provider.

All potential interviewees were approached and invited for the interview, at which point the purpose and broader aims of the assessment were explained. Written consent was obtained from each interviewee. For those interviewees who were illiterate, the consent form was read out in his/her language, with a witness present. For those requiring it, brief counselling was provided, and referrals made as appropriate.

[5] The protocols for the psychological autopsy and focus group discussions are attached as Annexes 3 and 4.

Stakeholder Interviews

Interviews were conducted with key stakeholders, including staff of international organizations, non-governmental organizations, community leaders, mental health and psychosocial professionals, service providers, and religious leaders. The interviews followed an interview protocol with open-ended questions that were read qualitatively. The questions were aimed at grasping local discourse of psychosocial and suicide concepts across different subcultures/subgroups. Interviews with service providers focused particularly on the organization of services and challenges encountered in their provision. A list of the interviewed stakeholders is provided in Annex 1.

Focus Group Discussions

A total of 19 focus group discussions were conducted, with a total of 228 participants, disaggregated by age, gender, and religion. The breakdown of the focus groups is provided in Annex 2.

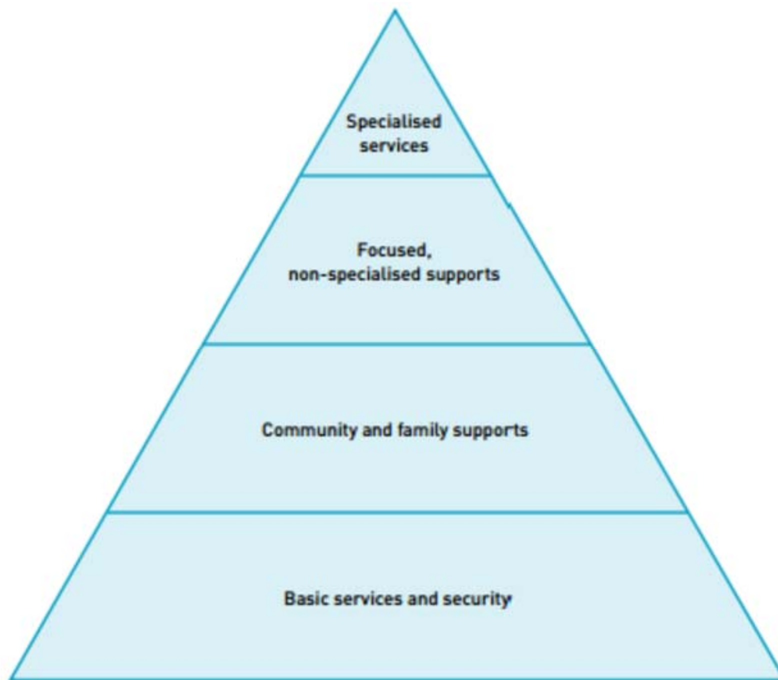
The focus group discussions used a qualitative and nomothetic approach, in order to facilitate the grasp of concerns and emotions that are cognitively most accessible in the respondents' community, rather than adherence to assessors' induced priorities. Focus group discussions adopted a cluster approach, encompassing four clusters within each focus group discussion, followed by an open-ended discussion, as follows:

- *Cluster One – Profile*: To identify the profile of the participants, including registration statues, levels of education, and marriage and employment status;
- *Cluster Two: Fact Finding:* To determine the degree to which participants had experienced suicide, either having heard of cases and/or personally knowing somebody that had attempted or completed suicide;
- *Cluster Three: Concepts of Suicide:* To determine the concepts of suicide amongst participants on suicide, at both a personal and community level, through open-ended questions about attitudes towards people who committed or attempted suicide, including it constituting a sin, prevention measures, and means of support.
- *Cluster Four: General Psychosocial Factors:* To determine psychosocial factors amongst participants, including stress factors, coping mechanisms, perceptions on the future, and support structures.
- *Open-ended discussion:* An opportunity for participants to openly discuss any other issues.

Mapping

Existing psychosocial support and suicide prevention activities were mapped through interviews with stakeholders and focus groups with the population. The activities and services were mapped into the Inter-Agency Standing Committee (IASC) pyramid of Mental Health and Psychosocial Support (MHPSS) in emergencies.

Figure 1: IASC pyramid of MHPSS in emergencies[6]:



[6] IASC, 2007: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

RESULTS

Statistical analysis.

A total of 1,163 individuals (1,092 in the control group and 71 in the suicide group) were analyzed in this study. There were 649 unregistered and 514 registered individuals amongst the study population, of which 33 suicide cases were unregistered and 38 cases were registered. There was an equal distribution of gender in this study; 594 individuals (51 %) were female and 569 (49 %) were male. In terms of age, 435 (37%) were < 15 years of age; 289 (25%) were 15-25 years of age; 328 (28%) were 26-50 years of age; and 111 (10%) individuals were > 50 years of age. The median age of study population was 19 years of age. The majority of the study population resided in camp Zone C and B; 463 (40%) and 478 individuals (41%) respectively; 565 individuals (49%) were Buddhist, 440 (38%) were Christian, and 158 (14%) were Muslim. The majority of the population were Karen, encompassing 1,063 individuals (91%); 61 (5%) were Burmese, and 39 (3%) were other. There were 989 individuals (85%) recorded as having no PSN criteria, and 174 individuals (15%) had at least one PSN criteria. Thirteen out of 50 individuals in the attempted suicide group and 4 out of 21 in suicide completers held at least one PSN criteria.

Figure 2: Basic demographic characteristics of the control group, attempted and completed suicide groups among refugee resided in the camp (Jun 2014 - May 2017)

	Control group (No suicide)		Attempted suicide		Completed suicide	
	Total N=1092		Total N=50		Total N=21	
	N	%	N	%	N	%
Registration status						
Unregistered	616	56.41	23	46	10	47.62
Registered	476	43.59	27	54	11	52.38
Sex						
Male	534	48.9	19	38	16	76.19
Female	558	51.1	31	62	5	23.81
Age group						
<15	431	39.47	3	6	1	4.76
15-25	260	23.81	20	40	9	42.86
26-50	298	27.29	21	42	9	42.86
>50	103	9.43	6	12	2	9.52
Ethnicity						
Karen	998	91.39	46	92	19	90.48
Burmese	58	5.31	2	4	1	4.76
Other	36	3.3	2	4	1	4.76
Religion						
Christian	417	38.19	18	36	5	23.81
Buddhism	530	48.53	20	40	15	71.43
Islam	145	13.28	12	24	1	4.76
Camp zone						
Zone A	208	19.05	11	22	3	14.29

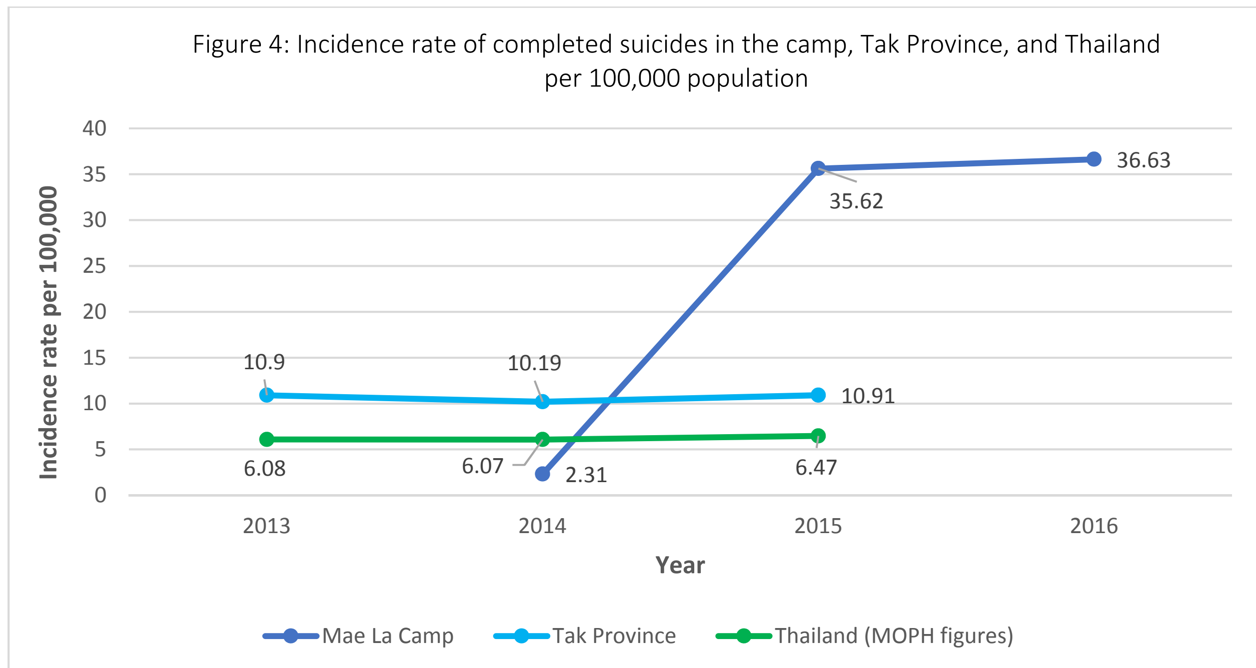
Zone B	451	41.3	16	32	11	52.38
Zone C	433	39.65	23	46	7	33.33

Incidence rates

The incidence rates of suicides and attempted suicides in the years 2014, 2015 and 2016 in the camp are significantly higher than the ones in the Tak province, in which the camp is located, as well as in Thailand and at a global level. The incidence rate is illustrated in the table below, which details completed and attempted suicides in the camp.

Figure 3: Incidence rate of completed suicides per 100,000 population in the Camp

Period	Completed	Attempted	Total	Population in January		Incidence of completed suicides per 100,000 population	
2016 Jun '16 – May '17	14	35	49	38,224		36.63	
2015 Jun '15- May '16	14	31	45	39,302		35.62	
2014 Jun '14- May '15	1	30	31	43,279		2.31	



The incidence rates for 2015 and 2016 are significantly higher than the rates in Thailand in general, which, according to the Ministry of Public Health of Thailand, were 6.47 per 100,000 population and according to WHO were 16 per 100,000 population in 2015, and the annual global age-standardized suicide rate of 10.7 per 100 000 population (WHO: 2015).

The incidence rates show a rapid surge of suicides in the camp from June 2014 onwards. In particular, a very significant increase can be noted in the numbers and incidence rates of completed suicides. In the framework of this assessment, it could not be evaluated if the low number of identified completed prior 2015 can be attributed to a weaker surveillance system, though this is an explanation provided by a number of stakeholders.

Correlations and predictive factors

Religion, sector of residence in the camp, ethnicity and the fact of being registered or unregistered are not statistically significant predictors of suicidality.

Age and gender differences are correlated with suicidality. In particular, all age groups are significantly at risk of suicide ($p<0.001$), but mid-age people are proportionally more at risk. Gender is also predictive, since males are significantly more at risk than females of completing suicide ($p<0.01$), in line with international rates. Among the individual registered vulnerability criteria, sexual and gender-based violence (SGBV) is highly correlated with suicidality ($p<0{,}001$).

Other vulnerability factors, including usual predictors such as illness, are not statistically significant in this analysis.

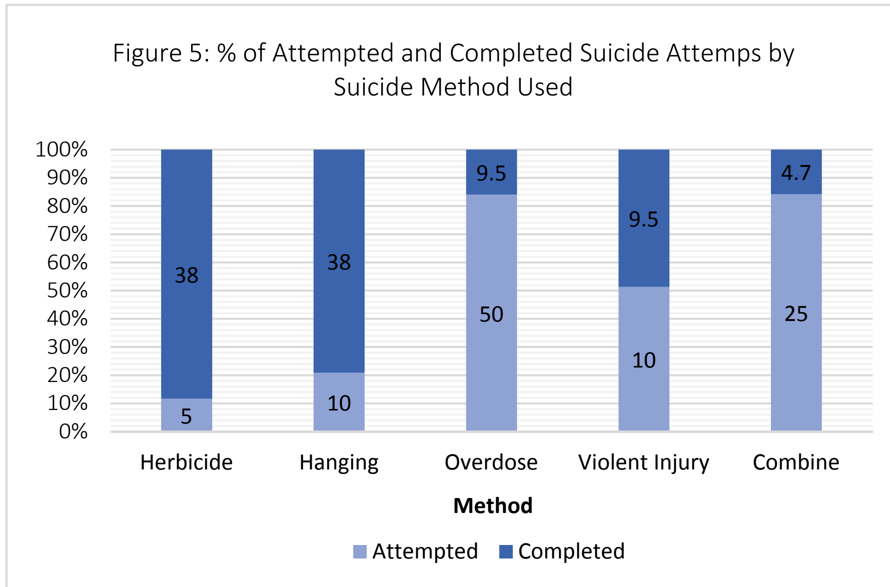
In brief, none of the significant correlations seem to explain a surge in suicidality in 2015 and 2016. However, being a man and being older enhances the odds of suicide, as does being a victim of SGBV. There may be other contributing factors, but these may not be apparent from the statistical analysis, either because they are not registered in the UNHCR list (for instance alcohol abuse, or family conflicts not characterized by violent behavior), or because they have been overlooked in registration. The post mortem interviews aimed at complementing these data.

Psychological Autopsy (Postmortem)

Post mortem and post incident interviews were conducted with the families of 21 victims of suicide and with 20 individuals who attempted suicide, respectively. Post mortem interviews for both attempt group and completed group were conducted by a qualified psychiatrist and provisional diagnoses recorded based on case histories (self-reported for attempt group, family reported for completed group).

1. *Victims' self-harm circumstances and details*

The circumstances and details of the victims' self-harm were examined. Levels of distress at the time of either attempting or completing suicide showed that 14 out of the 20 (70%) cases in those that attempted suicide reported experiencing symptoms of distress within twelve months of the suicide, including SGBV, family conflict, financial problems, and medical problems, with 18 out of 21 (85.9%) reported to have exhibited or expressed distress prior to completing suicide. SGBV was more common in the completed (23.8%) group than attempted (15%), and family conflict was more common in completed group (42.8%) than attempted (25%).

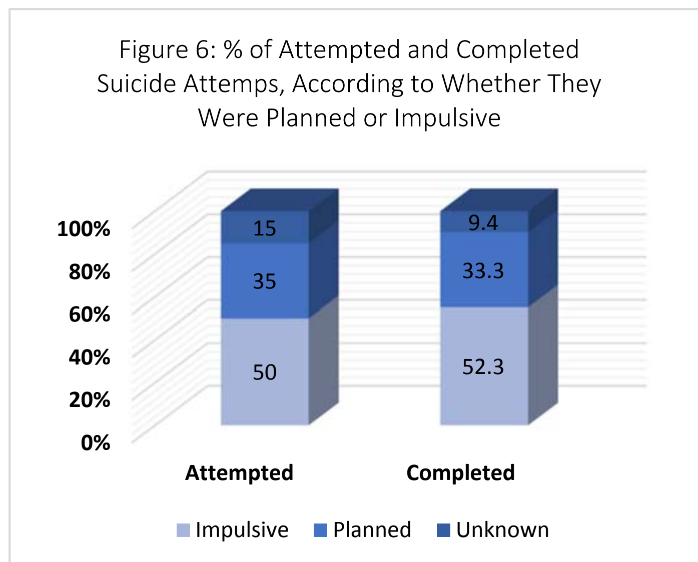


Slight differences were found among the two groups in terms of the site of harm, whereby for those that attempted suicide, 15 out of 20 (75%) occurred in the home, whereas for those that completed suicide, 11 out of 21 occurred at home (52.3), with the rest occurring in different locations outside the home.

Notable differences were observed in the methods utilized. Fifty % of those that attempted suicide used a drug (medication) overdose, but 'herbicide consumption' (38.1%) and 'hanging' (38.1%) were the most common methods attributable to completed suicide cases.

A similar rate of suicide attempts and completions occurred whilst the victims were alone, 55% %and 61.9%%, respectively. In addition, a similar rate of suicide attempts and completions were undertaken in locations that avoided sight, 85% and 80.9%, respectively.

It was observed that slightly more of those that had completed suicide used high classification lethal methods (76%), compared to those that had attempted suicide (65%). Furthermore, none of the group that had completed suicide used a low classification lethal method.



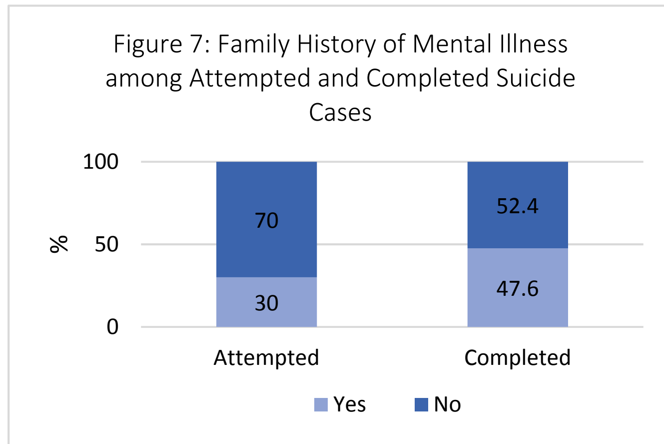
There was a notable difference in previous suicide attempts among the two groups, whereby no victim in the attempted suicide group had attempted suicide before. In contrast, 7 (33.3%) victims in the completed suicide group had previously attempted suicide. Furthermore, double the number of those that had completed suicide had been reported to have shared suicidal thoughts and ideas (N=8; 38.2%), in comparison with the group that did not complete suicide (N=4; 20%). There was, however, no dramatic difference in regards to the prior planning of the suicide, whereby 50%% of those attempted suicide cases, and 52.3% of those completed suicide cases appeared to have been thought out or planned.

Of those that attempted suicide, 40% stated that they were 'unhappy'; 30% stated that they felt 'nothing/indifferent' and 30% felt 'happy that they were alive'. Thus, 70% (N=14) of those that had attempted suicide did not express positive emotions relating to the fact they were still alive. The majority

of those that attempted suicide (N=13; 65%) sought some form of psychological assistance, while a slightly lower proportion of informants of those that completed suicide had sought assistance (57.1%).

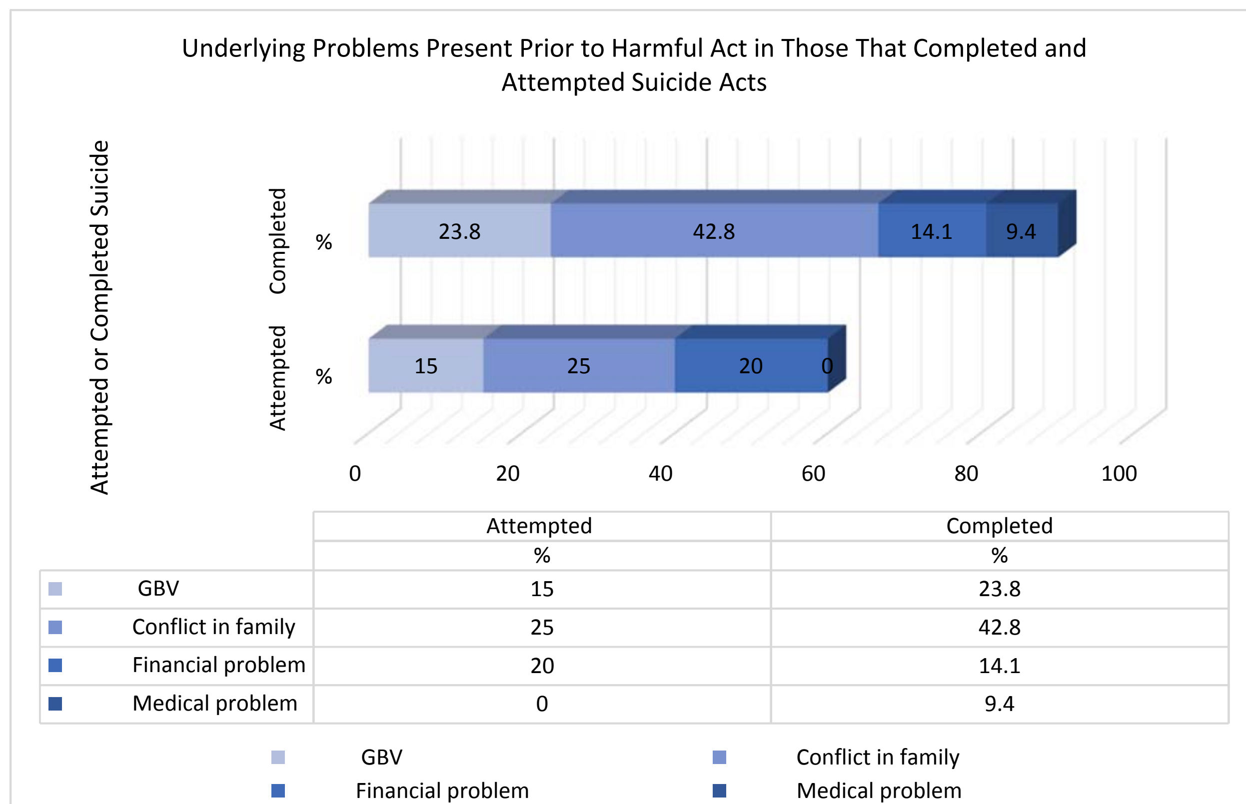
2. *Victim's family history, personality trait and life style*

Details regarding the victim's family history, personality traits and lifestyles were also collected, through which a number of observations were made. In terms of a family history of suicide, similar patterns may be observed between the two groups, whereby 20% (N=4) of attempted suicide cases had a family history of suicide, as opposed to 14.3% (N=3) of completed suicide cases.



A slight difference was noted among the two groups in terms of history of family mental illness, whereby 6 (30%) in the attempted suicide case group had a family history of mental illness, as opposed to 10 (47.6%) in the completed suicide case group. Examining personality traits revealed that being 'introverted' was the most common trait exhibited by both groups; 40% (N=8) of those that had attempted suicide and 66.6% (N=14) of those that had completed suicide.

Respondents were also asked if the victim had been exhibiting symptoms of stress in the run up to either attempting or completing suicide. 70% of those that had attempted suicide and 85% of completed suicide cases had either been, or been perceived as being under stress prior to the event. Potential secondary



	Attempted %	Completed %
GBV	15	23.8
Conflict in family	25	42.8
Financial problem	20	14.1
Medical problem	0	9.4

causes were explored, whereby a quarter (25%) of attempted suicide case respondents cited that 'family conflict' could have been a secondary cause, followed by financial issues (20%). Among the completed suicide case respondents, nearly half (42.8%) cited family conflict; 14.1% cited financial constraints; and 9.4% stated medical conditions had played a role.

There was a disparity in SGBV rates among groups, with 15% of attempted suicide cases and 23.8% of completed suicide cases reporting that the victim had experienced SGBV. Further disparities were found between the two groups regarding the victims' relationship with their spouse and near relatives. Of those that had attempted suicide, the majority (65%) cited that they had a 'good' relationship with close relatives/their spouse, but only 19% of those that had completed suicide had a 'good' relationship with their spouse/family member, whilst 66.6% classified these relationships as 'poor'. It should, however, be noted that one's relationship with a spouse/family member is extremely subjective, and that for those that had completed suicide, information on the status of this relationship was provided by the relatives. Among the responders in the completed suicide group concerning their reaction to the family member's death, an equal amount (38.1%) expressed that they were 'shocked' and that it was 'unexpected'. The remaining 23.8% cited that their death was 'expected', which was particularly found to be the case for consumers of excessive levels of alcohol.

Regarding the resettlement status of victims, 40% of attempted cases were 'unregistered', compared with 52.3% of those that had completed suicide.

3. *Victim's mental health, substance use/abuse problem and treatment*

Sixty five per cent (65%) of the 'attempt group' reported signs and symptoms consistent with a mental health disorder, the commonest being signs and symptoms consistent with provisional 'Clinical Depression' (35.0%), followed by signs and symptoms consistent with 'Alcohol Use Disorder' (25.0%). Based on case histories as relayed by family members, over eighty per cent (80.9%) of the individuals that committed suicide had reported signs and symptoms consistent with mental health and or alcohol abuse, with alcohol use disorder the most common cited, at 38.2%, followed by clinical depression (33.3%) and psychosis (9.6%). None of the cases had received treatment for substance use, but 40% of attempters received some form of mental health care, compared to 14.2% of those that completed suicide, both prior to and at the time of the act.

4. *Informants' demographic profile (Completers)*

Among those that completed suicide, demographic profiling showed that 16 out of 21 (76.1%) were between the ages of 26-50, and 14.2% were 51 or above. There was a considerable gender disparity, whereby 81% of informants were female. In terms of education, 57% of informants had no formal education, and the remaining 43% were educated to a primary level. The majority of respondents were spouses and parents (33.3%), followed by children (14.1%) and siblings (9.4%), and all claimed to be at least 'quite familiar' with the deceased. The majority were Buddhist (66.7%), followed by Christian (19%) and Muslim (14.3%).

Regarding the emotional impact due to the victim's death, the majority (57.1%) cited that it had caused a 'moderate' psychological impact, whilst 20% cited that it had a 'severe' emotional impact. In the aftermath of the incident, over 50% of respondents stated that they required mental health assistance, and during the interview 42.8% were referred to appropriate professionals for further psychological assistance. Depending on need, appropriate counselling and support was provided during and after the interview.

Focus groups with the community

Cluster – Socialization of suicide:

In all groups, all participants have heard about suicides happening in the camp and know details about cases, which hints that suicide is socialized and talked about quite openly. Since participants to the focus groups were selected randomly, two of the participants had attempted suicide themselves, and were open in discussing this within the group. Moreover, in most groups one or more participants knew a person that had committed or attempted suicide, be it a family member, a relative, a neighbor, a colleague, a schoolmate, or a friend. The only groups where none knew anyone who had attempted or committed suicide personally were Buddhist men above 50, male Muslims above 50, and female Christians above 50, which shows a recurrent patterns across religions and genders, under the unifying factor of older age.

Cluster – Concepts of Suicide:

With few exceptions, all groups across ages, genders and religions consider suicide as a sin, as forbidden by religion. Opinions whether suicide should be considered a crime differ, with a majority of groups and participants in each groups not considering it a crime. Only men above 50 of all religions show a more normative approach and do consider it as a crime. For none of the groups is suicide a normal fact of life, which shows that suicide is socialized but not interiorized as a normal fact of everyday life in the camp, and therefore a culture of suicide does not exist in the camp. On the other side, opinions differ as to whether suicide is an understandable reaction to unbearable hardship. For most of the younger people of all groups, it is not. Opinions start to be more mixed among older people, whereas Buddhists of all genders and ages still do not consider it an understandable response to hardship, while Muslims and Christians of both genders above 26, and especially Christian and Muslim men above 50, tend to consider it an understandable response to hardship.

When asked what most motivate people to commit suicide, a common set of answers emerge in all groups and relate to economic and emotional hardship, family and relationship problems, and drug and alcohol abuse. Additionally, younger people refer to bad parenting and its effects on children, including family violence, the shame to be put in a demeaning position by the parents in front of neighbors and friends, and having controlling families. Older groups refer to the worsening law enforcement conditions in the camp, the diminished freedom of movement and the subsequent worsening of financial conditions and sense of "suffocation" or being trapped in the camp, paired with insecurity about the future due to fear of repatriation and insecurity concerning the chances of resettlement. For most respondents, these last are not direct causes of suicide but create an overall stressful environment that contributes to an increase in family conflicts and alcohol abuse and, therefore, to suicide.

All participants stated they would not discriminate or stigmatize a person who attempted suicide, but rather support him or her morally, if possible. While all groups above 26 years old share the view that the community at large would act in the same way, all groups below 26 years old across genders and religions but one believe that the community at large would be less supportive or are not sure, since they had heard of cases in which suicidal cases had been labelled as a coward or been more generally stigmatized.

In terms of what can be done to prevent suicide, younger people tend to highlight possibilities to receive counselling or ways to express their feelings, as well as livelihood support that will enable them to be self-sufficient, regain self-esteem, and look towards the future. Older people refer to more qualified mental

health services in the camp, freedom of movement, and clarity from the different systems about their future prospects as fundamental actions. Older people were also more inclined to refer to informal and traditional support such as religious education and activities as a way to respond.

Cluster 4 – General Distress

All participants report a high level of distress, due to issues related with **lack of freedom of movement, uncertainty about the future, decrease in food rations, worries about the fact that the camp will be closed and they will be forced into repatriation while resettlement is slowing down, economic hardship and lack of educational opportunities for the younger ones, with increase in alcohol abuse and antisocial behavior among their children**. These concerns are consistent across the board with no significant differences between the various groups.

When asked what makes life worth living, young individuals of all religions concur on the **community support, the love of their families and the hope for their future, which includes resettlement, good education and the possibility to give their parents a better future**. Christian females aged between 15 and 25 refer also to religion. Individuals between 26 and 50, and over 50 mainly refer to **family** as the reason that makes their life worth living, including parents, spouses and children. Some of the groups also refer to resettlement in other countries and to **religion** as well.

Natural ways to respond to negative feelings vary among groups. Young males of all religions include sport, music, watching movies, social media, spending time with friends and praying. In a few cases, the use of alcohol or other substances was referred to. Females under 26 years old refer to music and singing, reading and talking to their families. For Muslims and Christians, reference was made to praying and religion. Also, in this case, reference was made by one individual to the use of psychotropics. Among adults aged 26-50 the differences are more evident. Male Buddhists mention meditating and listening to the teachings of the Buddha, sports, friends and alcohol. Prayers and spending time with friends are also at the top of the resilience factors mentioned by the Muslim males, who, however, have a more social approach to their suffering which they share with friends and family, and some of them are drinking alcohol with friends. Christian males put friends and social activities, within which alcohol was also highlighted as a coping strategy. Females in the same age range tend to pray or socialize their distress within the family, in the case of Buddhist and Muslims, or with friends in the case of Christians. For males above 50, friend support constitutes the most recurrent strategy to overcome negative feelings in all religious groups. Christians and Muslims above 50 will also pray, and Buddhists explicitly mention the use of alcohol to cope. Muslim and Christians are more prone to socialize distress within the family to find solace than Buddhists are. The same applies to females that tend to express negative feelings more within the family then with friends. Muslim women in particular seemed to find solace in being directly involved in livelihood activities.

Mapping

Interviews with stakeholders and questions over existing services within the focus groups revealed the following information concerning existing services.

At the level of basic needs and security

According to IASC guidelines, the level of basic needs and security relates to the (re)establishment of security, adequate governance and services that address basic physical needs, such as food, shelter, water, basic health care, and control of communicable diseases (IASC: 2007). Basic needs and security are provided

in the camps amidst reductions in food rations, unequal opportunities to exit the camps and law enforcement strategies perceived as unfairly strict inside the camp in general, which is perceived to impose unnecessary hardship on the population. Whilst some volunteer workers from within the camp population had received mental health awareness raising sessions, there was no evidence of formal Psychological First Aid training available.

At the level of family and community support

Family and community support relates to a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family support (IASC: 2007). In camps that are over 20 years old, most of the family and community support activities are not run by international agencies but spontaneously organized by the communities around churches, schools and community actions. In addition, Handicap International organizes some level two protection and psychosocial-related activities around the inclusion of people with disabilities and educational and livelihood programs for youth. Within the focus group discussions, some participants have received general orientation training and awareness raising, but formal training activities are not conducted.

At the level of focused services

Focused, non-specialized support represents the support necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (IASC: 2007).

A drug and alcohol rehabilitation facility exists in the camp. The model is a non-pharmacologic approach combined with herbal remedies and traditional physical rehabilitation methods such as massages. While it is not verifiable, several stakeholders reported concerns over the use of corporal punishment as a measure of re-enforcement of abstinence within the center. While all admissions to the center goes through a three-month program, relapses after discharge from the center seem to be a frequent occurrence.

In addition, a group of refugees trained to act as psychosocial workers have been active in the camps for several years. They have changed umbrella agency a few times and are currently under contract with International Rescue Committee (IRC). These teams have received several trainings in the past, including by experts from John Hopkins University in the Common Elements Treatment Approach (CETA), as well as in trauma-based Cognitive Behavioral Therapy. However, due to a high turnover, only two of the five psychosocial counsellors currently employed participated at the trainings, while the others have been trained mainly in-service by a supervisor. Their follow up with cases pertain mainly to the follow up of treatment prescribed by the general doctors at the IRC clinic. Post-suicidal care includes dedicated follow-up visits over a period of 3 months, but the content of these visits seems not to be focused on post-suicide care and does not include the families of those who committed suicide. Concerning the background of the psychosocial counsellors, most are former teachers in the camp schools.

There is a camp-based SGBV Committee, which works in collaboration with Karen Women Organization (KWO), and the IRC program for Women's Protection and Empowerment (WPE). If medical services are required, IRC provides assistance and provides referral to the One Stop Crisis Centre (OSCC) at Mae Sot General Hospital, and psychological and legal support services are provided by the IRC WPE program and IRC Legal Assistance Program. The cases who do not require medical service or referral to IRC WPE program are provided with care by KWO, which supports and advocates about women rights and acts against gender based violence. There is also a safe house for victims of SGBV.

Specialized mental health care

Specialized services represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric support for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services (IASC: 2007).

Mental health services in the camp consists of basic primary responses and limited-capacity focused services; specialized mental health care is not available. Therefore, cases requiring specialized care are referred to the Mae Sot psychiatrist services. Such referrals are dependent on camp-based psychosocial workers or camp based medical workers' recognition of the need for higher level mental health services and the availability of specialized practitioners at a given time, with which comes inherent limitations.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The incidence rates of completed suicide in the last two years have been disproportionately high in the camp (35.62; 36.63), at about three times the rates of suicides in the surrounding province (10.91), in Thailand (10.9, according to the Ministry of Public Health in Thailand) and globally (10.7 [WHO: 2015]). **The rates have increased dramatically from 2014 onwards**, which **may be due to the fact that surveillance and registration systems started to be more comprehensively applied**. Indeed, no specific cause for such a dramatic surge was identified during the assessment. In addition, the fact that surveillance is now increasing but was not well organized is a possible explanation for the faults of the current system that made it difficult to retrieve information about all cases of suicidality in the camps. **The surveillance system needs to be strengthened further, but the issue of suicidality in the camp is worrisome and needs to be responded to urgently.**

Mid-age people, males and victims of SGBV are statistically more at risk of suicide than other populations and should be prioritized in responses. This notwithstanding, from the mapping of the sparse psychosocial services offered in the camps, it appears that older people and males are the least involved in those activities that target mainly youth and women. In addition, most of focus group participants and stakeholders interviewed did not know the existence of specialized psychological support service offered to victims of SGBV in the camp.

Additional correlated factors emerging from the post-mortem and post-incident interviews include **family conflicts** (48% of completed cases); **alcohol and substance abuse** (38% of completed cases); and **depression or depressive mood** (33% of completed cases). Even though the significance of these correlations cannot be evaluated since those factors are not registered in the UNHCR files of the global population of the camp, which impairs comparison, they seem important to consider.

Family and relationship problems may be overemphasized, since post mortem interviews are conducted with families of the deceased that naturally struggle with a sense of guilt. However, they are still relevant among the attempted group (25%) and perceived by almost all participants of focus groups, irrespective of gender, age and religion, as central in determining suicidal behavior. Moreover, in all focus groups, family is the fundamental factor of resilience and what makes life worth living. It is therefore not surprising than in an environment that is already stressful and tense, losing the support of the family or having conflict with the family can become a reason for suicidal behavior. While conflicts and aggressive communication within the families were often reported in focus groups, no family counselling service is available in the camp, except from unharmonized forms of pastoral or religious guidance.

Concerning **alcohol and substance abuse**, it must be noted that a social use of alcohol and substances seems to be widespread in the camp, and alcohol often emerged in focus groups as a socialization factor and as a usual and effective way to cope with distress. Alcohol seems to have an impact on suicidality, since 25% of attempted cases and 38% of the completed cases were abusers, and an even higher proportion was under the influence of alcohol when the suicidal behavior took place. In almost all focus groups, and especially in the ones with younger populations, alcohol and substance abuse was correlated to suicidal behavior. A rehabilitation set-up / clinic center exists in the camp, though the system seems to have problems of outreach, since none of the suicidal cases with an explicit history of abuse had ever been treated for addiction prior to the episode. In addition, stakeholders raised concerns about the methods used in the clinic. While they praise its holistic approach, they lament the high rate of relapses after treatment, as well as some issues in referral.

As for the association with depression, this is a known fact in suicidality. However, at the time of the assessment, there was not a systematic approach nor specific technical capacities within the camp for the treatment of moderate or severe mental disorders apart from pharmacological care and follow up on adherence to medication.

In terms of modalities of suicide, an equal proportion of suicides and attempts in the camp were well planned or impulsive. The main means of suicide are overdose and poison (of various sorts) and hanging, and the use of herbicide is particularly lethal. Most attempts and suicides happen in the home. Impulsive suicides can be limited through controlling the diffusion of the usual means people use to commit suicide. An attempt could be made to limit or forbid the access of herbicides in the camps, but the same cannot apply to suicide by overdose or hanging, and, in any case, half of the suicides in the camps are not impulsive. The focus of preventative and response interventions should remain on the person and the context and can only partially benefit from an action on the means.

In general, suicide is socialized, spoken about, not particularly stigmatized and not mythicized. People know about it, but do not consider it normal or a normal reaction to hardship. In most focus groups, the hardships people are facing in the camps make suicide understandable and in parts justifiable, which reduces stigma, but it is not normalized or considered a normal way to respond to hardship. In general, the problem does not seem to be a lack of suicide awareness. Suicide, on the contrary, has to be read in the context of high generalized distress due to the new situation in the camps characterized by slower resettlement, whilst the possibility to be resettled and "be free" remains a strong resilience factor and reason for hope in the camp; talks of possible repatriation, at a time when most people feel their country of origin is still an unsafe place, which has both practical and psychological implications related with their memories; reduced food rations, which affect wellbeing and increase fears about a progressive diminishment of services heading towards the closure of the camps; and reduced freedom of movement, which impact them psychologically (in terms of both a feeling of "being suffocated" and economically). In this environment, alcohol and substance abuse increases as a way to cope with the distress, and when the anchors in life, like family relations, are put into question, even superficially or temporarily by an argument or a dispute, suicide can happen. A valid strategy to prevent and respond to suicide cannot therefore be detached from the general situation in which suicides happen to be effective.

The existing psychosocial support and mental health services in the camps consist of provision of limited pharmaceutical treatment at the primary health care level, for those who are referred to the clinic. The clinic is equipped with three general practitioners (trained equivalent to Bachelor of Medicine, Bachelor of Surgery degree (MBBS), 42 medics who have received training by the general practitioners according to the Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT) training curriculum (within which basic mental health constitutes a topic) and the WHO Mental Health Gap Action Programme (mHGAP) intervention guideline, 75 nurses, and 7 psychosocial workers. The latter have been present in the camp for a while, albeit under different umbrella organizations, but the individuals holding the position have been subject to a high turnover. Currently, only 5 are active and 4 of them were hired in the last year and therefore did not participate in any of the trainings in MHPSS and counselling offered in past years to colleagues. Handicap International is planning to implement a psychosocial support program through workshops and psycho-education in schools. In general, the services seems quite unequipped to respond to the magnitude of needs, and indeed needs that will likely be on the increase in the forthcoming period due to the uncertainties about the future, the difficulties of resettlement, and changes in the political scenario in terms of resettlement to third countries, such as the United States. In particular, post-incident care is not particularly elaborated, and yet research shows that 1 in every 3 cases of completed suicide in

the camps had attempted beforehand, and many individuals escaped the necessary attention. Moreover, there is limited specific support in place for the families of people who committed suicide.

Recommendations

To respond to the issue of suicide in the camp, IOM proposes a range of actions, as follows:

At the general level:

- Restructure MHPSS services in line with task competencies in the pyramid of intervention.
- Train humanitarian workers, activists, service providers, community and religious leaders and teachers in the camp in psychological first aid, supportive communication, and suicide prevention.
- Inform the population about future perspectives and plans in a participatory way and through dedicated community fora.
- Provide livelihood activities that integrate MHPSS considerations and practices.
- Grant freedom of movement or enhanced freedom of movement to camp residents.
- Limit the access to herbicide in the camps.

At the level of family and community support

- Establish a family counselling unit in the camp.
- Train religious and community leaders in conflict mediation practices in family and community settings.
- Establish focus group discussions targeting the most vulnerable categories, facilitated by skilled counselors, and using survivors as peer-supporters, on the theme of suicide prevention. Involve religious leaders and peer groups.
- Create age and gender specific psychosocial support groups, including those for older men, in the camps and train a group of facilitators for these groups and provide them with monthly supervision.
- Establish a recreational and counselling center for families in the camp.
- Conduct a campaign on the effects of abuse of alcohol and drugs on impulsive behavior.

At the level of focused services:

- Deploy a professional expert counsellor on suicide in the camps.
- Expand the existing group of psychosocial counsellors in number and expertise, eventually bringing some team leaders from out of the camp with the right qualifications.
- Undertake a census of all attempted suicides and provide these indificuals with psychological counselling.
- Undertake a census of all families of suicides and establish a support group facilitated by an experienced psychologist.
- Establish a full post-incident care protocol for new cases.
- Establish a dedicated service of psychological assistance for SGBV victims regardless of perceived or apparent medical care needs
- Establish a protocol of interventions for assessing and targeting the most vulnerable groups specifically, and not only the community at large, e.g. victims of gender-based violence, families presenting more than 3 UNHCR special needs codes, persons with a family history of suicide.
- Establish a full post-incident care protocol for new cases.
- Establish specific activities and groups in support of men, with a combination of workshops and self-help materials.

- Establish support groups for addiction.
- Create a small team for suicide care and follow up only, as well as dedicated training.
- Review the activities of and eventually complement the existing addiction clinic's operations.

At the specialized care level:

- Add a psychiatrist to the personnel of the clinic in the camp.
- Create special provisions for people with mental disorders to access care at the hospital in Mae Sot in an outpatient fashion.
- Review and strengthen the drug rehabilitation services offered in the camp.
- Reinforced training for the medical personnel in MH Gap by specialized mental health experts, particularly the modules on depression, psychoses, drug and alcohol abuse and suicidality.
- Establish a protocol for treatment and management of attempted suicides and support to families of completed suicides. This should include a comprehensive package, including clinical intervention, consistent counseling path (over a period of three months and not a one-off), and socializing and educational activities.

These recommendations are based on the findings in the assessment and have been identified by the IOM experts who carried out the assessment research, which includes the Head of the Mental Health, Psychosocial Response and Intercultural Unit, the IOM Thailand psychiatrist, IOM medical doctors, IOM psychosocial workers, and other relevant staff. IOM will be identifying ways to implement these recommendations, in coordination with key donors, NGOs, and service providers within the camps, as well as the Office for the Coordination of Displaced Persons within the Ministry of Interior.

Annex 1

List of stakeholders interviewed

- Camp Chair Person: 1 person
- Camp Leaders: 3 representatives
- Religious Leaders: 3 representatives
- Doctors: 1 Director of the IRC clinic
- NGO representative: 1 Psychosocial specialist from Handicap International
- Local government representative: 1 Camp Commander
- Psychosocial actors: 5 psychosocial counsellors from International Rescue Committee (IRC)
- UNHCR: 3 Protection officials in Mae Sot
- Karen Refugee Committee : 1 representative
- Mae Tao Clinic: 2 Doctors: Director and clinical consultant

Annex 2

Breakdown of the focus groups

Age	# of participants	# registered	# verified	# undocumented
13-17 years	1) Male Buddhist: 8	1	7	
15-25 years	2) Male Buddhist: 8	4	4	
	3) Male Christian: 15	6	9	
	4) Male Muslim: 18	5	12	1
	5) Female Buddhist: 14	8	6	
	6) Female Christian: 8	8		
	7) Female Muslim: 24	3	20	1
26-50 years	8) Male Buddhist: 10	3	7	
	9) Male Christian: 11	4	6	1
	10) Male Muslim: 15	1	14	
	11) Female Buddhist: 10	5	4	1
	12) Female Christian: 11	5	6	
	13) Female Muslim: 15	2	13	
Over 50 years	14) Male Buddhist: 10	7	3	
	15) Male Christian: 8	2	6	
	16) Male Muslim: 8		8	
	17) Female Buddhist: 8	6	2	
	18) Female Christian: 11	8	3	
	19) Female Muslim: 16	4	12	