自殺対策の世界的傾向および WHO mhGAP介入ガイドライン

瀬戸屋雄太郎
World Health Organization (WHO)
Geneva, Switzerland

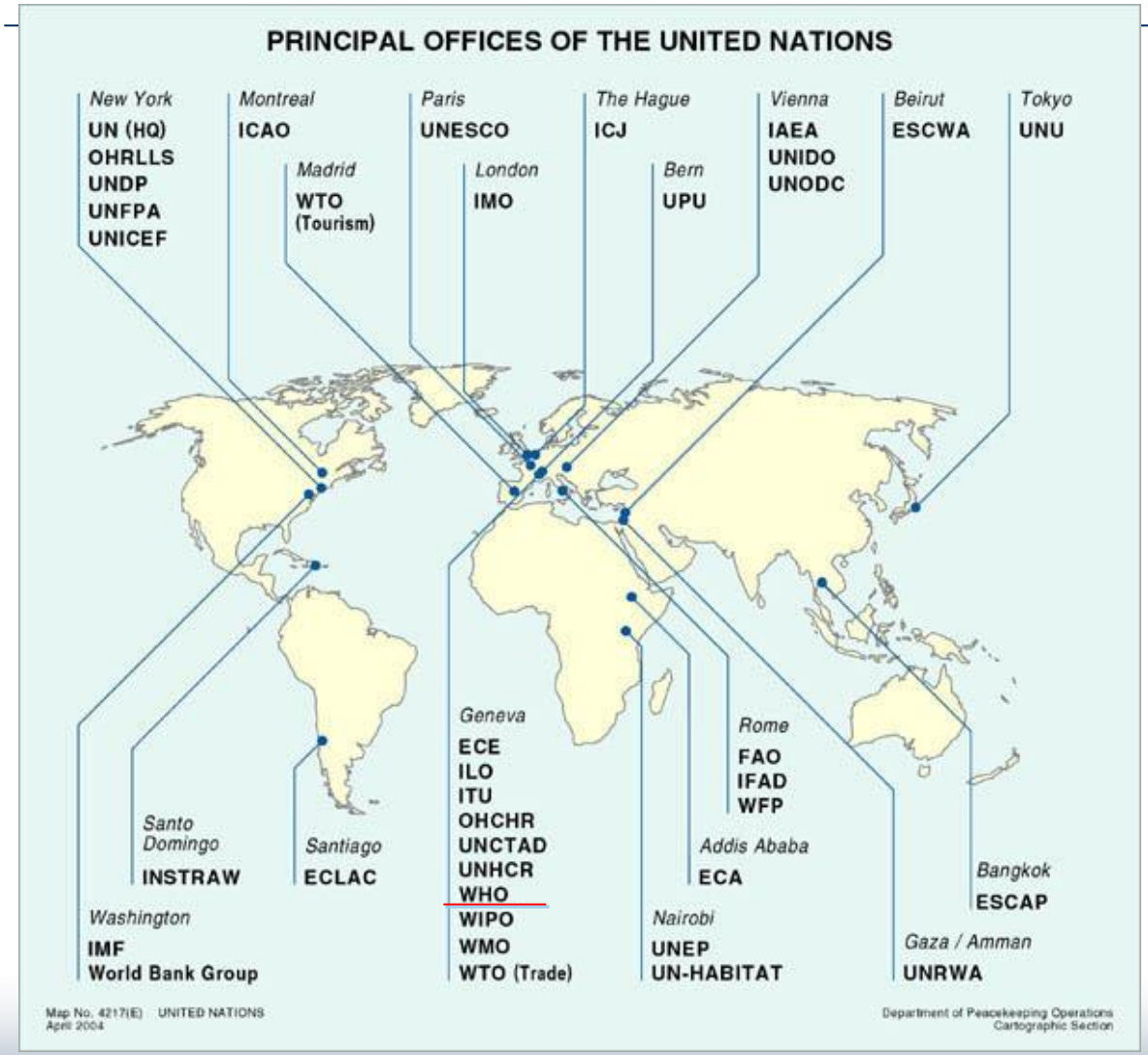
自己紹介

- 7年間、国立精神保健研究所で勤務。地域精神保健の推進に関する研究を実施
- 3年前よりWHO精神保健・薬物依存部にて勤務
- Public Health（公衆衛生）の専門家

公衆衛生？？

- 医師は患者を単位とし、診断し、医療を提供
- 公衆衛生は公衆を単位とし、状況を評価し、適切な（医療）システムを提供
- 予防に重点
- WHOは国連の公衆衛生に関する専門機関

国際連合（United Nations）



WHOは国連の専門機関のひとつ

世界保健機関とは

- 「すべての人々が可能な最高の健康水準に到達すること」を目的として設立された国連の専門機関
- 1948年に設立、日本は1951年に加盟
- 現在194の加盟国
- ジュネーブ本部
- アフリカ、アメリカ、南東アジア、ヨーロッパ、東地中海、西太平洋地域 に地域事務所
- 約150の国事務所

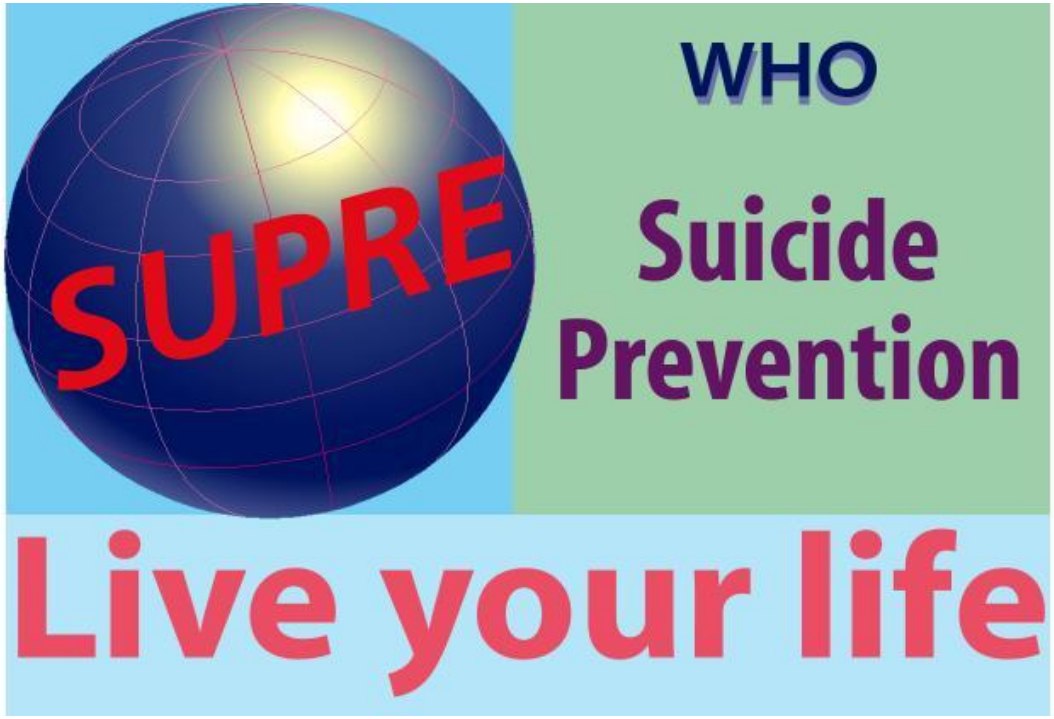
Dr Margaret Chan
Director-General
World Health Organization

精神保健・薬物依存部

Department of Mental Health and Substance Abuse

- 部長：Dr Shekhar Saxena
- 15名の専門職スタッフ、5名の一般職スタッフ、数名のコンサルタント、インターンより構成
- 3つのユニットからなる
  - Evidence, Research and Action （MER）
    データ収集、ガイドライン作成、診断基準作成（ICD-11）、自殺予防等
  - Mental Health Policy and Service Development（MHP）
    政策・法律レビュー、人権、サービス評価等
  - Management of Substance Abuse（MSB）
    アルコール・薬物関連障害

SUicide PREvention

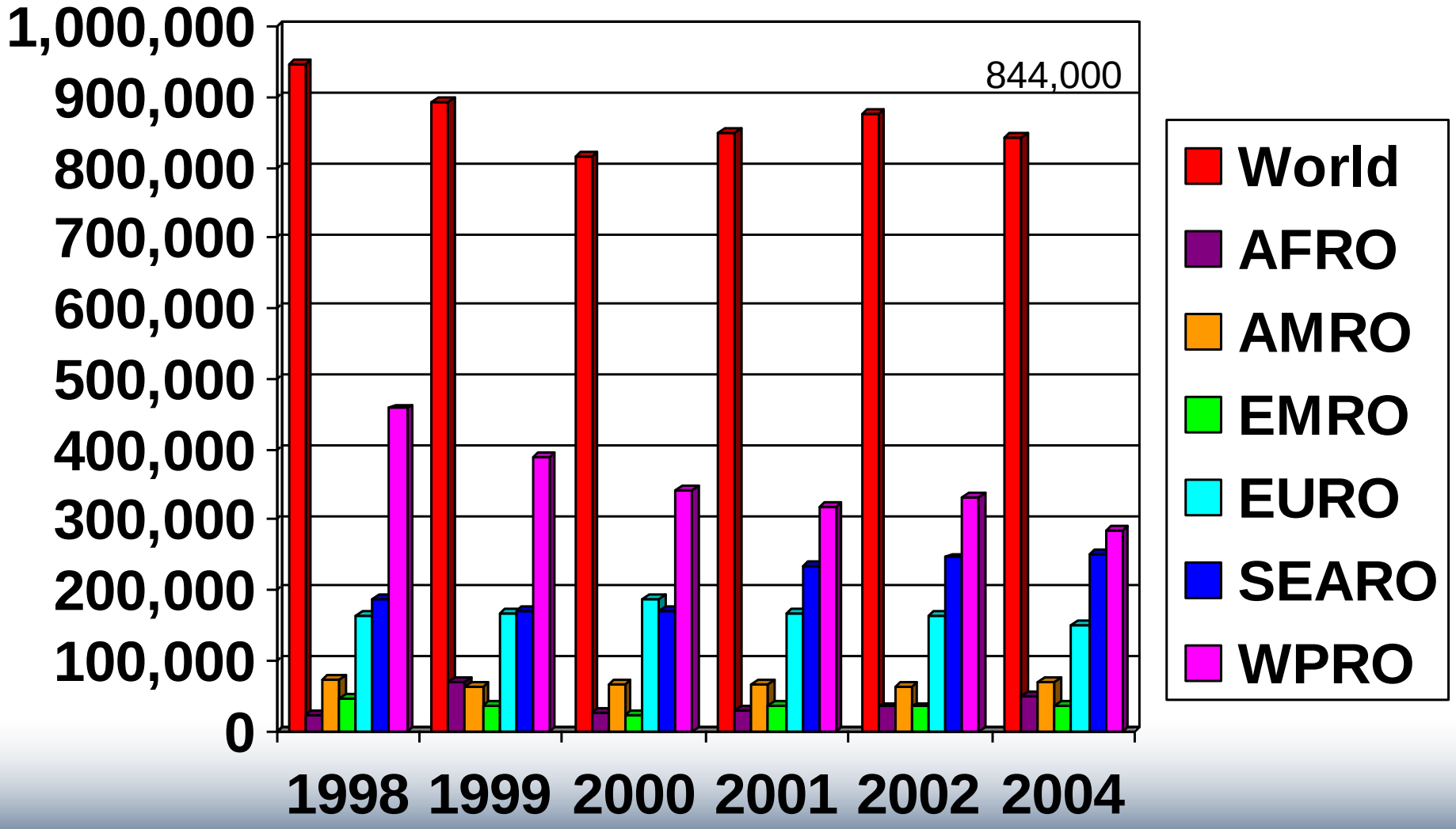


WHOの自殺予防プログラム:SUPRE

SUPRE:WHO Worldwide Initiative for the Prevention of Suicide

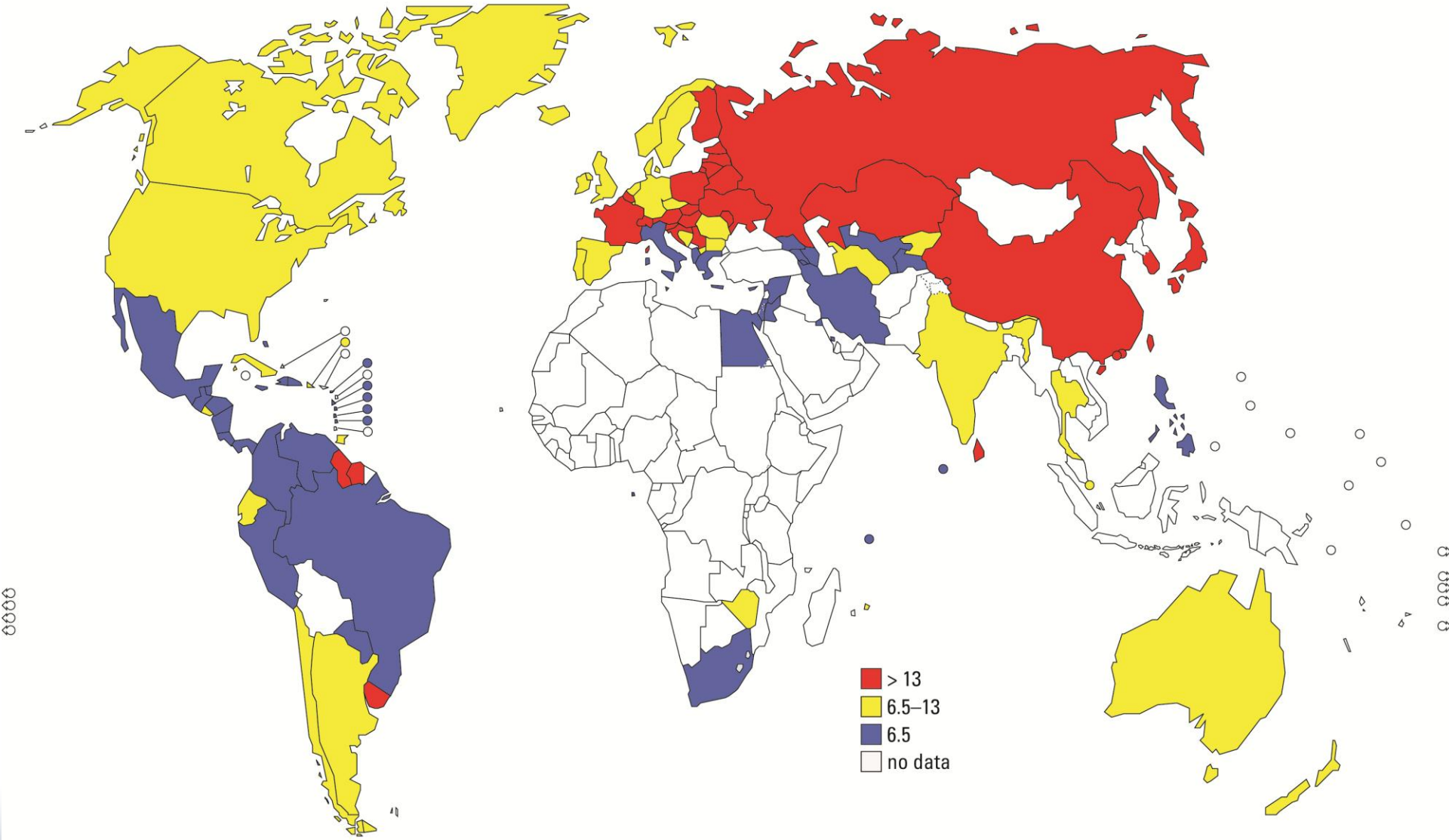
- 自殺死亡率のモニタリング
- 加盟国へのサポート
- 情報の提供。自殺予防リソースシリーズ
- Mental Health GAP Action Programme (mhGAP)
- 世界自殺レポート（2014年9月予定）

自殺による死亡数


1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
844,000
1998
1999
2000
2001
2002
2004
World
AFRO
AMRO
EMRO
EURO
SEARO
WPRO

Map of suicide rates

(per 100 000; most recent year available as of 2011)



The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dashed lines represent approximate border lines for which there may not yet be full agreement.

WHO 06.160

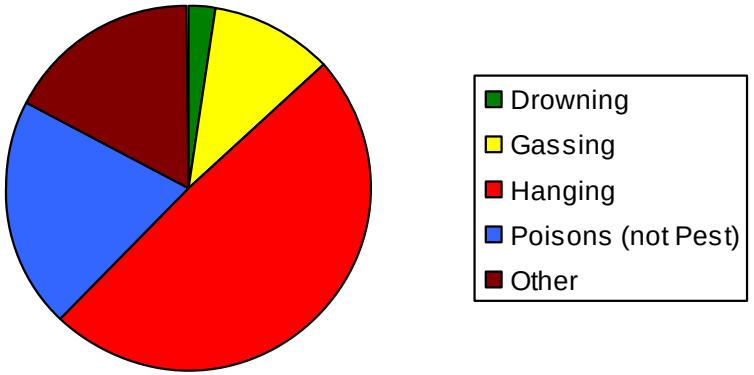
自殺数と自殺率トップ10

Country	Number of suicides	Rate per 100,000	Ranking by suicide rate	Country	Number of suicides	Rate per 100,000	Ranking by number of suicides
China	170,000 (1999)	13.9	27	Lithuania	1,100 (2009)	34.1	28
India	130,000 (2009)	10.5	44	Rep. Korea	15,000 (2009)	31	6
Russian F.	45,000 (2006)	30.1	3	Russian F.	45,000 (2006)	30.1	3
USA	33,000 (2005)	11	42	Belarus	3,000 (2007)	27.4	16
Japan	30,000 (2009)	24.4	8	Guyana	200 (2006)	26.4	87
Rep. Korea	15,000 (2009)	31	2	Kazakhstan	4,000 (2008)	25.6	14
Ukraine	10,000 (2009)	21.2	12	Hungary	2,500 (2009)	24.6	18
Germany	10,000 (2006)	11.9	33	Japan	30,000 (2009)	24.4	5
France	10,000 (2007)	16.3	20	Latvia	500 (2009)	22.9	43
Brazil	9,000 (2008)	4.8	67	Slovenia	500 (2009)	21.9	44

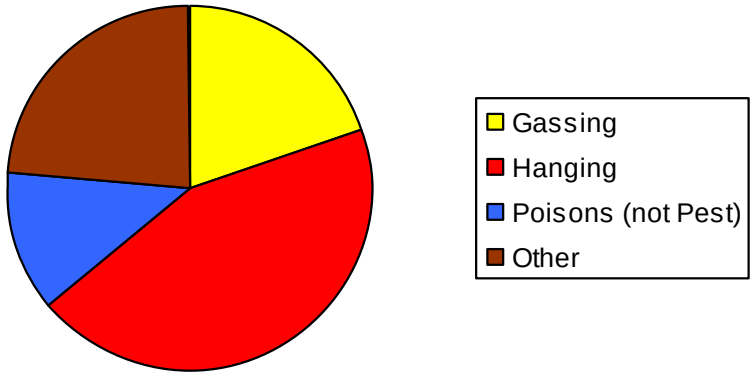
自殺方法の地域差 *(M. Eddleston)*

参考: 日本　首吊り65％、ガス15％、飛び降り5％

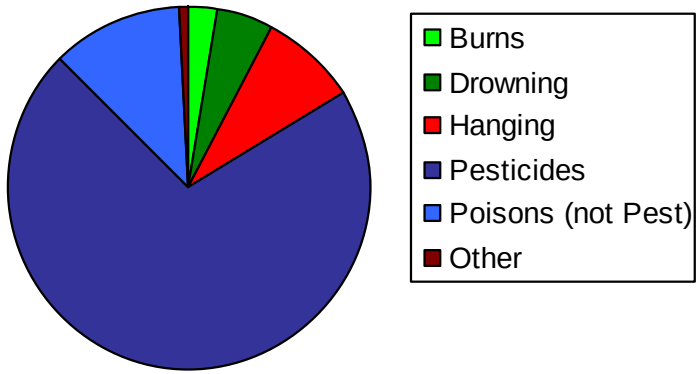
イギリス　**England & Wales 2000**



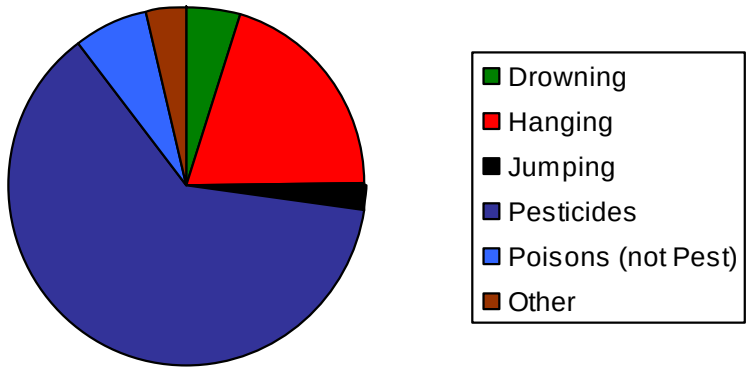
Australia 1998



スリランカ　**Jaffna 1980-89**



China 1998-2000



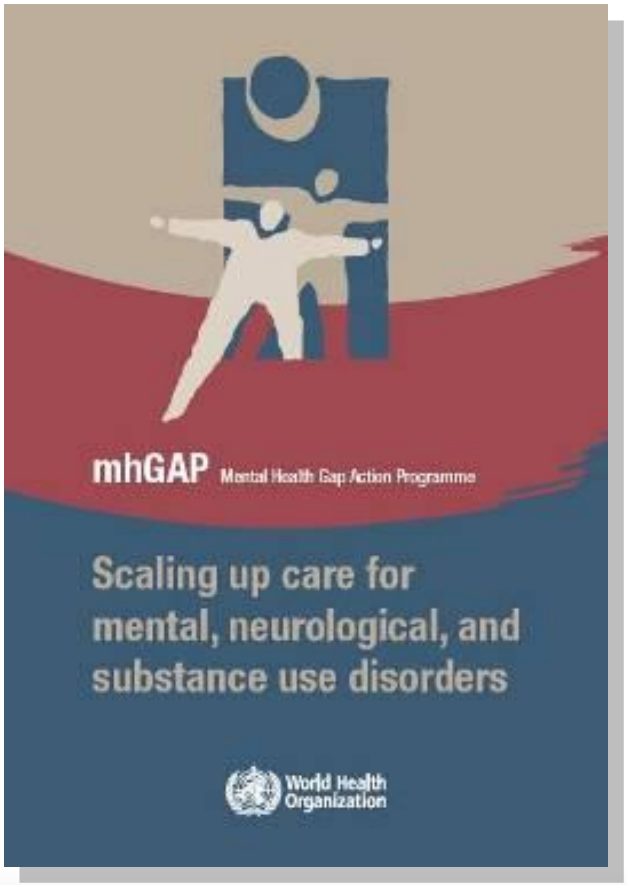
自殺予防リソースシリーズ

さまざまな支援者を対象としたもの
- 一般科の医師
- メディア
- 教師
- 矯正施設
- 職場
- カウンセラー
- 警察・消防署

マニュアル
- サバイバーグループの立ち上げ
- 自殺の統計の取り方
- 自殺未遂の統計の取り方

WHOのホームページよりダウンロード可能。日本語翻訳版もあり

Mental Health Gap Action Programme （mhGAP）

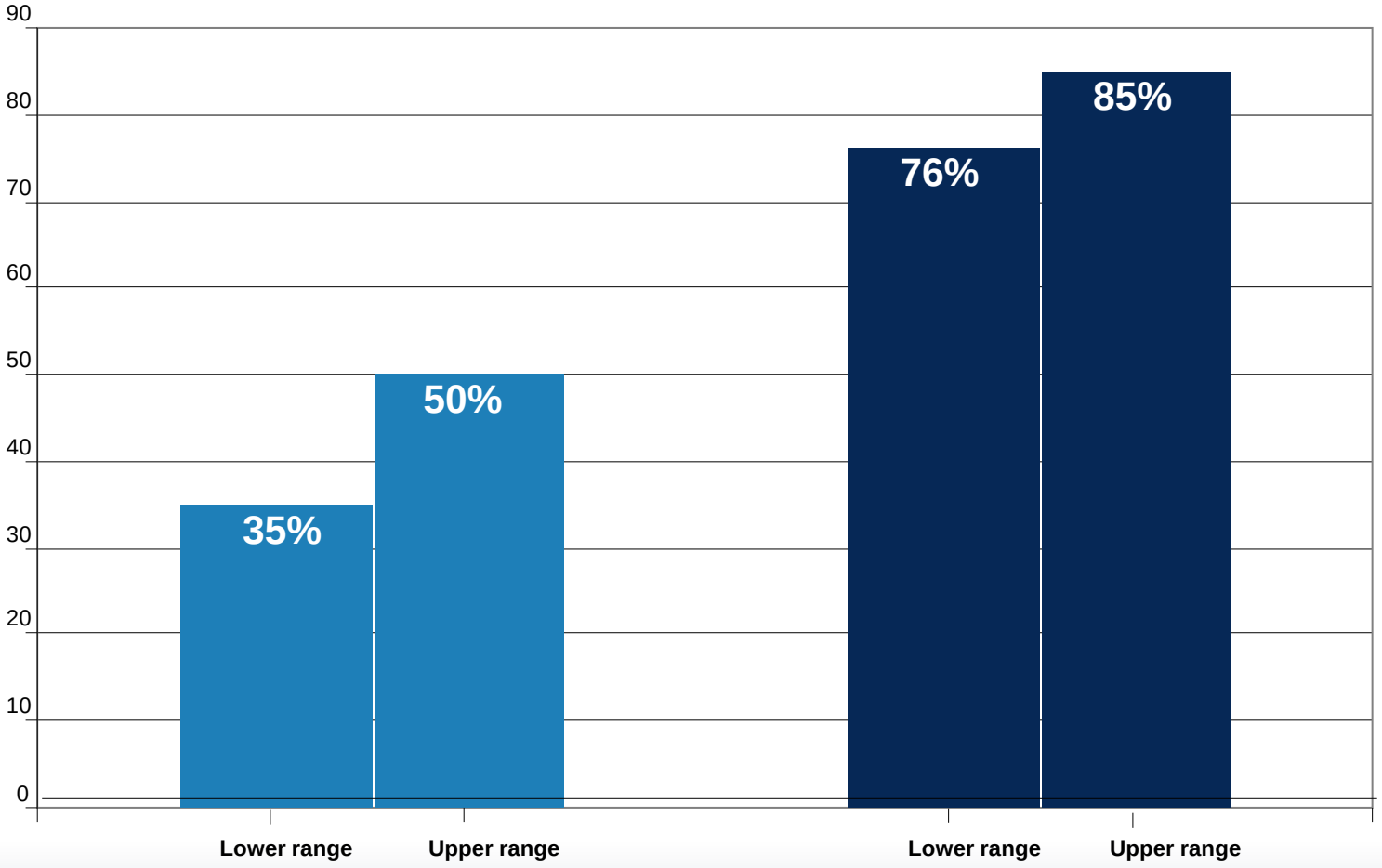


9 October 2008:
WHO 事務局長マーガレットチャンが
mhGAPを立ち上げ

ケアのスケールアップ

治療のギャップ

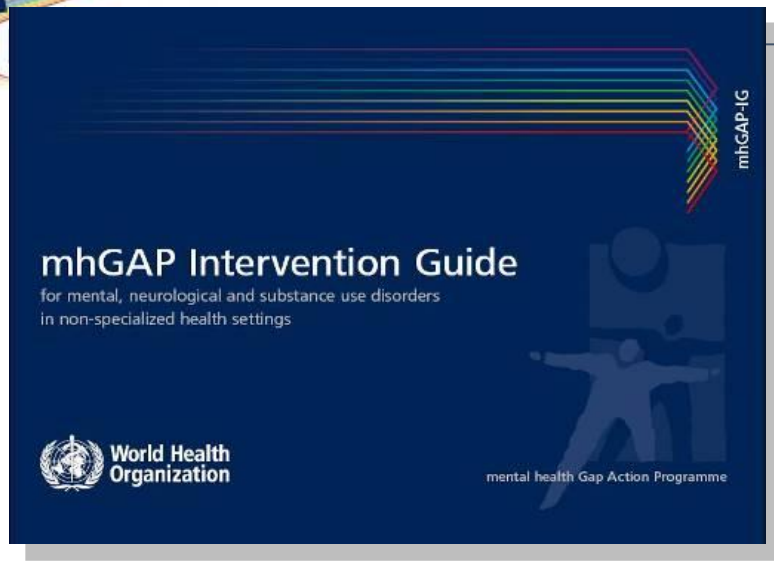
過去12カ月に治療を受けていない精神障害者



先進国　　*発展途上国*

(WHO World Mental Health Consortium, JAMA, June 2nd 2004)

mhGAP Intervention Guide（ 7 October 2010）



－アセスメント（診断）と治療のガイドライン

－途上国においても実施できるよう配慮

－精神科が専門でない一般科の医師・看護師を対象

－精神保健の専門家はスーパービジョンやサポートを提供

－日本語版も作成中

mhGAP-IG Master Chart: Which priority condition(s) should be assessed?

1. These common presentations indicate the need for assessment.
2. If people present with features from more than one condition, then all relevant conditions need to be assessed.
3. All conditions apply to all ages, unless otherwise specified.

COMMON PRESENTATION	CONDITION TO BE ASSESSED	GO TO
➤ Low energy; fatigue; sleep or appetite problems ➤ Persistent sad or anxious mood; irritability ➤ Low interest or pleasure in activities that used to be interesting or enjoyable ➤ Multiple symptoms with no clear physical cause (e.g. aches and pains, palpitations, numbness) ➤ Difficulties in carrying out usual work, school, domestic or social activities	Depression* ♠	DEP 10
➤ Abnormal or disorganized behaviour (e.g. incoherent or irrelevant speech, unusual appearance, self-neglect, unkempt appearance) ➤ Delusions (a false firmly held belief or suspicion) ➤ Hallucinations (hearing voices or seeing things that are not there) ➤ Neglecting usual responsibilities related to work, school, domestic or social activities ➤ Manic symptoms (several days of being abnormally happy, too energetic, too talkative, very irritable, not sleeping, reckless behaviour)	Psychosis*	PSY 18
➤ Convulsive movement or fits/seizures ➤ During the convulsion: – loss of consciousness or impaired consciousness – stiffness, rigidity – tongue bite, injury, incontinence of urine or faeces ➤ After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches, or weakness on one side of the body	Epilepsy / Seizures	EPI 32
➤ Delayed development: much slower learning than other children of same age in activities such as: smiling, sitting, standing, walking, talking/communicating and other areas of development, such as reading and writing ➤ Abnormalities in communication; restricted, repetitive behaviour ➤ Difficulties in carrying out everyday activities normal for that age	Developmental Disorders Children and adolescents	DEV 40

- Excessive inattention and absent-mindedness, repeatedly stopping tasks before completion and switching to other activities
- Excessive over-activity: excessive running around, extreme difficulties remaining seated, excessive talking or fidgeting
- Excessive impulsivity: frequently doing things without forethought
- Repeated and continued behaviour that disturbs others (e.g. unusually frequent and severe temper tantrums, cruel behaviour, persistent and severe disobedience, stealing)
- Sudden changes in behaviour or peer relations, including withdrawal and anger

Behavioural Disorders — BEH — 44

Children and adolescents

- Decline or problems with memory (severe forgetfulness) and orientation (awareness of time, place and person)
- Mood or behavioural problems such as apathy (appearing uninterested) or irritability
- Loss of emotional control – easily upset, irritable or tearful
- Difficulties in carrying out usual work, domestic or social activities

Dementia — DEM — 50

Older people

- Appearing to be under the influence of alcohol (e.g. smell of alcohol, looks intoxicated, hangover)
- Presenting with an injury
- Somatic symptoms associated with alcohol use (e.g. insomnia, fatigue, anorexia, nausea, vomiting, indigestion, diarrhoea, headaches)
- Difficulties in carrying out usual work, school, domestic or social activities

Alcohol Use Disorders — ALC — 58

- Appearing drug-affected (e.g. low energy, agitated, fidgeting, slurred speech)
- Signs of drug use (injection marks, skin infection, unkempt appearance)
- Requesting prescriptions for sedative medication (sleeping tablets, opioids)
- Financial difficulties or crime-related legal problems
- Difficulties in carrying out usual work, domestic or social activities

Drug Use Disorders — DRU — 66

- Current thoughts, plan or act of self-harm or suicide
- History of thoughts, plan or act of self-harm or suicide

Self-harm / Suicide — SUI — 74

* *The **Bipolar Disorder (BPD)** module is accessed through either the **Psychosis** module or the **Depression** module.*

^ *The **Other Significant Emotional or Medically Unexplained Complaints (OTH)** module is accessed through the **Depression** module.*

Self-harm / Suicide

Assessment and Management Guide

1. Has the person attempted a medically serious act of self-harm?

Observe for evidence of self-injury

Look for:
- Signs of poisoning or intoxication
- Signs/symptoms requiring urgent medical treatment such as:
  - bleeding from self-inflicted wound
  - loss of consciousness
  - extreme lethargy

Ask about:
- Recent poisoning or other self-harm

YES

If person requires urgent medical treatment for act of self-harm

- Medically treat injury or poisoning.
- If **Acute Pesticide Intoxication**, follow Pesticide Intoxication Management. » SUI 2.3
- If medical hospitalization is needed, continue to monitor the person closely to prevent suicide.

NO

If NO, assess for imminent risk of self-harm/suicide

In all cases:
lace the person in a secure and supportive environment at the health facility while being assessed (do not leave them alone).

- Care for the person with self-harm. » SUI 2.1
- Offer and activate psychosocial support. » SUI 2.2
- Consult mental health specialist if available.
- Maintain regular contact and follow-up. » SUI 2.4

Всемирная организация здравоохранения
Organisation mondiale de la Santé
世界卫生组织
منظمة الصحة العالمية
Organización Mundial de la Salud
World Health Organization

Self-harm / Suicide

SUI 2

Intervention Details

Advice and Treatment

2.1 Care for the person with self-harm

Place the person in a secure and supportive environment at the health facility (do not leave them alone). If a person with self-harm must wait for treatment, offer an environment that minimizes distress, if possible in a separate, quiet room with supervision and regular contact with a named staff member or a family member to ensure safety.

» Remove the means of self-harm.

» Consult a mental health specialist, if available.

» Mobilize family, friends and other concerned individuals or available community resources to monitor and support the individual during imminent risk period. » SUI 2.2

» Treat people who have self-harmed with the same care, respect and privacy given to other people, and be sensitive to likely emotional distress associated with self-harm.

» Include the carer(s) if the person wants their support during assessment and treatment, although the psychosocial assessment should usually include a one-to-one interview between the person and health worker to help explore private concerns or issues.

» Provide emotional support to relatives/carers if they need it.

» Ensure continuity of care.

» Hospitalization in non-psychiatric services of general hospitals with the goal of preventing acts of self-harm is not recommended. If admission to a general (non-psychiatric) hospital for management of medical consequences of an act of self-harm is necessary, monitor the person closely to prevent subsequent self-harm in the hospital.

» **If prescribing medication:**
- use medicines that are the least dangerous in case of overdose;
- give prescriptions for short duration (e.g. one week at a time).

2.2 Offer and activate psychosocial support

Offer psychosocial support

» Offer support to the person.

» Explore reasons and ways to stay alive.

» Focus on the person's positive strengths by getting them to talk of how earlier problems have been resolved.

» Consider problem-solving therapy for treating people with acts of self-harm in the last year, if sufficient human resources are available. » INT

Activate psychosocial support

» Mobilize family, friends, concerned individuals and other available resources to ensure close monitoring of the individual as long as the risk persists.

» Advise the person and carer(s) to restrict access to the means of self-harm (e.g. pesticides and other toxic substances, medication, firearms) while the individual has thoughts, plans or acts of self-harm.

» Optimize social support from available community resources. These include informal resources such as relatives, friends, acquaintances, colleagues and religious leaders, or formal community resources, if available, such as crisis centres and local mental health centres.

» Inform carers and other family members that asking about suicide will often reduce the anxiety surrounding the feeling; the person may feel relieved and better understood.

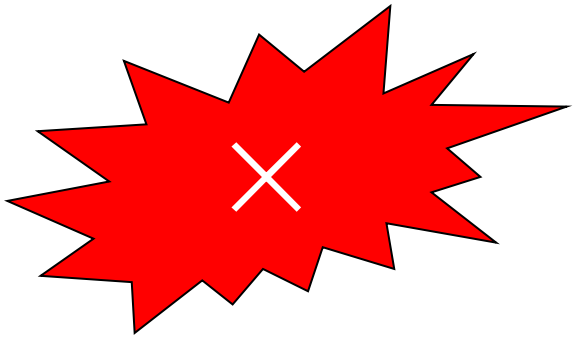
» Carers of people at risk of self-harm often experience severe stress. Provide emotional support to relatives/carers if they need it.

» Inform carers that even though they may feel frustrated with the person, it is suggested to avoid hostility or severe criticism towards the person at risk of self-harm.

Base Course
Self-harm/Suicide

○か×か？

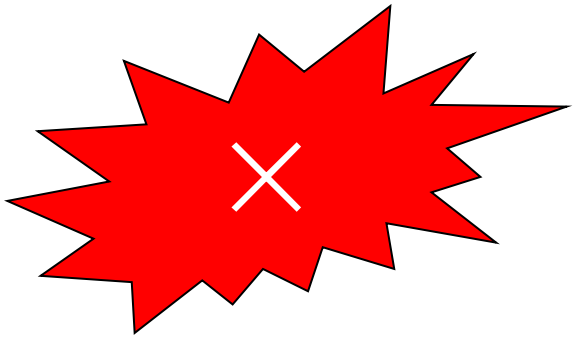
- 自殺について聞くと、自殺という選択肢を想起させてしまうので自殺のことについて聞くべきではない



- 自殺の意志の有無を聞くことは自殺や自傷を増やさない。むしろ 自殺や自傷のリスクを減少する

○か×か？

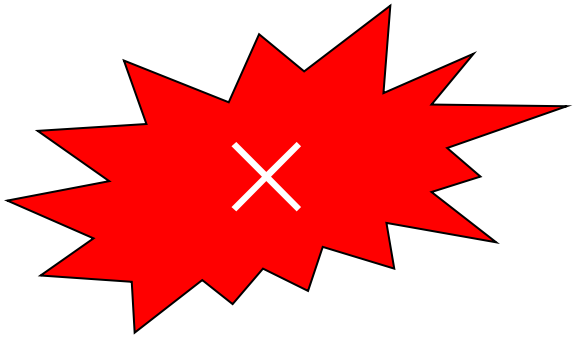
- 自殺する人は精神障害をわずらっている



- 自殺にはさまざまなリスク要因があり、精神障害はリスク要因のひとつである。ただし精神障害を持つ人は自殺のリスクが高いので自殺の可能性について検討する必要がある

○か×か？

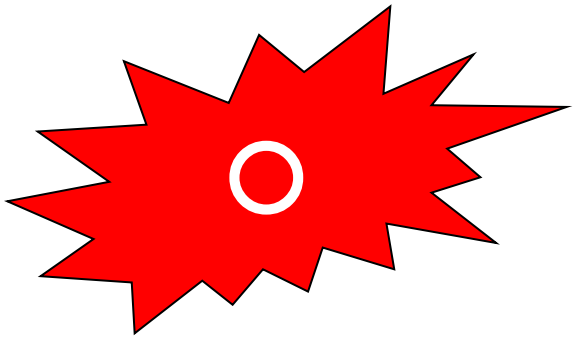
- 自殺未遂を何度も繰り返す人は、実際に自殺をする可能性は低い



- 自殺未遂は自殺の最大のリスク要因である。一番危険な時期は自殺未遂をした直後あるいは自殺未遂による入院中である。また退院後 一週間も自傷/自殺のリスクが高い。
- 2度目、3度目と繰り返すたびに自殺のリスクは高くなる

○か×か？

- メディアは自殺予防に貢献することができる



メディアは:

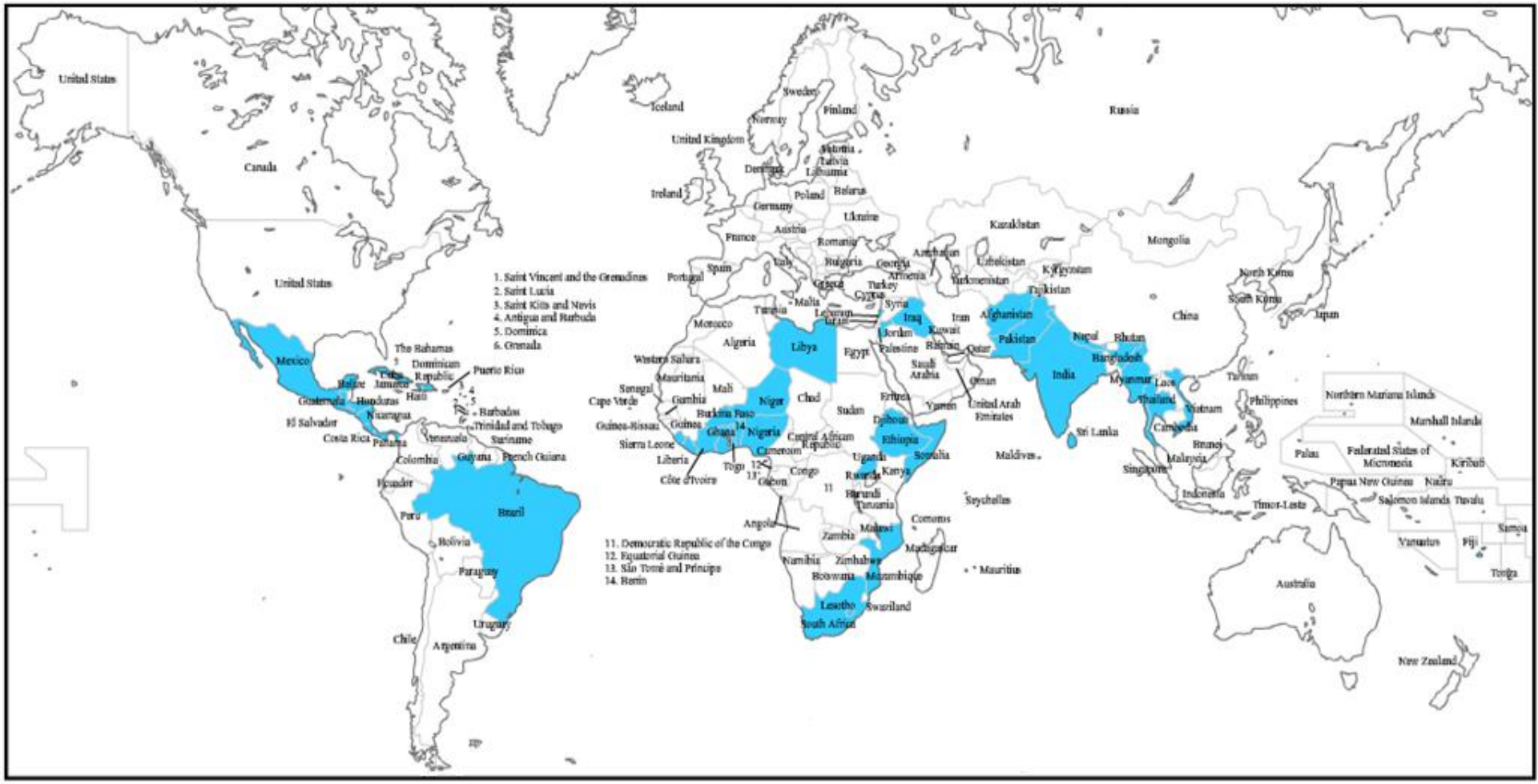
- 自殺をセンセーショナルに取り扱ったり、自殺が問題解決の方法である、という報道をすべきではない
- 写真や自殺の方法については報道しない
- どこで助けをできるかどうか、情報を提供する

効果的な自殺対策

一般人口	• 自殺方法へのアクセスの制限（農薬、拳銃等火器、フェンスの設置など） • アルコール入手経路の制限（未成年など） • 責任ある報道（自殺方法を具体的に報道しない、センセーショナルに報道しないなど）
リスクの高い人	• 精神障害もつ人への治療 • 失職後などリスクが高い人へのケア
自殺未遂者	• 自殺未遂した人へのケア （未遂者は自殺のリスク高い）

Mrazek & Haggerty, 1994

mhGAPを実施している国々



mhGAPトレーニングの様子

エチオピア

ヨルダン

ナイジェリア

ウガンダ

タイ

パナマ

Всемирная организация здравоохранения
Organisation mondiale de la Santé
世界卫生组织
منظمة الصحة العالمية
Organización Mundial de la Salud
World Health Organization

メンタルヘルスアクションプラン

WHO Comprehensive Mental Health Action Plan 2013-2020

194カ国の大臣が合意した、2020年までに到達すべきターゲットを設定

うち一つが自殺対策

-2020年までに各国の自殺率を10％減少させる

World Suicide Report

- 世界自殺レポート
- WHOとしてはじめての自殺に関するレポート
- 自殺対策への関心が世界中で高まり、予防、支援が提供されることを目指す
- 自殺予防先進国である日本からの貢献が期待されている

Thank you!!

ありがとうございました

setoyay@who.int