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CHILD SUICIDE IN KAZAKHSTAN

SPECIAL REPORT

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SPECIAL REPORT

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International comparisons show that not only are total suicide rates higher in Kazakhstan, compared to other developing and developed countries, but suicide rates for children between 5 and 14 years of age, and youth between 15 and 24 years of age are also higher in Kazakhstan (see Table 1). In recent years, high rates of child suicide[1] in Kazakhstan has resulted in discussion among government officials and other key stakeholders, and has led to the development of a joint plan for prevention of suicide among minors for 2011.

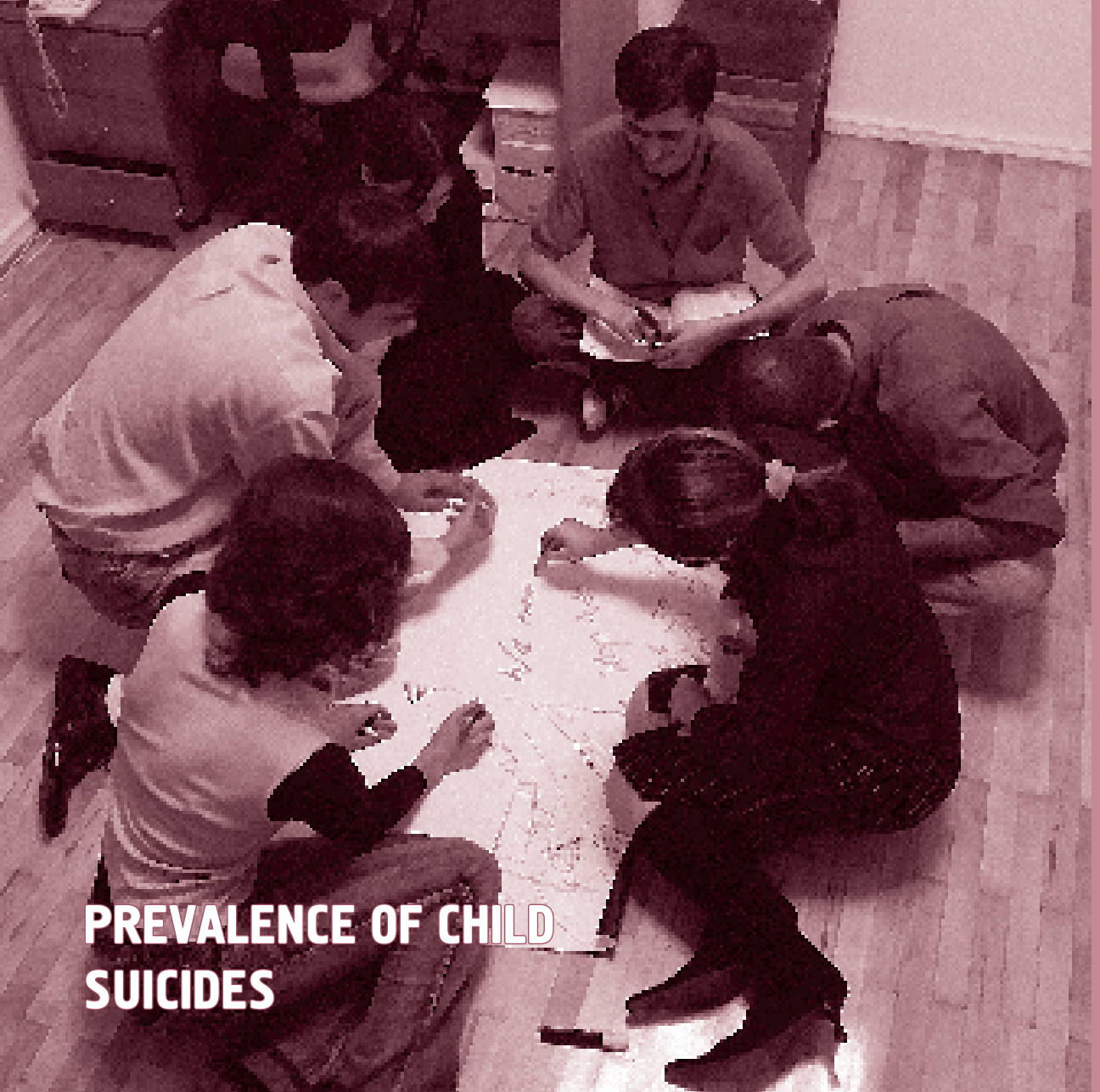
It is crucial that any policy and program efforts developed to prevent child suicide be grounded in an understanding of the nature and extent of suicide[2] among children in Kazakhstan. Currently, however, systematic data on the prevalence of child suicide in Kazakhstan is scant and often inconsistent or conflicting. Moreover, systematic data on the nature of child suicides, including methods of suicide and causes of suicide are virtually nonexistent. With a lack of systematic data and research on child suicides in Kazakhstan, prevention efforts and responses being developed are more likely based upon assumptions and some anecdotal information from a few reported cases of child suicide versus based upon a systematic and comprehensive analysis and understanding of child suicides and suicide attempts. Thus, research on child suicide and suicide attempts must be undertaken, and the findings of such research should be used to inform policy and program development.

[1] The term child is used through this report to refer to any human being below 18 years of age.

[2] According to the World Health Organization (2002, p. 185), "suicidal behavior ranges in degree from merely thinking about ending one's life, through developing a plan to commit suicide and obtaining the means to do so, attempting to kill oneself, to finally carrying out the act (referred to as a completed suicide). Suicidal actions that do not result in death are often called attempted suicide."

Suicides rates per 100,000 (2004-2009)

Note: Data is obtained from the World Health Organization for the most recent years available between 2004 and 2009.



PREVALENCE OF CHILD SUICIDES

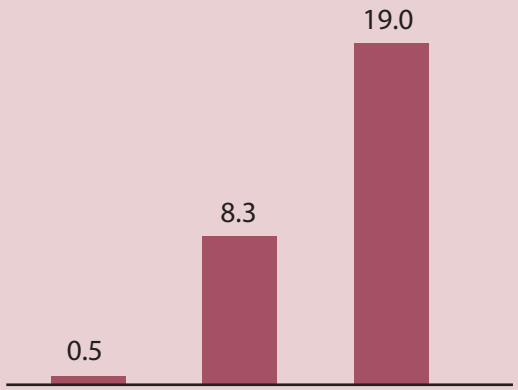
What do we currently know about the prevalence of child suicide in Kazakhstan? According to data obtained from the Ministry of Education, regional offices reported 264 child suicides in 2009 and 256 child suicides in 2010. In comparison, the Office of the Prosecutor General reported only 144 child suicides (including attempted suicides) in 2009 and 152 child suicides (including attempted suicides) in 2010. While this data is useful, it is problematic that the data is inconsistent and conflicts. In addition, it is not clear what age groups are being reported on by the Ministry of Education or the Office of the Prosecutor General. Is it data for only children under 18 years of age? Or, is it data similar to that reported by World Health Organization, including children between 5 and 24 years of age? If it is the latter, the data can be misleading because it includes suicide among young adults between 18 and 24 years of age. Suicide rates among young adults between 18 to 24 years of age can be very different than for children under 18 years of age.

In a recent report on child suicides prepared by the Agency of Statistics of Kazakhstan, it was reported that in 2010 there were 3,617 suicides, of which 1,286 suicides (35.5%) were committed by those between 0 and 29 years of age. The problem with this data is that it does not really reflect child suicides, as it includes suicide among adults between 18 to 29 years of age. And suicide rates among young adults between 18 and 29 years of age can be very different than suicide rates for children under 18 years of age. So, this data does not tell us much about the prevalence of suicide for children under 18 years of age.

The report prepared by the Agency of Statistics of Kazakhstan also maintains there was a slight increase from 2009 to 2010 in suicides among children between 0 and 14 years of age. In particular, they reported there were 69 child suicides in 2009 and 74 child suicides in 2010. This data conflicts with data provided by the Ministry of Education and the Office of the Prosecutor General, possibly because the age categories differ; moreover, this data does not include children between 15 and 17 years of age that according to the World Health Organization data have some of the highest rates of suicide among children. In fact, the Agency of Statistics of Kazakhstan reported the 2010 suicide rates for children were as follows:

- 0-11 years old, 0.5 suicide deaths per 100,000
- 12-14 years old, 8.3 suicide deaths per 100,000

Suicide rates for children were as follows



Agency of Statistics of Kazakhstan

- 15-17 years old, 19.0 suicide deaths per 100,000

This data reveals that suicide rates significantly increase as children grow older and enter into their teen years.

Overall, the data presented in this section provides us with little insight into the true extent of the problem of child suicide because the data is inconsistent and conflicting, and much of the data is incomplete as it does not include all children under 18 years of age. In most cases these data problems relate to issues of reporting, registration, and data collection practices at the regional and national levels.

There are clearly gaps and inconsistencies in the way data is collected, reported, and recorded at the regional and national levels, and categories for disaggregation are either unclear or nonexistent. In particular, age and gender are typically not recorded in the suicide data, or are attempted suicides versus deaths related to suicide. Another problem is that there is no one organization responsible for data collection and collation related to suicides; as a result, data on suicides are inconsistent and conflict.

In Central Asia countries, another data collection problem is due to the fact that there are social and religious taboos surrounding suicide; thus, suicides are rarely reported and typically disguised as accidents [1, 2]. For instance, victims that survive their suicide attempts often deny the incident was intentional for fear their family will disown them. Victims' family members will also conceal the suicide as an accident for fear of embarrassment or humiliation. Many suicides also go unreported because they occur in rural areas where victims often die because emergency medical care was either not expediently provided or not available. The result has been significant underreporting and misclassification of suicide attempts and deaths in countries throughout Central Asia [1, 2].

RECOMMENDATIONS

In terms of data collection related to suicides and suicide attempts there are several recommendations:

- There needs to be guidelines for data collection on suicide attempts and suicide deaths to reduce gaps and inconsistencies in the data and increase the reliability of data.
- There needs to be clearly defined categories for disaggregating data (e.g., age, gender, method of suicide, suicide attempts and deaths) and guidelines for data collection to reduce gaps and inconsistencies in data and increase the reliability of the data.
- It is necessary to communicate these categories for disaggregating data and guidelines for data collection and reporting down to the administrative and district levels so the data will be properly registered and recorded at the local levels, and then subsequently reported and recorded in a consistent manner at the national level.
- There needs to be one organization at the national level that is responsible for collecting and collating data from all of the regions, this will help to reduce conflicting data problems.

Addressing such data collection and management problems often requires training and technical assistance to those responsible.

In terms of data analysis, it would be best if existing data on child suicides and suicide attempts in Kazakhstan were analyzed only for those children under 18 years of age and disaggregated by age groupings, specifically 0 to 9 years of age, 10 to 14 years of age, and 15 to 17 years of age. It is also important that the data is disaggregated by gender, comparing girls to boys. It would also be particularly useful to analyze the data by age-gender groupings: girls 0 to 9 years; boys 0 to 9 years; girls 10 to 14 years; boys 10 to 14 years; girls 15 to 17 years; boys 15 to 17 years. Such analysis would help to better understand age and gender differences in the terms of the extent of child suicides and suicide attempts, but also specific age-gender group differences that affect suicide rates among children. The reason that specific age-gender group analysis is important is because it might reveal that boys between 0 and 9 years and 10 and 14 years of age are more likely to commit suicide than girls in the same age-groups; but girls between 15 and 17 years of age are more likely to commit suicide compared to boys in the same age-group. Important information such as this can be learned from the proposed analysis.

In addition, it is important that data on child suicides and suicide attempts is analyzed to reveal urban vs. rural differences and Oblast differences.

RISK FACTORS FOR CHILD SUICIDE

Suicide can be one of the hardest behaviors for people to understand, but worldwide many children attempt and commit suicide, as well as engage in a variety of deliberate self-harming behaviors (i.e., a child intentionally inflicts harm to his/her body by intentionally cutting of skin, self-bruising or scratching, self-burning, pulling skin or hair, swallowing toxic substances, breaking bones). International research has found that self-harm can be undertaken without suicidal intent; however, children that engage in self-harm are more likely to have considered or attempted suicide [3].

Children are normally very secretive about their self-harming and suicidal behaviors; however, international research has revealed that children who admit to engaging in deliberate self-harm and suicidal behaviors often say they do it to help alleviate feelings of sadness, anxiety, or emotional distress, to escape a hopeless situation, and because they want to die [3]. International research has also found that deliberate self-harm and suicidal behaviors can start early in life, around 7 years of age, but most begin between 12 and 15 years of age and can last for weeks, months, or years [3].

International research reveals the reasons children commit suicide can vary significantly; yet, there are common situations, circumstances, and factors that place children at risk for suicide [4, 5]. The sections that follow summarize current research findings and knowledge about the underlying risk factors for suicide and suicide attempts among children and youth.

SOCIAL AND FAMILY RISK FACTORS

International research reveals that suicidal behaviors are related to various social, economic, and family factors [4, 5, 6].

SOCIAL DISADVANTAGE – Most studies which have examined associations between measures of social disadvantage and suicide or risk of suicide attempt have revealed increased risk of suicidal behaviors among children and youth from socially disadvantaged backgrounds, particularly backgrounds characterized by low income and poverty, welfare involvement or dependency, and limited educational achievement [5, 6].

PARENTAL SEPARATION OR DIVORCE – Studies have reported that children and youth from families with histories of parental separation or divorce have increased risk of suicide and suicide attempts [4, 5, 6]. For instance, research has found that suicide victims are more likely to come from a "non-intact family of origin" [5]. Research has also found that youth that attempted suicide were more likely to have experienced at least three changes of parental figures between 5 and 15 years of age, compared to youth that did not attempt suicide [5]. Some research has also found that parental loss by divorce or separation is more likely to be associated with increased risk of psychopathology in children (including depression and suicidal behaviors), than is the loss of a parent by death [5].

PARENTAL PSYCHOPATHOLOGY – Research suggests that rates of suicide and suicide attempt are higher among children with histories of exposure to parents with psychopathologies, including depression, substance use/abuse disorders, and antisocial behaviors. Moreover, higher rates of depression and substance use/abuse disorders have been reported among families of suicide victims [5].

FAMILY HISTORY OF SUICIDAL BEHAVIOR – Most research reveals that a family history of suicidal behavior is associated with increased risk of suicide and suicide attempts in children and youth [4, 5].

MARITAL CONFLICT – Numerous studies have found higher rates of suicide attempt among children that have been exposed to parents' marital conflicts and discord, including marital and family violence [6]. In fact, children have often reported that parents' marital conflict was the reason for their suicide attempt [5].

HISTORY OF PHYSICAL AND/OR SEXUAL ABUSE DURING CHILDHOOD – A significant amount of research has examined associations between histories of physical and/or sexual abuse during childhood and risk of suicide and suicide attempts, as well as other deliberate self-harming behaviors. This research has consistently found that rates of suicide and suicide attempt, and other deliberate self-harming behaviors are higher among children and youth with histories of childhood physical and/or sexual abuse (i.e., incest, sexual assault, rape) [4, 5, 7-10]. Studies also reveal that childhood sexual and physical abuse predict repeated suicide attempts [7].

PARENT-CHILD RELATIONSHIPS – There is consistent research evidence that weak parent-child relationships, poor family communication styles, and extreme high and low parental expectations and control (including discipline) are associated with increased risk of suicide and suicide attempts among children [5, 6].

STRESSFUL LIFE EVENTS AND ADVERSE LIFE CIRCUMSTANCES

There is research evidence that among those children and youth that attempt and commit suicide there is a high rate of exposure to recent stressful life events and adverse circumstances [5]. In fact, psychological autopsy studies of young people who died by suicide have revealed that in most cases an identifiable stressful life event (e.g., interpersonal loss and conflict, disciplinary crises, rape) preceded the suicide attempt [5, 17]. There is a recognition that the life event that preceded the child's suicide may often occur in the lives of other adolescents, but it may act as the precipitating factor for suicidal behavior only when it occurs in the lives of individuals who are vulnerable to suicidal behavior [5].

Research has also found that children in problematic and vulnerable families (i.e., families which are exposed to multiple and severe stresses and are unable to provide a supportive environment for children) may respond to stress poorly, impulsively, and in, extreme cases, with suicidal behavior. Research has found that the "immature cognitive functioning style of children makes them vulnerable in times of family stress to the view that their families will be better off without them" [6].

ENVIRONMENTAL AND CONTEXTUAL FACTORS

International research has also examined the extent to which suicidal behaviors are related to environmental and contextual factors [5].

INSTITUTIONALIZATION – Research has found that children in residential institutions, such as orphanages and juvenile detention centers, are at increased risk of deliberate self-harm and suicidal behaviors. For children detained in adult correctional facilities, the risk of self-harm and suicide is even greater [8]. Recent research of children in state-run residential institutions in Kazakhstan revealed that children reported engaging in self-harming behaviors. Children that engaged in self-harm were significantly more likely to identify conditions in the institution as bad, to witness violence in the institution, and to be the victim of violence in the institution (see Box 1).

SCHOOL VIOLENCE AND BULLYING – Research reveals that children that experience school violence, including peer bullying and harassment in school, are at increased risk of suicidal behaviors [4, 8]. In addition, children that frequently experience corporal punishment from teachers and administrators in schools are at increased risk of suicidal behaviors [8].

RURAL, REMOTE AND URBAN FACTORS IN SUICIDE

Research findings reveal there are often higher suicide rates in rural and remote areas than in urban areas; suicide rates are almost twice as high in remote areas compared to capital cities [4, 5]. There may also be differences in methods of suicide between rural and urban areas [5]. The reasons for higher suicide rates among rural youth remains unclear, but may include social isolation and greater difficulty in detecting warning signs, limited access to health care facilities and doctors, higher rates of poverty, and lower levels of educational achievement [4].

Box 1 – Deliberate self-harm and suicidal behaviors among children in residential institutions in Kazakhstan

In 2010, the National Human Rights Centre (Ombudsman Office) of the Republic of Kazakhstan with support from UNICEF Kazakhstan conducted an assessment of violence against children in state-run residential institutions for children [11]. This study also assessed the situation of self-harm among children in institutions. Based upon a survey of 997 children from 15 state-run residential institutions for children, this study revealed that 8.5% of children (n=85) reported engaging in acts of self-harm (i.e., purposely hurting themselves because they were unhappy or sad). Among the 85 children that engaged in self-harm, 55% were boys and 45% were girls. Most of these children (75.3%) reported engaging in repeated acts of self-harm (2 to 100 times). Children in institutions of education for children with deviant behavior (12.4%) were at increased risk of self-harming behaviors than children in orphanages (8.1%) and shelters (5.4%). These statistics are based upon children's self-reports; however, children most likely underreported their self-harming behaviors given the secrecy and taboo that surrounds children's self-harming behaviors. A limitation of this research is that data on the number of children who attempted and committed suicide in the institutions was not available, and children who attempted suicide were not specifically sought out.

To understand the effects of institutionalization on children's self-harming and suicidal behaviors, this study compared children that engaged in self-harm to children that did not engage in self-harm. Findings revealed that children that engaged in self-harm were significantly more likely to rate the conditions in the institutions as "bad/very bad," and twice as likely to report they feel unsafe in the institution, compared to children that did not engage in self-harm. Children that engaged in self-harm were three times more likely to report they are afraid of children and staff in the institution, compared to children that did not engage in self-harm. Also, children that engaged in self-harm were more likely to witness violence in the institution; they were nearly twice as likely to witness violence among children, and three times more likely to witness staff using violence against children.

	Children that engage in self-harm N=85		Children that do not engage in self-harm N=912	
	n	%	n	%
Conditions in the institution				
Rate conditions in the institution as "bad/very bad"	16	18.8	24	2.6
Feel unsafe in the institution	23	27.1	92	10.1
Afraid of children in the institution	18	21.2	59	6.5
Afraid of staff in the institution	16	18.8	56	6.1
Witness violence in the institution				
Witnessed violence among children (all forms)	72	84.7	426	46.7
Witnessed violence by staff on children (all forms)	73	85.9	280	30.7
Victim of violence in the institution				
Physically attacked and hurt by another child in the institution	32	37.6	108	11.8
Physically hurt by staff at the institution	31	36.5	61	6.7
Neglect				
Experienced neglect in the institution	47	55.3	168	18.4
Runaway				
Ran away from the institution	27	31.8	80	8.8

In regard to victimization, children that engaged in self-harm were three times more likely to be physically attacked and hurt by another child in the institution, and five times more likely to be physically hurt by staff at the institution, compared to children that did not engage in self-harm. In terms of neglect, children that engaged in self-harm were three times more likely to experience neglect in the institution, compared to children that did not engage in self-harm.

Finally, children that engaged in self-harm were three times more likely to run away from the institution, compared to children that did not engage in self-harm. In fact, nearly 1 out of 3 children that engaged in self-harm ran away from the institution.

These findings reveal that the environment in children's institutions causes some children significant anxiety and emotional distress, resulting in self-harming and suicidal behaviors.

INDIVIDUAL AND PERSONALITY FACTORS

Research has also linked individual and personal factors, including personality and genetic factors, to suicidal behaviors [5].

PERSONALITY FACTORS – Certain personality traits (such as, low self-esteem, hopelessness, social inadequacy, worthlessness, introversion, neuroticism, impulsivity, recklessness, agitation, irritability, aggression, and impulsive violence) have often been cited as predisposing factors in suicidal behavior; however, there is a lack of research evidence that any specific personality trait is actually linked to suicidal behavior [4, 5].

SEXUAL ORIENTATION – In recent years, research has found an increased risk of suicide and suicide attempts among gay, lesbian, and bisexual youth. The argument is that because of societal homophobic attitudes, gay, lesbian, and bisexual youth are exposed to serious social and personal stresses that increase their likelihood of suicidal behavior [4, 5].

GENETIC FACTORS – Higher rates of suicidal behavior have been reported in families of children with suicidal behaviors, suggesting that genetic factors may play a role in suicidal behavior. In addition, data from studies on twins and adopted children confirm the possibility that biological or genetic factors may play a role in some suicidal behavior [4, 5].

MENTAL HEALTH FACTORS

There is overwhelming evidence that suggests three mental disorders, specifically affective mood disorders, substance use/abuse disorder, and antisocial behaviors, are the major psychiatric conditions associated with suicidal behaviors among youth [5].

AFFECTIVE MOOD DISORDERS – Numerous studies have revealed that youth with affective mood disorders have increased risks of suicide and suicide attempts [4, 5]. Affective mood disorders are typically characterized by dramatic changes or extremes of mood, including manic and depressive episodes, and often combinations of the two (i.e., bipolar disorder).

SUBSTANCE USE/ABUSE DISORDERS – Research has also found that substance use/abuse disorders are linked to suicide and suicide attempts among youth [4, 5].

ANTISOCIAL BEHAVIORS – Significant associations have been reported between measures of antisocial behavior (including conduct disorder, oppositional defiant disorder, and antisocial personality disorder) and risk of suicide and suicide attempt in youth [5].

ANXIETY DISORDERS – Increased risk of suicide and suicide attempts have also been reported among youth with anxiety disorders [4, 5].

International research has also found that previous suicide attempts are one of the most powerful predictors of subsequent suicide attempts and the risk that a person will commit fatal suicide. In fact, risk is higher in the first year, especially in the first six months, after the suicide attempt [4]. Still, however, the majority of those who commit suicide have not previously attempted suicide [4].

Clearly, the causes of child suicide are complex. The risks factors can be numerous and they often interact with one another [4]. There is no one reason for child suicide; rather, there a variety of stressors and underlying factors that children experience and that increase their risk of suicide and suicide attempts. Suicide ultimately becomes a last resort coping response to stressful events and/or living under oppressive circumstances for a long period of time [12]. Suicide can also be a means to send a "powerful message to the outside world or toward a specific individual, conveying misgiving, anger, sadness, hopelessness, or

frustration" [12]. Unfortunately, for some children, suicide becomes a solution to their life problems and stresses.

Unfortunately, there is no systematic data or information about the underlying causes of child suicide in Kazakhstan. Much of the information that exists is based upon myths or stereotypical assumptions about the causes of child suicide and anecdotal information obtained from a few single cases of child suicide. The problem with stereotypical assumptions is that they are often grounded in myths and misperceptions that are untrue. In fact, there are numerous myths related to child suicide. One myth is that there are no warning signs for child suicide. The truth is, most children, either through their behavior or conversations, exhibit a number of warning signs; the key is knowing what to watch for [13]. Another myth is that the main reason children attempt suicide is to manipulate others or get attention. The truth is, the main reasons children attempt suicide is because they want to die or to escape from a hopeless situation or horrible state of mind. Very few children attempt suicide to get attention [13].

The problem with anecdotal information is that it is unscientific and often inaccurate because it is based upon a few single cases, second-hand accounts or events, and hearsay. Anecdotal information is unreliable because it is not based upon facts or careful study, including a sufficient amount of evidence and cases. In most cases, anecdotal information leads to overestimates of the prevalence and causes of child suicide. Ultimately, because anecdotal information is unscientific it does not proof anything.

RECOMMENDATIONS

There needs to be systematic research conducted on child suicides in Kazakhstan, and such research needs to measure not only the prevalence of child suicide and suicide attempts, but also the underlying causes of child suicide. It is important that such research is designed to quantitatively and qualitatively measure the various risk factors for child suicide and suicide attempts outlined in this report. This is important based upon the fact that international research demonstrates there are a wide range of situations, circumstances, and factors that increase children's risk of suicide. Being able to measure and analyze the effects of multiple risk factors in children's lives and the affects they have on child suicide is extremely important. Research should not reduce children's suicidal tendencies down to single situations, circumstances, or factors.

It is also important that such research include a focus on gender differences in the causes of suicide. We cannot assume that boys and girls commit suicide for the same reasons; thus, any child suicide research should be designed to capture quantitatively and qualitatively differences between boys and girls in suicidal tendencies and reasons for suicide and suicide attempts. Such information will enable policy makers to better understand gender differences in child suicide and develop gender-specific prevention and intervention programs.

Child suicide research should also focus on understanding age differences. We cannot assume that children under 10 years of age and those between 11 and 14 years, and 15 and 17 years of age attempt or commit suicide for the same reasons. In fact, children's situations and circumstances change as they grow from childhood into adolescence [4, 5]. At the same time, their risk of suicide significantly increases as revealed in the data from the World Health Organization and the Agency of Statistics of Kazakhstan. Thus, there is a real need to understand what situations, circumstances, and factors in children's lives are accounting for the increased risk of suicide as children age. It is also important to understand at what age children develop suicide thoughts and how many times they attempt suicide and engage in deliberate self-harming behaviors throughout their childhood and into adolescence.

It would also be extremely useful to measure whether children ever told anybody about their self-harming and suicidal behaviors, and who they told. But also, what was the response of the person(s) they told, and did they ever receive any support or treatment for their self-harming and suicidal behaviors. Such information will enable policy makers to understand help-seeking behaviors of at-risk children and to identify important points of intervention and prevention, as well as gaps in the system of child protection.

METHODS OF CHILD SUICIDE

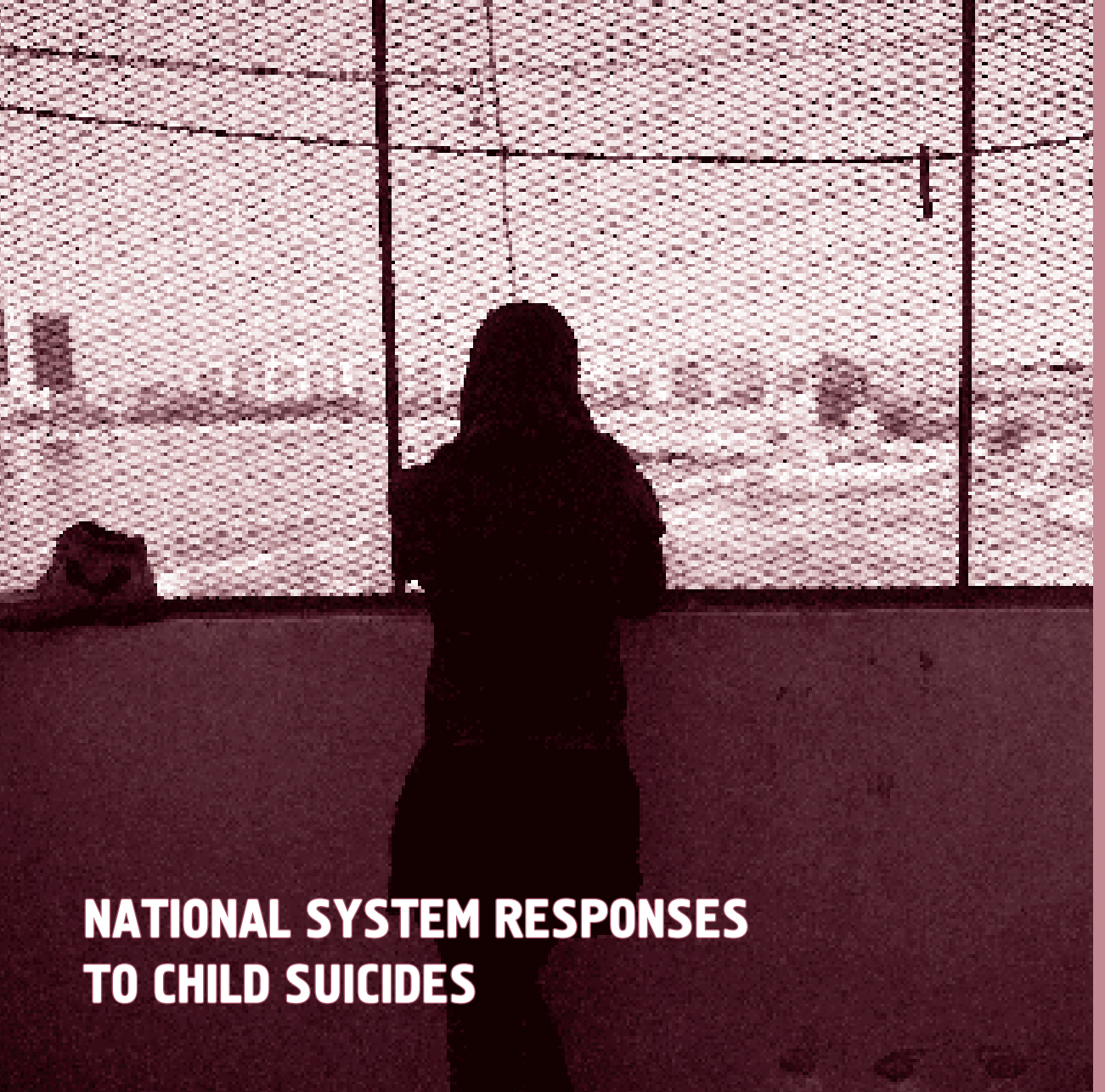
The various methods by which children commit suicide is another important area that needs to be studied. International research reveals the main methods by which children attempt and commit suicide depend on what lethal means are available and their age. For instance, in countries where guns are readily available they are commonly used in suicides; in the United States, guns are used in approximately two-thirds of all suicides. In other parts of the world where guns are not as readily available, individuals commit suicide by hanging, overdose, self-poisoning (e.g., pesticide poisoning), drowning, and jumping from heights [4]. Some research has found that suicide by hanging is more common among children under 15 years of age, given their age and the limited range of methods available to them [6]. Research has also found that suicide rates by particular methods are amenable to change over time [4, 5].

In some part of the world, such as throughout Central Asia, the Middle East, and South Asia, self-immolation is a "dramatic and deadly form of suicide" that is commonly used by women and girls [14]. Acts of self-immolation are often committed in the presence of others in an attempt to force those who are abusing them to suffer feelings of guilt [15]. Self-immolation research has shown that such suicides are not necessarily an expression of a desire to end one's life, but are more often a form of rebellion or protest against the discrimination, oppression, and overregulation that girls and women experience in the family and society, and a denouncement against their oppressors and abusers [1, 2, 14, 16]. In many countries where social and religious taboos surround suicide, self-immolation suicides are disguised as cooking accidents by family members and not reported to authorities. In some countries, government authorities do not even keep statistics on self-inflicted burnings and deny the occurrence of self-immolation altogether [1, 2].

Unfortunately, there is virtually no systematic data or information about the methods of suicide used by children in Kazakhstan.

RECOMMENDATIONS

It is important that research on child suicides in Kazakhstan is designed to quantitatively and qualitatively measure the various methods by which children attempt and commit suicide. It is also important that research include a focus on gender and age differences in the methods of suicide. We cannot assume that boys and girls use the same methods to commit suicide; thus, any child suicide research should be designed to capture quantitatively and qualitatively differences between boys and girls in methods of committing suicide. Child suicide research should also focus on understanding age differences in methods of committing suicide. Such information will enable policy makers to better understand gender and age differences in the methods by which children attempt and commit suicide, and develop gender- and age-specific prevention and intervention efforts.



NATIONAL SYSTEM RESPONSES TO CHILD SUICIDES

Finally, there is virtually no systematic information available on the current system of response to child suicides in Kazakhstan, including efforts to prevent child suicide, to identify children with deliberate self-harming and suicidal behaviors, and to intervene in cases of self-harm and suicide involving children. In addition, there is little understanding of the individual, family, and community factors which may protect against the development of suicidal behaviors in children [5].

RECOMMENDATIONS

There needs to be an assessment of the national system of response to child suicides in Kazakhstan. Such an assessment should identify and evaluate existing efforts to prevent child suicides, to identify children with deliberate self-harming and suicidal behaviors, and to intervene in cases of self-harm and suicide involving children. Such an assessment should occur at the district and Oblast levels, in both urban and rural areas. Such an assessment should also set out to map the various government agencies and nongovernmental organizations that are part of the system of response to child suicides, and the roles they play in prevention, identification, and intervention.

There also needs to be a special assessment of efforts to prevent, identify, and respond to child suicides in state-run residential institutions for children.

The benefits of such an assessment is that it will help to identify progress being made nationally to prevent, identify, and intervene in child suicides, as well as gaps in the system of response to child suicides and the child protection system. Such an assessment can also generate important recommendations on how to improve the system response to child suicides and the child protection system in Kazakhstan.

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