

Editorial

Suicide Prevention in an International Context



Progress and Challenges

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Strategic Global Developments in Suicide Prevention

In recent years, the World Health Organization (WHO) *Global Mental Health Action Plan, 2013–2020*, has been a major step forward in pushing the agenda of suicide prevention globally (WHO, 2013; Saxena, Funk, & Chisholm, 2013). This plan was adopted by health ministers in all 194 WHO member states to formally recognize the importance of mental health, which was a remarkable achievement. Among WHO member states are 25 countries where suicide is currently still criminalized and an additional 20 countries where according to Sharia law suicide attempters may be punished with jail sentences (Mishara & Weisstub, 2016). The action plan covers specified actions to improve mental health and to contribute to the attainment of a set of agreed global targets, in particular to aim for (a) a 20% increase in service coverage for severe mental disorders, and (b) a 10% reduction of the suicide rate in countries by 2020.

The subsequent publication of the WHO report *Preventing Suicide: A Global Imperative*, in 2014 (WHO, 2014), was strategically a major and timely next step to increase the commitment of national governments and health ministers to move from agreement to action in relation to suicide prevention. Many members of the International Association for Suicide Prevention (IASP) representing all regions in the world were involved in preparing this report. IASP in collaboration with WHO's Department of Mental Health and Substance Abuse has initiated workshops inviting country representatives to discuss and share experiences in the development and implementation of national suicide prevention programs, during IASP world congresses

and regional seminars. In addition, IASP is in the process of establishing an International Special Interest Group to support the development and implementation of national suicide prevention programs at a global level.

In all six WHO regions, both IASP and WHO underline the importance of national suicide prevention programs on World Suicide Prevention Day on a yearly basis. The WHO report provides guidance in developing and implementing national suicide prevention programs while taking into account the different stages at which a country is, that is, countries where suicide prevention activities have not yet taken place, countries with some activities, and countries that currently have a national response. Within geographic regions, countries that have adopted a national suicide prevention program can impact positively on surrounding countries and increase prioritization of suicide prevention in countries that do not yet have a national program and do not want to be an exception in a negative sense, that is, they do not want to be left behind!

Are We Making Progress in Suicide Prevention at Global Level?

We are indeed! Since the publication of the WHO *Global Mental Health Action Plan* and the WHO report on preventing suicide, there are several indications that the development and the implementation of national suicide prevention programs have accelerated, in particular in countries and regions where so far little or no suicide prevention initiatives were present, such as Guyana (Ministry of Public Health, 2014), Suriname (Ministerie van

heid, 2016), and Bhutan (Royal Government of Bhutan, 2015). In addition, IASP has supported an initiative by the Ministry of Public Health in Afghanistan to develop a national suicide prevention program, supported by a multisectoral advisory group, which was again reinforced by the WHO global report on preventing suicide. However, liaising with partners and stakeholders in suicide prevention in Afghanistan, in particular arranging face-to-face meetings, is challenging due to infrastructural limitations and the ongoing adversity resulting from conflicts and war.

A further incentive is the fact that the WHO report has been translated in all six UN languages. Regional launches have been held in Mexico with representatives from Spanish-speaking countries, in Cairo, with representatives from the WHO Eastern Mediterranean Region, and in Tokyo, with representatives from the WHO Western Pacific Region. Furthermore, a growing number of countries have recently completed their second national suicide prevention program, such as England (Department of Health, 2012), Scotland (The Scottish Government, 2013), Ireland (Department of Health, 2015), and the United States (US Department of Health and Human Services, 2012).

A particular positive development was the recently published national suicide prevention plan for Guyana (2015–2020; Ministry of Public Health, 2014). The overall age-standardized rate of suicide for Guyana in 2012 was 44.2 per 100,000, the highest reported suicide rate in the world. This represents an extremely high rate of 70.8 per 100,000 for men and a relatively high rate, within an international context, of 22.1 per 100,000 for women. Due to concerns about the current high suicide rates and the commitment of the Departments of Health and Public Health in Guyana, and the Pan American Health Organisation/World Health Organization (PAHO/WHO), a comprehensive multisectoral 5-year national suicide prevention action plan was prepared. The strategy incorporates activities across the continuum of suicide prevention representing universal interventions, targeting the entire population to reduce access to means and reducing inappropriate media coverage of suicide. In addition, selective interventions, targeting high-risk groups of suicide, and indicated interventions, targeting individuals who show signs of symptoms that are strongly associated with suicide, for example, suicide prevention helplines and peer support networks for those with suicide ideation and suicide attempt, are included. The strategy is based on cross-cutting values and principles: (a) universal health coverage; (b) human rights; (c) evidence-based practice – and interventions for treatment and prevention; (d) life course approach; and (e) multisectoral approach.

Considering that a suicide attempt in Guyana is still considered a criminal law offence with the consequence that the person involved may be liable to imprisonment for 2

years (Mishara & Weisstub, 2016), the publication of the national suicide prevention plan is a significant achievement. Hopefully, thanks to increased awareness and stigma reduction, which is a key objective of the national plan, the legal status of suicide and attempted suicide in Guyana will be revisited as a matter of urgency.

IASP-WHO Global Survey on Suicide and Suicide Prevention

On the basis of a global survey, conducted by IASP and the WHO Department of Mental Health and Substance Abuse in 2013, IASP national representatives of 90 countries (57%) completed the survey questionnaire, attaining information on national strategies and activities in suicide prevention. In nearly two thirds (61%) of the responding countries, suicide was perceived as a significant public health concern. In 31% of the countries a comprehensive national strategy or action plan was adopted by the government. Among the countries that did not have a national strategy, a number of suicide prevention activities were carried out in just over half (52%) of the countries, which included training on suicide risk assessment and intervention (38%), training for general practitioners (26%), and suicide prevention training for non-health professionals including first responders, teachers, and journalists (37%). A unique contribution of this survey was that for some regions across the world, such as the WHO Eastern Mediterranean and African regions, where previously information on suicide prevention activities was limited or absent, new information was obtained. For example, in 40% of the responding countries in the Eastern Mediterranean Region a training program on suicide assessment and intervention for GPs was available, and in 20% of the countries in this region, training programs were available on suicide prevention for non-health professionals. A detailed overview of the survey outcomes for the different geographic regions is currently being prepared for publication in an IASP monograph.

Challenges Ahead

Despite the progress in suicide prevention globally, we still face numerous challenges. The accuracy and reliability of suicide statistics are an ongoing issue of concern in a considerable number of countries (Tollefsen, Hem, & Ekeberg, 2012). In terms of implementing national suicide prevention programs and the sustainability of interventions, a number of challenges remain. On-going challenges include insufficient resources, ineffective co-ordination, lack of en-

forcement of guidelines, limited access to surveillance data on suicide and attempted suicide or self-harm, and lack of independent and systematic evaluations (WHO, 2014). In addition, it would be important for a national suicide prevention program to address real-time developments, such as emerging suicide contagion and clustering, emerging methods of suicide, and new vulnerable and high-risk groups, such as migrants and refugees from Eastern Mediterranean countries, with increased risk of suicide and self-harm.

Typical Components of a National Suicide Prevention Program and the Evidence Base

In terms of the content of a national suicide prevention program, the WHO global report recommends a systematic approach and summarizes typical components (WHO, 2014). Even though these components are supported by evidence, the strength and consistency of the evidence for some of the components/interventions in reducing suicide and attempted suicide or self-harm vary across different studies.

Surveillance

Increasing the quality and timeliness of national data on suicide and suicide attempts/self-harm is a core component of a national suicide prevention program, in particular establishing integrated data collection systems that serve to identify vulnerable groups, individuals, and situations. WHO recently published a practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. This manual aims to provide guidance to countries who wish to set up a public health surveillance system for suicide attempts and self-harm cases presenting to general hospitals (WHO, 2016). While there is a lack of reliable national data on the prevalence of suicide attempts/self-harm presentations to hospital emergency departments in low- and middle-income countries (LMICs) and the demographic and psychosocial profile of those involved, surveillance and follow-up of this high-risk group could be an initial step toward building a national suicide prevention program (Fleischmann et al., 2016).

Restricting Access to Means

This involves implementation of measures to reduce availability of and access to frequently used means of suicide,

for example, pesticides, drugs, firearms, enhancing safety of bridges etc. Internationally, there is consistent evidence that restricting access to lethal means is associated with a decrease in suicide and that substitution to other methods is limited (Zalsman et al., 2016). In addition, evidence from 18 studies showed a consistent reduction of suicide following restricted access and increased safety of sites where people frequently took their lives (Pirkis et al., 2015). Fleischmann et al. (2016) further reported consistent findings supporting implementation of this intervention in LMICs.

Media

This refers to implementing guidelines to enhance responsible reporting of suicide in print, broadcast, Internet, and social media. The role of the mass media has been shown to be effective in reducing stigma and increasing help-seeking behavior. There are also indications of promising results based on multilevel suicide prevention programs (Niederkröthaler, Reidenberg, Till, & Gould, 2014). A systematic review covering 30 studies on social media sites for suicide prevention (Robinson et al., 2016) showed that social media platforms can reach large numbers of individuals and may allow others to intervene following expression of suicidal behavior. However, reported challenges include lack of control over user behavior, possibility of suicide contagion, limitations in accurately assessing suicide risk, and issues relating to privacy and confidentiality. The importance of responsible media reporting of suicide in LMICs is underlined by Fleischmann et al. (2016). It must be noted, however, that evaluation of the effectiveness of this intervention in LMICs is required.

Training and Education

Educating health-care and community-based professionals to recognize depression and early signs of suicidal behavior is important for determining the level of care and referral for treatment and subsequent prevention of suicidal behavior (Coppens et al., 2014; Wasserman et al., 2012). Sustainability and capacity building of trainers and benefits in terms of knowledge, attitudes, and confidence can be achieved via a train-the-trainer model (Coppens et al., 2014; Isaac et al., 2009). There are some indications for a link between improvements in intermediate outcomes (e.g., improved knowledge, attitudes, and confidence) among health-care and community-based professionals and primary outcomes, for example, reduced suicide and self-harm rates (Hegerl, Rummel-Kluge, Värnik,

Arensman, & Koburger, 2011; Mann et al., 2005; Zalsman et al., 2016). Fleischmann et al. (2016) underline the importance of training and education via the WHO mhGAP program in LMICs.

Treatment

A recently published Cochrane systematic review on the effectiveness of psychosocial interventions for self-harm included 29 RCTs including 8,480 participants (Hawton et al., 2016). The most commonly evaluated intervention involved CBT-based psychological therapy with a duration of an average of 10 sessions. At follow-up, people who had received CBT were significantly less likely to have engaged in repeated self-harm compared with those receiving treatment as usual. For people with a history of multiple self-harm episodes, dialectical behavior therapy was identified as reducing the frequency of repeated self-harm, but did not reduce the proportion of individuals repeating self-harm. However, the number of RCTs conducted so far is relatively small. In addition, Zalsman et al. (2016) found consistent evidence for the effectiveness of lithium in reducing suicidal behavior among people with mood disorders. Even though there are indications for the eligibility of these treatments in LMICs, national implementation may not be feasible due to the costs and lack of trained mental health professionals (Fleischmann et al., 2016).

Awareness and Stigma Reduction

This refers to increasing awareness via public information campaigns to support the understanding that suicides are preventable, and increasing public and professional access to information about all aspects of preventing suicidal behavior. Stigma reduction involves promoting the use of mental health services and services for the prevention of substance abuse and suicide as well as reducing discrimination against people using these services (WHO, 2014). There is emerging evidence for these interventions from community-based multilevel interventions to improve the care for people diagnosed with depression and simultaneously address awareness and skills in early identification of suicide risk among health-care and community-based professionals (Hegerl et al., 2013; Szekely et al., 2013), with proven synergistic effects of simultaneously implementing evidence-based interventions (Harris et al., 2016). Due to the feasibility of implementing community-based multilevel interventions in culturally different countries, this approach is also eligible for implementation in LMICs (Fleischmann et al., 2016).

Postvention

Improving the response to and caring for those affected by suicide and suicide attempts is considered a key component of national suicide prevention programs (WHO, 2014). There is emerging evidence supporting beneficial effects of a number of interventions, including counseling postvention for survivors and outreach at the scene of a suicide (Szumilas & Kutcher, 2011). In addition, evidence-based guidelines for responding to suicide in a secondary school setting have been published recently (Cox et al., 2016). However, further research is required into the effectiveness of postvention services and interventions on reducing suicide and attempted suicide/self-harm.

Crisis Intervention and Access to Services

This involves increasing the capacity of communities to respond to crises, such as emerging suicide clusters or murder-suicide, with appropriate interventions, including access to emergency mental health care for individuals in a crisis situation, through telephone helplines or the Internet (WHO, 2014). The systematic review by Zalsman et al. (2016) found inconsistent effects for crisis and follow-up interventions on suicide attempts and ideation, and they recommend further investigation into the effectiveness. However, Fleischmann et al. (2016) considered implementation of these interventions in LMICs albeit with ongoing monitoring of the feasibility and evaluation of the effects on reducing suicide and attempted suicide or self-harm.

In addition to the components as recommended in the WHO report (WHO, 2014), the review by Zalsman et al. (2016) also reported that the quality of evaluation studies involving school-based programs has improved over the past decade since the review by Mann et al. (2005). There is increasing evidence from RCTs addressing mental health literacy, suicide risk awareness, and skills training in a secondary school setting and their impact on reduced suicide attempts and severe suicidal ideation (Zalsman et al., 2016).

The inclusion of the suicide mortality rate as an indicator of the UN sustainable development goals (SDGs) for 2030 directs further attention to suicide and its prevention. The progress of suicide prevention at a global level and the evidence base for national suicide prevention programs will be an ongoing priority for IASP and a key topic on the program of the forthcoming 29th IASP World Congress, "Preventing Suicide: A Global Commitment, from Communities to Continents," July 28–22 2017, in Kuching, Sarawak, Malaysia (<http://www.iasp2017.org>).

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