Suicide Prevention in International Context: Progress and Challenges

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Overview

- The extent of suicide globally
- Suicide prevention globally and country examples
- Evidence informed interventions
- Evaluation of national suicide prevention programmes
Global Mental Health Action Plan, 2013-2020: Commitment by Health Ministers in all 194 WHO member states to formally recognise the importance of mental health.

Key targets:
- 20% increase in service coverage for severe mental disorders
- 10% reduction of the suicide rate in countries by 2020

WHO Global Report on Preventing Suicide (WHO, 2014)

UN Sustainable Development Goals: SDGs 2030, e.g. Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
Suicide rates by WHO region

FIG. 5.2.1 Age-standardized suicide rates per 100,000 population, by region, 2016

- Close to 800,000 people die by suicide every year
- More than e.g. malaria, breast cancer

Mental Health Atlas, 2017
Leading causes of death, ages 15-19 years

- Road injury
- Interpersonal violence
- Suicide
- Maternal conditions
- Suicide
- Road injury
- Road injury
- Interpersonal violence
- Suicide

Number of deaths in 2016

- Both sexes
- Females
- Males
Data Quality

- The quality and availability of data on suicide and suicide attempts is poor globally

- ONLY 20 countries are known to have gathered national survey data and 3 have national hospital-based suicide attempt data

- ONLY 60 countries have good-quality vital registration data on suicide mortality

- Improvement of surveillance and dissemination of data is necessary to inform action
Suicide viewed by government as significant public health problem

- Yes: 61%
- No: 39%

Has the national strategy been fully or partially implemented?

- Fully: 21%
- Partially: 25%
- No response: 54%
Promotion and prevention programmes at global level

FIG. 5.1.3 Promotion and prevention programmes (N = 349): Main types of programme

- Mental health awareness/anti-stigma/human rights protection: 40%
- Workplace mental health promotion: 7%
- School-based mental health promotion: 10%
- Parental/maternal mental health promotion: 7%
- Early childhood development/stimulation: 7%
- Violence prevention (women, child abuse): 7%
- Suicide prevention: 12%

Other: 9%

Mental Health Atlas, 2017
Challenges in developing and implementing national suicide prevention programmes

- Ineffective planning, co-ordination, collaboration, lack of enforcement of guidelines and insufficient resources

- Lack of independent and systematic evaluations of national suicide prevention programmes

- Address real-time developments, in particular, mental health needs and suicide prevention among refugees and migrants

- Despite challenges, encouraging developments in relation to initiating or completing national suicide prevention programmes, e.g: Lithuania, Namibia, Guyana, Afghanistan
## Core components of national suicide prevention strategies

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Country examples
Namibia

• Leadership role in developing the 2\textsuperscript{nd} national suicide prevention strategy in the WHO African Region

• National Strategic Plan on the Prevention of Suicide in Namibia, 2012-2016, supported by the Ministry of Health and Social Services, and developed with all stakeholders in the field of suicide

• Mission: To provide comprehensive, affordable and accessible services by relevant stakeholders pertaining to suicide.

• 24 objectives, strengthening key areas in suicide prevention, including involvement of stakeholders, internal processes, learning and growth, and budgetary and financial aspects
Other countries with recently completed/initiated national suicide prevention programmes despite many challenges

Namibia

Guyana

Afghanistan
• National Suicide Prevention Plan (2015-2020)

• High rate of suicide: 44.2 suicides per 100,000 people in 2012 (WHO)

• Long-term criminalisation of suicide and attempted suicide

• Universal interventions, targeting the whole of a population to reduce access to means and reduce inappropriate media coverage of suicide.

• The Strategy relies on cross-cutting values and principles:
  1) Universal health coverage; 2) Human rights; 3) Evidence-based practice – and interventions for treatment and prevention; 4) Life course approach;
Afghanistan

- National Suicide Prevention Strategy in Development

- In 2014, the suicide rate in Afghanistan was 5.7 per 100,000 people (WHO)
  - However, the accuracy of the suicide data is limited

- The Afghan Ministry of Public Health (MoPH) reported 4,466 self-poisoning and 4,136 self-immolation cases in 2014 across Afghanistan, where suicides exceed deaths by homicide and war combined annually

- The strategy is based on the following key values, respect for diversities; sensitiveness to socio-culture-religious and gender issues; promotion of the society dignity and respect for the human rights of people.
Evidence informed components of a national suicide prevention programme
In countries where a fully developed, comprehensive national strategy is not yet in place, this should not delay targeted suicide prevention programmes, while these can contribute to a national response.

Regardless of the current level of implementation and context, countries can commence with strategic actions for suicide prevention (bottom up), e.g:

- Engaging with relevant stakeholders
- Training of health and community based professionals, and changing attitudes.
- Reducing access to means
- Building surveillance
- Raising awareness
- Engaging with the media

A community driven, regional action plan, can draw national interest and provide a basis for wider implementation.
Recent systematic reviews

- ‘Suicide prevention strategies revisited: 10-year systematic review’
  - provides an update of the evidence on effective suicide prevention interventions since 2005

- ‘Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis’
  - outlines the findings of a Cochrane systematic review and meta-analysis of the effectiveness of psychosocial interventions for self-harm in adults.
Surveillance

- Provides a tool for countries to use in setting up a public health surveillance system for suicide attempts and self-harm cases presenting to general hospitals, based on medical records (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, and the demographic and psychosocial profile of those involved, surveillance and follow-up of this high-risk group could be an initial step to building a national suicide prevention programme.
Consistent evidence that restricting access to lethal means is associated with a decrease in suicide and that substitution to other methods appears to be limited. This is clearly a major strategy to be integrated in national suicide prevention plans (Zalsman et al, 2016)

Reducing access to frequently used sites for suicide. Evidence from 18 studies showed a consistent reduction of suicide following restricted access and increased safety of the sites involved (Pirkis et al, 2015)

Increasing trends of suicides involving helium gas in the Western Pacific Area and in Europe (Chang et al, 2016; Gunnell et al, 2015)

Restricting access to means to be implemented in conjunction with other suicide prevention strategies/interventions.
Restricting access to pesticides (Zalsman et al, 2016)

- Restrictions on the availability of pesticides contribute to reduced suicides in countries where this method of suicide is prevalent (Mann et al, 2005)

- The withdrawal of more toxic pesticides (Gunnell et al, 2007), restriction of access to these pesticides (Lin & Lu, 2011), and measures related to decreasing absorption of toxic substances (Wilks et al, 2008) are likely to reduce suicide in such countries.

- Safer storage of pesticides is another promising approach to suicide prevention in Sri Lanka (Hawton et al, 2009) and India (Vijayakumar, 2013).
Media

- Systematic review of 56 studies *(Sisask & Varnik, 2012)*
  - Most studies provided evidence for an association between sensationalised media reporting and suicidal behaviour,

Social media

- Systematic review covering 30 studies on social media sites for suicide prevention *(Robinson et al, 2016)*
- Social media platforms can reach large numbers of individuals and may allow others to intervene following expression of suicidal behaviour
- Challenges: controlling user behaviour, possibility of contagion, and accurately assessing suicide risk, issues relating to privacy and confidentiality

Media awareness campaigns

- The role of mass media in reducing stigma and increasing help seeking behaviour.
  - Indications for most promising results based on multi-level suicide prevention programmes *(Niederkrotenthaler et al, 2016)*

Based on international evidence, responsible media reporting is recommended as an important intervention in low- and middle income countries. However, evaluation of the quality of the implementation and effectiveness in these countries is required *(Fleischman et al, 2016)*
Training and education

- Educating health care and community based professionals to recognise depression and early signs of suicidal behaviour are important for determining level of care and referral for treatment, and subsequent prevention of suicidal behaviour

  (Wasserman et al, 2012; Kapur et al, 2013; Coppens et al, 2014)

- Sustainability and capacity building of trainers and benefits in terms of knowledge, attitudes and confidence via a Train-The-Trainer model

  (Coppens et al, 2014; Isaac et al, 2009)

- 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, e.g. reduced suicide and self-harm rates

  (Mann et al, 2005; Hegerl et al, 2011; Zalsman et al, 2016)

In LMIC countries, training and education could be implemented via the WHO mhGAP programme (Fleischmann et al, 2016)
Availability of training programmes on suicide risk assessment & intervention

- National SP strategy
  - No Training for GPs
  - Training for GPs

- No national SP strategy

- National SP strategy
  - No training for MHPs
  - Training for MHPs

- No national SP strategy
School based intervention programmes

- Quality of evaluation studies involving school based programmes has improved over the past decade

- Evidence from RCTs addressing mental health literacy, resilience and positive coping skills, suicide risk awareness and skills training impacted on reduced suicide attempts and severe suicidal ideation

Increasing evidence for consistent evidence of mental health promotion programmes in secondary school settings across different cultural contexts (Fleischmann et al, 2016; Zalsman et al, 2016; Arensman et al, 2017)
Effectiveness of treatments for people who have engaged in self-harm

- Updated Cochrane review (Hawton et al, 2016)
  - Review of 55 RCTs including 17,699 participants
  - Most commonly evaluated intervention: CBT-based psychological therapy
  - Most of the CBT studies: one-to-one; max. 10 sessions
  - At follow-up, people who had received CBT were less likely to self-harm; 6% fewer people self-harm compared to those with treatment as usual.

- For people with a history of multiple self-harm episodes, other interventions, such as Dialectical Behaviour Therapy, may reduce repeated self-harm. However, this involved only a small number of trials.

Approaches like CBT and DBT may currently be too costly and not feasible due to the lack of trained personnel in some LMIC countries (Fleischmann et al, 2016)
Multi-level suicide prevention programmes

- Community based interventions to improve the care for people diagnosed with depression and simultaneously address awareness and skills in early identification of suicide risk among healthcare and community based professionals (EAAD, NOCOMIT-J)

- Reductions in fatal and non-fatal suicidal behaviour combined up to 32% (Szekely et al, 2013; Hegerl et al, 2013)

- Proven synergistic effects of simultaneously implementing evidence based interventions (Harris et al, 2016)
European Alliance Against Depression: Multi-level suicide prevention programme

Aim: Improving the treatment for people with depression and prevention of suicide

1. Training for GPs
2. Training for Community Facilitators
3. Awareness campaign for the general public
4. Interventions for patients & family members (evidence based interv. & guided self-help)

Reduction in suicide and suicide attempts up to 31% in 3 years (Hegerl et al, 2013)
From the Nuremberg Alliance to the European Alliance Against Depression (www.EAAD.net)

- EU-funded project
- To promote the implementation of regional alliances against depression
- Adaptation to different cultures and languages

Implementation in more than 100 regions in 19 countries incl. Countries outside Europe, e.g. Chili, South Korea, French Polynesia

Hegerl et al, 2013; 2008
Reducing stigma associated with mental health

https://www.youtube.com/watch?v=EhwXUyM9V7g

https://www.youtube.com/watch?v=aSAeOhCrv_s
Evaluation of national suicide prevention programmes from an international perspective

- Evaluation of implementation in 6 countries; reports from 3 countries: Finland, Scotland and Northern Ireland

- Evidence of impact of national suicide prevention programmes: inconsistent

- Challenges related to evaluating complex interventions, incl. multiple interacting components, change over time, quality of implementation, synergistic effects
How IASP and WHO can facilitate the development and implementation of national suicide prevention programmes

• Disseminating information and exchange of information and expertise via National Representatives

• Sharing of best practice and evidence based intervention and prevention programmes via Special Interest Groups and Task Forces

• Supporting the development of national and regional suicide prevention programmes

• World Congresses and regional congresses

• World Suicide Prevention Day
Thank you!

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