National Suicide Prevention Strategies: Progress and Challenges

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World Health Organisation

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Overview

- Introduction by WHO
- Update on suicide at global level
- Core components of national suicide prevention programmes: An update of the evidence base
- Progress in implementing suicide prevention programmes at global level
- 1st and 2nd national suicide prevention programmes: Country examples
- Developing, implementing and evaluating a national suicide prevention programme
- Work in subgroups

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Suicide prevention from a global perspective

Dr Aiysha Malik
Department of Mental Health and Substance Abuse

http://www.who.int/mental_health/suicide-prevention/en/

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UN Sustainable Development Goals (SDGs)

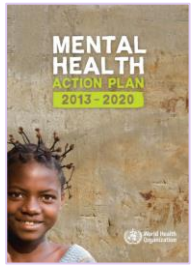
Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote **mental health** and well-being

- **Indicator 3.4.2: <u>Suicide mortality rate</u>**

WHO General Programme of Work (GPW 2019-2023)

- **Indicator 28: Reduce suicide mortality rate by 15%**

WHO Mental Health Action Plan 2013-2020



Objective 3: To implement strategies for promotion and prevention in mental health

- **Target 3.2: <u>Rates of suicide</u>** in countries will be reduced by 10% by year 2020

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Suicide Facts

- Close to 800 000 people die by suicide every year, more than e.g. malaria, breast cancer
- Second leading cause of death among 15-29 year olds and 15-19 year old girls
- For each suicide, there are likely to be more than 20 others making an attempt
- Male:female ratio is lower in LMICs
- Pesticides, hanging and firearms are among the most common means of suicide globally

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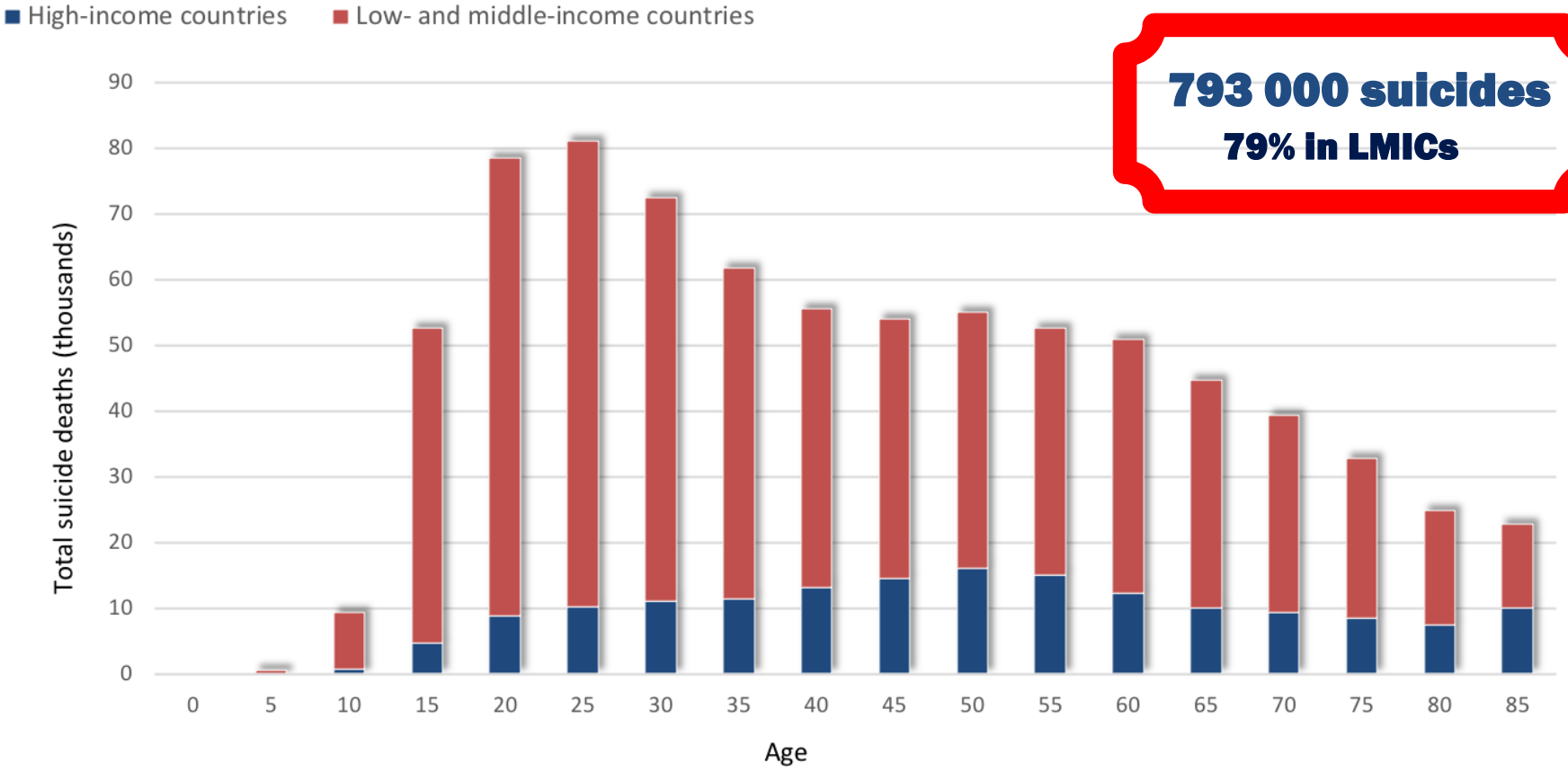
Suicides by age and income level

Global suicides, by age and country income level (thousands), 2016



793 000 suicides

79% in LMICs

Source: WHO Global Health Estimates (*http://www.who.int/healthinfo/global_burden_disease/estimates*)

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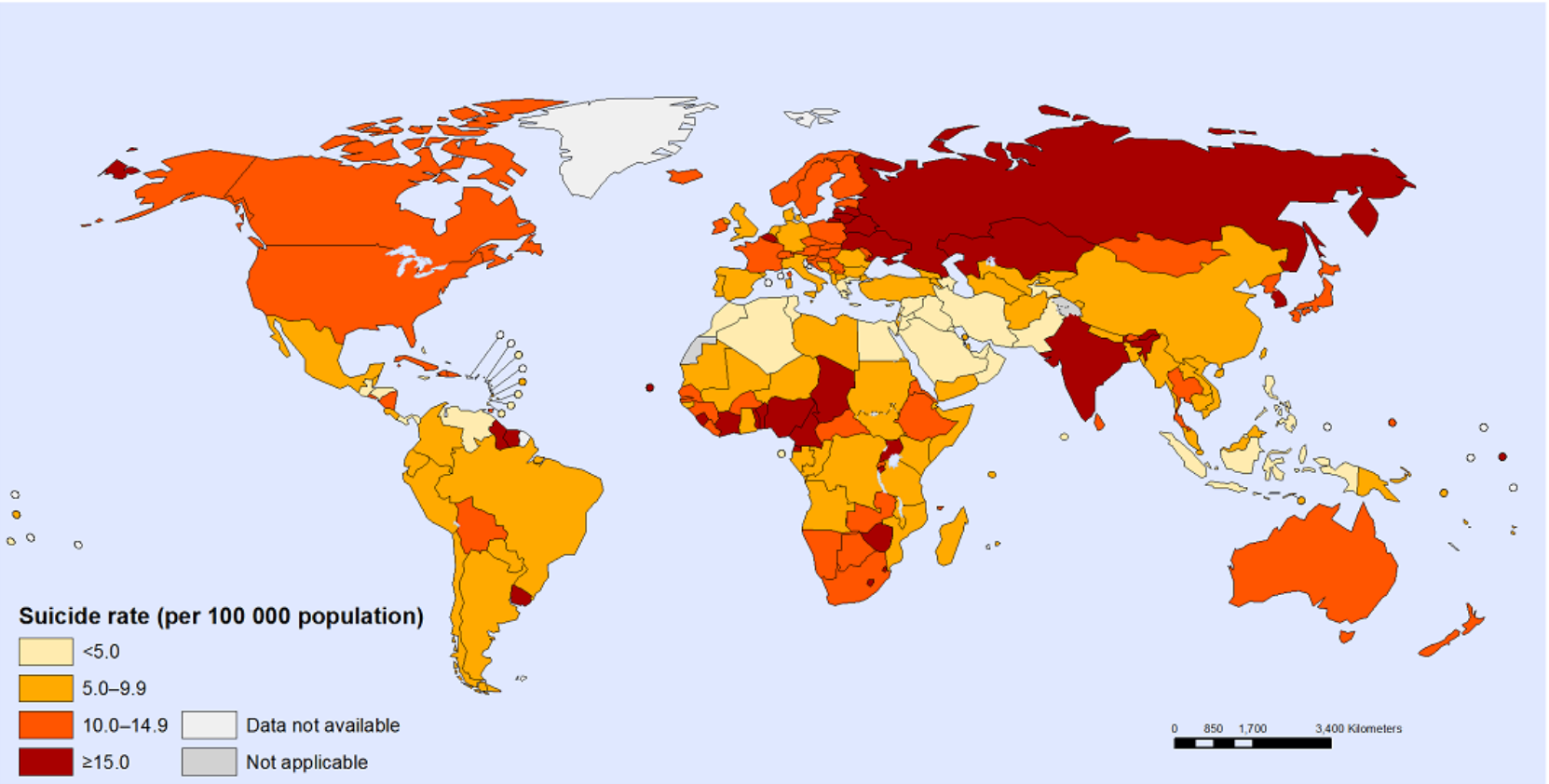
Age-standardized suicide rates (per 100 000 population), both sexes, 2016



The boundaries and names shown and the designations used 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. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Information Evidence and Research (IER)
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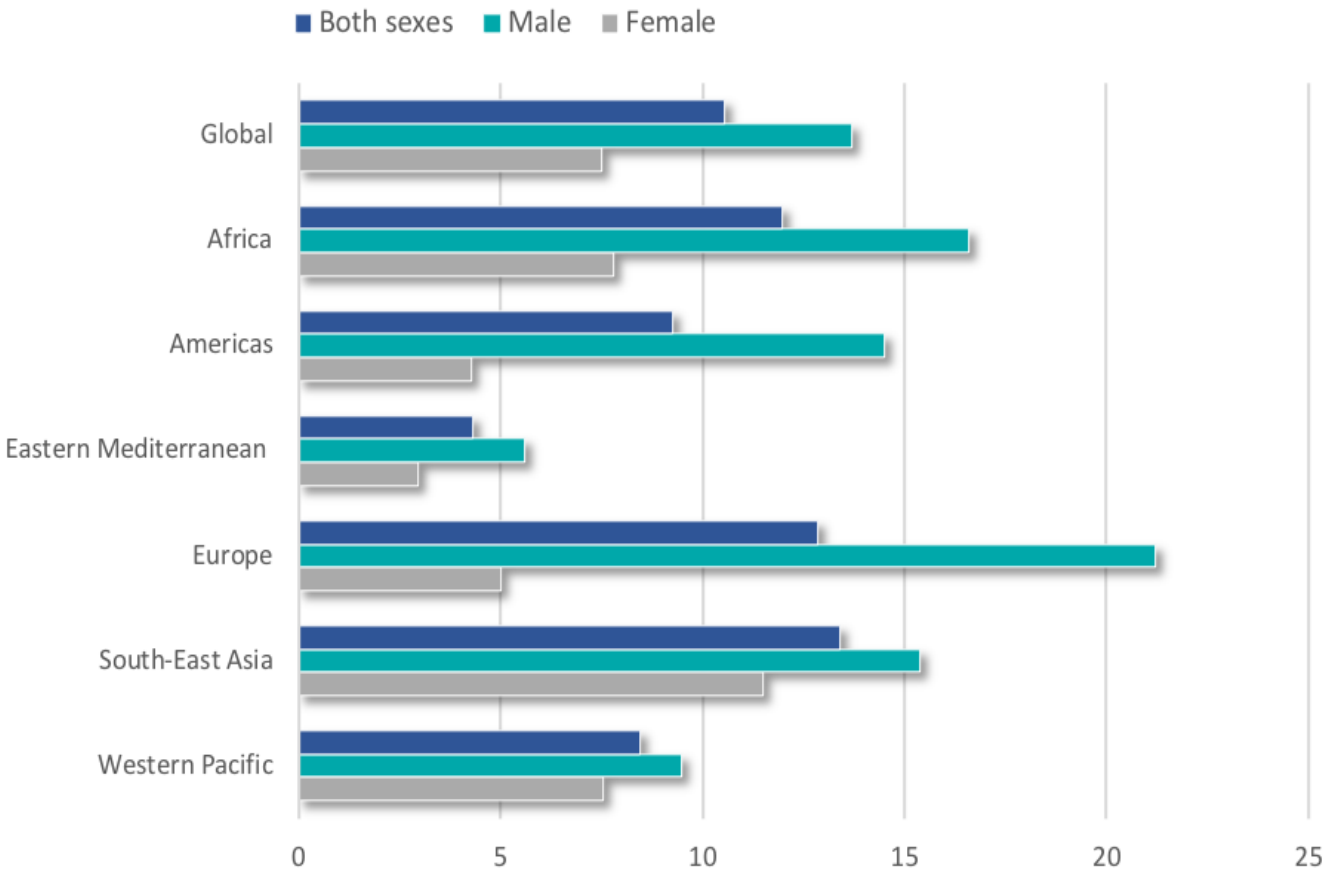
Suicide rate per 100,000 population by WHO region, 2016



Source: WHO Global Health Estimates (*http://www.who.int/healthinfo/global_burden_disease/estimates*)
Regional data shown are age-standardized estimates.

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Launched in September 2014

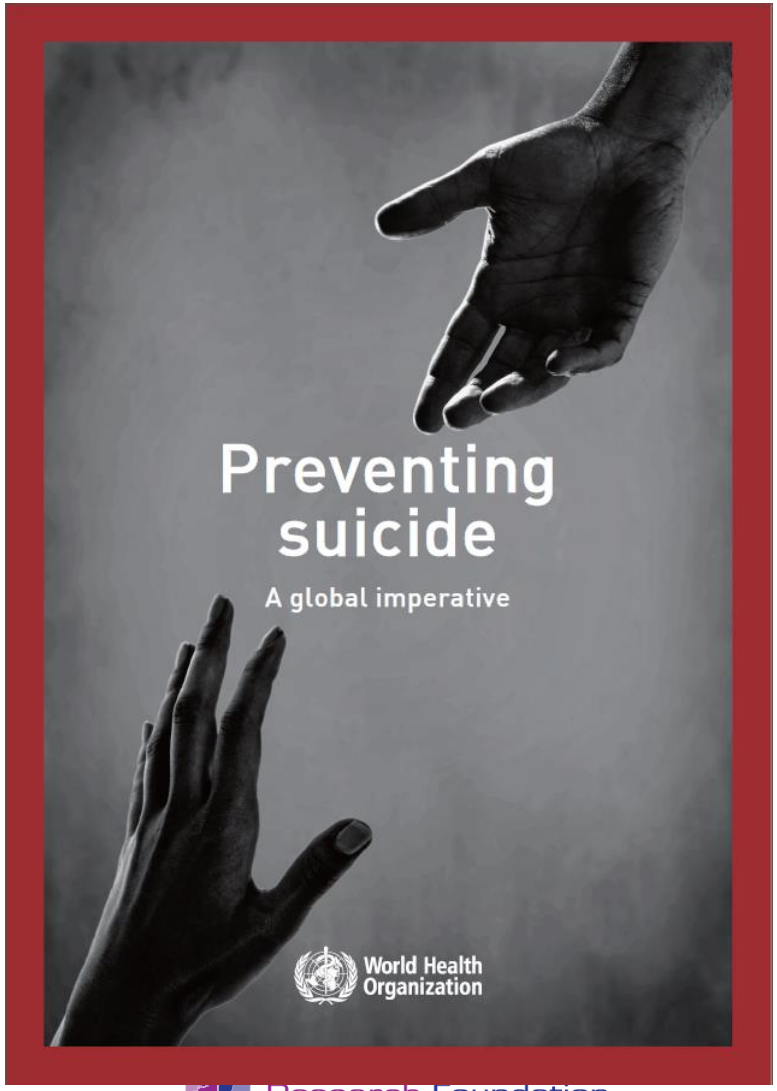

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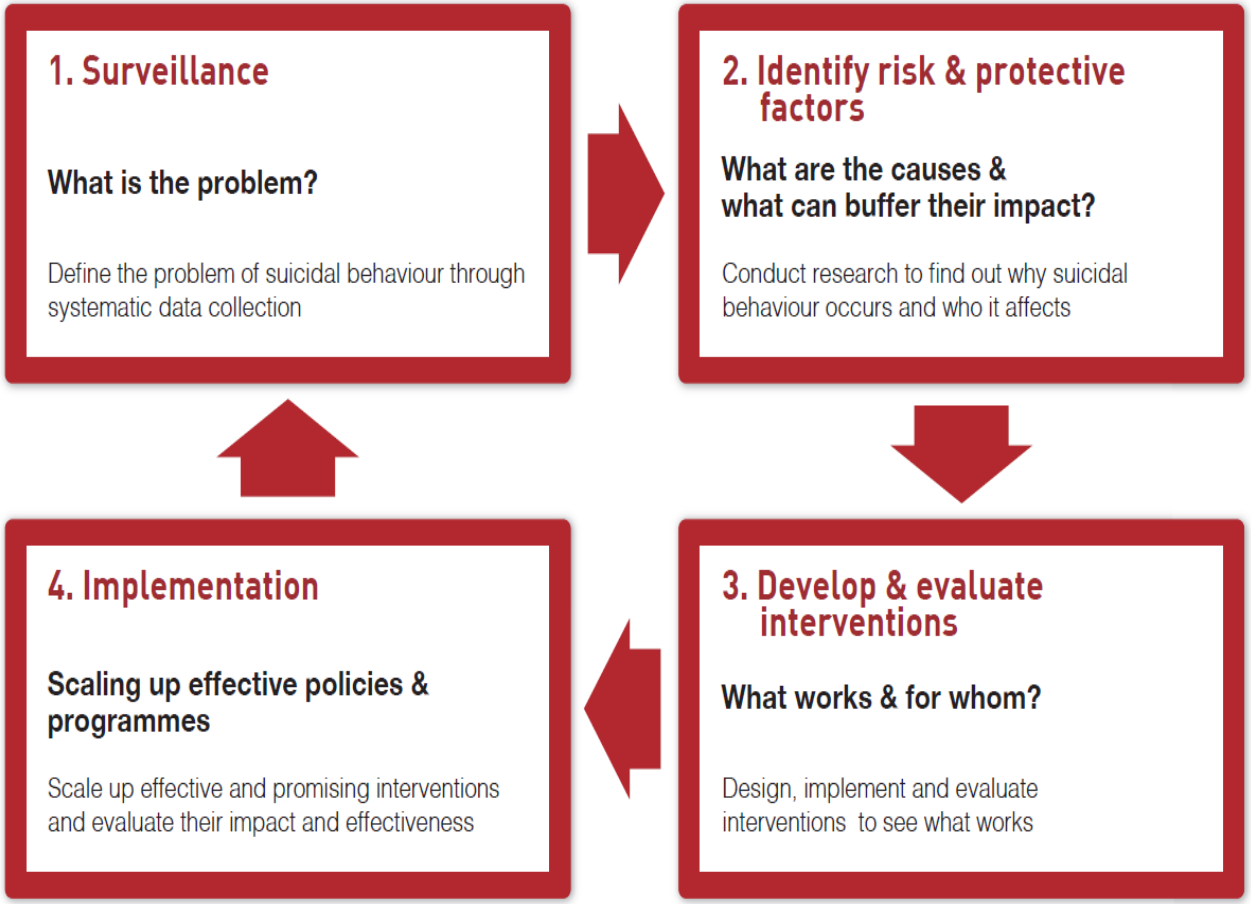
Figure 1. **The public health model**



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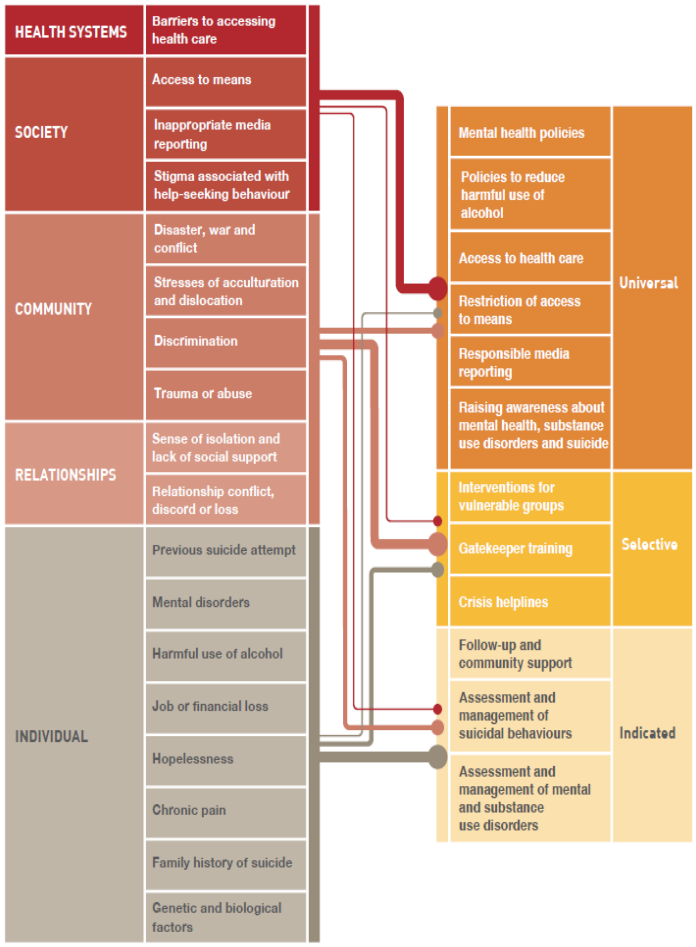
Evidence-based interventions

Figure 7. **Key risk factors for suicide aligned with relevant interventions**
(Lines reflect the relative importance of interventions at different levels for different areas of risk factors)



- → **Reducing access to means**
- → **Responsible media reporting**
- → **Introducing alcohol policies**
- → **School-based interventions**
- → **Early identification and treatment**
- → **Training of health workers**
- → **Follow-up care and community support**

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A multisectoral approach

→ A complex issue with a multitude of factors, there is no one answer to this problem

→ Governments must assume their role of leadership in suicide prevention

→ Multisectoral collaboration is key

HEALTH SYSTEMS	Barriers to accessing health care
SOCIETY	Access to means
	Inappropriate media reporting
	Stigma associated with help-seeking behaviour
COMMUNITY	Disaster, war and conflict
	Stresses of acculturation and dislocation
	Discrimination
	Trauma or abuse
RELATIONSHIPS	Sense of isolation and lack of social support
	Relationship conflict, discord or loss
INDIVIDUAL	Previous suicide attempt
	Mental disorders
	Harmful use of alcohol
	Job or financial loss
	Hopelessness
	Chronic pain
	Family history of suicide
	Genetic and biological factors

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Why a National Strategy ?

- Recognizes suicide and suicide attempts as a major public health problem.
- Signals the commitment of a government to tackling the issue.
- Recommends a structural framework, incorporating various aspects of suicide prevention.
- Provides authoritative guidance on key evidence-based suicide prevention activities, i.e. identifies what works and what does not work.
- Identifies key stakeholders and allocates specific responsibilities among them. It outlines the necessary coordination among these various groups.
- Identifies crucial gaps in legislation, service provision and data collection.
- Indicates the human and financial resources required for interventions.
- Shapes advocacy, awareness raising, and media communications.
- Proposes a robust monitoring and evaluation framework, thereby instilling a sense of accountability among those in charge of interventions.
- Provides a context for a research agenda on suicidal behaviours.

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The time to act is now….

Table 5. **Proposed strategic actions for suicide prevention (categorized by current implementation levels)**

Areas of strategic action	Lead stakeholders	No activity (currently there is no suicide prevention response at national or local level)	Some activity (some work has begun in suicide prevention in priority areas at either national or local level)	Established suicide prevention strategy exists at national level
Engage key stakeholders	Ministry of Health as lead, or other coordinating health body	Initiate identification of and engagement with key stakeholders on country priorities, or where activities already exist.	Identify all key stakeholders across sectors and engage them comprehensively in suicide prevention activities. Assign responsibilities.	Assess the roles, responsibilities, and activities of all key stakeholders on a regular basis. Use the results to expand sector participation and increase stakeholder involvement.
Reduce access to means	Legal and judicial system, policy-makers, agriculture, transportation	Begin efforts to reduce access to means of suicide through community interventions.	Coordinate and expand existing efforts to reduce access to the means of suicide (including laws, policies and practices at national level).	Evaluate efforts to reduce access to the means of suicide. Use the evaluation results to make improvements.
Conduct surveillance and improve data quality	Ministry of Health, Bureau of Statistics, all other stakeholders, and particularly the formal and informal health systems to collect data	Begin surveillance, prioritizing mortality data, with core information on age, sex and methods of suicide. Begin identification of representative locations for development of models.	Put a surveillance system in place to monitor suicide and suicide attempts at national level (including additional disaggregation) and ensure the data is reliable, valid and publicly available. Establish feasible data models that are effective and can be scaled up.	Monitor key attributes such as quality, representativeness, timeliness, usefulness and costs of the surveillance system in a timely manner. Use the results to improve the system. Scale up effective models for comprehensive data coverage and quality.
Raise awareness	All sectors, with leadership from the	Organize activities to raise awareness that	Develop strategic public awareness campaigns	Evaluate the effectiveness of public

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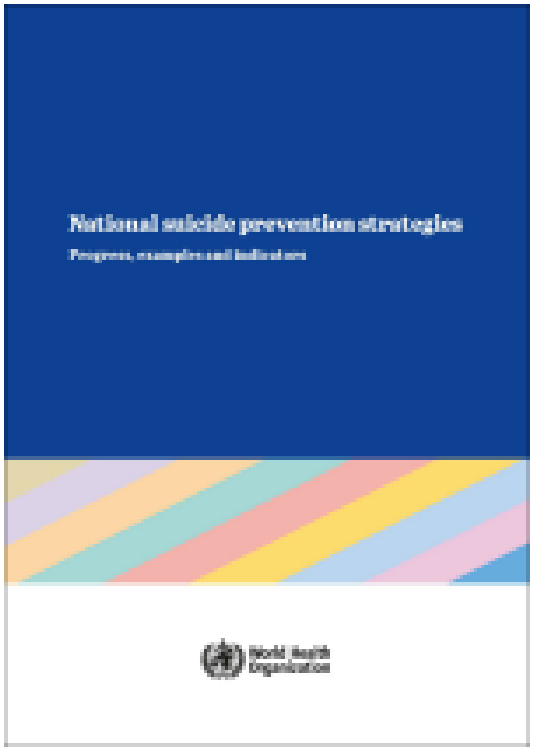
Examples of national suicide prevention strategies



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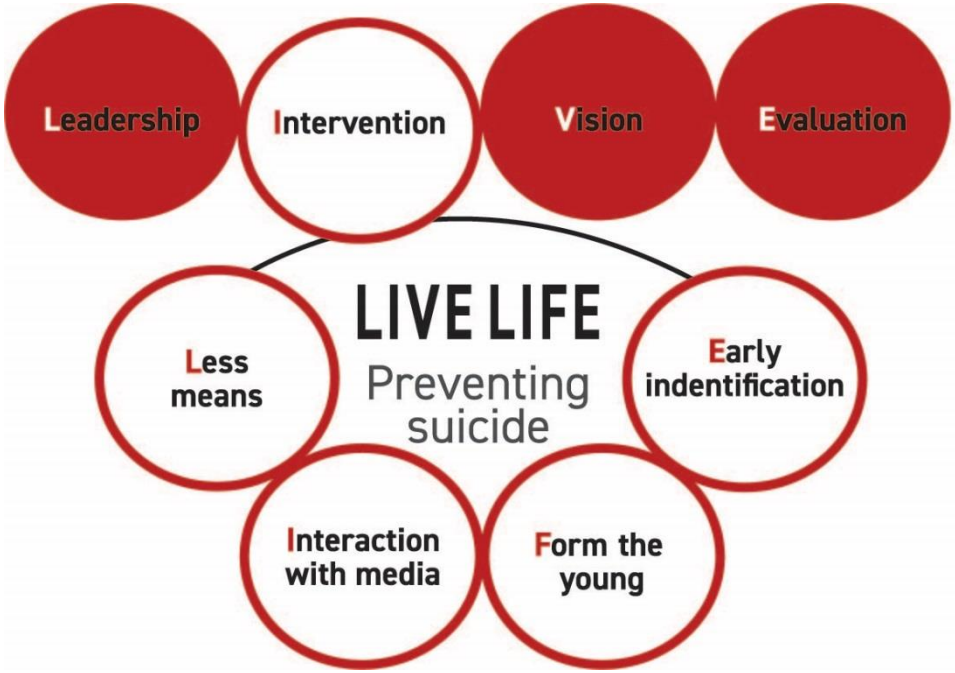
Guidance to embody LIVE LIFE which comprises four cross-cutting implementation strategies and four key effective evidence-based interventions



Leadership in policy and multisectoral collaboration
Interventions for implementation
Vision for innovation, financing, and delivery platforms
Evaluation, monitoring, surveillance and research

Less means by restricting access
Interaction with media for responsible reporting
Form the young in their life skills
Early identification, management and follow-up

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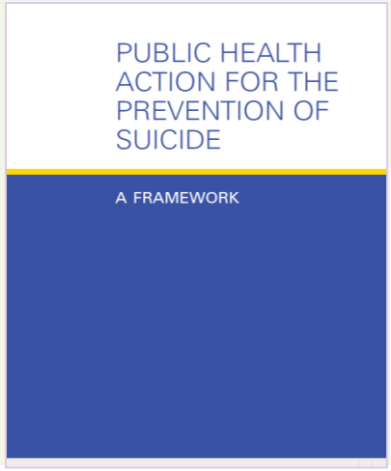
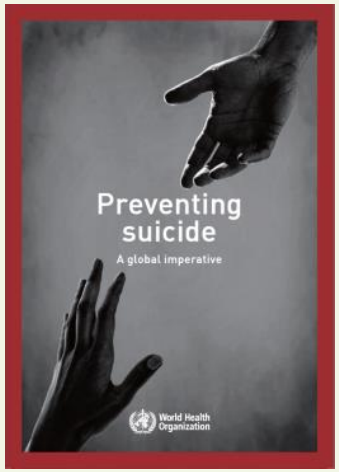
Technical tools and resources for implementation

National suicide prevention strategies

- Public Health Action for the Prevention of Suicide: A Framework



- Preventing suicide: a global imperative



- MiNDbank online platform

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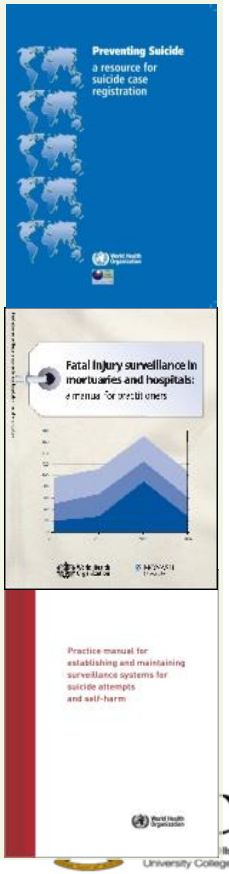
Technical tools and resources for implementation

Surveillance

- Preventing suicide: a resource for suicide case registration
- Fatal injury surveillance in mortuaries and hospitals: a manual for practitioners
- Practice manual for establishing and implementing suicide attempt and self-harm surveillance systems



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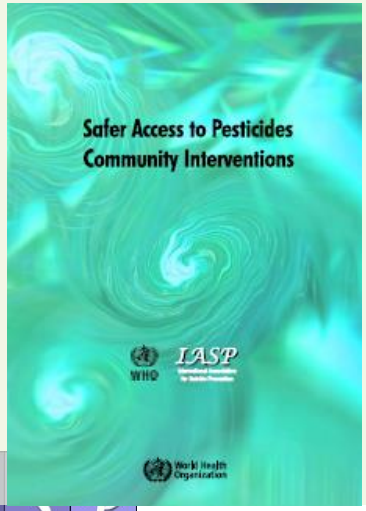
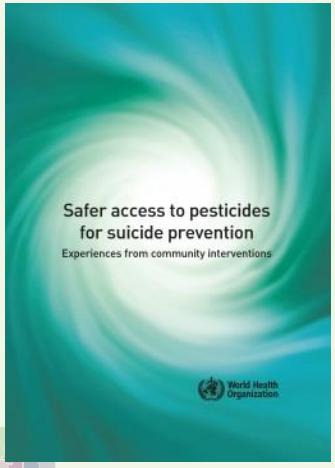
Technical tools and resources for implementation

Reducing access to means: pesticides

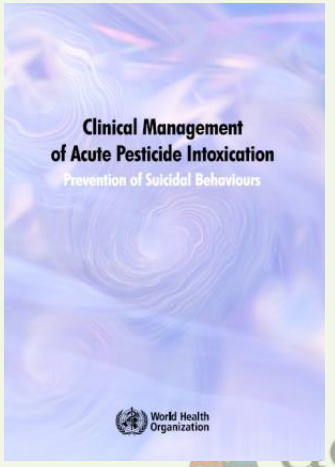
- Safer Access to Pesticides: Community Interventions



- Safer Access to Pesticides: Experiences from Community Interventions



- Clinical Management of Acute Pesticide Intoxication



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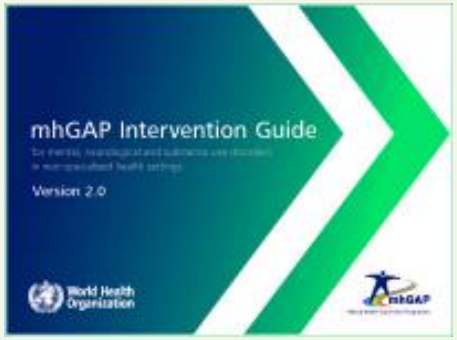
Technical tools and resources for implementation

Early identification, assessment, management, follow-up

- mhGAP Intervention Guide, version 2.0: self-harm/suicide module

  (used in more than 90 countries, translated into more than 20 languages)



- mhGAP recommendations for assessment and management of self-harm/suicide
  http://www.who.int/mental_health/mhgap/evidence/en/

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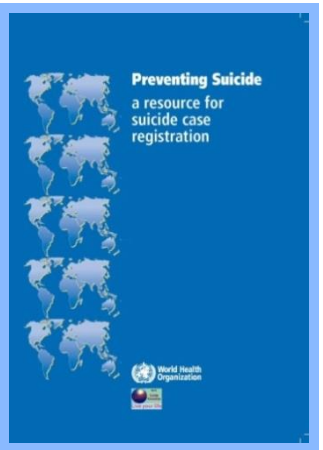
Technical tools and resources for implementation

Communities and social, professional groups

Community Engagement Toolkit for suicide prevention, pilot version 1.0

Preventing suicide: a resource series

1. for General physicians
2. for Media professionals (2008) NEW 2017
3. for Teachers and other school staff
4. for Primary health care workers
5. in Jails and prisons (2007)
6. How to start a survivors' group (2008)
7. for Counsellors
8. at Work
9. for Police, firefighters and other first line responders
10. for suicide case registration
11. for non-fatal suicidal behaviour case registration



Available in more than 20 different languages

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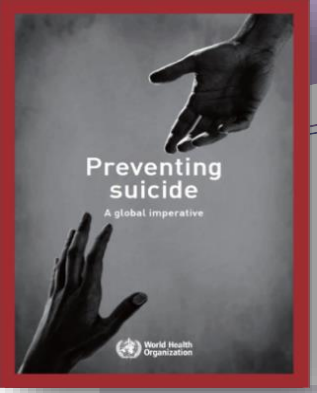
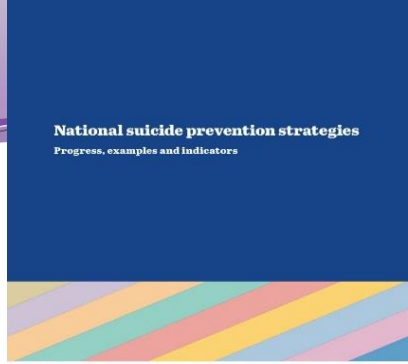
Core components of national suicide prevention programmes: An update of the evidence base



Core components of national suicide prevention strategies



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1) Surveillance	7) Crisis Intervention
2) Means Restriction	8) Postvention
3) Media	9) Awareness
4) Access to Services	10) Stigma Reduction
5) Training and Education	11) Oversight and Coordination
6) Treatment	

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Strategic actions and targeted suicide prevention activities that may reinforce the development of a national strategy


global mental health

INTERVENTIONS

REVIEW

Overview evidence on interventions for population suicide with an eye to identifying best-supported strategies for LMICs


Editorial

Suicide Prevention in an International Context

Progress and Challenges

Ella Arensman

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.

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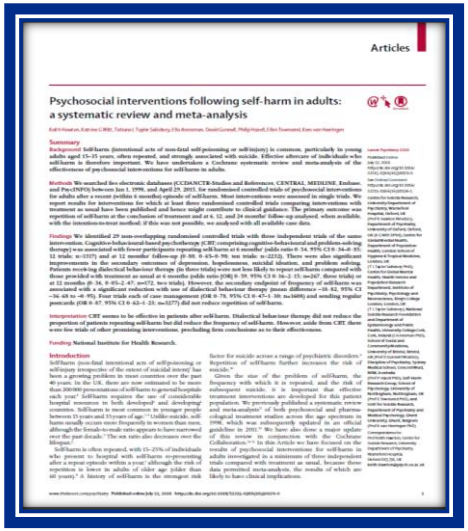
Recent systematic reviews


Articles

Suicide prevention strategies revisited: 10-year systematic review

- 'Suicide prevention strategies revisited: 10-year systematic review' *(Zalsman et al, 2016)*
- Provides an update of the evidence on effective suicide prevention interventions since 2005.


Articles

Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis

- 'Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis' *(Hawton et al, 2016)*
- Outlines the findings of a Cochrane systematic review and meta-analysis of the effectiveness of psychosocial interventions for self-harm in adults.

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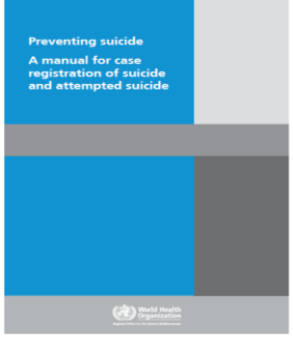
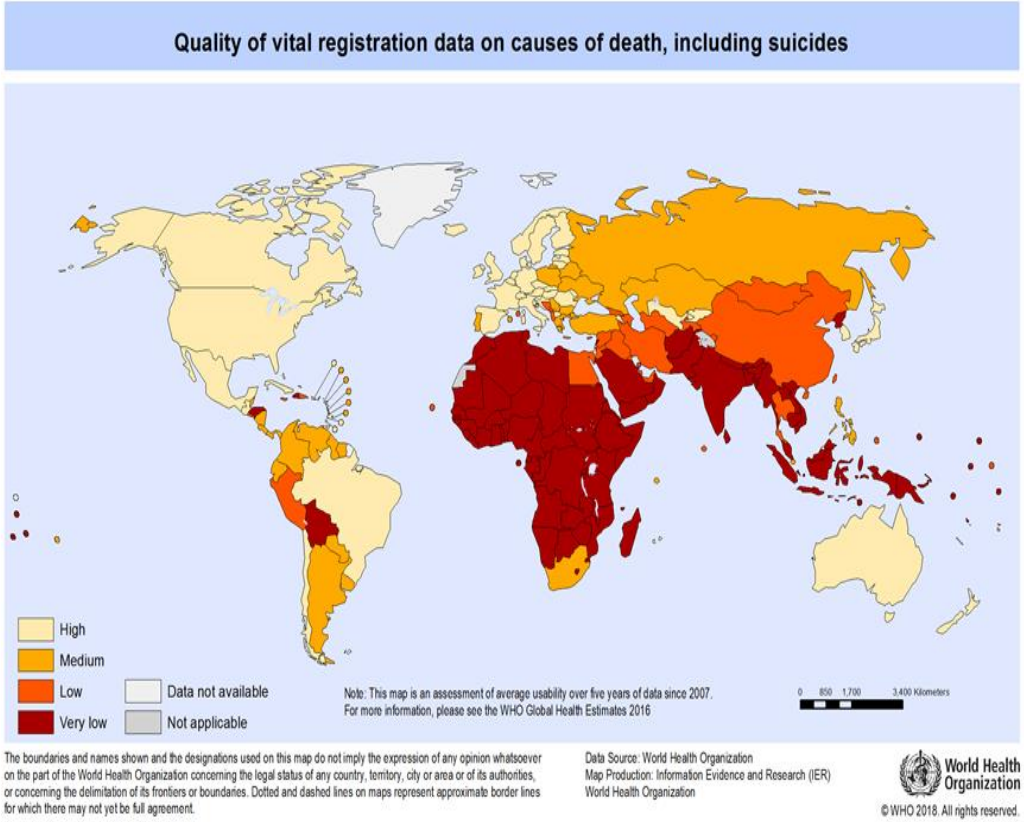


Suicide surveillance - Data Quality

- 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



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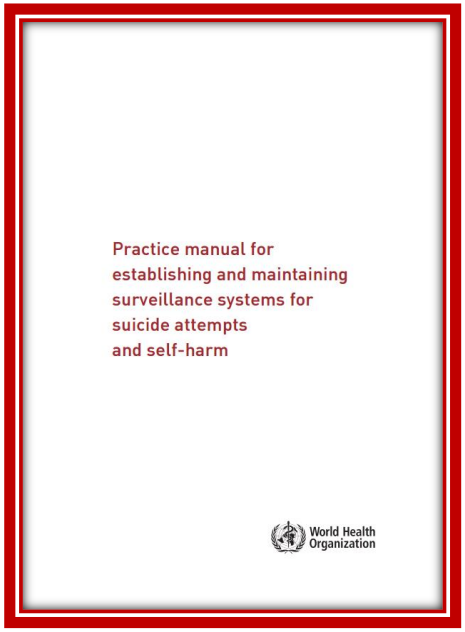
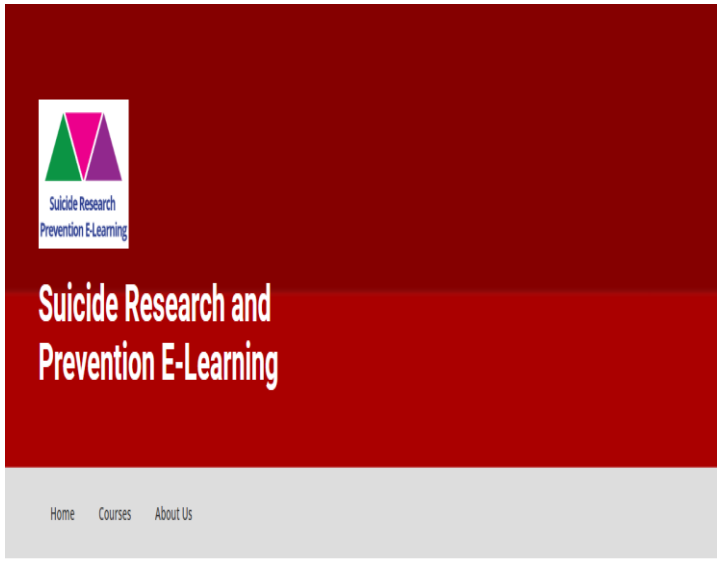
Surveillance of suicide attempts/self-harm





- 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)*

https://suicideresearchpreventionelearning.com/?sfwd-courses=establishing-and-maintaining-surveillance-systems-for-suicide-attempts-and-self-harm

While there is a lack of reliable national data on the prevalence of suicide attempts/ self-harm presentations to hospital emergency departments, 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.

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Articles

Suicide prevention strategies revisited: 10-year systematic review


MENTAL HEALTH

The effectiveness of structural interventions at suicide hotspots: a meta-analysis

Restricting access to means

- 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.

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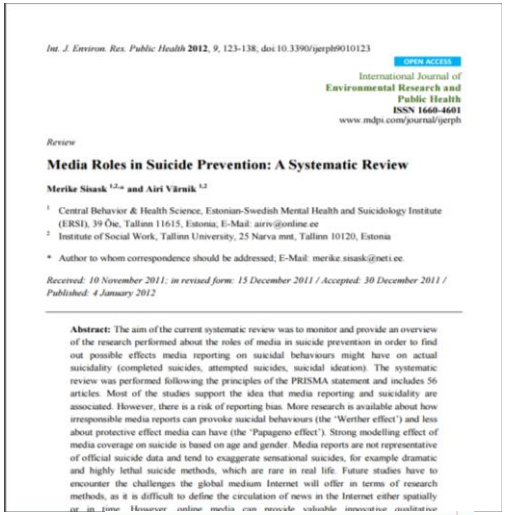
Media

- Systematic review of 56 studies *(Sisask & Varnik, 2012)*

- Most studies provided evidence for an association between sensationalised media reporting and suicidal behaviour,



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Review

Media Roles in Suicide Prevention: A Systematic Review

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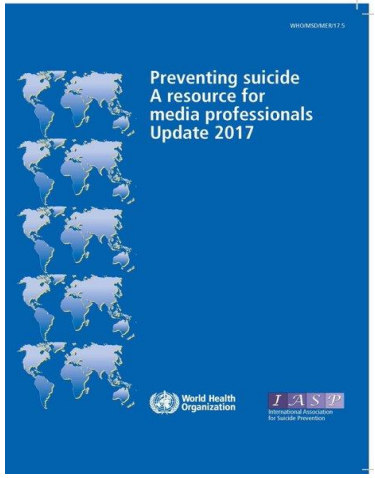
Abstract: The aim of the current systematic review was to monitor and provide an overview of the research performed about the roles of media in suicide prevention in order to find out possible effects media reporting on suicidal behaviours might have on actual suicidality (completed suicides, attempted suicides, suicidal ideation). The systematic review was performed following the principles of the PRISMA statement and includes 56 articles. Most of the studies support the idea that media reporting and suicidality are associated. However, there is a risk of reporting bias. More research is available about how irresponsible media reports can provoke suicidal behaviours (the 'Werther effect') and less about protective effect media can have (the 'Papageno effect'). Strong modelling effect of media coverage on suicide is based on age and gender. Media reports are not representative of official suicide data and tend to exaggerate sensational suicides, for example dramatic and highly lethal suicide methods, which are rare in real life. Future studies have to encounter the challenges the global medium Internet will offer in terms of research methods, as it is difficult to define the circulation of news in the Internet either spatially or in time. However, online media can provide valuable innovative qualitative

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)*

Media and copycat suicides and suicide attempts/ self-harm

Families blame '13 Reasons Why' for the suicides of 2 teens in California (US), April 2017)

Netflix officials defend 13 Reasons Why against claims it glamourises suicide

Dylan Minnette and Katherine Langford in 13 Reasons Why

Netflix drama series blamed for inspiring teens' suicide and attempted suicide (Austria), May 2017

'13 Reasons Why' copycat suicide in Peru, June 2017

Increase in teen suicidal behaviour linked to '13 Reasons Why', Toronto, June 2017

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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)

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Research report

Effectiveness of community facilitator training in improving knowledge, attitudes, and confidence in relation to depression and suicidal behavior: Results of the OSPI-Europe intervention in four European countries

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ABSTRACT

Background: Community facilitators (CFs), such as teachers, nurses and social workers, are well placed as gatekeepers for depression and suicidal behavior, but not properly prepared to provide preventive and supportive services. The current study aimed: (1) to improve CFs' attitudes toward depression, knowledge on suicide, and confidence to detect suicidal behavior in four European countries and (2) to identify specific training needs across regions and CF groups.

Methods: A standardized training program was provided to 1276 CFs in Germany, Hungary, Ireland, and Portugal. Attitudes toward depression, knowledge about suicide, and confidence in identifying suicidal persons were assessed before training, after training, and at three to six months follow-up. Additionally, several participants' characteristics were registered.

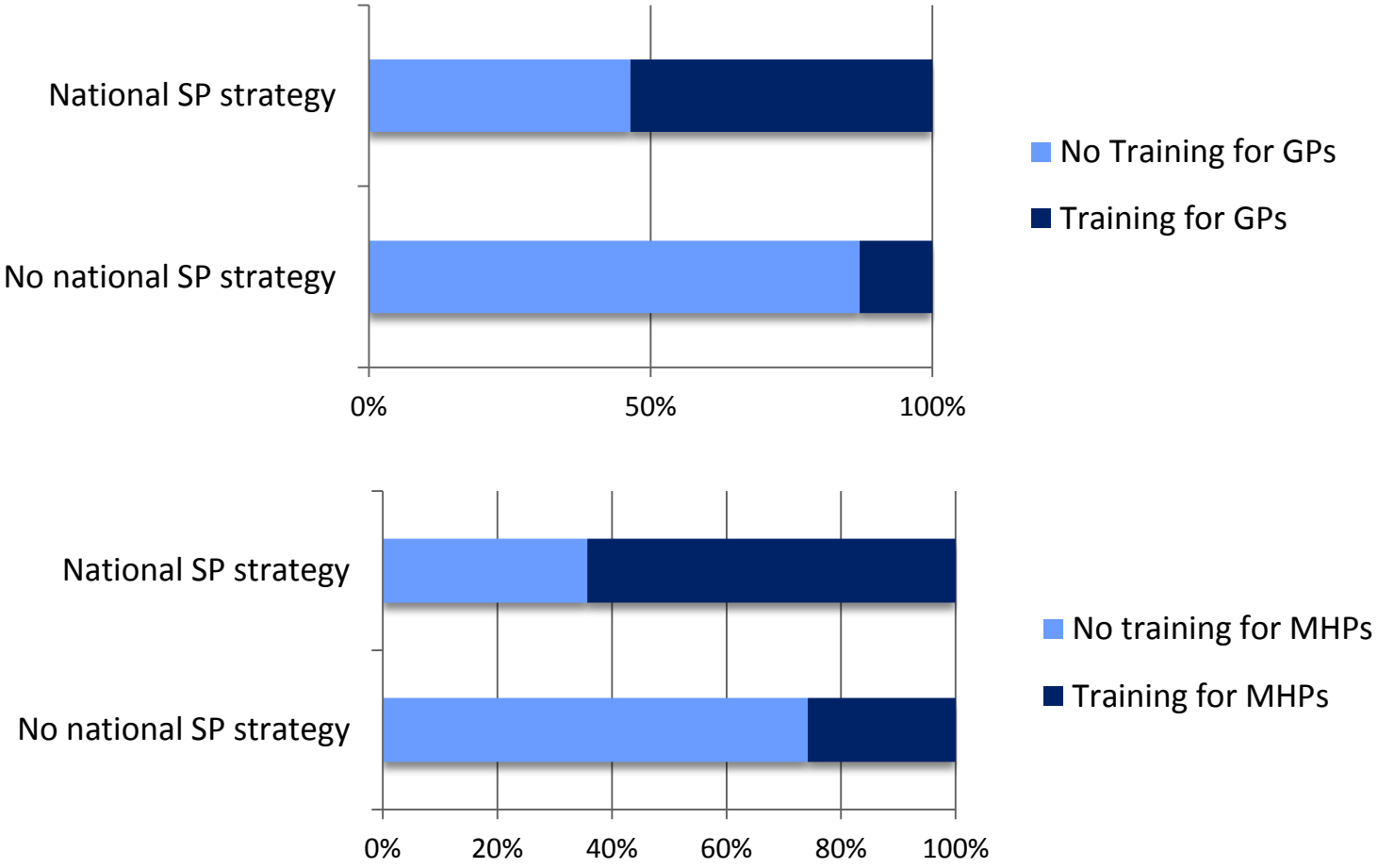
Results: At baseline, CFs showed relatively favorable attitudes toward depression, but limited knowledge on suicide, and little confidence to identify suicidal behavior. Basic skills strongly differed across CF groups and countries. For example, in Germany, carers for the elderly, nurses, teachers, and managers were most in need of training, while in Portugal pharmacists and the clergy appeared to be important target groups. Most importantly, the training program improved the competencies of CF groups across countries and these improvements were sustained after three to six months. CFs with low basic skills benefited most of the training.

Limitations: The observed training effects could be influenced by other external factors as our results are based upon a pre–post comparison with no control group.

Conclusions: Gatekeeper trainings in community settings are successful in improving knowledge, reshaping attitudes, and boosting the confidence of gatekeepers. The most effective strategy to achieve the preferred objectives is to target those CF groups that are most in need of training and to tailor the content of the training program to the individual needs of the target group.

1. Background

Availability of training programmes on suicide risk assessment & intervention



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

Articles

Suicide prevention strategies revisited: 10-year systematic review

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)*

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Effectiveness of treatments for people who have engaged in self-harm

Cochrane Library
Cochrane Database of Systematic Reviews

Psychosocial interventions for self-harm in adults (Review)

Hawton K, Witt KG, Taylor Salisbury TL, Arensman E, Gunnell D, Hazell P, Townsend E, van Heeringen K

- 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.

Articles

Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis

- 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

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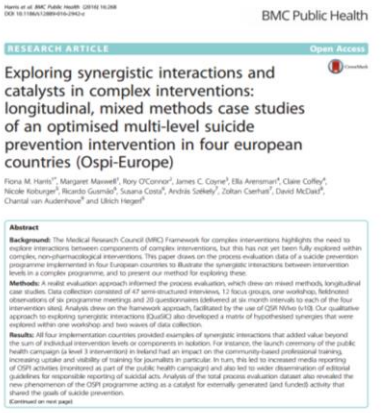
Multi-level suicide prevention programmes

- 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)*

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EUROPEAN ALLIANCE AGAINST DEPRESSION

targeting depression and suicide globally

European Alliance Against Depression:

Multi-level suicide prevention programme


BMC Public Health

Study protocol

Optimizing Suicide Prevention Programs and Their Implementation in Europe (OSPI Europe): an evidence-based multi-level approach

Ulrich Hegerl[1], Lisa Wittenburg[1], Ella Arensman[2], Chantal Van Audenhove[4], James C Coyne[13], David McDaid[5], Christina M van der Feltz-Cornelis[5,14], Ricardo Gusmão[11], Mária Koppi[6], Margaret Maxwell[8], Ullrich Meise[15], Saska Roskar[9], Marco Sarchiapone[12,16], Armin Schmidtke[10], Airi Värnik[2] and Anke Bramesfeld*[1]

Abstract

Background: Suicide and non-fatal suicidal behaviour are significant public health issues in Europe requiring effective preventive interventions. However, the evidence for effective prevention strategies is scarce. The protocol of a European research project to develop an optimized evidence based program for suicide prevention is presented.

Method: The groundwork for this research has been established by a regional community based intervention for suicide prevention that focuses on improving awareness and care for depression and prevention of suicide in primary care (OSPI-Europe). The OSPI-Europe intervention consists of (1) training sessions and practice support for primary care physicians, (2) public relations activities and mass media campaigns, (3) training sessions for community facilitators who serve as gatekeepers for depressed and suicidal persons in the community and treatment and (4) outreach and support for high risk and self-help groups (e.g. helplines). The intervention has been shown to be effective in reducing suicidal behaviour in an earlier study, the Nuremberg Alliance Against Depression. In the context of the current research project described in this paper (OSPI-Europe)

Reduction in suicide and suicide attempts up to 31% in 3 years

(Hegerl et al, 2013)

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From the Nuremberg Alliance to the European Alliance Against Depression and global implementation (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, Canada, Australia

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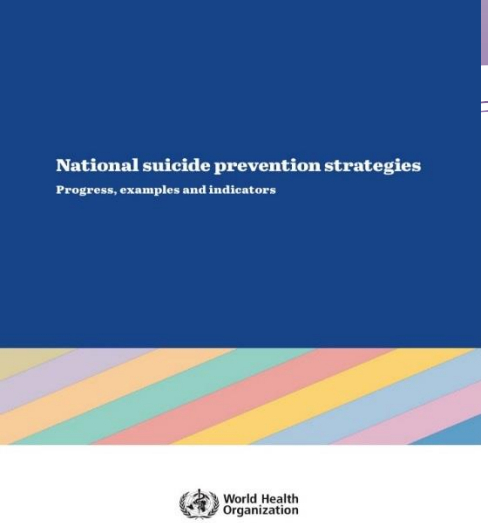

National Suicide Prevention Strategies: Progress and challenges

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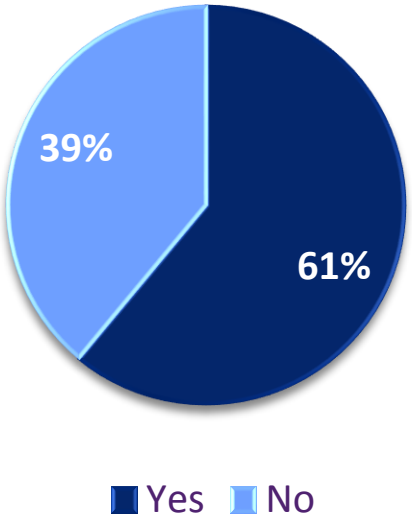
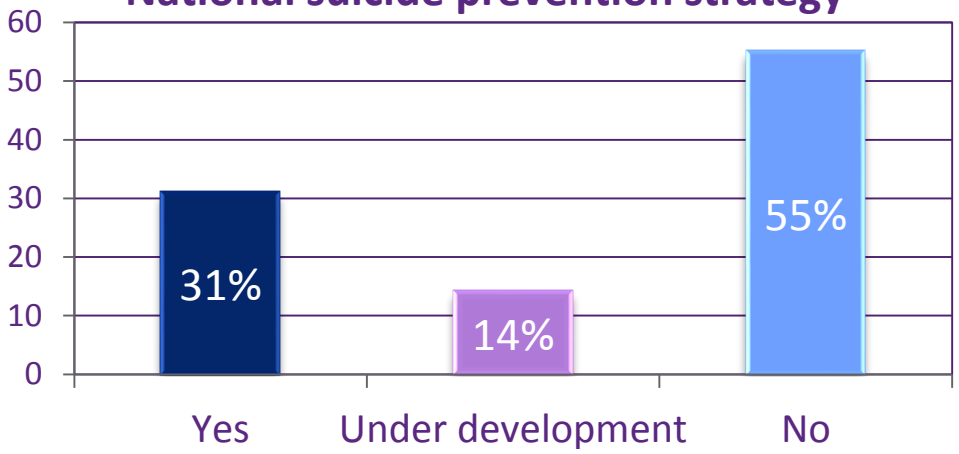
IASP-WHO Global Survey on Suicide Prevention

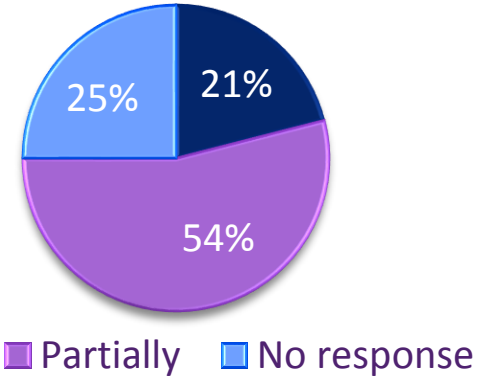
Suicide viewed by government as significant public health problem



National suicide prevention strategy



Has the national strategy been fully or partially implemented?



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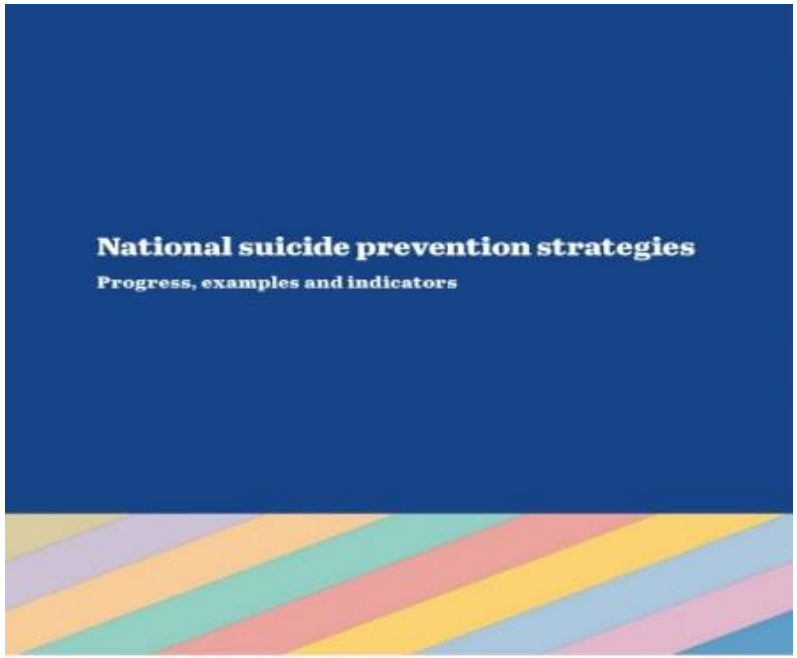
Country examples of 1st or 2nd national suicide prevention strategy

First strategy:

- Bhutan
- Guyana
- Iran
- Republic of Korea
- Switzerland
- Namibia (2nd national strategy in progress)
- Uruguay

Second strategy:

- England
- Ireland
- Sweden
- Japan
- USA



Challenges in developing and implementing national suicide prevention programmes

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

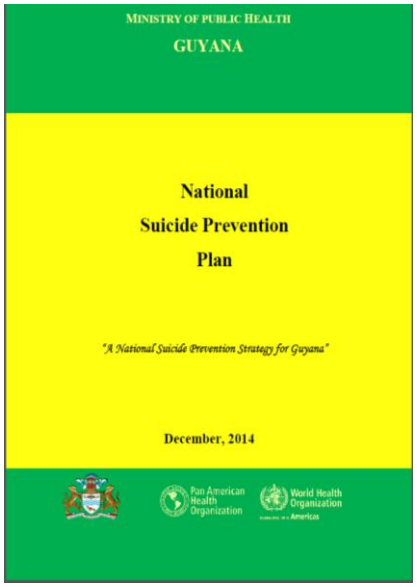
- Lack of independent and systematic evaluations of national suicide prevention programmes

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

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

Countries with recently completed/initiated national suicide prevention programmes despite many challenges – Examples

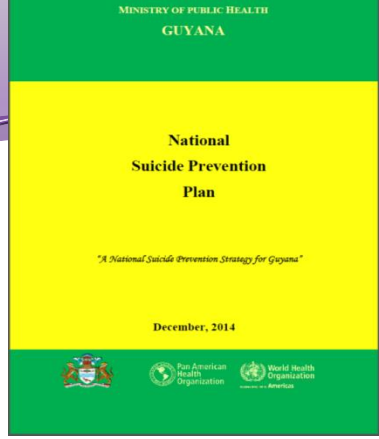
Guyana



Afghanistan

Example Guyana

Ministry of Health
Guyana



- 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;

Example 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.

Developing and implementing a national suicide prevention programme

Summary of the full strategy process for *Connecting for Life*, 2015-2020

Co-ordinated by the
National Office for Suicide Prevention

Research and Evidence

- An examination of key learning points from *Reach Out;*
- 272 written submissions arising from the public consultation;
- Evidence brief on risk and protective factors for suicide;
- Information from the Central Statistics Office (CSO);
- National Self-Harm Registry Ireland research reports;
- A review of the evidence base for interventions for suicide prevention by the Health Research Board
- The WHO 2014 Report *Preventing suicide: A global imperative*

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Connecting for Life
Ireland's National Strategy to Reduce Suicide, 2015-2020

Strategic Goals of the Strategy (7 goals and 69 actions):

1. To improve the nation's understanding of and attitudes to suicidal behaviour (fatal and non-fatal), mental health and wellbeing

2. To support local communities' capacity to prevent and respond to suicidal behaviour

3. To target approaches to reduce suicidal behaviour and improve mental health among priority groups

4. To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour

5. To ensure safe and high quality services for people vulnerable to suicide

6. To reduce and restrict access to means of suicidal behaviour

7. To improve surveillance, evaluation and high quality research relating to suicidal behaviour

Connecting for Life

Ireland's National Strategy to Reduce Suicide 2015-2020

Connecting for Life

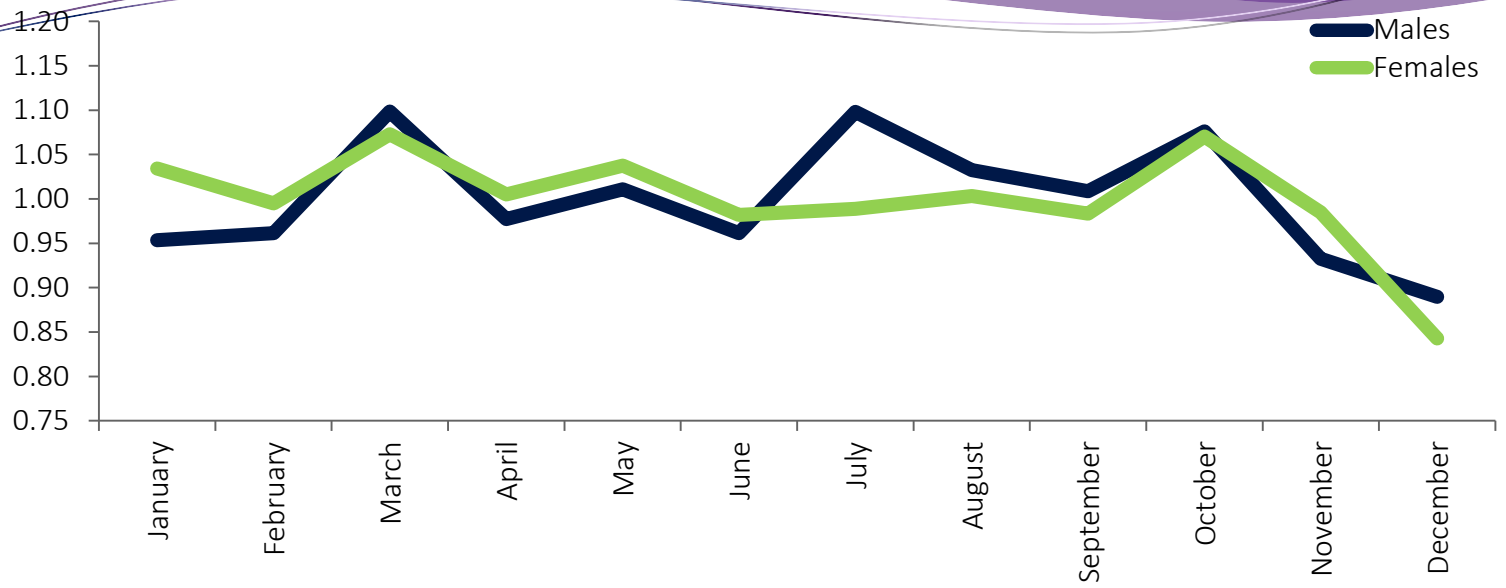
Ireland's National Strategy to Reduce Suicide, 2015-2020

Example of strategic goal and evidence informed action:

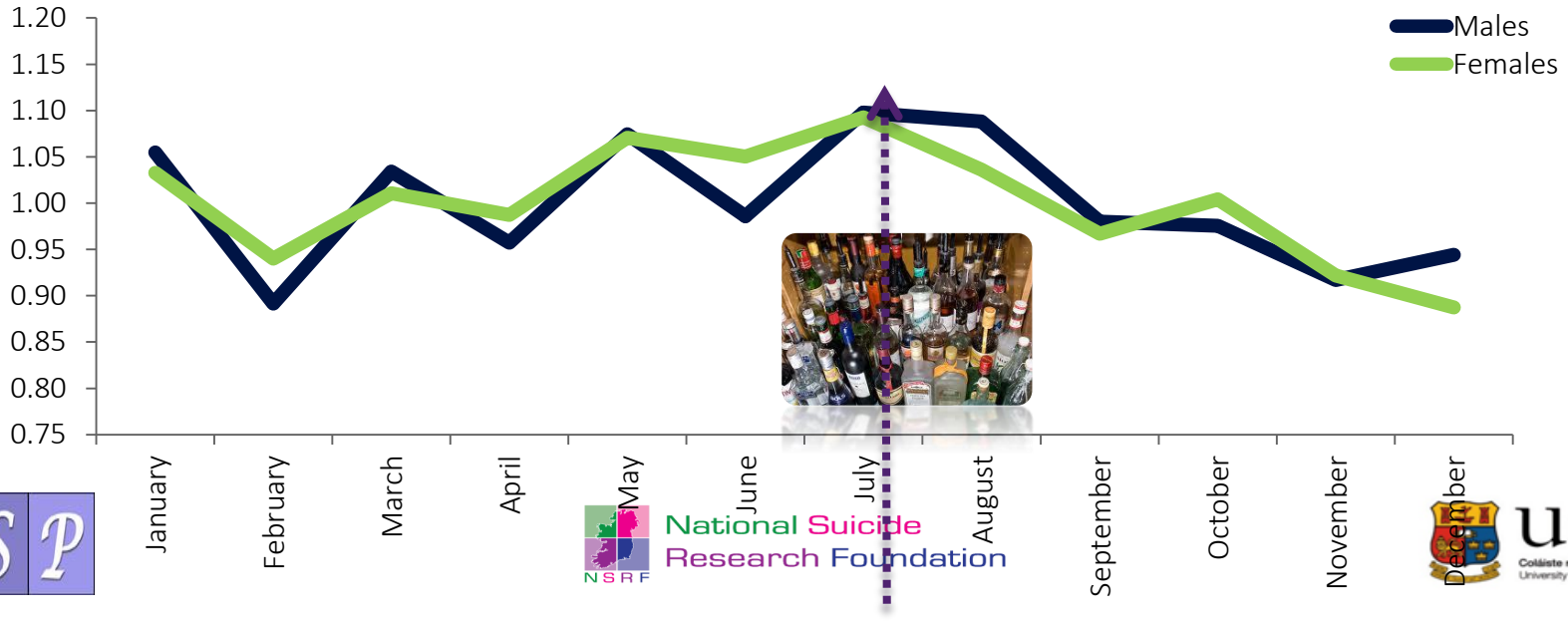
1. To improve the nation's understanding of and attitudes to suicidal behaviour, mental health and wellbeing

Action 1.1.4: Build the link between alcohol/drug misuse and suicidal behaviour into all communication campaigns

The impact of alcohol on seasonal patterns of self-harm: Non-Alcohol related self-harm



The impact of alcohol on seasonal patterns of self-harm: Alcohol related self-harm



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Ireland's National Strategy to Reduce Suicide 2015-2020

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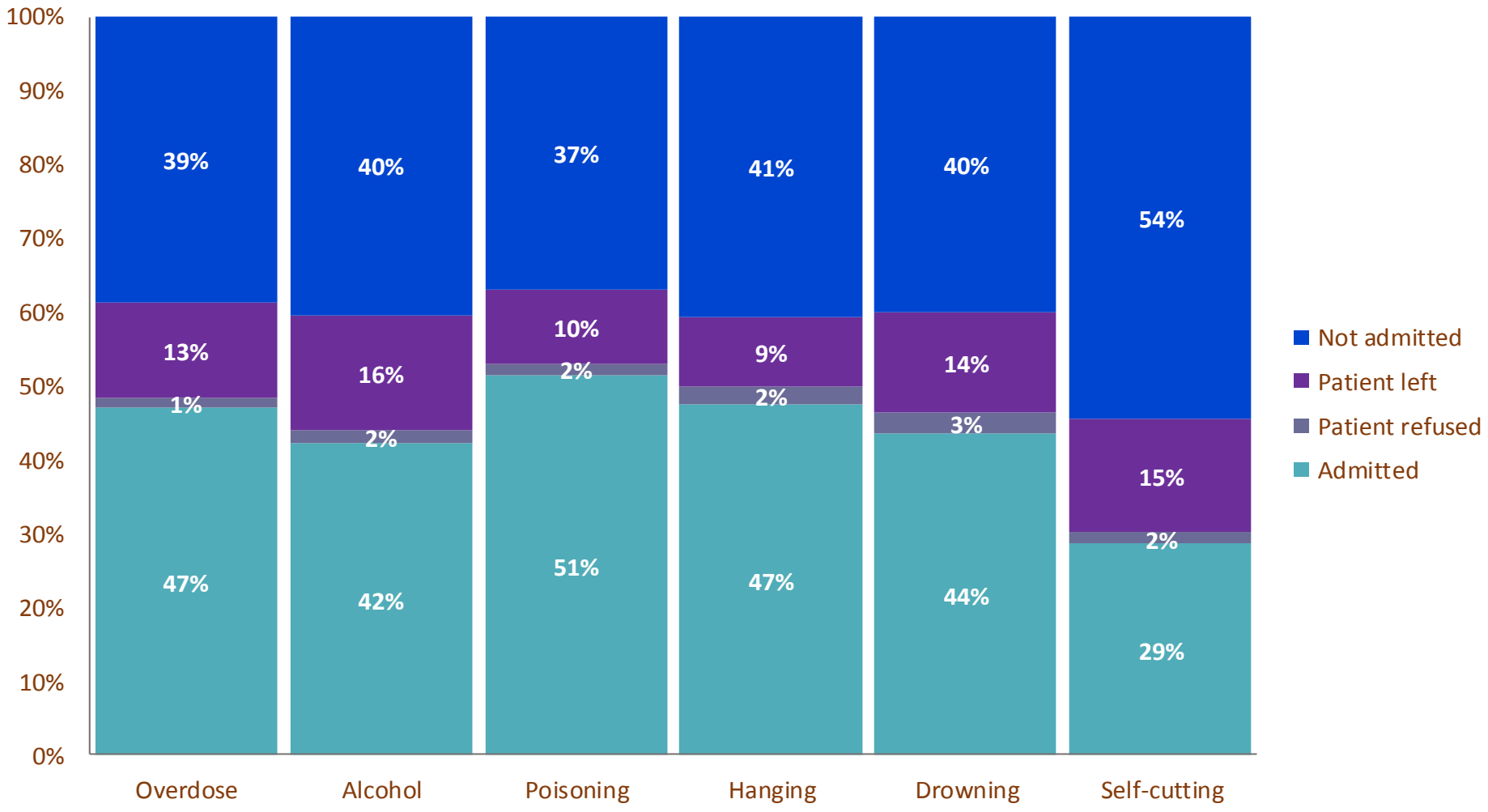
Ireland's National Strategy to Reduce Suicide, 2015-2020

Example of strategic goal and evidence informed action:

4. To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour

Action 4.1.4. Deliver a uniform assessment approach across the health services, in accordance with existing and recognised guidelines for people who have self-harmed or are at risk of suicide

Variation in recommended aftercare following hospital ED presentation due to self-harm by method of self-harm



Strategic Goal 7: To improve surveillance, evaluation and high quality research relating to suicidal behaviour

7. To improve surveillance, evaluation and high quality research relating to suicidal behaviour			
Objective	**Action**	**Lead**	**Key Partners**
7.1 Evaluate the effectiveness and cost-effectiveness of *Connecting for Life*.	7.1.1 Conduct proportionate evaluations of all major activities conducted under the aegis of *Connecting for Life*; disseminate findings and share lessons learned with programme practitioners and partners.	NOSP	
7.2 Improve access to timely and high quality data on suicide and self-harm.	7.2.1 Develop capacity for observation and information gathering on those at risk of or vulnerable to suicide and self-harm. This includes children/young people in the child welfare/protection sector and places of detention, including prisons.	DJE DCYA/ TUSLA	IPS, Coroners' Offices (in the context of the recording of deaths), CSO, NSRF
	7.2.2 Collate and report on incidences of suicide through current and expanded health surveillance systems over the life of *Connecting for Life*.	HSE MH	
	7.2.3 Collect, analyse and disseminate high quality data on suicide and self-harm and ensure adequate access to and understanding of the data among those working in suicide prevention across all sectors.	NOSP	DOH, NSRF DJE/IPS, DCYA/ TUSLA
7.3 Review (and, if necessary, revise) current recording procedures for death by suicide.	7.3.1 The Justice and Health sectors will engage with the Coroners, Garda Síochána, NOSP, CSO and research bodies in relation to deaths in custody, and recording of deaths by suicide and open verdicts, to further refine the basis of suicide statistics.	DJE	DOH, NOSP, Coroners' Offices, Garda Síochána, CSO, Research Bodies

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Connecting for Life

Ireland's National Strategy to Reduce Suicide 2015-2020

Innovative aspects of *Connecting for Life*

- Whole-of-Government engagement, cross-sectoral collaboration and multi-agency approach to suicide prevention

- A focus on formal accountability, adequate response, and openness for change in line with emerging evidence-based initiatives
- Evaluation and high-quality research with regard to suicidal behaviour by tracking the progress of the strategy implementation against set indicators over the next five years
- Outcomes framework including primary, secondary and intermediate outcomes

Connecting for Life

Ireland's National Strategy to Reduce Suicide 2015-2020

Implementation, Monitoring and Evaluation

CABINET COMMITTEE ON SOCIAL POLICY AND PUBLIC SERVICE REFORM
(SUICIDE PREVENTION AS A REGULAR AGENDA ITEM)
PROVIDING HIGH LEVEL POLITICAL LEADERSHIP

NATIONAL CROSS SECTORAL STEERING AND IMPLEMENTATION GROUP

DRIVING POLICY, IMPLEMENTATION AND CHANGE

NATIONAL OFFICE FOR SUICIDE PREVENTION

PROVIDING CROSS SECTORAL SUPPORT FOR IMPLEMENTATION

LOCAL CROSS SECTORAL IMPLEMENTATION STRUCTURES FOR SUICIDE PREVENTION

RESPONSIBILITY: HSE National Mental Health Division through Community Health Organisation structures

PLANNING: Local Area Suicide Prevention Plans, linked to the Local Economic and Community Plans

SUPPORT: HSE Resource Officers for Suicide Prevention

INDIVIDUAL AGENCY IMPLEMENTATION SYSTEMS:

INCLUDING CO-ORDINATED HSE SYSTEM

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Specific aspects of evaluating a national suicide prevention programme

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

Evaluation of National Suicide Prevention Programmes - Challenges

Primary outcomes:

- Identify effects on the incidence of suicide and suicide attempts/self-harm at national level
- Issues related to accuracy and timeliness of suicide mortality data

Intermediate outcomes:

- Changes in intermediate outcomes, e.g. knowledge, attitudes, help-seeking behaviour, not consistently associated with changes in primary outcomes
- Assessing the impact of confounding factors

Zalsman et al, 2016

Evaluation of the quality of the implementation/ process evaluation

- Follow steps of a logic model via assessment of resources, actions, outputs and outcomes

- Process evaluation measures

- Assessment of the actual implementation of a programme (whether and how well services are delivered as intended or planned),

Including:

- Tracking participation or attendance (exposure and intensity)
- Participant satisfaction
- Programme fidelity, i.e. implementation adherence to original design
- Assessing capacity and resources required to implement tasks

Intermediate and long-term outcome measures

- Increased awareness of suicide signs and symptoms
- Improved identification of those at risk
- Improved access to care
- Improved provision of capacity and quality mental health care
- Reduction in access to lethal suicide methods
- Reduction in suicidal ideation and behaviour
- Reduction in completed suicide

How IASP can facilitate the development and implementation of national suicide prevention programmes

- Disseminating information and exchange of information and expertise via IASP National Representatives
- Sharing of best practice and evidence based intervention and prevention programmes via IASP 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
- Advisory role and close collaboration with WHO

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Work in subgroups

1. In your opinion, what is the best example of implementation in suicide prevention in your context/country - no matter how small or comprehensive?
    - How was it achieved? What were key ingredients of success?
    - Was this evaluated? If yes, what were the outcomes?
    - What challenges were faced and were you able to overcome some of these?

2. In your opinion, what do you think are the key factors which have pushed, strengthened, or scaled-up the implementation of suicide prevention in your context/country?

3. In your opinion, what are the barriers to the progress of comprehensive, coordinated and sustained implementation of suicide prevention in your context/country? What would it take to overcome these barriers?

Work in subgroups

4. Please describe an example of multisectoral collaboration for suicide prevention in your context/country? What contributed to establishing this multi-sectoral collaboration?

- What have been the barriers to multisectoral collaboration in your context/country?

Prof. Ella Arensman and Dr. Aiysha Malik

School of Public Health & National Suicide Research Foundation, University College Cork, Ireland
WHO Collaborating Centre on Surveillance and Research in Suicide Prevention
International Association for Suicide Prevention

Department of Mental Health and Substance Abuse
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