National Suicide Prevention Strategies: Progress and Challenges

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Department of Mental Health and Substance Abuse
World Health Organisation
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
Suicide prevention from a global perspective

Dr Aiysha Malik
Department of Mental Health and Substance Abuse

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: Suicide mortality rate

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: Rates of suicide in countries will be reduced by 10% by year 2020
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.
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)
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.
Launched in September 2014

Preventing suicide
A global imperative

IASP
Research Foundation

World Health Organization

UCC
Figure 1. The public health model

1. Surveillance
   - What is the problem?
   - Define the problem of suicidal behaviour through systematic data collection

2. Identify risk & protective factors
   - What are the causes & what can buffer their impact?
   - Conduct research to find out why suicidal behaviour occurs and who it affects

3. Develop & evaluate interventions
   - What works & for whom?
   - Design, implement and evaluate interventions to see what works

4. Implementation
   - Scaling up effective policies & programmes
   - Scale up effective and promising interventions and evaluate their impact and effectiveness
Evidence-based interventions

- 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
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.

### A multisectoral approach

<table>
<thead>
<tr>
<th>HEALTH SYSTEMS</th>
<th>Barriers to accessing health care</th>
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<tbody>
<tr>
<td>SOCIETY</td>
<td>Access to means</td>
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<td></td>
<td>Inappropriate media reporting</td>
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<td>Stigma associated with help-seeking behaviour</td>
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<tr>
<td>COMMUNITY</td>
<td>Disaster, war and conflict</td>
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<td>Stress of acculturation and dislocation</td>
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<td>Discrimination</td>
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<td>Trauma or abuse</td>
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<tr>
<td>RELATIONSHIPS</td>
<td>Sense of isolation and lack of social support</td>
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<td></td>
<td>Relationship conflict, discord or loss</td>
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<tr>
<td>INDIVIDUAL</td>
<td>Previous suicide attempt</td>
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<td></td>
<td>Mental disorders</td>
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<td>Harmful use of alcohol</td>
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<td>Job or financial loss</td>
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<td>Hopelessness</td>
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<td>Chronic pain</td>
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<td>Family history of suicide</td>
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<td>Genetic and biological factors</td>
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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.
The time to act is now....

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

<table>
<thead>
<tr>
<th>Areas of strategic action</th>
<th>Lead stakeholders</th>
<th>No activity (currently there is no suicide prevention response at national or local level)</th>
<th>Some activity (some work has begun in suicide prevention in priority areas at either national or local level)</th>
<th>Established suicide prevention strategy exists at national level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage key stakeholders</td>
<td>Ministry of Health as lead, or other coordinating health body</td>
<td>Initiate identification of and engagement with key stakeholders on country priorities, or where activities already exist.</td>
<td>Identify all key stakeholders across sectors and engage them comprehensively in suicide prevention activities. Assign responsibilities.</td>
<td>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.</td>
</tr>
<tr>
<td>Reduce access to means</td>
<td>Legal and judicial system, policy-makers, agriculture, transportation</td>
<td>Begin efforts to reduce access to means of suicide through community interventions.</td>
<td>Coordinate and expand existing efforts to reduce access to the means of suicide (including laws, policies and practices at national level).</td>
<td>Evaluate efforts to reduce access to the means of suicide. Use the evaluation results to make improvements.</td>
</tr>
<tr>
<td>Conduct surveillance and improve data quality</td>
<td>Ministry of Health, Bureau of Statistics, all other stakeholders, and particularly the formal and informal health systems to collect data</td>
<td>Begin surveillance, prioritizing mortality data, with core information on age, sex and methods of suicide. Begin identification of representative locations for development of models.</td>
<td>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.</td>
<td>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.</td>
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<tr>
<td>Raise awareness</td>
<td>All sectors, with leadership from the</td>
<td>Organize activities to raise awareness that</td>
<td>Develop strategic public awareness campaigns</td>
<td>Evaluate the effectiveness of public</td>
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World Health Organization
Examples of national suicide prevention strategies
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
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

IAASP
National Suicide Research Foundation
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World Health Organization
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
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
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
Technical tools and resources for implementation

Communities and social, professional groups

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

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<tr>
<td>1)</td>
<td>Surveillance</td>
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<td>2)</td>
<td>Means Restriction</td>
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<td>3)</td>
<td>Media</td>
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<td>4)</td>
<td>Access to Services</td>
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<td>5)</td>
<td>Training and Education</td>
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<td>6)</td>
<td>Treatment</td>
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<td>7)</td>
<td>Crisis Intervention</td>
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<td>8)</td>
<td>Postvention</td>
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<td>9)</td>
<td>Awareness</td>
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<td>10)</td>
<td>Stigma Reduction</td>
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<td>11)</td>
<td>Oversight and Coordination</td>
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Strategic actions and targeted suicide prevention activities that may reinforce the development of a national strategy

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’ (Zalsman et al, 2016)
  - 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’ (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.
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
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)


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.
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.
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)
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 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
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
  
  \textit{(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
  
  \textit{(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
  
  \textit{(Mann et al, 2005; Hegerl et al, 2011; Zalsman 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
  - No Training for MHPs
  - Training for MHPs
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.
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

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)

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

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 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
National Suicide Prevention Strategies: Progress and challenges
Suicide viewed by government as significant public health problem

- Yes: 31%
- Under development: 14%
- No: 55%

Has the national strategy been fully or partially implemented?

- Fully: 25%
- Partially: 21%
- No response: 54%
Country examples of 1\textsuperscript{st} or 2\textsuperscript{nd} national suicide prevention strategy

First strategy:
- Bhutan
- Guyana
- Iran
- Republic of Korea
- Switzerland
- Namibia (2\textsuperscript{nd} 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**

![Guyana National Suicide Prevention Plan](image)

**Afghanistan**

![Afghanistan National Suicide Prevention Plan](image)
Example
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;
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*
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
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**

![Graph showing seasonal patterns of self-harm]

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

![Graph showing seasonal patterns of self-harm]
Connecting for Life
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

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<tr>
<th>Objective</th>
<th>Action</th>
<th>Lead</th>
<th>Key Partners</th>
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<tr>
<td>7.1 Evaluate the effectiveness and cost-effectiveness of Connecting for Life.</td>
<td>Conduct proportionate evaluations of all major activities conducted under the aegis of <em>Connecting for Life</em>; disseminate findings and share lessons learned with programme practitioners and partners.</td>
<td>NOSP</td>
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<td>7.2 Improve access to timely and high quality data on suicide and self-harm.</td>
<td>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.</td>
<td>DJE/DCYA/TUSLA</td>
<td>IPS, Coroners’ Offices (in the context of the recording of deaths), CSO, NSRF</td>
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<td>Collate and report on incidences of suicide through current and expanded health surveillance systems over the life of <em>Connecting for Life</em>.</td>
<td>HSE/MH</td>
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<td></td>
<td>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.</td>
<td>NOSP/DOH/NSRF</td>
<td>DJE/IPS, DCYA/TUSLA</td>
</tr>
<tr>
<td>7.3 Review (and, if necessary, revise) current recording procedures for death by suicide.</td>
<td>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.</td>
<td>DJE</td>
<td>DOH, NOSP, Coroners’ Offices, Garda Síochána, CSO, Research Bodies</td>
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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
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

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

NATIONAL OFFICE FOR SUICIDE PREVENTION

PROVIDING CROSS SECTORAL SUPPORT FOR IMPLEMENTATION

INDIVIDUAL AGENCY IMPLEMENTATION SYSTEMS:
INCLUDING CO-ORDINATED HSE SYSTEM
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
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 multisectoral collaboration?

- What have been the barriers to multisectoral collaboration in your context/country?
Prof. Ella Arensman and Dr. Aiysha Malik

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Department of Mental Health and Substance Abuse
World Health Organisation