Examples of countries where the development and implementation of national suicide prevention programmes recently has been initiated

International Symposium on Psychological Prevention

21st-24th July 2019

Vitoria-Gasteiz

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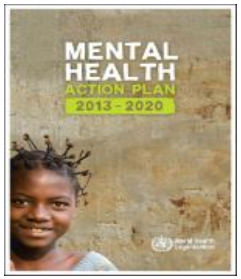
School of Public Health & National Suicide Research Foundation,
WHO Collaborating Centre on Surveillance and Research in Suicide Prevention
University College Cork, Ireland
International Association for Suicide Prevention
Visiting Professor, Australian Institute for Suicide Prevention

Context

- 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

SUSTAINABLE DEVELOPMENT GOALS

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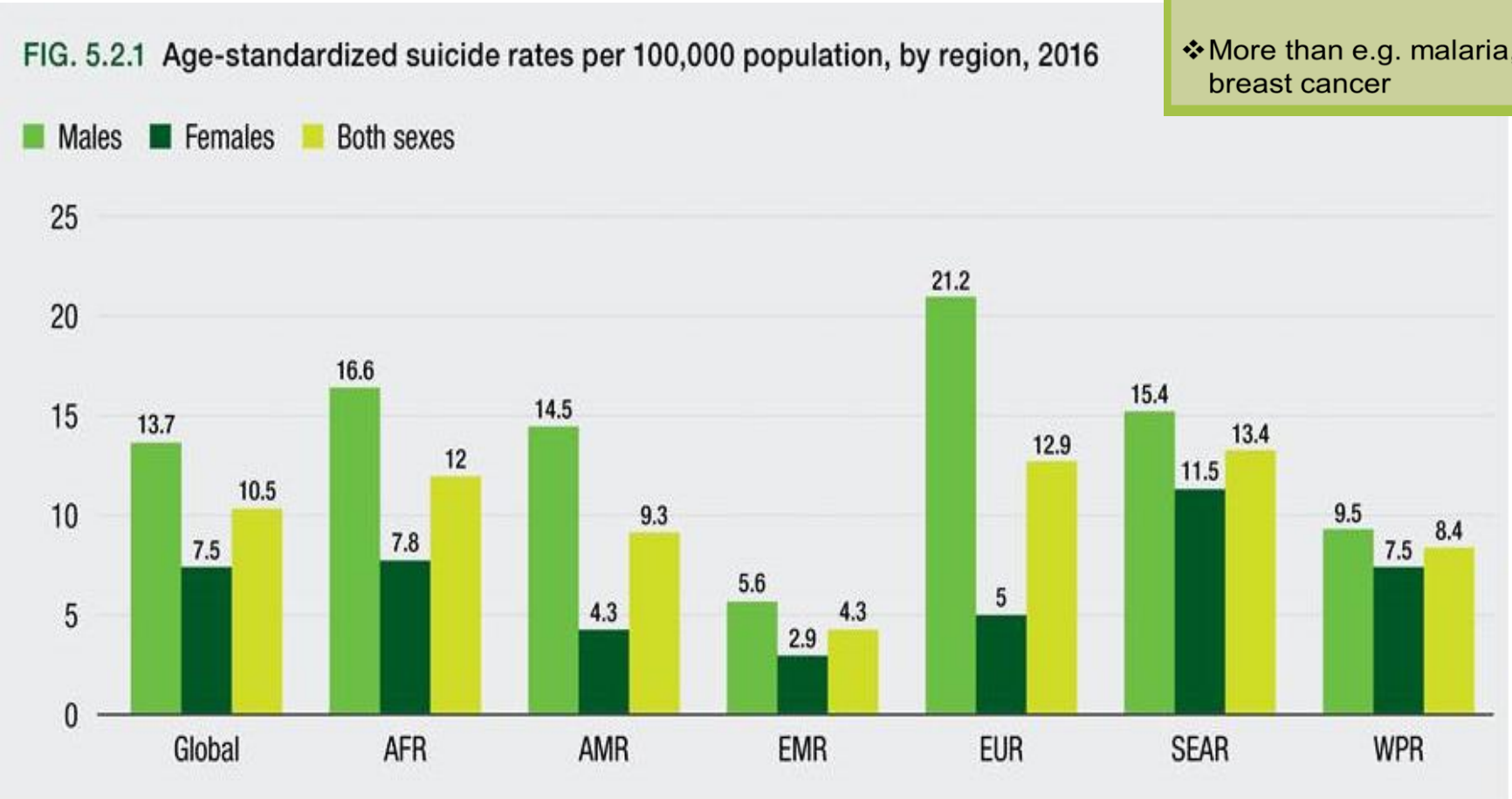
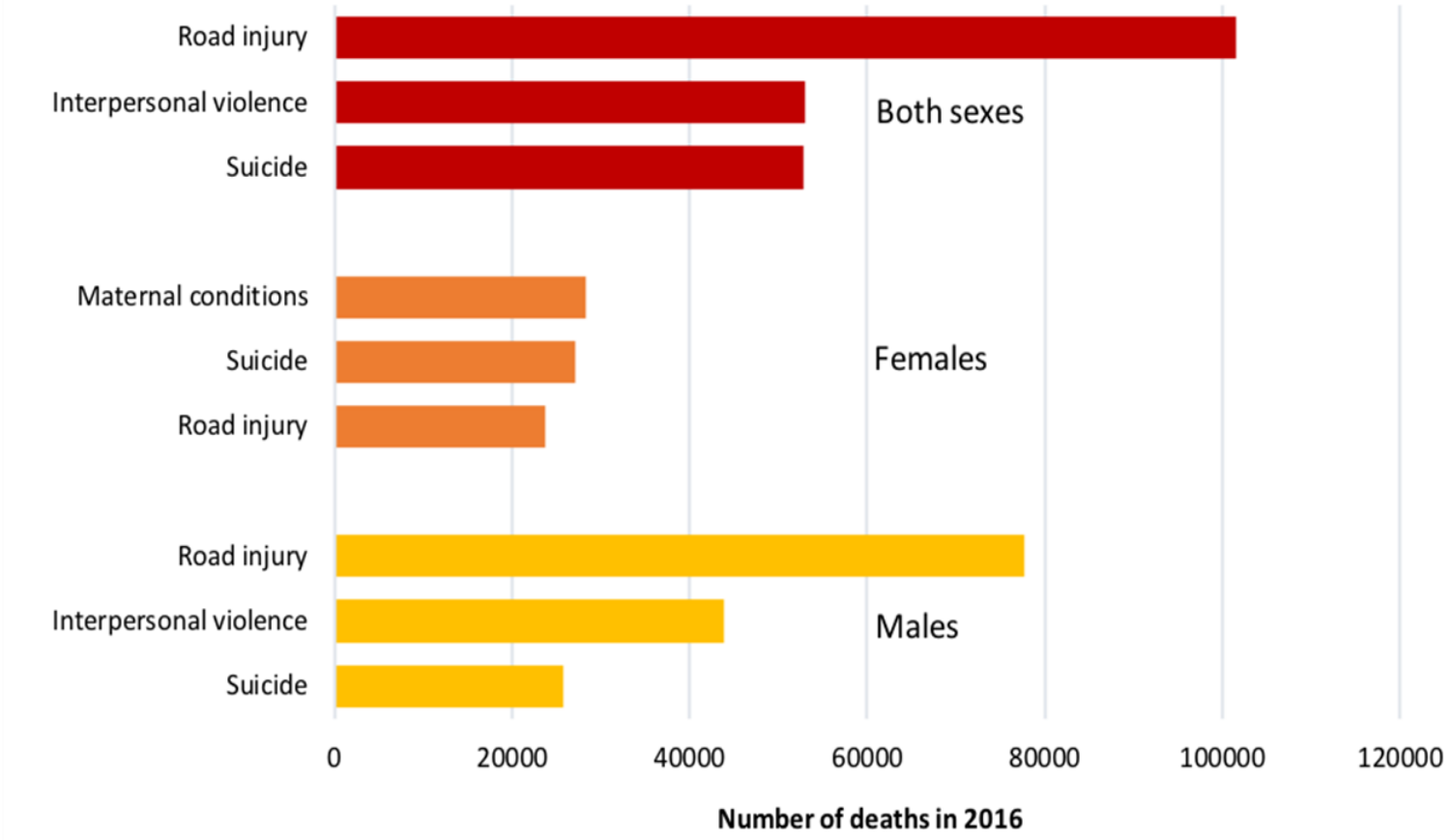
Suicide rates by WHO region

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



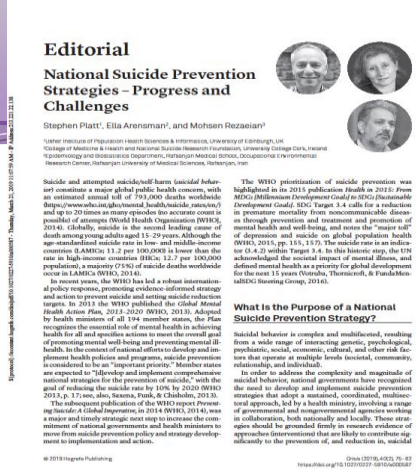
Mental Health Atlas, 2017

Leading causes of death, age group 15-19 years



Mental Health Atlas, 2017

Challenges in developing and implementing national suicide prevention programmes



Editorial

National Suicide Prevention Strategies – Progress and Challenges

Stephen Platt[1], Ella Arensman[2], and Mohsen Rezaeian[3]

[1]Usher Institute of Population Health Sciences & Informatics, University of Edinburgh, UK
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[3]Epidemiology and Biostatistics Department, Isfahan University of Medical Sciences, Isfahan, Iran

Suicide and attempted suicide/self-harm (*suicidal behaviour*) constitute a major global public health concern, with an estimated annual toll of 793,000 deaths worldwide (https://www.who.int/gho/mental_health/suicide_rates/en/) and up to 20 times as many episodes (no accurate count is possible) of attempts (World Health Organization [WHO], 2014). Globally, suicide is the second leading cause of death among young adults aged 15–29 years. Although the age-standardized suicide rate in low- and middle-income countries (LAMICs; 11.2 per 100,000) is lower than the rate in high-income countries (HICs; 12.7 per 100,000 population), a majority (75%) of suicide deaths worldwide occur in LAMICs (WHO, 2014).

In recent years, the WHO has led a robust international policy response, promoting evidence-informed strategy and action to prevent suicide and setting suicide reduction targets. In 2013 the WHO published the *Global Mental Health Action Plan, 2013–2020* (WHO, 2013). Adopted by health ministers of all 194 member states, the Plan recognizes the essential role of mental health in achieving health for all and specifies actions to meet the overall goal of promoting mental well-being and preventing mental ill-health. In the context of national efforts to develop and implement health policies and programs, suicide prevention is considered to be an "important priority." Member states are expected to "[d]evelop and implement comprehensive national strategies for the prevention of suicide," with the goal of reducing the suicide rate by 10% by 2020 (WHO 2013, p. 17; see, also, Saxena, Funk, & Chisholm, 2013).

The subsequent publication of the WHO report *Preventing Suicide: A Global Imperative*, in 2014 (WHO, 2014), was a major and timely strategic next step to increase the commitment of national governments and health ministers to move from suicide prevention policy and strategy development to implementation and action.

The WHO prioritization of suicide prevention was highlighted in its 2015 publication *Health in 2015: From MDGs [Millennium Development Goals] to SDGs [Sustainable Development Goals]*. SDG Target 3.4 calls for a reduction in premature mortality from noncommunicable diseases through prevention and treatment and promotion of mental health and well-being, and notes the "major toll" of depression and suicide on global population health (WHO, 2015, pp. 155, 157). The suicide rate is an indicator (3.4.2) within Target 3.4. In this historic step, the UN acknowledged the societal impact of mental illness, and defined mental health as a priority for global development for the next 15 years (Votruba, Thornicroft, & FundaBeltalSDG Steering Group, 2016).

What is the Purpose of a National Suicide Prevention Strategy?

Suicidal behavior is complex and multifaceted, resulting from a wide range of interacting genetic, psychological, psychiatric, social, economic, cultural, and other risk factors that operate at multiple levels (societal, community, relationship, and individual).

In order to address the complexity and magnitude of suicidal behavior, national governments have recognized the need to develop and implement suicide prevention strategies that adopt a sustained, coordinated, multisectoral approach, led by a health ministry, involving a range of governmental and nongovernmental agencies working in collaboration, both nationally and locally. These strategies should be grounded firmly in research evidence of approaches (interventions) that are likely to contribute significantly to the prevention of, and reduction in, suicidal

Crisis (2019), 40(2), 75–82
https://doi.org/10.1027/0227-5910/a000587

- 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

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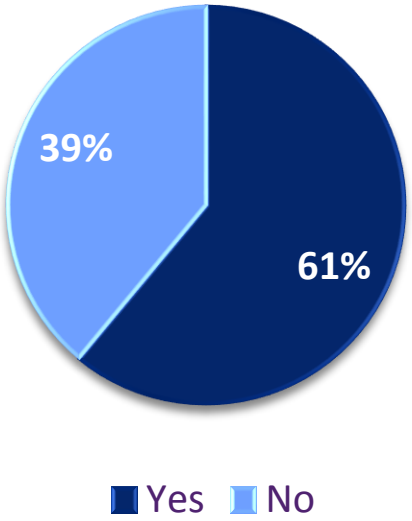
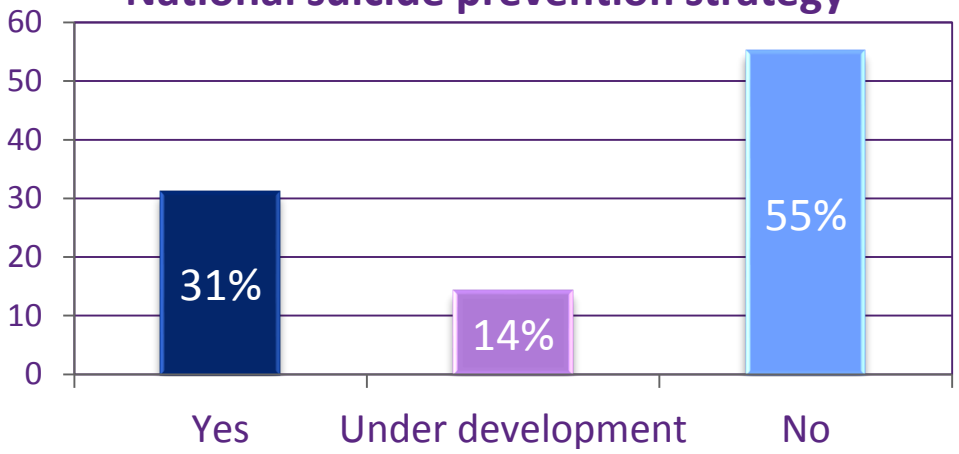
Outcomes IASP-WHO Global Survey on Suicide Prevention

(N countries: 157, response rate: 57%)

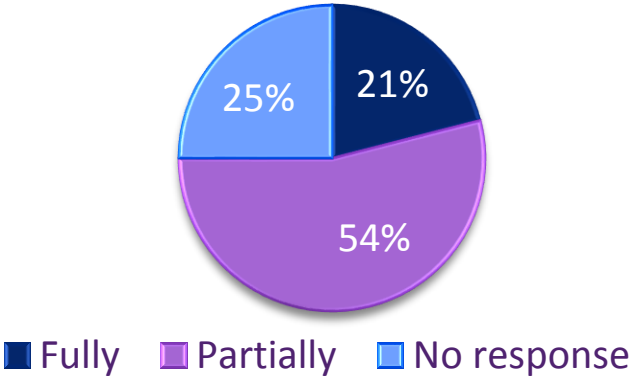
Suicide viewed by government as significant public health problem



National suicide prevention strategy



Has the national strategy been fully or partially implemented?



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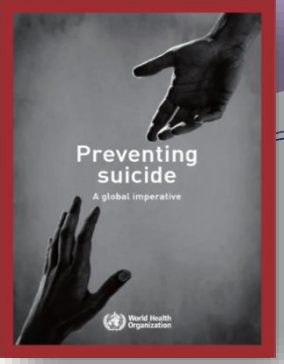
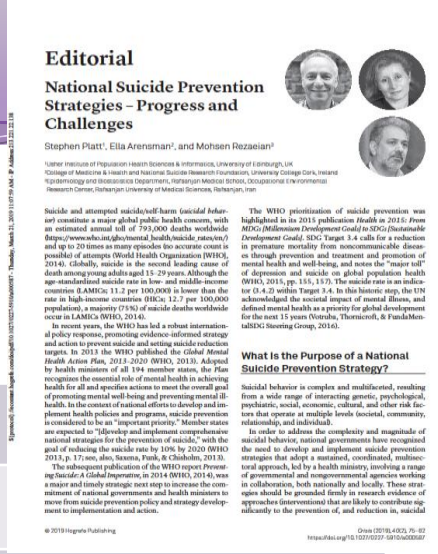


Core components of national suicide prevention strategies



Editorial

National Suicide Prevention Strategies – Progress and Challenges

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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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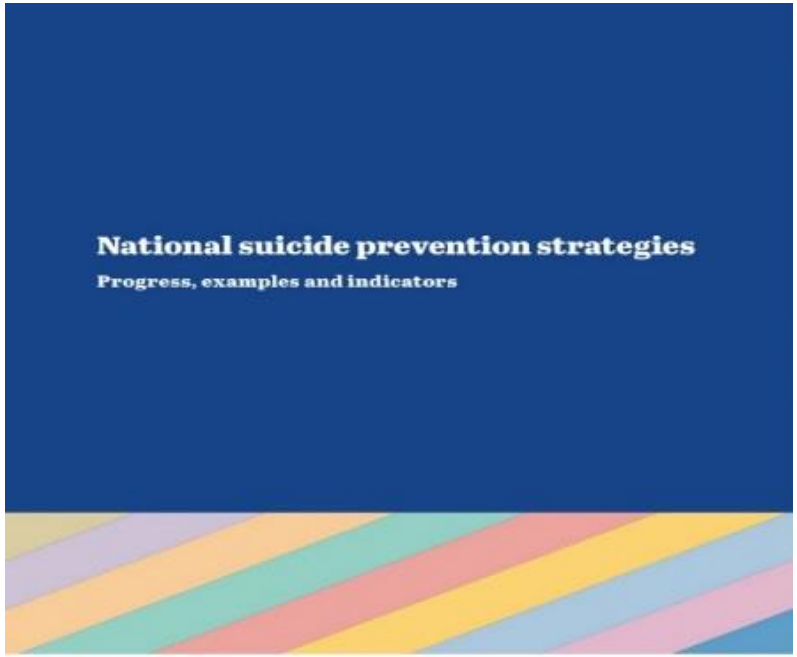
Country examples of 1st or 2nd national suicide prevention strategy (2014-2018)

First strategy:

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

Second strategy:

- England
- Ireland
- Sweden
- Japan
- USA



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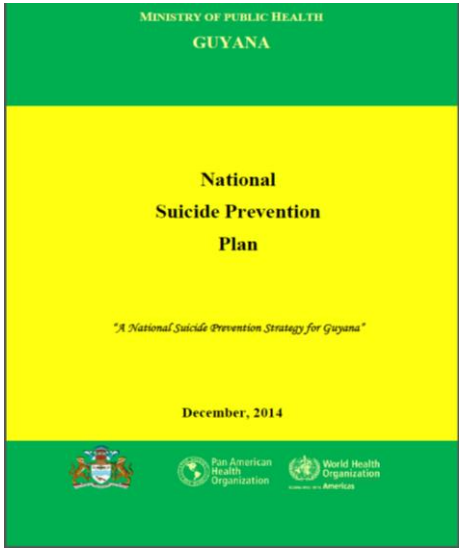
Countries with recently completed/initiated national suicide prevention programmes despite many challenges

Guyana



Afghanistan

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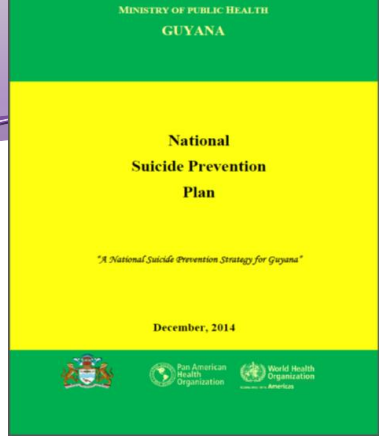
Guyana

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;

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.

Example of country with 2nd National Suicide Prevention Strategy - Ireland

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

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

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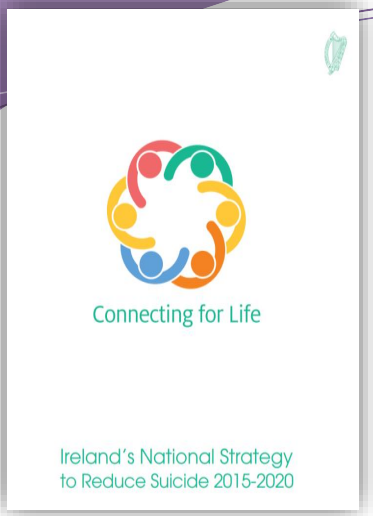

Strategic Goal 7: To improve surveillance, evaluation and high quality research relating to suicidal behaviour

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

- Five year implementation plans at regional level
- 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

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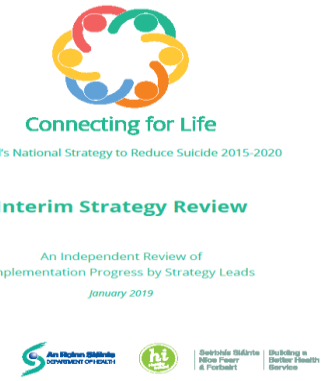
Connecting for Life Interim Strategy Review 2015-2018



- To provide an assessment of implementation advancements across all *Connecting for Life a*ctions, objectives and goals
- To identify what is working well and where barriers lie
- To help set strategic priorities for 2019 and 2020
- To identify longer-term strategic goals for *Connecting for Life*, beyond 2020

➢ For most of the actions relating to the strategic goals, moderate to good progress was determined.

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Developing a national suicide prevention programme in Spain

2014

Rev Psiquiatr Salud Ment (Barc.). 2014;7(1):1–4

Revista de Psiquiatría y Salud Mental

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EDITORIAL

Suicide prevention in Spain: An uncovered clinical need☆

Prevención del suicidio en España: una necesidad clínica no resuelta

Pilar A. Sáiz*, Julio Bobes

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Suicide constitutes one of the most important problems in global public health.[1] That is why several studies have been published in the last 2 years among other considerations, in which a possible association is established between different economic crisis indicators and the varying suicide rates from countries of very different latitudes.[2–5] There have been mixed results. The most consistent data supporting such an association came from developed countries in the Anglo-Saxon world.[6,7] In contrast, in Spain the data were discrepant. There are studies that postulated an association between economic crisis and an increase in the number of suicides[4,5] and others that contradicted this affirmation.[8] The reasons for such discrepancies are not clear. Some authors suggest that socio-cultural aspects could explain the apparent resilience to the crisis seen in our population,[8] while others mention the different crisis indicators in the studies[2] or the different statistical approaches used as the possible cause of these discrepancies. The analysis performed by our group, using the annual unemployment rate as our crisis indicator, showed no association between this indicator and the number of suicides. However, when annual variation in the unemployment rate (which could be a more specific indicator of the number of people who lost their job during a certain period) was compared with annual variation in the suicide rate, an association was indeed found. It was estimated that each 10% annual increase in unemployment was associated with a 1.25% increase in the number of suicides during the period before the crisis (1998–2007). The increase was similar (1.22%) after the start of the crisis (2008–2012).

Independent of the information previously mentioned, it should be emphasised that in Spain, the data provided by the National Statistical Institute (*INE* in Spanish) have placed suicide as the primary unnatural cause of death since 2008, overtaking death by traffic accident. This situation has remained unchanged through 2012, when the latest official data were released.[9] Furthermore, the discrepancy existing between data provided by the INE and the Legal Medicine Institute made us consider that there is a clear tendency to underreport the number of suicide deaths in Spain.[10]

The transcendence of the afore-mentioned information contrasts with some aspects to be highlighted in this editorial. First of all, the scientific community and professional circles in our country are sensitive to the problem, as demonstrated by the growing number of publications on "suicide" and "suicidal behaviour" in relevant journals in which Spanish authors contributed substantially. There was also the recent publication of preventative recommendations promoted by the Spanish Society of Psychiatry (*SEP* in Spanish) and Spanish Society of Biological Psychiatry (*SEPB*),[11] as well as the "Clinical Practice Guidelines for Prevention and Treatment of Suicidal Behaviour," sponsored by the Ministry of Health, Social Policy and Equality and the Galician Health Technology Assessment Agency.[12] However, this sensitivity does not seem to have penetrated other levels, with examples of these below.

☆ Please cite this article as: Sáiz PA, Bobes J. Prevención del Suicidio en España: una necesidad clínica no resuelta. Rev Psiquiatr Salud Ment (Barc.). 2014;7:1–4.

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Suicide prevention: towards an evidence-based policy

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Suicide prevention and adequate management of those with suicidal behaviour should be one of the major drivers in designing clinical services and guiding mental health policy decisions at all levels. In order for these decisions and this guidance to be effective, they need to be based on relevant and robust evidence covering both the magnitude of the problem at the local level where the decisions aim to have an impact, and on the effect that potential interventions may have on suicide and suicidal behaviour at the clinical and the population level. This issue of *Epidemiology and Psychiatric Sciences* includes two valuable contributions to the theoretical framework that needs to be used for an evidence-based policy on this area.

The contribution of Blasco-Fontecilla and collaborators (Blasco-Fontecilla *et al.*, 2018) presents and argues the advantages and potential applicability of an indicator based on attempted suicides at the population level. The most widely used indicator for monitoring suicide at the national level is the annual age-standardised suicide rate per 100 000. It is employed to rank suicide mortality within countries by causes of death but also for cross-country comparisons, to identify trends over the years and to establish global, regional and/or national targets (WHO, 2014; NCD Countdown, 2030 collaborators, 2018). However, the global mortality figures provide limited information for planning, selecting, and evaluating targeted preventive interventions, particularly at the regional and local levels. For a proper analysis of the problem we need incorporate indicators related to risk factors that could be the specific target of interventions, and that could be sensible to change as a consequence of those interventions. Attempted suicide (AS) is the most relevant risk factor for completed suicide, and it is widely used as an outcome in longitudinal studies that focused on suicidal behaviour on both clinical and population samples (Hegerl *et al.*, 2009; Arana *et al.*, 2010). Thus the relevance of the proposal of Blasco-Fontecilla and his colleagues of a ratio of ASs/completed suicides as an indicator to be used in guiding policy at the population level. They list three potential measures of AS to be included in the numerator: annual AS rates from population surveys, annual AS rates from clinical registries and lifetime AS from population surveys. Because of the lack of worldwide information for the first two choices, they select the third option and calculate the proposed ratio in several countries to illustrate its potential use. There are limitations on their approach that are appropriately discussed in their editorial. As previously recognised, the information about past history of suicidal attempts collected in epidemiological surveys is by its nature retrospective and self-reported, and is thus subject to recall bias, underreporting and denial (Miret *et al.*, 2014). In addition, it is not an adequate method for identifying trends in different age ranges or of properly evaluating preventive interventions. Their contribution highlights the need to advance towards a systematic collection, and reporting of information on the annual rate of suicidal attempts for refining our analysis capacity of suicidal behaviour at the population level for both monitoring and evaluation of interventions and policies.

As in other areas of medicine, the basis for the prevention of suicide is the identification of risk factors that are relevant to the context, and their alleviation by implementing appropriate interventions (WHO, 2014). However, suicidal behaviour is the result of a complex array of contributing factors that are in many circumstances interconnected, as illustrated in this issue of Epidemiology and Psychiatric Services by Hegerl and Heinz (Hegerl and Heinz, 2018). They critically discussed two different theoretical explanatory models concerning the causal relationships between psychosocial factors, depression and suicides. Ulrich Hegerl and his team have widely and successfully implemented suicide prevention programmes in several countries focusing on improving the care of people with depression (Székely *et al.*, 2013), and thus favour an explanatory model that attributes a strong casual role to depression and other psychiatric disorders in explaining suicidal behaviour. They confront their favoured model with an alternative one that assumes that social determinants and life adversities are the major causes of suicidal behaviour. Their arguments clearly reflect the daily experience of clinicians attending to patients with suicidal ideation and behaviour. However, it needs to be highlighted that the dramatic decline of global suicide mortality observed in the last few decades (NCD Countdown, 2030 collaborators, 2018) can only be explained if we consider big social changes affecting urbanisation, social stability, social freedom and policies that have an impact

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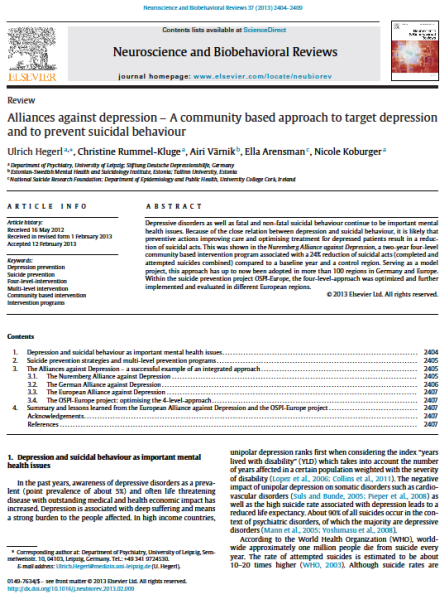
Multi-level suicide prevention programmes

European Alliance Against Depression:

Reduction in suicide and suicide attempts up to 31% in 3 years
(Hegerl et al, 2013)



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Review

Alliances against depression – A community based approach to target depression and to prevent suicidal behaviour

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ABSTRACT

Depressive disorders as well as fatal and non-fatal suicidal behaviour continue to be important mental health issues. Because of the close relation between depression and suicidal behaviour, it is likely that preventive actions improving care and optimising treatment for depressed patients result in a reduction of suicidal acts. This was shown in the Nuremberg Alliance against Depression, a two-year four-level community based intervention program associated with a 24% reduction of suicidal acts (completed and attempted suicides combined) compared to a baseline year and a control region. Serving as a model project, this approach has up to now been adopted in more than 100 regions in Germany and Europe. Within the suicide prevention project OSPI-Europe, the four-level-approach was optimized and further implemented and evaluated in different European regions.

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Contents

1. Depression and suicidal behaviour as important mental health issues

In the past years, awareness of depressive disorders as a prevalent (point prevalence of about 5%) and often life threatening disease with outstanding medical and health economic impact has increased. Depression is associated with deep suffering and means a strong burden to the people affected. In high income countries, unipolar depression ranks first when considering the index "years lived with disability" (YLD) which takes into account the number of years affected in a certain population weighted with the severity of disability (Lopez et al., 2006; Collins et al., 2011). The negative impact of unipolar depression on somatic disorders such as cardiovascular disorders (Sids and Bunde, 2005; Pieper et al., 2008) as well as the high suicide rate associated with depression leads to a reduced life expectancy. About 90% of all suicides occur in the context of psychiatric disorders, of which the majority are depressive disorders (Mann et al., 2005; Yoshimasu et al., 2008).

According to the World Health Organization (WHO), worldwide approximately one million people die from suicide every year. The rate of attempted suicides is estimated to be about 10–20 times higher (WHO, 2003). Although suicide rates are

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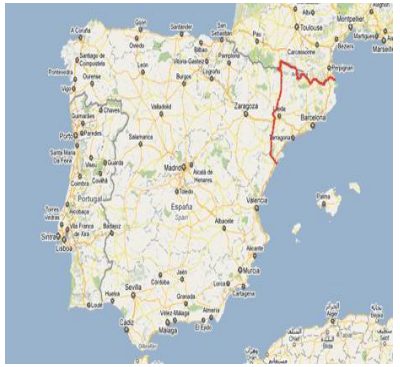

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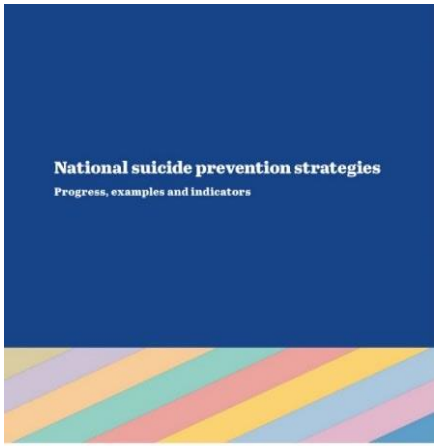
How IASP and WHO can facilitate the development and implementation of national suicide prevention programmes

- 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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World Suicide Prevention Day

Working Together to Prevent Suicide

September 10, 2019

International Association for Suicide Prevention

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BREAKING DOWN WALLS

BUILDING BRIDGES

17-21 September 2019

IV Congreso Nacional de Psicología

International Symposium on Psychological Prevention

Muchas Gracias!

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