Do National Suicide Prevention Strategies Work?

25th September 2025

Prof Ella Arensman
School of Public Health & National Suicide Research Foundation, University College Cork, Ireland & WHO Collaborating Centre on Surveillance and Research in Suicide Prevention

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HRB Health Research Board

Overview

- Policy context
- Recent trends in suicide and self-harm
- The Status of National Suicide Prevention Strategies at Global Level
- Impact of National Suicide Prevention Strategies
- Evaluation of National Suicide Prevention Strategies: Barriers and Facilitators
- Priorities for Suicide Prevention in Changing Environments

WHO Collaborating Centre for Surveillance and Research in Suicide Prevention

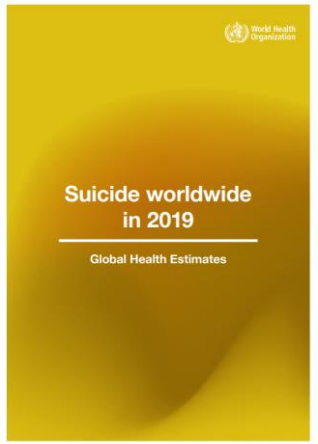
- Since December 2015, the National Suicide Research Foundation has been designated as a WHO Collaborating Centre for Surveillance and Research in Suicide Prevention.

Work plan:
Provide Technical Support for WHO member states in:

- ➢ Establishing and Maintaining Surveillance Systems for Medically Treated Suicide Attempts.
- ➢ Enhancing Screening and Registration of Suicide Mortality Cases.
- ➢ Indicators for the Evaluation of National Suicide Prevention Programmes E-Learning Programme for Establishing and Maintaining Surveillance Systems for Suicide Attempts and Self-Harm
- ➢ Mental health promotion and suicide prevention in the workplace.

Context

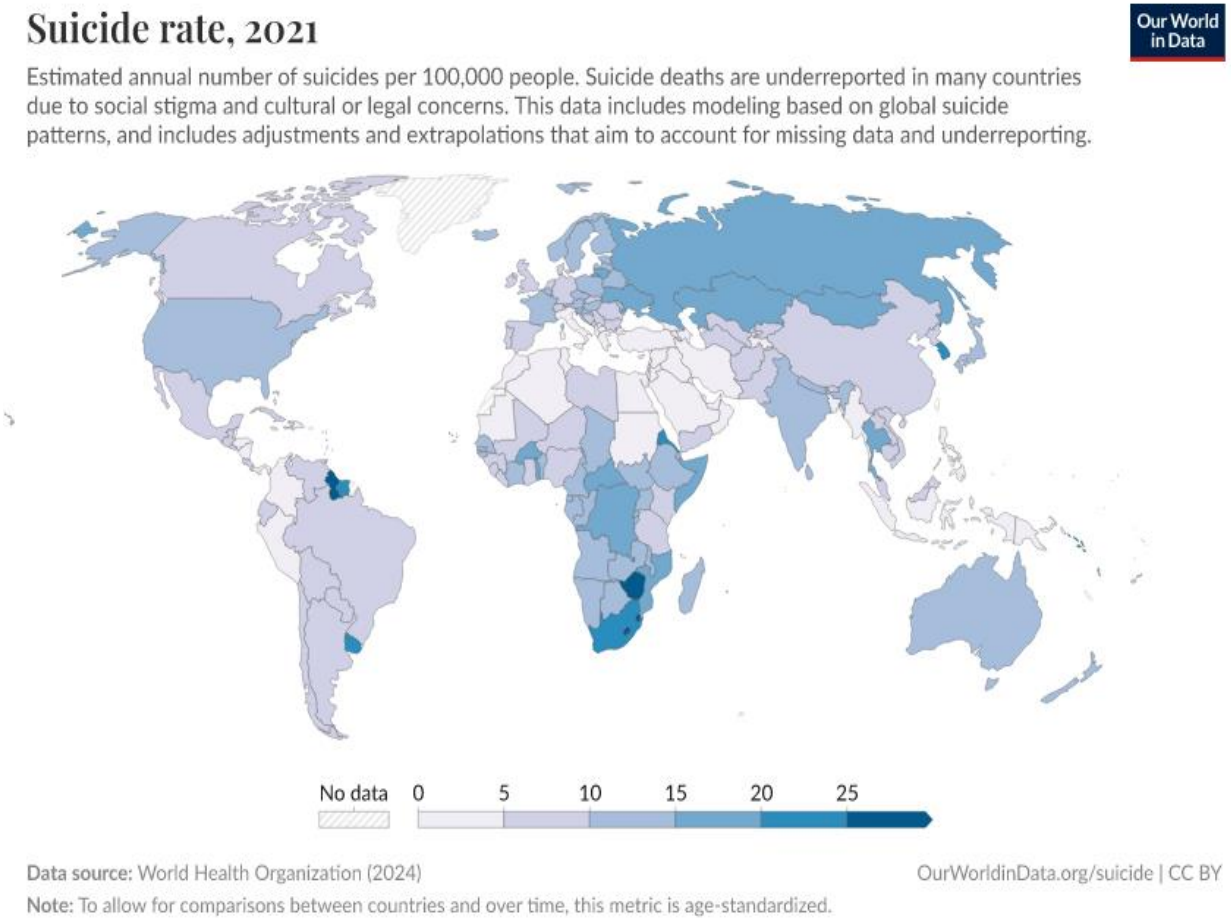
- WHO Global Report on Preventing Suicide (WHO, 2014)
- Suicide worldwide in 2019: global health estimates. World Health Organization. (WHO, 2021)
- UN Sustainable Development Goals: SDGs 2030, e.g. Target 3.4: By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
- LIVE LIFE: An implementation guide for suicide prevention in countries (WHO, 2021)

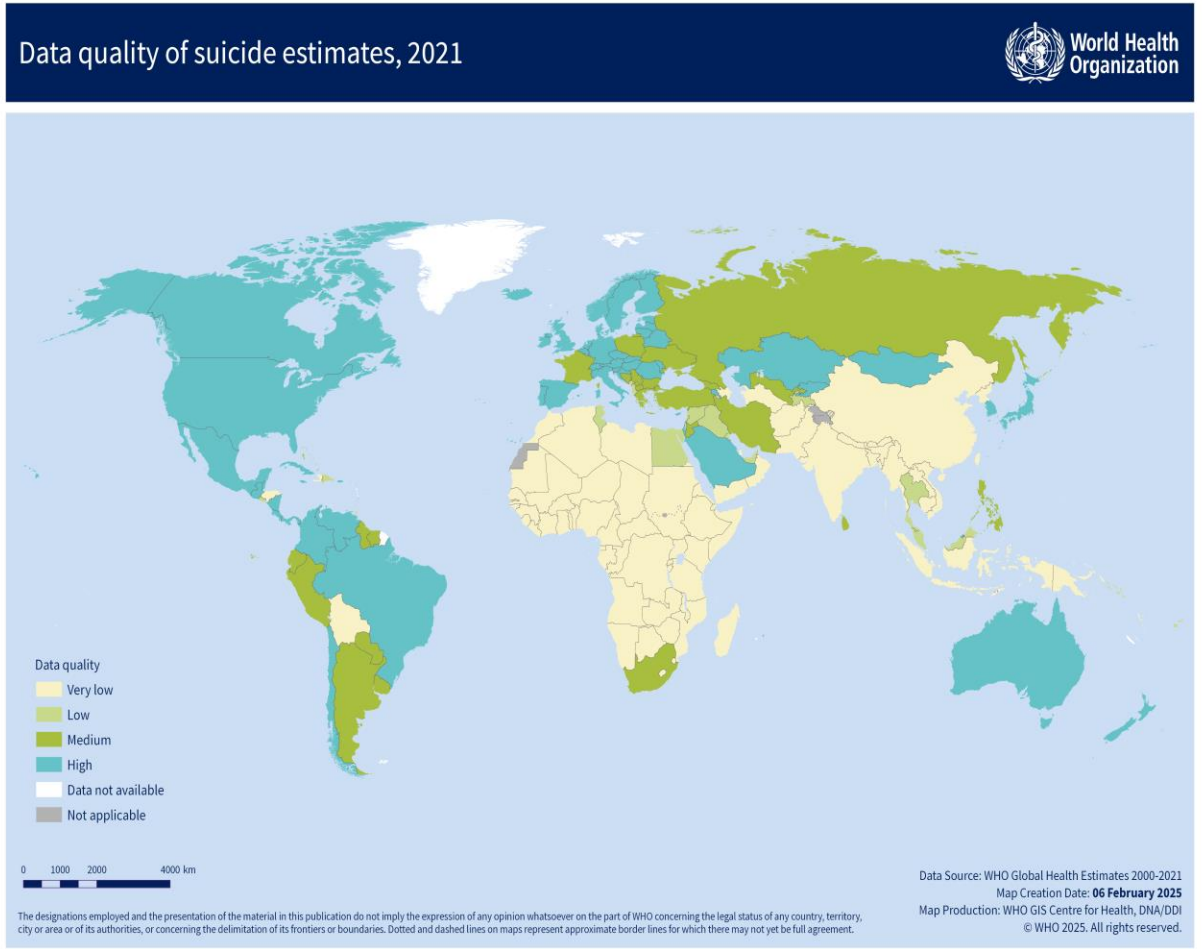


“Shifting the narrative on suicide, means driving systemic change, where governments prioritise and invest in quality mental health care and policies to ensure everyone gets the support they need.”

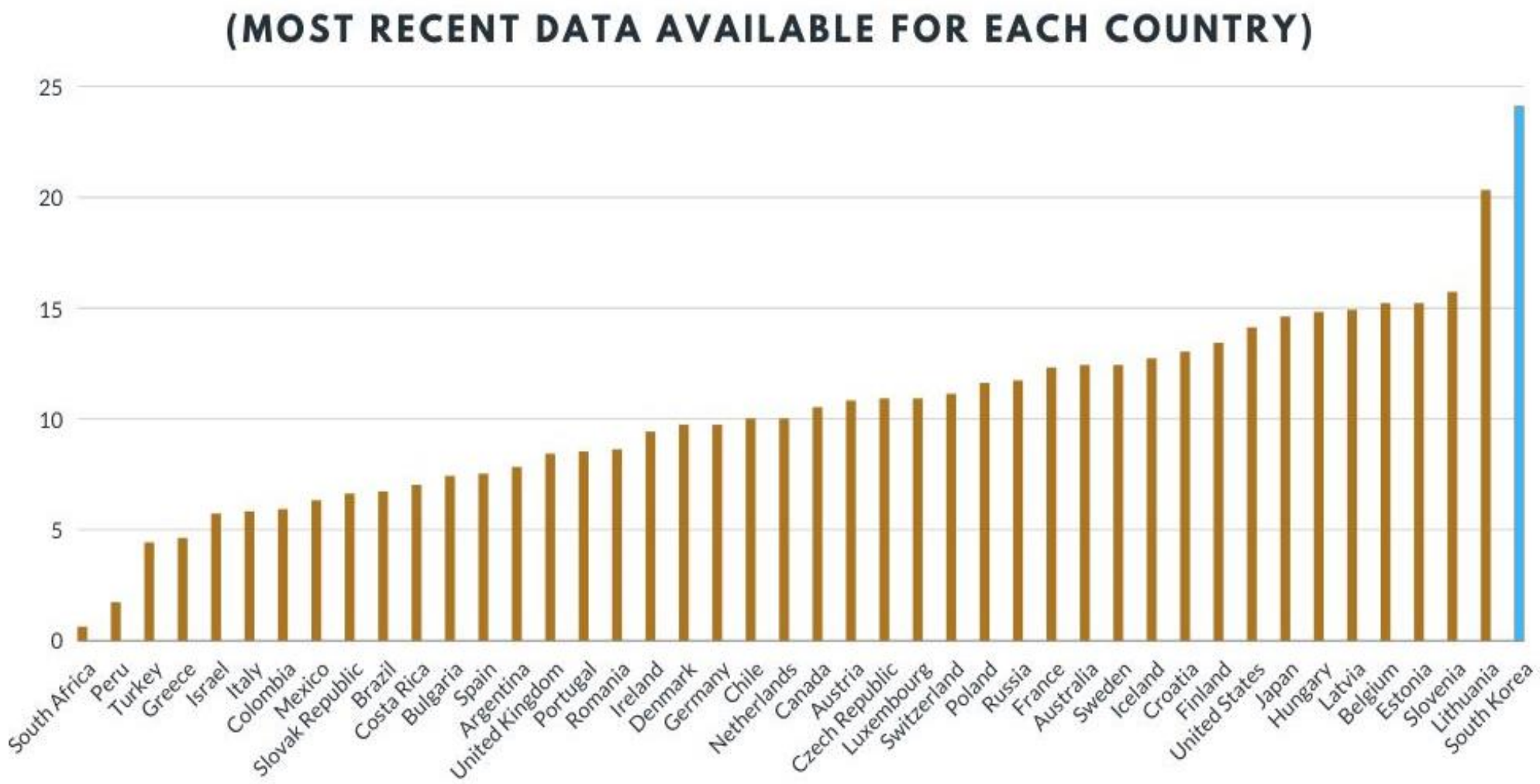
“Mental health issues are truly global. When it comes to mental health, all countries are developing countries. Lots to learn!”

Global status of suicide rates versus data quality of suicide estimates





Suicide in OECD Countries



Society at a Glance,

SOCIAL INDICATORS,

OECD 2024

Increasing trends of self-harm trends among children and adolescents internationally

Social Psychiatry and Psychiatric Epidemiology (2018) 53:663–671
https://doi.org/10.1007/s00127-018-1522-1

ORIGINAL PAPER

Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007–2016

Eve Griffin[1] · Elaine McMahon[1] · Fiona McNicholas[2,3,4] · Paul Corcoran[1,5] · Ivan J. Perry[5] · Ella Arensman[1,5]

Received: 30 November 2017 / Accepted: 25 April 2018 / Published online: 2 May 2018

Abstract

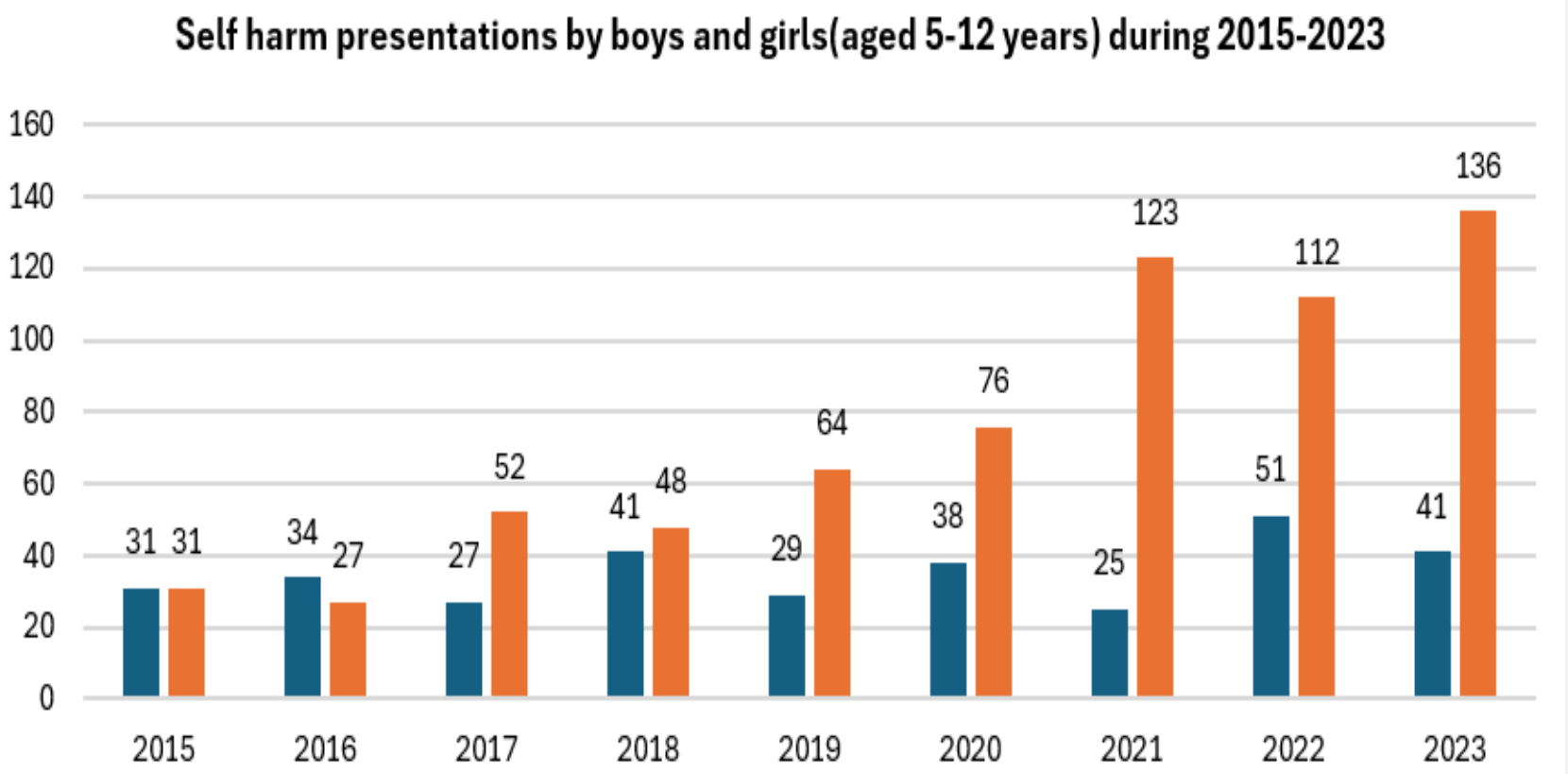
Purpose Rates of hospital-treated self-harm are highest among young people. The current study examined trends in rates of self-harm among young people in Ireland over a 10-year period, as well as trends in self-harm methods.

Methods Data from the National Self-Harm Registry Ireland on presentations to hospital emergency departments (EDs) following self-harm by those aged 10–24 years during the period 2007–2016 were included. We calculated annual self-harm rates per 100,000 by age, gender and method of self-harm. Poisson regression models were used to examine trends in rates of self-harm.

Results The average person-based rate of self-harm among 10–24-year-olds was 318 per 100,000. Peak rates were observed among 15–19-year-old females (564 per 100,000) and 20–24-year-old males (448 per 100,000). Between 2007 and 2016, rates of self-harm increased by 22%, with increases most pronounced for females and those aged 10–14 years. There were marked increases in specific methods of self-harm, including those associated with high lethality.

Conclusions The findings indicate that the age of onset of self-harm is decreasing. Increasing rates of self-harm, along with increases in highly lethal methods, indicate that targeted interventions in key transition stages for young people are warranted.

Keywords Self-harm · Young people · Epidemiology



Social Psychiatry and Psychiatric Epidemiology
https://doi.org/10.1007/s00127-021-02133-6

ORIGINAL PAPER

Self-harm in children 12 years and younger: characteristics and outcomes based on the Multicentre Study of Self-harm in England

Galit Geulayov[1] · Debbie Casey[1] · Liz Bale[1] · Fiona Brand[1,2] · Ellen Townsend[3] · Jennifer Ness[4] · Muzamal Rehman[4] · Keith Waters[4] · Caroline Clements[5] · Bushra Farooq[5] · Nav Kapur[5,6] · Keith Hawton[1,2]

Between 2000 and 2016, 387 children aged 5–12 years presented to the study hospitals:

39% were 5–11 years

61.5% of children self-poisoned,
50.6% of them by ingesting analgesics.

Of children who self-injured:
- 45.0% self-cut/stabbed
- 28.9% used hanging/asphyxiation
- 32% had a repeat hospital presentation for SH
- 13.5% re-presented within a year.

SELF-HARM IN CHILDREN IS STRONGLY ASSOCIATED WITH SOCIO-ECONOMIC DEPRIVATION:
The proportion of study children living in neighbourhoods ranked most deprived (43.4%) was twice the national average.

Gender Breakdown:
boys outnumbered girls 2:1 at 5–10 years, rates were similar at age 11, at 12 years there were 3.8 girls to every boy.

Psychiatry Research 334 (2024) 115807

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Self-harm and suicide death in the three years following hospitalization for intentional self-harm in adolescents and young adults: A nationwide study

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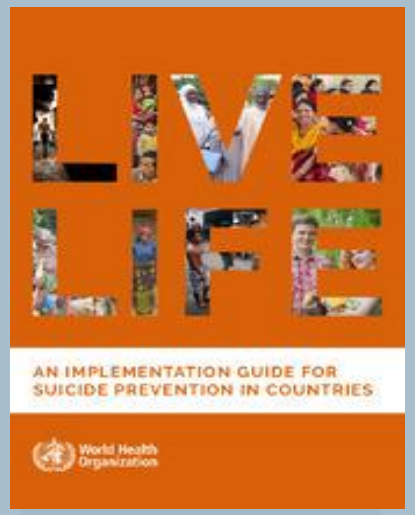
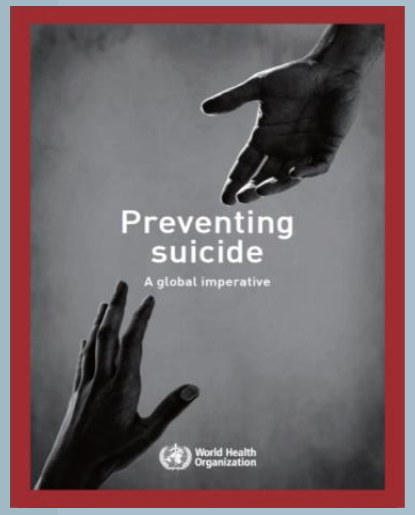
- Highest rates of self-harm among females aged 14-16 years

Three year follow up:

- Higher rates of prospective self-harm among those with a self-harm history, psychiatric and somatic disorder, and dispensed drugs
- 1 in 5 repeated self-harm
- 1 in 200 died by suicide

World Health Organization





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

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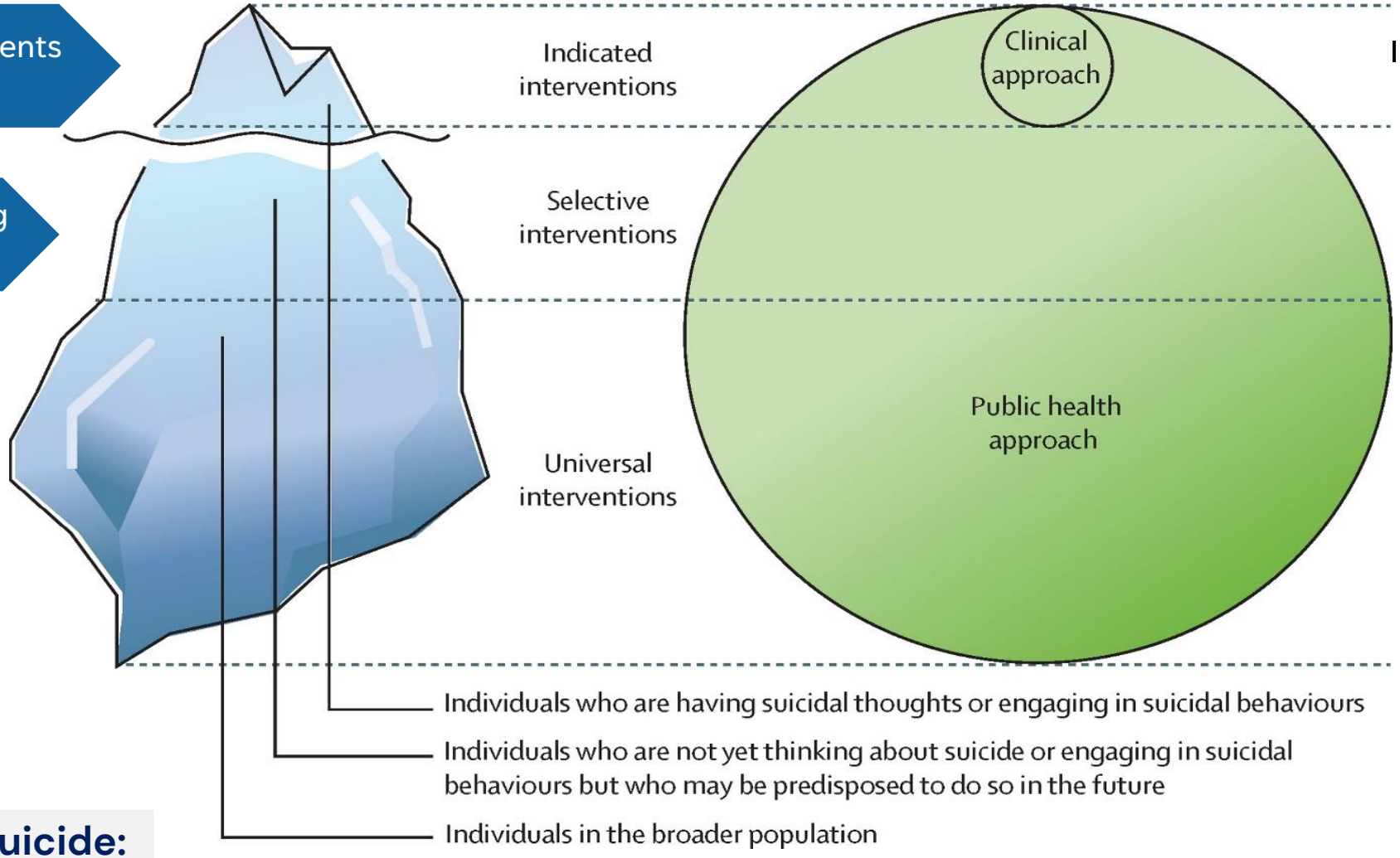
The Iceberg Model

Evidence-based treatments and postvention

Evidence-based training and education

Evidence-based mental health promotion

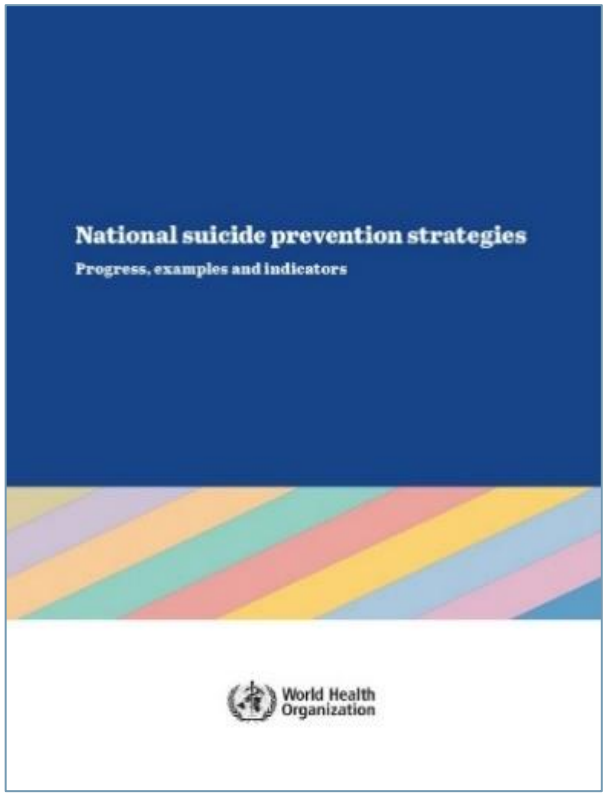


"Preventing suicide: a public health approach to a global problem"

Hawton & Pirkis, 2024

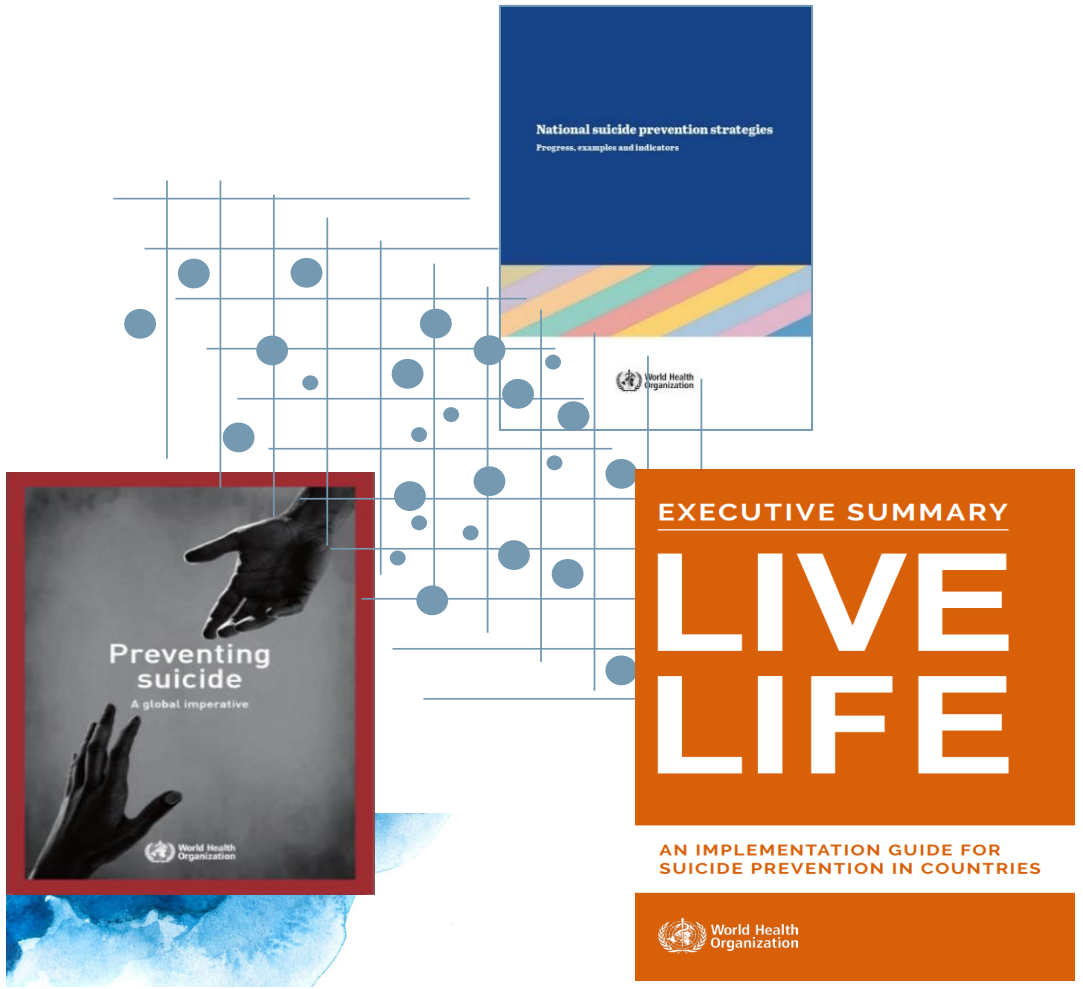
Number of countries with a national suicide prevention strategy

- According to WHO's data, 41 countries report having a national suicide prevention strategy
- In Europe, 6 further countries are in the process of developing a national suicide prevention strategy, through the **EU Joint Action ImpleMENTAL**
- An increasing number of countries are implementing a second or third national suicide prevention strategy, however only a limited number of strategies are evaluated.

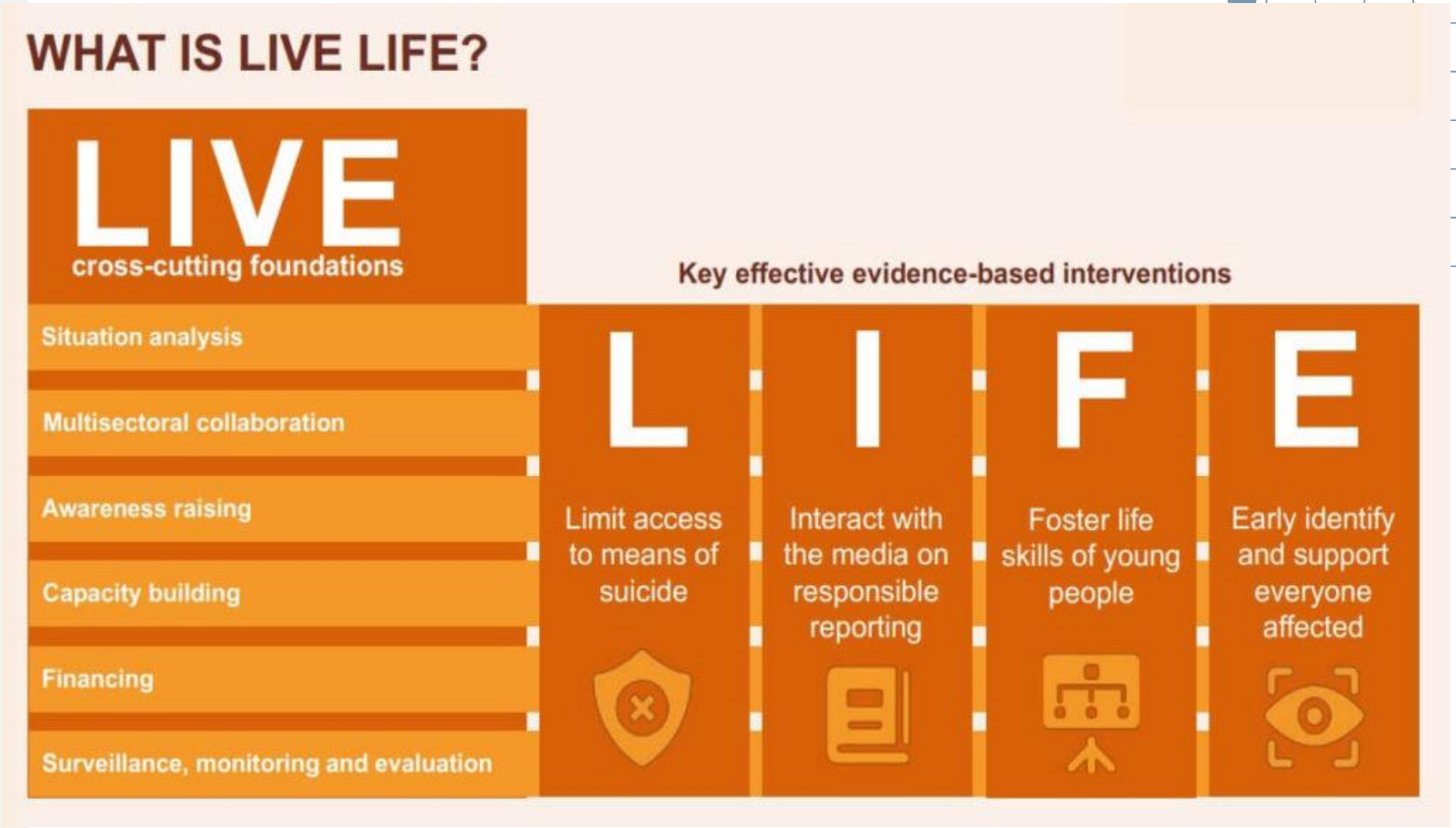


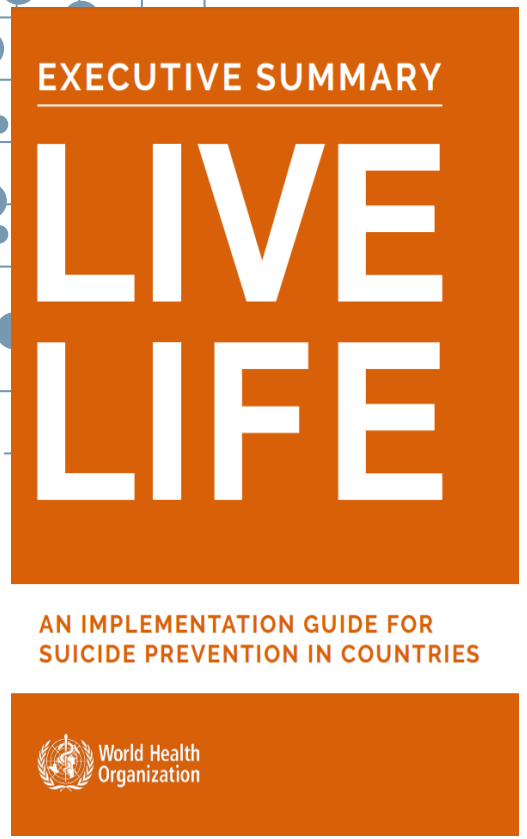
Core components of national suicide prevention strategies

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	



WHO: Live Life





Effectiveness of National Suicide Prevention Strategies (NSPSs) and their Components

- A recent review focused on the effectiveness of national suicide prevention strategies and their components in 29 countries, with suicide mortality data from 24 countries
- The overall “period effects” (how rates changed over time in countries with NSPSs) ranged from significant decrease for South Korea (RR ~0.80), to a significant increase in Uzbekistan (RR ~1.12)
- There was a pattern of NSPSs containing many (4-11) components, and nearly all included training/education
- Despite the variation in components, no statistically significant associations were found between specific components and changes in suicide mortality, and more likely point in the direction of synergistic effects.

Crisis → VOL. 44, NO. 4 |

Research Trends

Evaluating the Effectiveness of Components of National Suicide Prevention Strategies

An Interrupted Time Series Analysis

Marisa Schlichthorst, Lennart Reifels, Matthew Spittal, Angela Clapperton, Katrina Scurrah, Kairi Kolves, Stephen Platt, Jane Pirkis, and Karolina Krysinska

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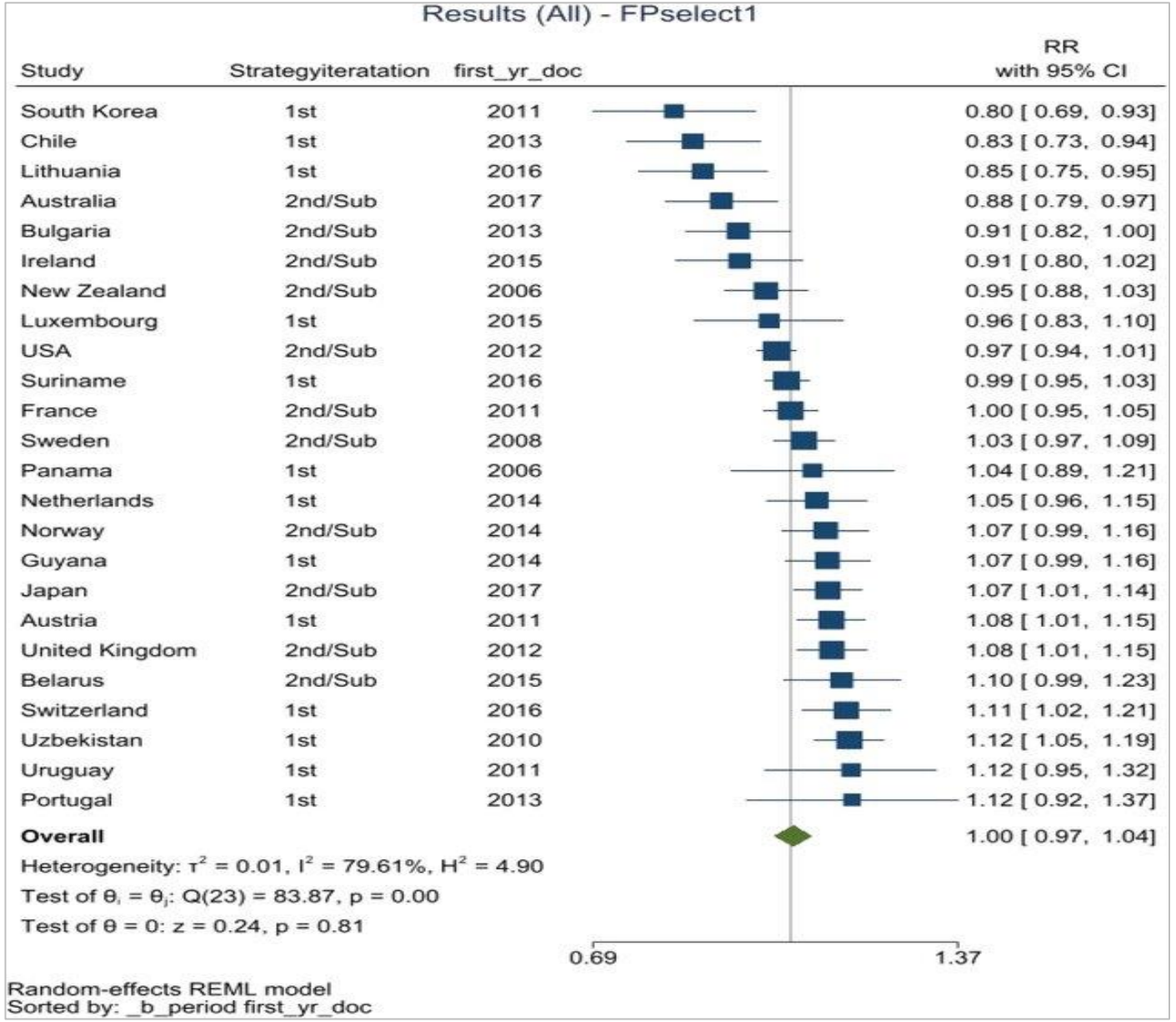
Forest plots of period effects for 24 countries for both sexes combined

Research Trends

Evaluating the Effectiveness of Components of National Suicide Prevention Strategies

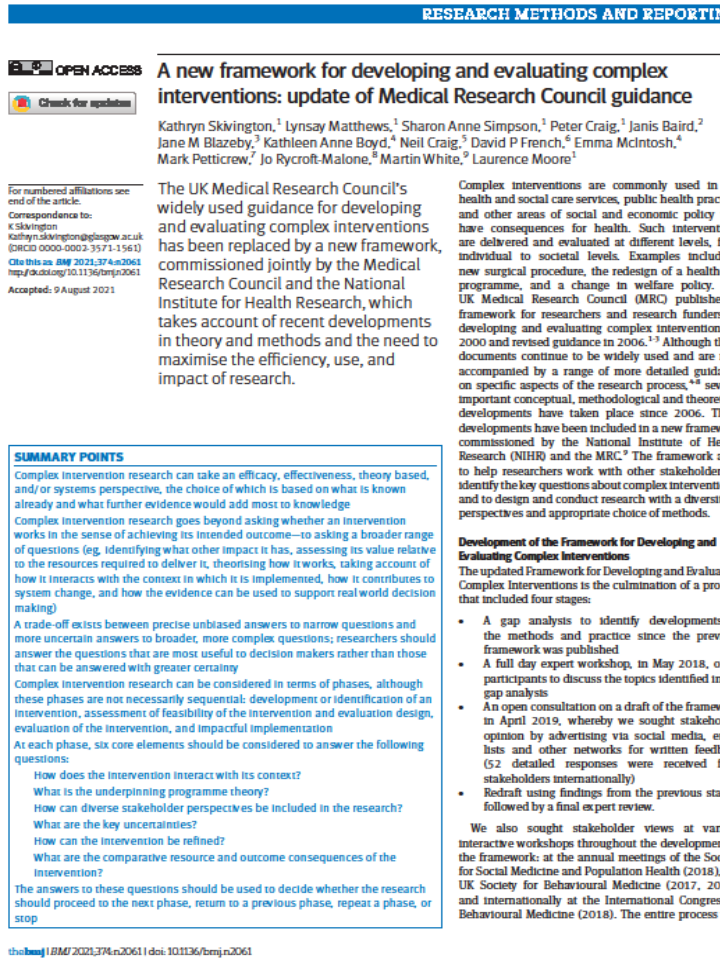
An Interrupted Time Series Analysis

Marisa Schlichthorst[1], Lennart Reifels[1], Matthew Spittal[1], Angela Clapperton[1], Katrina Scurrah[1], Kairi Kolves[1], Stephen Platt[2], Jane Pirkis[1], and Karolina Krysinska[1]



Possible explanations for variable effectiveness of National Suicide Prevention Strategies

- It may take longer than anticipated to show an effect, or to identify an effect only in certain subgroups (intensity and consolidation of actions and interventions)
- In addition to reductions in suicide, other outcome indicators need to be considered, such as secondary or in intermediate outcome indicators, including non-fatal self-harm, awareness of suicide risk factors, access to quality health care, access to lethal means of suicide, and numbers of people hospitalized after an act of self-harm
- Lack of information as to whether specific actions and interventions had been implemented or, if implemented, the quality, scale, intensity, completeness, and timing of the implementation process



RESEARCH METHODS AND REPORTI

OPEN ACCESS

A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance

Kathryn Skivington,[1] Lynsay Matthews,[1] Sharon Anne Simpson,[1] Peter Craig,[1] Janis Baird,[2] Jane M Blazeby,[3] Kathleen Anne Boyd,[4] Neil Craig,[5] David P French,[6] Emma McIntosh,[4] Mark Petticrew,[7] Jo Rycroft-Malone,[8] Martin White,[9] Laurence Moore[1]

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Cite this as: BMJ 2021;374:n2061
http://dx.doi.org/10.1136/bmj.n2061
Accepted: 9 August 2021

The UK Medical Research Council's widely used guidance for developing and evaluating complex interventions has been replaced by a new framework, commissioned jointly by the Medical Research Council and the National Institute for Health Research, which takes account of recent developments in theory and methods and the need to maximise the efficiency, use, and impact of research.

Complex interventions are commonly used in health and social care services, public health prac and other areas of social and economic policy have consequences for health. Such intervent are delivered and evaluated at different levels, individual to societal levels. Examples includ new surgical procedure, the redesign of a health programme, and a change in welfare policy. UK Medical Research Council (MRC) publishe framework for researchers and research funder developing and evaluating complex intervention 2000 and revised guidance in 2006.[1-3] Although t documents continue to be widely used and are accompanied by a range of more detailed guid on specific aspects of the research process,[4-8] se important conceptual, methodological and theore developments have taken place since 2006. T developments have been included in a new framew commissioned by the National Institute of He Research (NIHR) and the MRC.[9] The framework to help researchers work with other stakeholde identify the key questions about complex interventi and to design and conduct research with a diversi perspectives and appropriate choice of methods.

SUMMARY POINTS

Complex intervention research can take an efficacy, effectiveness, theory based, and/or systems perspective, the choice of which is based on what is known already and what further evidence would add most to knowledge

Complex intervention research goes beyond asking whether an intervention works in the sense of achieving its intended outcome—to asking a broader range of questions (eg, identifying what other impact it has, assessing its value relative to the resources required to deliver it, theorising how it works, taking account of how it interacts with the context in which it is implemented, how it contributes to system change, and how the evidence can be used to support real world decision making)

A trade-off exists between precise unbiased answers to narrow questions and more uncertain answers to broader, more complex questions; researchers should answer the questions that are most useful to decision makers rather than those that can be answered with greater certainty

Complex intervention research can be considered in terms of phases, although these phases are not necessarily sequential: development or identification of an intervention, assessment of feasibility of the intervention and evaluation design, evaluation of the intervention, and impactful implementation

At each phase, six core elements should be considered to answer the following questions:

- How does the intervention interact with its context?
- What is the underpinning programme theory?
- How can diverse stakeholder perspectives be included in the research?
- What are the key uncertainties?
- How can the intervention be refined?
- What are the comparative resource and outcome consequences of the intervention?

The answers to these questions should be used to decide whether the research should proceed to the next phase, return to a previous phase, repeat a phase, or stop

Development of the Framework for Developing and Evaluating Complex Interventions

The updated Framework for Developing and Evalua Complex Interventions is the culmination of a pro that included four stages:

- A gap analysis to identify developments the methods and practice since the prev framework was published
- A full day expert workshop, in May 2018, o participants to discuss the topics identified in gap analysis
- An open consultation on a draft of the framew in April 2019, whereby we sought stakeho opinion by advertising via social media, e lists and other networks for written feedb (52 detailed responses were received f stakeholders internationally)
- Redraft using findings from the previous sta followed by a final expert review.

We also sought stakeholder views at var interactive workshops throughout the developme the framework: at the annual meetings of the So for Social Medicine and Population Health (2018), UK Society for Behavioural Medicine (2017, 20 and internationally at the International Congres Behavioural Medicine (2018). The entire process

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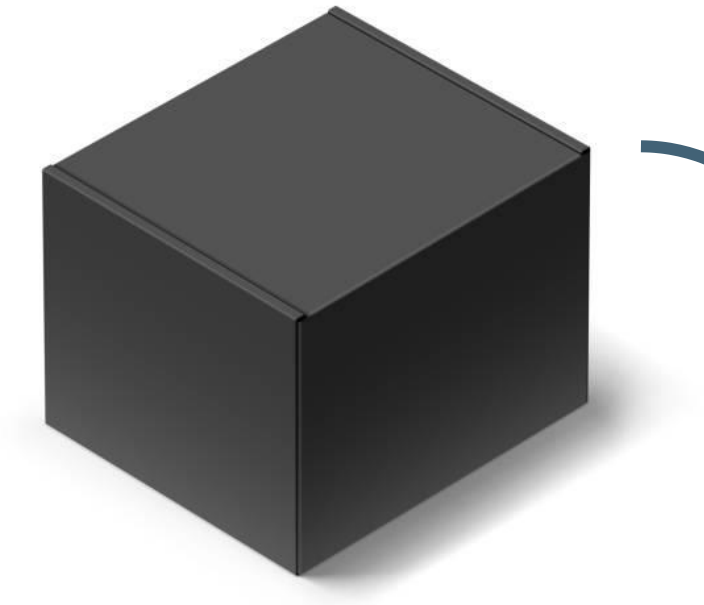
Addressing the “black box” challenge -

What happens during the implementation of a national suicide prevention strategy?

INPUT

- Launch of a national suicide prevention strategy and national/ regional implementation plans
- Baseline assessment of suicide rates



OUTPUT

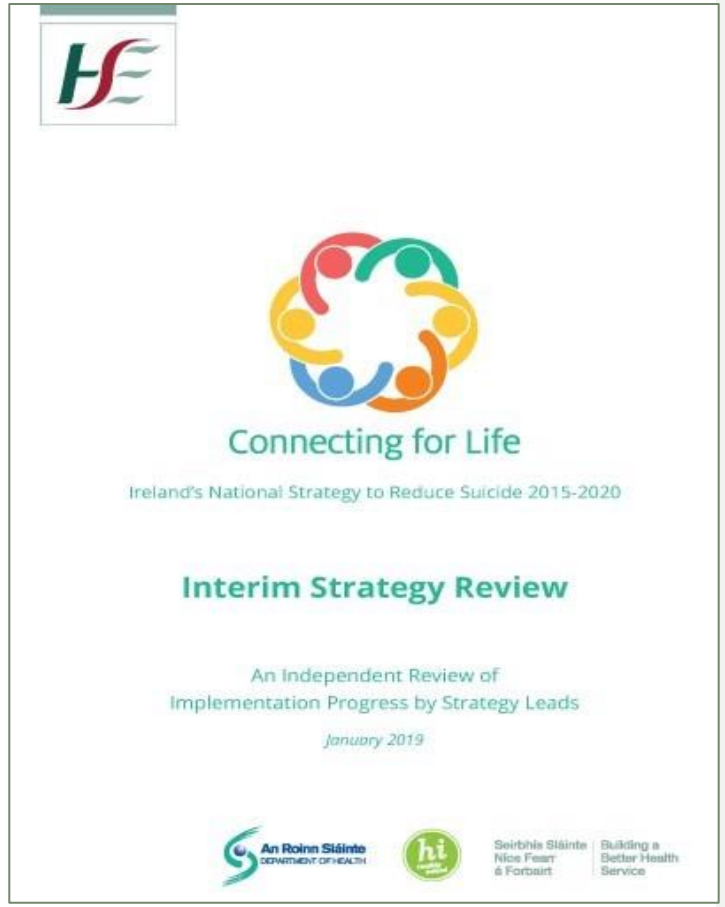
Assessment suicide rates including trend analysis

It is fundamental to include expertise in **Implementation Science!**

There is significant lack of information and national variation in the rigour of implementation. In addition, what may look like a trend over a certain period of time, does not always account for external factors (i.e. public health emergencies).

Addressing the ‘black box’ via continuous monitoring and evaluation during the implementation of the strategy

- **Independent monitoring and evaluation committee** to review the National Implementation Plan
- **Quarterly National Steering Group meetings and updates on actions, with accountability** of all relevant Government Departments, chaired by the Department of Health
- **Reporting via an online ‘dashboard’ system** accessible by all members of the Steering Group
- Quarterly reporting allows for **timely mitigation of challenges and barriers** in implementing the actions.



Intermediate, primary and secondary indicators

Increased awareness of suicide signs and symptoms

Improved identification of people at risk

Improved access to care

Improved provision of capacity and quality of mental health care

Reduction in access to lethal suicide methods

Reduction in suicidal ideation and non-fatal self-harm and repetition

Reduction in suicide

Example: The European Alliance Against Depression's Four-level intervention programme – Evidence base

Population- and community-based interventions to prevent suicide: A...

by Linskens, Eric J; Venables, Noah C; Gustavson, Allison M ; More...

Peer-Reviewed

Review Article

Population- and Community-Based Interventions to Prevent Suicide

A Systematic Review

Eric J. Linskens[1], Noah C. Venables[1,2,3], Allison M. Gustavson[1], Nina A. Sayer[1,3,4], Maureen Murdoch[1,2,4], Roderick MacDonald[1], Kristen E. Ullman[1], Lauren G. McKenzie[1], Timothy J. Wilt[1,2,4,5], and Shahnaz Sultan[1,2,4]

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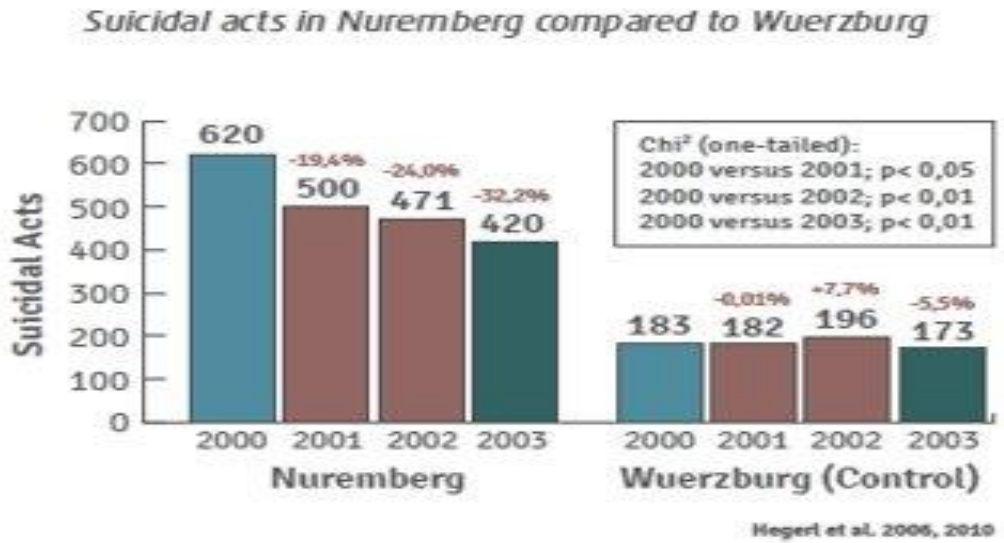
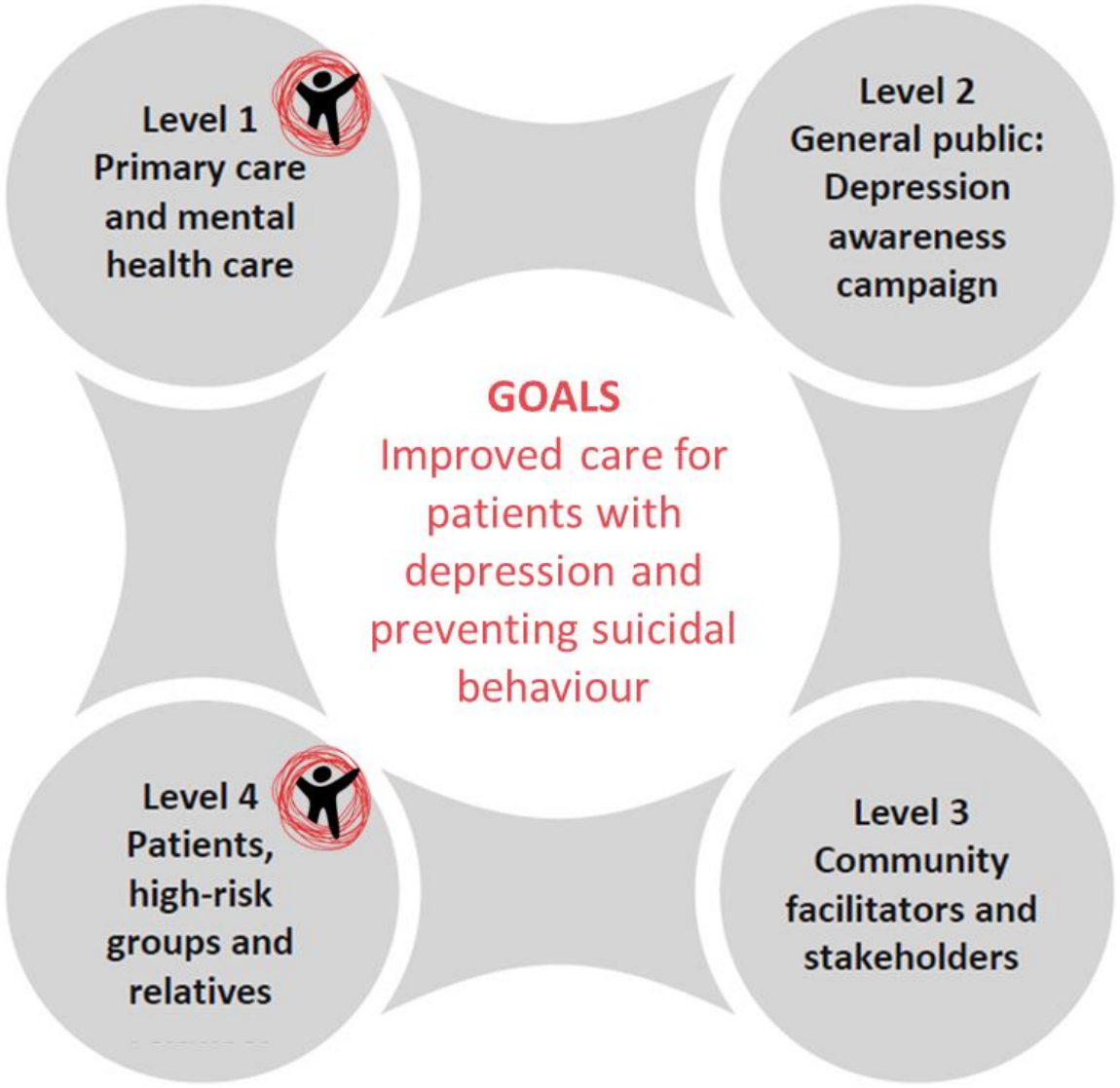
Abstract. *Background:* Suicide is estimated to account for 1.4% of deaths worldwide, making it among the leading causes of premature death. Public health approaches to reduce suicide have the potential to reach individuals across the spectrum of suicide risk. *Aims:* To review the effectiveness of newer community-based or population-level suicide prevention strategies. *Methods:* We conducted a systematic review of literature published from January 2010 to November 2020 to evaluate the effectiveness of community- and population-level interventions. The US Center for Disease Control framework was used for grouping studies by strategy. *Results:* We included 56 publications that described 47 unique studies. Interventions that reduce access to lethal means, implement organizational policies and culture in police workplace settings, and involve community screening for depression may reduce suicide deaths. It is unclear if other interventions such as public awareness and education campaigns, crisis lines, and gatekeeper training prevent suicide. Evidence was inconsistent for community-based, multistrategy interventions. The most promising multistrategy intervention was the European Alliance Against Depression. *Limitations:* Most eligible studies were observational and many lacked concurrent control groups or adjustment for confounding variables. *Conclusions:* Community-based interventions that may reduce suicide deaths include reducing access to lethal means, implementing organizational policies in workplace settings, screening for depression, and the multistrategy European Alliance Against Depression Program. Evidence was unclear, inconsistent, or lacking regarding the impact of many other single- or multistrategy interventions on suicide deaths.

Keywords: suicide, public health, community-based interventions, population-based interventions



This systematic review revealed that the EAAD 4-level intervention programme was the most promising approach.

The 4-level intervention concept of EAAD



EAAD Best

10 European countries

Belgium
Bulgaria
Estonia
Germany
Greece
Hungary
Ireland
Italy
Poland
Spain

MENTBEST

5 European countries

Spain
Ireland
Greece
Albania
Estonia

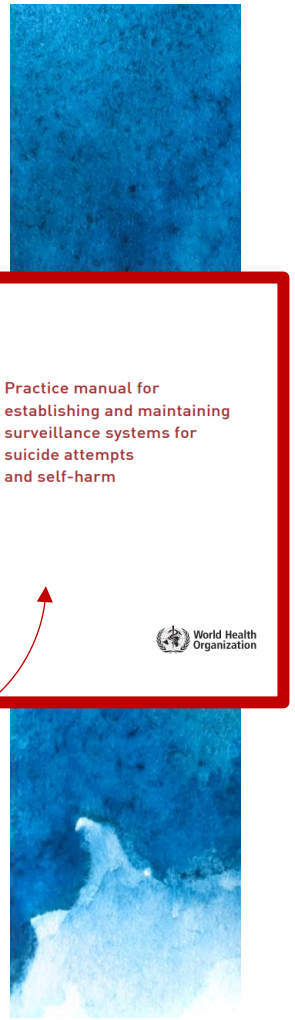
Challenges in developing and implementing national suicide prevention programmes

- 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, Kazakhstan, Namibia, Afghanistan, Uruguay**

Example : Uruguay

[WHO, August 2025]

- Among the countries in the Americas with the highest suicide rates
- Recent launch of a nationwide digital registry system (first paper-based, from 2013)
- Followed the WHO Practice manual



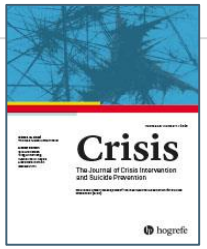
National Suicide Prevention Strategy in Development

Multi-layered quality assurance process : new data entries are initially validated by a mental health specialist and reviewed daily by the surveillance department of the Ministry.

From early detection to targeted follow-up care : authorised mental health professionals can access real-time data on recent suicide attempts, enabling rapid follow-up. Furthermore, Uruguay's national clinical guidelines mandates all individuals presenting to the ED with suicide attempts should be followed up by a trained mental health professional within 48 hours and 7 days post-attempt.

Key Priorities for Suicide Prevention in Changing Environments

- Changing online environments
- Changing work environments
- Cost-of-living crisis
- Climate change
- Artificial intelligence and suicide (prevention)
- Political turmoil and armed conflict



Editorial

Suicide Prevention in Changing Environments

Thomas Niederkrotenthaler[1], Ella Arensman[2], Gregory Armstrong[3], Katherine Keyes[4], Alexandra Pitman[5,6], and Benedikt Till[1]

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Changing Environments at *Crisis*

In January 2024, Dr. Jane Pirkis from Australia handed over the reins of Editor-in-Chief (EiC) to Dr. Thomas Niederkrotenthaler from Austria. From 2018, Dr. Pirkis guided the journal from strength to strength, together with her associate editors, Drs. Maria Oquendo and Ella Arensman. While Dr. Arensman will carry on in the leadership team of the journal, Dr. Pirkis and Dr. Oquendo will also continue as members of the broader editorial board. To cope with the increasing demand on journal editors, it was deemed necessary to expand the leadership to a team of six recognized experts in the area of suicide prevention, with clinical, psychiatric, psychological, epidemiological, and public health expertise, as reflected in the journal's content. Since January 2025, Drs. Gregory Armstrong (Australia), Katherine Keyes (United States), Alexandra Pitman (United Kingdom), Benedikt Till (Austria), Ella Arensman (Ireland), and Thomas Niederkrotenthaler (Austria) have worked together to handle manuscripts, develop the journal and the submission policies, and help promote *Crisis* in order for it to become a globally leading outlet in the area of suicide prevention research. A brief resumé of the leadership team members can be found at the end of this editorial.

We anticipate that the next few years will bring many changes to the journal, some of them related to changes in academic publishing, others reflecting the ever-changing social environments that are relevant to suicide and its prevention. This editorial will cover the dynamic content areas that are essential for the future of suicide prevention and require more research to better understand their implications for suicide and its prevention. The areas covered here are not exhaustive, but are meant to provide readers with examples of ongoing developments that will be relevant to the field and that readers of *Crisis*, including ourselves, will certainly be pleased to read and learn more about.

There are also some structural plans and visions for the journal that we want to tackle. First, it appears necessary to clarify and revise the authorship guidelines of the journal. We would like to sharpen the definitions of manuscript types and, potentially, expand the types of submissions that we consider. For example, we plan to commission a new type of article – Debates – and also consider pieces covering seminal works in suicide prevention from the past, together with commentary adding contemporary perspectives. Keep an eye on upcoming issues to learn more about this in the near future. Furthermore, *Crisis* will also continue to support open science and we will update our related guidance.

One of our primary goals is to further strengthen the links of editorial leadership with the editorial board and reviewers. The editorial board and peer reviewers, like the authors, are the backbone of *Crisis*, and their work is the basis for all developments to be successful. In our work to secure good-quality reviews, editorial boards and reviewers play an essential role and we would like to sincerely thank everyone involved in one (or often several) of these roles for their important contributions. At the same time, we want to ensure that the board is involved in the everyday work of the journal and want to encourage everyone on the board to review and submit their work to *Crisis*. Together, we can ensure that *Crisis* remains a premier journal for good-quality suicide prevention research, with a strong focus on clinical and public health research, observational and experimental studies,

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New initiative: Strengthening Health Systems for Equitable High-Quality Mental Health Care Outcomes in Refugee Populations in Europe and Low and Middle Income Countries – **SECUREH**

Articles

Incidence of sexual violence among recently arrived asylum-seeking women in France: a retrospective cohort study

Jérémy Khouani,[a,b,*] Marion Landrin,[b,f] Rachel Cohen Boulakia,[b,f] Sarah Tahtah,[d] Gaëtan Gentile,[b,e] Anne Desrues,[a] Marine Vengeon,[d] Anderson Loundou,[a,c] Adriaan Barbaroux,[d] Pascal Auquier,[a,c] and Maeva Jego[a,b]

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Summary

Background The prevention of sexual violence (SV) occurring shortly after arrival in host countries towards female asylum seekers requires knowledge about its incidence. We aimed to determine the incidence of SV and its associated factors during the past year of living in France among asylum-seeking females who had arrived more than one year earlier but less than two years.

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- **SECUREH** will **adapt and implement the proven EAAD 4-Level Intervention Programme** as an exemplar of rigorous implementation research.

The project will generate:

a) Optimised 4-level intervention programme to address depressive and anxiety symptoms, suicidal ideation, pain and sleep disorders among **three refugee populations in EU host countries and three LMIC settings**, and
b) Guidance on determinants of sustainable implementation to **increase capacity of health, mental health and community services.**

- 12 partners from 8 countries and along with engaging national and international policymakers: **UNHCR & WHO and NGOs**.

- Initial target groups: Refugees from **South Sudan, Ukraine and Syria, with expansion to refugees from Gaza.**

People who attempt suicide, don't want to die, what they want is a different life

A critical feature in working with people who self-harm is to recognise their **ambivalence** and the fragility and temporality of their decisions about their destiny.

Bermans et al, 2009; Scoliers et al, 2009; Rasumussen et al, 2016; Bermans et al, 2017

Merci beaucoup!

Prof Ella Arensman

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NSRF National Suicide Research Foundation