# PUBLIC HEALTH ACTION FOR THE PREVENTION OF SUICIDE

## A FRAMEWORK

**World Health Organization**

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# FOREWORD

Suicide is largely preventable. Unlike for many other health issues, the tools to significantly reduce the most tragic loss of life by suicide are available. With collective action to acknowledge and address this serious problem, as well as commitment to effective interventions, supported by political will and resources, preventing suicide globally is within reach.

Suicide is estimated to contribute more than 2% to the global burden of disease by the year 2020. Significantly, this figure fails to take account of the huge impact of suicide beyond the individual and the ripple effect it has on the lives and mental health of many families and communities. Suicide among youth is of particular concern.

Suicide impacts the most vulnerable of the world's populations and places a larger burden on low- and middle-income countries, which are often ill-equipped to meet the general health and mental health needs of their populations. Services are scarce and when they do exist, they are difficult to access and are under-resourced. Access to appropriate services as well as improved help seeking are essential to health and wellbeing.

While factors contributing to suicide can vary among specific demographic and population groups, the most vulnerable, such as the young, the elderly and the socially isolated, are in the greatest need of suicide prevention efforts. It is important to address the specific underlying causes of suicide and develop action plans to suit each country and its communities.

This framework provides the strategies needed to achieve this goal. Importantly, it is a national suicide prevention strategy that allows communities to come together, and begin to tackle suicide and the issues specific to their needs without stigmatization.

Governments, international organizations, nongovernmental organizations and local communities all have a part to play in combating suicide. This framework builds on the 1996 United Nations Prevention of Suicide Guidelines and outlines the contribution everyone can make. With almost one million people dying from suicide around the world each year, and with a disproportionate impact on the world's youth, we owe it to future generations to act now.

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# INTRODUCTION

Every year, almost one million people die by suicide around the world. Suicide remains a significant social and public health problem. In 1998, suicide constituted 1.8% of the total disease burden; this is estimated to rise to 2.4% by 2020 (Bertolote, 2009). Young people are increasingly vulnerable to suicidal behaviours. Worldwide, suicide is one of the three leading causes of death among those in the most economically productive age group (15-44 years), and the second leading cause of death in the 15-19 years age group (Patton et al., 2009). At the other end of the age spectrum, the elderly are also at high risk in many countries.

Suicidal behaviours can be conceptualized as a complex process that can range from suicidal ideation, which can be communicated through verbal or non-verbal means, to planning of suicide, attempting suicide, and in the worst case, suicide. Suicidal behaviours are influenced by interacting biological, genetic, psychological, social, environmental and situational factors (Wasserman, 2001).

Risk factors for suicide include mental and physical illness, alcohol or drug abuse, chronic illness, acute emotional distress, violence, a sudden and major change in an individual's life, such as loss of employment, separation from a partner, or other adverse events, or, in many cases, a combination of these factors. While mental health problems play a role which varies across different contexts, other factors, such as cultural and socio-economic status, are also particularly influential. The impact of suicide on the survivors, such as spouses, parents, children, family, friends, co-workers, and peers who are left behind, is significant, both immediately and in the long-term.

Although suicide continues to remain a serious problem in high income countries, it is the low and middle income countries that bear the larger part of the global suicide burden. It is also these countries that are relatively less equipped to prevent suicide. Unable to keep pace with the rising demand for mental health care, they are especially hindered by inadequate infrastructure and scarce economic and human resources. These countries have also lower budgetary allocations for health in general and for mental health in particular. As a result, there are few sustained efforts and activities that focus on suicide prevention on a scale necessary to reduce the number of lives lost to suicide (Vijayakumar, 2005). Beyond financial realities, for all countries political will is an essential ingredient to bring about change at the policy and programme level. Suicidal behaviour is considered a criminal offence in some countries, which poses additional challenges for suicide prevention activities.

In the early 1990s, there were growing concerns in several countries about increased suicide mortality (suicidal deaths) and morbidity (suicide attempts). These concerns were in part due to effective control of other causes of death and prolonged life expectancies, which created a larger pool of individuals at risk of suicidal behaviours. Accordingly, a few of those countries approached both the United Nations (UN) and the World Health Organization (WHO) asking for help in designing comprehensive national plans that would tackle the issue in a cost- effective manner.

After consultations with a variety of experts and with technical support from WHO, the UN published a document titled "Prevention of Suicide: Guidelines for the formulation and implementation of national strategies" (United Nations, 1996). This seminal document

emphasized the need for intersectoral collaboration, multidisciplinary approaches, and continued evaluation and review, and also identified key elements as necessary means to increase the effectiveness of suicide prevention strategies, including:

- Support from government policy;

- Conceptual framework;

- Well-defined aims and goals;

- Measurable objectives;

- Identification of agencies and organizations capable of implementing those objectives;

- Ongoing monitoring and evaluation.

At the same time, the UN document highlighted some activities and approaches to attain the goals of national strategies, which included the following:

- Promote the early identification, assessment, treatment and referral of persons at risk of suicidal behaviours for professional care;

- Increase public and professional access to information about all aspects of preventing suicidal behaviour;

- Support the establishment of an integrated data collection system, which serves to identify at-risk groups, individuals, and situations;

- Promote public awareness with regard to issues of mental well-being, suicidal behaviours, the consequences of stress and effective crisis management;

- Maintain a comprehensive training programme for identified gatekeepers (e.g. police, educators, mental health professionals);

- Adopt culturally appropriate protocols for the public reporting of suicidal events;

- Promote increased access to comprehensive services for those at risk for, or affected by, suicidal behaviours;

- Provide supportive and rehabilitative services to persons affected by suicide/suicidal behaviours;

- Reduce the availability, accessibility, and attractiveness of the means for suicidal behaviour;

- Establish institutions or agencies to promote and coordinate research, training and service delivery with respect to suicidal behaviours.

When the UN guidelines were initially prepared, only Finland had a government-sponsored systematic initiative to develop a national framework and programme for suicide prevention. Fifteen years later, more than 25 countries – in the high, middle and

low income categories – have adopted a national (or regional, in some federal countries) strategy for the prevention of suicidal behaviours. Most of these countries acknowledge the fundamental importance of the UN guidelines in the development of their national strategies.

Along with the growing attention given to national suicide prevention strategies, a major shift has been observed in suicide-related research, from being basically oriented to suicide in general to being much more oriented towards the prevention of suicide, based on sound epidemiological research. This shift coincides with the growing importance of evidence-based recommendations throughout the field of public health.

More recently, in 2008, suicide was identified by the World Health Organization as a priority condition in the Mental Health Gap Action Programme (mhGAP), the programme to scale up care for mental, neurological and substance use disorders, particularly in low- and middle-income countries (World Health Organization, 2008a).

As suicide is largely preventable, it is imperative that governments – through their health, social and other relevant sectors – invest human and financial resources in suicide prevention. The purpose of this document is a resource to assist governments to develop and implement such a strategy for the prevention of suicide as well as to help those that have already begun the process of conceptualizing national suicide prevention strategies. It draws on the evidence base built in the 15 years since the publication of the UN guidelines to outline the processes involved in developing a national suicide prevention strategy. It also identifies the critical elements of a framework (see Figure 1 in the Annex) for taking public health action to prevent suicide.

# THE NEED FOR TAKING ACTION

Given the magnitude of the public health problem of suicidal behaviours, there is an urgent need for governments to develop a comprehensive national suicide prevention strategy that contextualizes the problem and outlines specific actions that can be taken at multiple levels. Without a suicide prevention strategy, governments cannot put in place mechanisms to address this issue in a sustained manner.

It is important to review existing national health-related policies and strategies to ensure that a national suicide prevention strategy fits with an overall national health development policy. This will also enable the identification of any existing gaps with regard to suicide prevention in the other policies/strategies and provide opportunities to propose relevant changes in them.

## Why is a national suicide prevention strategy necessary?

- A national strategy not only outlines the scope and magnitude of the problem, but more crucially, recognizes that suicidal behaviours are a major public health problem.

- A strategy signals the commitment of a government to tackling the issue.

- A cohesive strategy recommends a structural framework, incorporating various aspects of suicide prevention.

- A strategy provides authoritative guidance on key evidence-based suicide prevention activities, i.e. identifies what works and what does not work.

- A strategy identifies key stakeholders and allocates specific responsibilities among them. Moreover, it outlines the necessary coordination among these various groups.

- A strategy identifies crucial gaps in existing legislation, service provision and data collection.

- A strategy indicates the human and financial resources required for interventions.

- A strategy shapes advocacy, awareness raising, and media communications.

- A strategy proposes a robust monitoring and evaluation framework, thereby instilling a sense of accountability among those in charge of interventions.

- A strategy provides a context for a research agenda on suicidal behaviours.

# DEVELOPING A SUICIDE PREVENTION STRATEGY: A STEPWISE APPROACH

## Identifying stakeholders

Identifying the key stakeholders in suicide prevention is among the first steps towards developing a strategy. Suicide prevention demands a multi-sectoral approach, involving health care professionals as well as representatives from other sectors. A list of stakeholders could include representatives from:

- Various government sectors, including the Ministry of Health, Education and Social Welfare. In some cases, it would be useful to also involve other relevant ministries, such as Agriculture (where suicide by self-ingestion of pesticides is a major issue) or Transport (e.g. where it is necessary to implement measures to prevent suicides on railway tracks or by jumping from bridges);

- The general public health sector, including public health managers, physicians, nurses, emergency care staff, paediatricians, geriatricians, bereavement specialists, administrators, statisticians, and other service providers;

- Mental health services, including service managers, psychiatrists, psychologists, mental health nurses, and social workers, from both the public and the private sectors;

- The education sector, including teachers, school counsellors, administrators, other education professionals, and student leaders;

- Legal authorities, including coroners and medico-legal staff;

- Police, fire services, ambulance services, prison and criminal services, courts, and defence forces;

- Parliamentarians, policy makers, and politicians;

- Relevant vulnerable groups, which could include, depending on a country's suicide demographics, e.g. the elderly, youth, indigenous peoples, refugees, and ethnic minorities;

- Survivors and families;

- Communities, spiritual and religious leaders;

- Nongovernmental organizations (NGOs), family organizations, community-based organizations, and volunteers;

- Media;

- Researchers;

- National statistics representatives;

- Professional associations; and

- Private sector and foundations.

> The role of NGOs cannot be underestimated. NGOs and non-profit organizations often continue to work actively in both suicide prevention and advocacy, particularly where the public sector action is weak or absent. NGOs frequently offer counselling services, operate helplines, conduct research, conceptualize and implement public education programmes and work with the media.

Identifying these stakeholders is merely the first step; the process of bringing them together and clearly demarcating roles and responsibilities can be difficult and challenging. Strong leadership is therefore essential to provide vision to these stakeholders and ensure that they work together, beyond solely the development of the strategy, but also on its implementation and evaluation. Depending on the national circumstances, the leadership need not necessarily come from the health sector; however, to succeed, leadership that is acceptable to all stakeholders is crucial to coordinate the input of those involved and to ensure that the process moves forward. It may also be helpful to establish a steering committee and/or advisory body in order to succeed not only in the development process but also subsequently in the implementation of the national strategy.

## Undertaking a situation analysis

A meticulous situation analysis that identifies the extent of the problem in a particular geographical area (whether an entire country or a specific subregion in a country) is a vital step. It should include an estimate of the annual incidence of suicide and suicide attempts in an area and point to relevant socio-demographic, structural and clinical factors, thereby identifying those populations that are especially vulnerable. Also, it should indicate the most commonly used methods of suicide and potential reasons for the same, and assess the availability, use and quality of services for those who attempt suicide as well as existing gaps in the health system, in responses from other sectors, and in intersectoral mechanisms. A comprehensive analysis should identify the presence of a policy to reduce the harmful use of alcohol, audit the quality of media reporting on suicide, consider the quality of statistics on suicide and suicide attempts, assess the quality of existing surveillance systems, and identify any gaps that exist in data collection. Additionally, it should identify key 'hotspots', which include bridges or high-rise buildings with low fences or roof walls, or other areas associated with previous suicides.

The analysis of barriers to implementation is an important part of the situation analysis in which all the barriers are listed and solutions are suggested to remove them one by one. Without barrier identification, strategies may not move from paper to action.

## Assessing the requirement and availability of resources

The availability of and access to both human and financial resources is central to the relative success of any public health intervention, as is the willingness of policy makers to engage with the key issues. This can be seen as a three-stage process:

i. What are the human and financial resources required to formulate and implement a suicide prevention strategy?

ii. What are the currently available resources?

iii. What is the gap and how can this be met?

Evaluating human resources could include identifying the number of the following:

• Primary care and mental health professionals;

• Other facility and community-based health workers;

• Personnel in charge of developing and implementing policies on mental health and to reduce the harmful use of alcohol;

• Counsellors at schools, workplaces, prisons and jails;

• First line responders including emergency, police and fire services; and

• Native healers and practitioners of alternative medicine, where relevant.

There are typically several potential sources of support and funding including:

• Allocation in annual budgets by federal or central governments for suicide prevention;

• Allocation by state, provincial or local governments;

• Private funding from philanthropists or foundations;

• Support from NGOs;

• Support from international agencies;

• Public-private partnerships (PPPs).

## Achieving political commitment

Without political commitment, a strategy is likely to remain on paper. Political commitment is essential to ensure that suicide prevention receives the resources it requires as well as its fair share of attention from national and state leaders. Some ways to build political commitment could include:

• Enhancing awareness of national and state leaders;

- Frequent publication of well-researched policy and position papers on suicide prevention;

- Identification of political leaders and/or an ambassador who may particularly empathize with the issue (e.g. someone who has lost a family member or friend to suicide);

- Frequent and adequate reference to suicide as a public policy issue in the media;

- Consistent lobbying with parliamentarians as well as government representatives at various levels.

Achieving political commitment that is sustainable and which transcends changes in the government is, inevitably, a long and arduous process, but one with considerable potential benefits, particularly in the long-term. Political commitment could manifest in many ways, as follows:

- Revised policies and legislation, which may lead to improvements in the judiciary system's approach to the legal status of acts of self-harm and suicide;

- Increased and sustained allocation of resources;

- Established or strengthened effective mechanisms to gather and monitor data on suicide and suicide attempts;

- Enhanced support for training key staff in the public sector on their role in suicide prevention;

- Information on suicide and suicide prevention incorporated into curricula of health and social sector professionals;

- Increased government efforts to tackle environmental, socio-economic, and other risk factors, and greater access to services.

World Suicide Prevention Day, on 10 September, organized by the International Association for Suicide Prevention (IASP), World Mental Health Day on 10 October, organized by the World Federation for Mental Health (WFMH), or other international or national occasions could be used for advocacy purposes and demonstration of political commitment.

## Addressing stigma

Stigma related to suicide remains a major obstacle to suicide prevention efforts in many countries. Those who have lost someone to suicide, as well as those who have a history of suicide attempts, often face considerable stigma within their communities. Stigma may prevent people from seeking help and can become a barrier to accessing suicide prevention services including counselling and postvention support; this is of particular concern in countries where suicidal acts are illegal. Also, high levels of stigma may negatively affect proper reporting and recording of suicidal behaviours with its public health consequences. Together with increasing awareness and mental health literacy among the general population, governments and other stakeholders should also tackle stigma from the beginning and throughout the process. While efforts to reduce the stigma of suicidal behaviours can benefit from being incorporated into the more general process of de-stigmatizing mental illness, typically, additional efforts to reduce stigma attached to suicidal behaviours are required.

## Increasing awareness

The process of developing a suicide prevention strategy offers opportunities for increasing awareness about suicide prevention. It is not necessary to wait until the implementation phase of a suicide prevention strategy to seek the media's support in highlighting the importance of suicide prevention. The media can play a vital role in the strategy development process, keeping stakeholders informed about the progress made and generating wider understanding of the issue, thus creating broad sense of ownership and increasing participation. Awareness raising, along with advocacy and communication can influence policy-makers and public opinion, thus mobilizing political commitment and resources to drive the process forward. Increased awareness can result in increased commitment and resource allocation. The public requires an understanding of the issue and the vital need for an intervention in order for it to be successful. Awareness efforts can also generate greater, and more sustained, involvement from stakeholders, and most of all, a buy-in from communities recognizing the importance of suicide prevention.

# KEY COMPONENTS OF A NATIONAL SUICIDE PREVENTION STRATEGY

The overarching aim of a national suicide prevention strategy is eventually to promote, coordinate and support appropriate inter-sectoral action plans and programmes for the prevention of suicidal behaviours at national, regional and local levels. There are several key elements that constitute an effective national suicide prevention strategy. At the same time, it must be remembered that suicide always has a specific social and cultural context. This section broadly outlines the potential components of a suicide prevention strategy:

## Clear objectives

An effective suicide prevention strategy could have several parallel and intertwined objectives, all of which need to be stated clearly. Some potential objectives include:

- Increase awareness about the magnitude of the problem and the availability of effective prevention strategies;

- Reduce the incidence of suicide and attempted suicide, thereby preventing premature death from suicide or morbidity/disability from attempted suicide, across the life span;

- Tackle risk factors of suicide and attempted suicide;

- Reduce stigma associated with suicidal behaviours;

- Improve data collection on the incidence of both suicide and attempted suicide;

- Improve research and evaluation of effective interventions;

- Strengthen the health and social system response to suicidal behaviours.

A suicide prevention strategy should have specified financial and human resources, a time frame for implementation, as well as short to medium and long-term objectives.

## Relevant risk and protective factors

The identification of risk and protective factors is a key component of a national suicide prevention strategy, and can help determine the nature and type of interventions required. Risk factors, in this context, are indicative of whether an individual, a community or a population is particularly vulnerable to suicide. Risk factors can exist at various levels, including the individual, social, or contextual level and at multiple interaction points. Where risk factors are present, it needs to be assumed that there is a greater likelihood of suicidal behaviours. National strategies must therefore clearly identify risk groups, while simultaneously focusing on the entire population, in order to mitigate suicide risk as much as possible at the individual level. There are broadly three categories of risk factors that interact with each other, as seen below:

**RISK FACTORS (NON-EXHAUSTIVE LIST)**

| Individual | Socio-cultural | Situational |
|---|---|---|
| • Previous suicide attempt<br>• Mental disorder<br>• Alcohol or drug abuse<br>• Hopelessness<br>• Sense of isolation<br>• Lack of social support<br>• Aggressive tendencies<br>• Impulsivity<br>• History of trauma or abuse<br>• Acute emotional distress<br>• Major physical or chronic illnesses, including chronic pain<br>• Family history of suicide<br>• Neurobiological factors | • Stigma associated with help-seeking behaviour<br>• Barriers to accessing health care, especially mental health and substance abuse treatment<br>• Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)<br>• Exposure to suicidal behaviours, including through the media, and influence of others who have died by suicide | • Job and financial losses<br>• Relational or social losses<br>• Easy access to lethal means<br>• Local clusters of suicide that have a contagious influence<br>• Stressful life events |

Equally critical is the identification of broader socio-cultural, environmental and individual protective factors, which may reduce a person's vulnerability to suicidal behaviours. Protective factors can help individuals cope with particularly difficult circumstances and thereby minimize the risk of suicide. An effective strategy should therefore identify ways to establish, enhance and sustain protective factors for suicide.

**PROTECTIVE FACTORS**

- Strong connections to family and community support;
- Skills in problem solving, conflict resolution, and non-violent handling of disputes;
- Personal, social, cultural and religious beliefs that discourage suicide and support self-preservation;
- Restricted access to means of suicide;
- Seeking help and easy access to quality care for mental and physical illnesses.

## Effective interventions

Based on relevant risk and protective factors, a national strategy can propose the most suitable type and combination of evidence-based interventions – universal, selective and indicated. Universal intervention targets the general population with coverage of the population as a whole, irrespective of the degree of risk. Selective intervention focuses on sub-populations that are known to have an elevated risk and can be employed on the basis of socio-demographic characteristics, geographical distribution, or prevalence of mental and substance use disorders, depending on the contribution of these various factors to the overall burden of suicide. Indicated intervention is aimed at those who are already known to be vulnerable to suicide or who have attempted suicide.

A comprehensive suicide prevention programme typically employs a combination of these three approaches.

## Prevention strategies at the general population level

As part of its mhGAP programme, WHO identified three evidence-based population level strategies to prevent suicide, as follows:

### Restrict access to means of self-harm/suicide

It has been demonstrated that restricting access to means of suicide reduces the incidence of suicide. Thus, according to the local context, access to pesticides, firearms, charcoal, or high places should be reduced. The WHO recommends:

- Actively involving the community to find locally feasible ways to implement interventions at the population level to reduce access to means of suicide;

- Establishing collaboration between health and other relevant sectors to restrict access to these locally relevant means of suicide.

Depending on the situation analysis, governments should consider implementing steps to restrict access to firearms, pesticides or other noxious substances, charcoal, or high places depending on the country's specific context (WHO, 2009; WHO, 2008b, WHO, 2006). For instance, in the case of pesticides, which account for an estimated one-third of the world's suicides (Gunnell et al., 2007), several measures are feasible including ratifying, implementing, and enforcing the relevant international conventions on hazardous chemicals and wastes; enforcing the regulations on the sale of pesticides; reducing access to pesticides through safer storage by individuals or communities; reducing the toxicity of pesticides, as well as improving the medical management of those who attempted suicide by self-ingestion of pesticides; educating individuals, communities and the public about the proper handling, storage, use, and disposal of pesticides.

### Develop policies to reduce harmful use of alcohol as a component of suicide prevention

Alcohol abuse is considered a risk factor for attempted and completed suicide. Restricting the availability of alcohol to reduce the harmful use of alcohol is particularly critical within populations with a high prevalence of alcohol use. The WHO Global Strategy to reduce the harmful use of alcohol (World Health Organization, 2010a) outlines ten areas of policy options and interventions, including leadership, awareness and interventions; health services response; community action; drink-driving policies and countermeasures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; and monitoring and surveillance.

### Assist and encourage the media to follow responsible reporting practices of suicide

The role of the media in suicide prevention is often underestimated. The media have a distinct responsibility in how they report instances of suicide. The fact is, responsible reporting can – and does - save lives. mhGAP recommends that the media:

- Avoid language which sensationalizes or normalizes suicide or presents it as a solution to a problem;

- Avoids pictures and explicit description of the method used;

- Provides information about where to seek help.

A national suicide prevention strategy can emphasize the need for regular workshops for the media at national, regional and local levels. Journalists can be motivated to form a regulatory and self-monitoring system for the reporting of suicide. In many countries media guidelines have been developed. Also, media consumers can form a 'media watch' to monitor inaccurate, inappropriate, simplistic or sensational portrayal of suicide.

## Prevention strategies for vulnerable sub-populations at risk

### Gatekeeper training

Gatekeepers are those who come into frequent contact with members of the community on a regular basis, usually, but not exclusively, on account of their professional status. Gatekeepers interact with community members in natural and often non-medical environments and can be trained to recognize risk factors for suicide. In order to be effective, gatekeeper training must be a continuous, sustained effort with close monitoring and evaluation, ideally as part of a professional training curriculum. Training gatekeepers should go hand-in-hand with quality service development. Otherwise their efforts in identification of at risk individuals will be in vain.

**Key gatekeepers**

- Primary health care providers
- Mental health care providers
- Emergency health care providers
- Teachers and other school staff
- Community leaders
- Police officers and other first responders
- Military officers
- Social welfare workers
- Spiritual and religious leaders
- Traditional healers

A resource booklet series on preventing suicide has been published by WHO, as part of Suicide Prevention (SUPRE), the worldwide initiative for the prevention of suicide. These booklets are addressed to specific social and professional groups that are particularly relevant to the prevention of suicide, and include a resource for general physicians; primary health care workers; teachers and other school staff; police, fire fighters and other first line responders; counsellors; and media professionals; as well as a resource at work, and in jails and prisons. There is also a booklet on suicide case registration and one on how to start a survivors' group (World Health Organization, 2000-2011).

### Mobilizing communities

In communities, crisis centres should actively collaborate with health services as they may serve as an entry point for those who need care. A national suicide prevention strategy should support scaling up human resources that can provide crisis care, particularly in remote areas and for vulnerable populations, and encourage the formation of local NGO networks to promote shared learning. The overall aim should be to encourage help seeking behaviour and to provide timely assistance, be it by governmental, nongovernmental, community health, or social services.

Where there are few human resources providing crisis care and inadequate resources for scaling up, alternative means of community mobilization may be considered. There

are many examples, such as in India and Sri Lanka where community members have monitored access to pesticides, thereby helping to prevent suicide. Low-cost interventions such as these are potentially more sustainable in the long run, particularly if a core group from the local community is actively involved. Local governments can also look to network with, and enhance, existing community networks created by other organizations for different purposes. For example, women's self-help groups, which are effective and influential in many developing countries, could be encouraged to participate in suicide prevention efforts.

### Survivors

Survivors are those who have lost someone to suicide. This could include immediate family members, close friends, co-workers or classmates. Reaching out to this vulnerable group is crucial, as they can be prone to depression and suicidal behaviours. This process, known as postvention not only offers timely support to the bereaved but also becomes a method of suicide prevention in itself. The WHO resource series on preventing suicide mentioned above includes one booklet on how to start a survivors' group (World Health Organization, 2000-2011).

## Prevention strategies at the individual level

### Identification and treatment of mental disorders

Mental and substance use disorders are proven risk factors for suicide. The continued shortage of mental health professionals and inadequate service provision globally has heightened the risk of suicide, leaving several at-risk groups unrecognized and/or untreated and thereby more vulnerable to suicide. A national strategy should:

- Emphasize the need for integrating mental health service provision into primary health care;

- Draw attention to the lack of mental health care services, if necessary;

- Highlight the need to regularly educate primary health workers about suicide prevention, specifically identification, management, support and referral of suicidal individuals in communities. This is especially critical given that a vast majority of suicidal persons do not seek help from mental health providers initially, but rather present with various physical symptoms.

According to the WHO mhGAP Intervention Guide (mhGAP-IG), a guide for the assessment and management of the mhGAP priority conditions including self-harm/suicide, developed from evidence-based recommendations (World Health Organization, 2010b), any person over the age of 10 years experiencing any of the following conditions should be asked about thoughts or plans of self-harm in the last month, and about acts of self-harm in the last year:

- Self-harm/suicide, depression, alcohol use disorders, drug use disorders, bipolar disorders, psychosis, epilepsy, developmental and behavioural disorders in children and adolescents, mild dementia and other significant emotional or medically unexplained complaints.

- Chronic pain;

- Acute emotional distress.

The mhGAP-IG is designed in a way that those who present with thoughts, plans, or acts of self-harm/suicide are assessed for concurrent mhGAP mental, neurological or substance use disorders. The relevant conditions must then be managed according to mhGAP-IG.

### Management of persons who attempted suicide or who are at risk

For the assessment and management of persons who present to a health care facility, different steps in WHO's mhGAP-IG module on self-harm/suicide are included to assess whether a person has attempted a medically serious act of self-harm, to assess for an imminent risk of suicide or self-harm, and to assess for a history of thoughts, plans, or acts of self-harm, as well as for concurrent priority mental, neurological or substance use disorders, chronic pain, and severe emotional distress.

The management of a person includes interventions such as taking various specific steps to care for the person, removing the means of suicide from the individual, offering psychosocial support, and maintaining regular contact and follow-up (World Health Organization, 2010b). WHO has developed and tested at multiple sites a brief intervention and contact approach that has demonstrated its effectiveness for reducing suicide mortality among suicide attempters. This approach is uncomplicated, affordable and particularly appropriate for low-resource settings (Fleischmann et al., 2008).

## Improving case registration and conducting research

In reality, suicidal behaviours remain unreported or underreported in many countries. What is known is merely the tip of the iceberg. A national strategy can outline the current, or needed, registration and reporting mechanisms and could, subsequently, propose the establishment or modification of these systems in order to improve data collection on suicide and suicide attempts, and set a research agenda. A multi-sectoral approach is integral in order to gather data in a systematic and sustained manner, including multiple sources, such as the government, police, hospitals, NGOs, and mental health service providers.

While separate surveys on suicidal behaviours can be costly and unfeasible, a national strategy can also advocate for the inclusion of questions on suicidal behaviours in population-based surveys or the participation in large international surveys. Simultaneously, research on suicidal behaviours should be encouraged, so as to facilitate systematic review and analysis of this data. Identifying and triangulating multiple sources of data could be a useful approach towards data collection and validation, particularly in countries with high levels of stigma around suicide.

In countries with a functioning civil registration system, information on causes of death is compiled from individual death certificates as recorded in civil registries. Such data, which are collected through a routine system, are invaluable for the assessment and monitoring of the health status of a population, and for planning prevention or intervention strategies. The cause of death can be medically-certified and coded according to the International Classification of Diseases (ICD) (http://www.who.int/classifications/icd). More than 100 countries report such cause-of-death data to WHO (http://www.who.int/healthinfo/morttables).

In the absence of a national registration system, establishing a recording system for suicide and suicide attempts is helpful in quantifying the size of the problem, the methods used, as well as the age, sex, and ethnic background of persons who die from, or attempt,

suicide. To this end, WHO has published a resource booklet on suicide case registration and is developing one for suicide attempts (World Health Organization, 2000-2011). This issue is gaining further attention with the establishment of the IASP Task Force on National Systems for Certifying Suicidal Deaths. Great care should be taken to keep personal data as confidential as possible.

## Monitoring and evaluation

Various suicide prevention programmes to address vulnerable populations, such as young people, the elderly, indigenous peoples, armed forces, or prisoners, are carried out in different settings. However, most lack rigorous evaluation, making it difficult to draw any conclusions on their effectiveness. Recent studies, like the Saving and Empowering Young Lives (SEYLE) project in Europe (Wasserman et al., 2010) or interventions for military service members in the United States of America, in collaboration with the National Institute of Mental Health (NIMH and Army STARRS, 2010), have strong evaluation components in their study design. This is also true for Optimizing Suicide Prevention Programmes and Their Implementation in Europe (OSPI Europe), which utilizes a multilevel approach (Hegerl et al., 2009). In order to generate a larger body of evidence, the importance of evaluating interventions needs to be emphasized.

A national suicide prevention strategy should propose a comprehensive monitoring and evaluation framework to assess the quality and effectiveness of interventions. Ascertaining and recording numbers of attempted and completed suicides, and monitoring them, is an integral component in the development of a suicide prevention strategy. While it is difficult to evaluate a national suicide prevention strategy as a whole, evaluations of individual components of a national strategy at reasonable intervals offer opportunities to critically examine the outcome and impact of interventions vis-à-vis the stated objectives. Evaluations can also indicate whether it is time to make changes to the intervention process or to scale-up interventions. In order to achieve all of the above, evaluation needs to be planned and agreed upon in advance to ensure the involvement of all relevant stakeholders, including inputs from key personnel involved in the implementation of a programme or specific intervention as well as feedback from community members.

Ideally, a national strategy should outline a set of specific, measurable, achievable, relevant and time-bound (SMART) indicators. At least one SMART indicator must be linked to each specific objective of the national strategy. Indicators can measure the input, process, impact and outcome of individual interventions as well as the strategy on the whole. Resource allocation is an example of an input indicator. Process indicators could include an assessment of the acceptability of the strategy and community participation in suicide prevention activities. Impact indicators could be used to measure change in community attitudes to suicide and stigma. Outcome indicators could include assessing any change in the rate of suicide attempts and the number of premature deaths due to suicide, both across the life span and especially for vulnerable age groups.
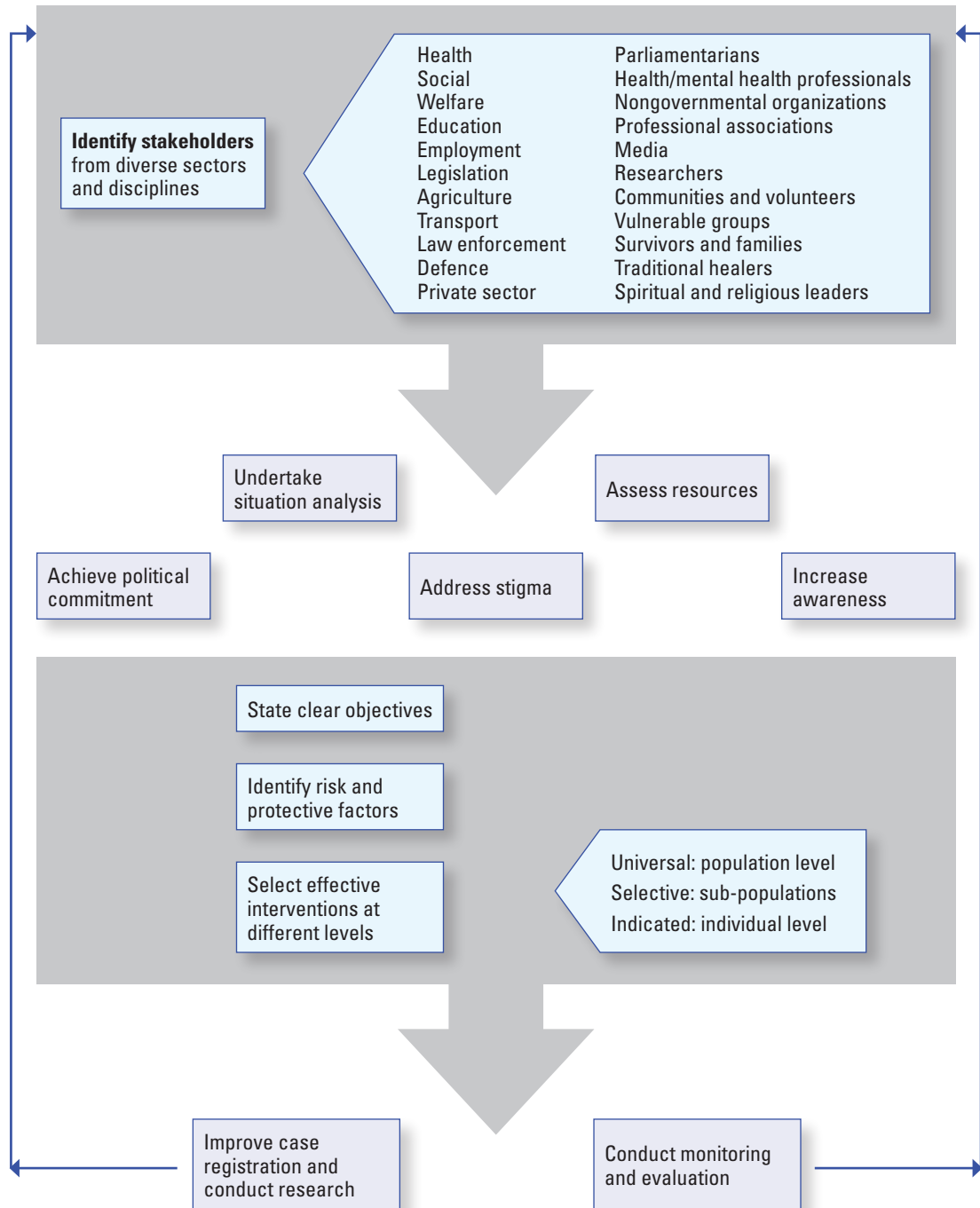
# CONCLUSION

Suicide is a priority condition globally and has been identified as such by the WHO. A national suicide prevention strategy should be developed through a stepwise approach. Such a strategy acknowledges, as a first step, that suicide is a major problem and that it is preventable. The process of developing a national strategy provides an impetus to suicide prevention by improving awareness among government representatives and local communities. The lack of resources – human or financial – can no longer remain an acceptable justification for not developing or implementing a national suicide prevention strategy. National governments have to focus on ways to use the available resources optimally and collaborate with state and local jurisdictions, as necessary. Once approved by the government, the implementation of the strategy, with its concrete action plans and programmes, will greatly benefit from the broad participation in its development. Suicide prevention is a collective responsibility, and must be spearheaded by governments and civil society throughout the world.

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# ANNEX

Figure 1. Framework for the development of a national suicide prevention strategy

**Identify stakeholders** from diverse sectors and disciplines

Health
Social
Welfare
Education
Employment
Legislation
Agriculture
Transport
Law enforcement
Defence
Private sector

Parliamentarians
Health/mental health professionals
Nongovernmental organizations
Professional associations
Media
Researchers
Communities and volunteers
Vulnerable groups
Survivors and families
Traditional healers
Spiritual and religious leaders

Undertake situation analysis

Assess resources

Achieve political commitment

Address stigma

Increase awareness

State clear objectives

Identify risk and protective factors

Select effective interventions at different levels

Universal: population level
Selective: sub-populations
Indicated: individual level

Improve case registration and conduct research

Conduct monitoring and evaluation