CHAPTER 1

Suicide and suicide prevention from a global perspective

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Introduction

Suicide and non-fatal suicidal behavior (suicide attempts/self-harm) are major, global public health challenges, with an estimated annual number of 793,000 deaths worldwide and up to twenty times as many episodes of attempts and self-harm episodes (WHO, 2014). Currently, suicide is the second leading cause of death among young people aged 15-29 years at global level (WHO, 2018b). Although, overall, suicide rates in low- and middle-income countries (LMIC) are lower than the rates in high income countries (HIC) of 11.2 per 100,000 compared with 12.7 per 100,000 population, the majority of suicide deaths worldwide occur in LMICs (approximately 79%) (WHO, 2018b). However, it must be noted that there are ongoing challenges in relation to the accuracy of suicide figures obtained from many countries (Varnik, 2012; WHO, 2018a).

The World Health Organization (*WHO*) *Global Mental Health Action Plan, 2013-2020*, has been a major step forward in pushing the agenda of suicide prevention globally (Saxena, Funk, & Chisholm, 2013; WHO, 2013). This plan was adopted by Health Ministers in all 194 WHO member states to formally recognise the importance of mental health, a move that represented a remarkable achievement. Among these WHO Member States, there are 25 countries where suicide is currently still criminalised and an additional 20 countries where according to Sharia law suicide attempters may be punished with jail sentences (Mishara &

Weisstub, 2016). The *Action Plan* covers specified activities to improve mental health and to contribute to the attainment of a set of agreed global targets, in particular aimed at reaching: 1) a 20% increase in service coverage for severe mental disorders; and, 2) a 10% reduction of the suicide rate in countries by 2020.

The subsequent publication of the WHO Report: *Preventing Suicide: A Global Imperative*, in 2014 (WHO, 2014), was strategically a major and timely next step to increase the commitment of national governments and Health Ministers to reinforce action in relation to suicide prevention. Many members of the International Association for Suicide Prevention (IASP), representing all regions in the world, were involved in preparing this report (Arensman, 2017).

At the 29th IASP World Congress in Malaysia, the IASP Special Interest Group (SIG) was launched to support the development and implementation of national suicide prevention programmes at global level (Platt, Arensman, & Rezaeian, 2019). This SIG aims to establish an active forum of international experts which will collaborate with relevant organizations, ministries and NGOs in the development of suicide prevention strategies in countries (especially LMICs) where, historically, there has been little or no suicide prevention activity. It is tasked with developing guidance for establishing, implementing and evaluating community-level suicide prevention activities in countries where a national strategy is not currently feasible. Since 2017, this SIG has organised many workshops and seminars facilitating professionals and volunteers working in suicide prevention to develop and implement national suicide prevention programmes. In addition, annually, both IASP and WHO underline the importance of national suicide prevention programmes on World Suicide Prevention Day.

The WHO report (WHO, 2014) provides guidance in developing and implementing national suicide prevention programmes while taking into account the different stages at which a country is (i.e., countries where suicide prevention activities have not yet taken place, countries with some activities, and countries that currently have a national response). Within geographic regions, countries that have adopted a national suicide prevention programme can impact positively on surrounding countries, and increase prioritisation of suicide prevention in countries that do not yet have a national programme, a development that is illustrated in Chapters 2-7 of this Monograph. In terms of the content of a national suicide prevention programme, the WHO report recommends a systematic approach and summarizes typical components (WHO, 2014). Even though these components are supported by evidence, the strength and consistency of the evidence for some of the components/interventions in reducing suicide and attempted suicide or self-harm varies (Chapter 8).

An encouraging incentive is the fact that the WHO report has been translated in all six UN languages, and regional launches have been held in Mexico (with representatives from Spanish speaking countries), in Cairo (with representatives from the WHO Eastern Mediterranean Region), and in Tokyo (with representatives from the WHO Western Pacific Region). Furthermore, a growing number of countries have recently completed their second national suicide prevention programme, including England (Department of Health and Social Care, 2012), Scotland (The Scottish Government, 2013), Ireland (Department of Health, 2015), and the US (US Department of Health & Human Services, 2012). In this regard, it is worth noting that the WHO Country Office and the Ministry of Health and Social Services (MoHSS) in Namibia have also initiated the development of the 2nd National Suicide Prevention Strategy.

The ongoing global priority of suicide prevention is highlighted by the United Nations Sustainable Development Goals (SDGs) for 2030, which include a target of reducing by one third premature mortality from non-communicable diseases, with suicide mortality rate identified as an indicator for this target (UN, 2015). SDG target 3.4 calls for a reduction in premature mortality from non-communicable diseases through prevention and treatment and promotion of mental health and wellbeing (WHO, 2015). 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, 2015).

The WHO recently published a report on the progress of the content and indicators of national suicide prevention strategies, including 10 country examples, representing different WHO regions (WHO, 2018a). The report encourages governments and countries to continue the work where it is already happening, to strengthen suicide prevention efforts, and to place suicide prevention high on the political agenda. In addition, the report discusses barriers and facilitators for the implementation and evaluation of national suicide prevention strategies (WHO, 2018a).

In 2013-2014, IASP and the WHO Department of Mental Health and Substance Abuse conducted a global survey. IASP national representatives of ninety countries (57%) completed the survey, providing information on national strategies and activities in suicide prevention in their own countries. In nearly two thirds (61%) of the responding countries, suicide was perceived as a significant public health concern. In 31% of the countries a comprehensive national strategy or action plan was adopted by the government. Among the

countries that did not have a national strategy, a number of suicide prevention activities were carried out in just over half (52%). These activities included training on suicide risk assessment and intervention (38%), training for general practitioners (26%), and suicide prevention training for non-health professionals including first responders, teachers and journalists (37%). A unique contribution of this survey was that for some regions across the world, such as the Eastern Mediterranean and African regions, where previously information on suicide prevention activities was limited or absent, new information was accessed. For example, in 40% of the responding countries in the Eastern Mediterranean Region a training programme on suicide assessment and intervention for GPs was available, and in 20% of the countries in this region, training programmes were available on suicide prevention for non-health professionals. A detailed overview of the survey outcomes for the different geographic regions is provided in Chapters 2-7. In addition, information on recent progress in the development and implementation of national suicide prevention programmes in the different countries is included.

Despite the progress in suicide prevention globally, we still face numerous challenges. The accuracy and reliability of suicide statistics is an ongoing issue of concern in a considerable number of countries (Tollefsen, Hem, & Ekeberg, 2012). In terms of implementing national suicide prevention programmes and the sustainability of interventions, on-going obstacles are represented by insufficient resources, ineffective co-ordination, lack of enforcement of guidelines, limited access to surveillance data on suicide and attempted suicide or self-harm and the lack of independent and systematic evaluations (WHO, 2014). In addition, it would be important for a national suicide prevention programme to address real-time developments, such as emerging suicide contagion and clustering, emerging methods of suicide and evolving ‘new’ vulnerable and high-risk groups (e.g., responding to migrants and refugees

from Eastern Mediterranean countries, which have an increased risk of suicide and self-harm (Chapter 9)).

Within this context, it is essential that governments assume a leadership role for a national suicide prevention strategy, as they are able to bring together stakeholders who may not otherwise collaborate (WHO, 2014, 2018a). Suicide prevention needs to be prioritized on global public health and public policy agendas and awareness of suicide as a public health concern must be raised by using an interdisciplinary approach that recognizes social, psychological and cultural impacts. A national suicide prevention strategy is important because this indicates a government's clear commitment to prioritizing and tackling suicide by providing leadership and guidance on the key evidence-based suicide prevention interventions (WHO, 2014, 2018a).

This monograph provides a global overview of suicide and suicide prevention strategies, using insights obtained from the global survey. A distinction is made between geographic regions, with updates of progress in suicide prevention for the different countries. In addition, a review is provided of the evidence base and best practice of suicide prevention programmes. The monograph is concluded with an overview of future directions for suicide prevention at global level.

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