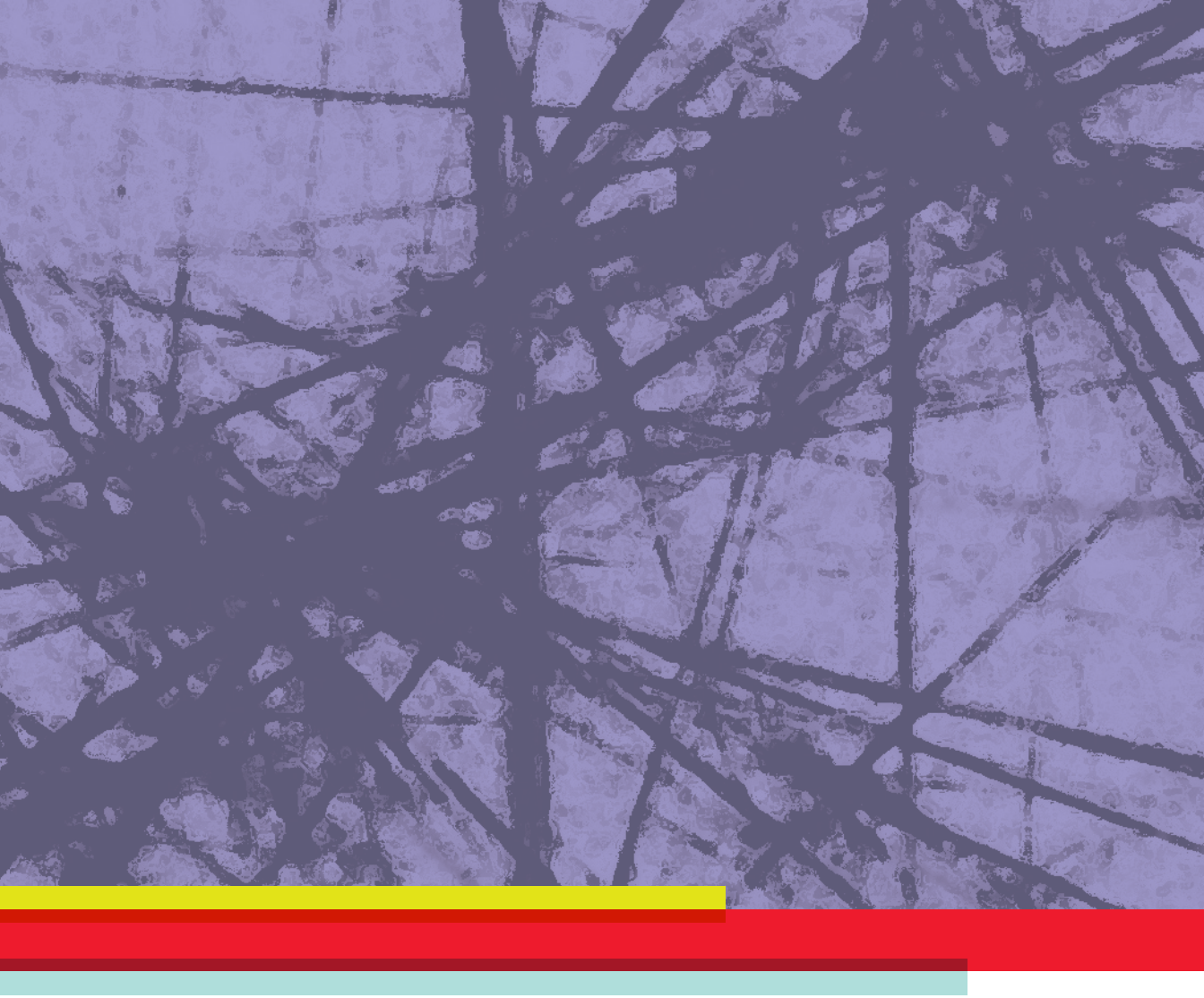

**Ella Arensman**
**Diego De Leo**
**Jane Pirkis**
(Editors)

# Suicide and Suicide Prevention From a Global Perspective

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Ella Arensman
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# Contents

# Foreword

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Suicide is one of the most personal yet one of the most complex acts anyone can perform. It continues to be a major global public health problem with an estimated 800,000 deaths annually. This is despite the fact that there have been significant advancements in the fields of science and technology, of material wealth and living conditions as well as in the early diagnosis and effective treatment of many mental disorders, including mood disorders. Hence, the continuing need to develop effective suicide prevention programs cannot be overemphasized.

This monograph is timely as the global priority of suicide prevention is highlighted by the United Nations Sustainable Development Goals (SDGs) for 2030, with a target of reducing premature mortality from noncommunicable diseases by one-third, with suicide mortality identified as an indicator for this target. The monograph is also highly relevant as it not only traces the major milestones and achievements in suicide prevention so far but also identifies key priority areas for the future. It takes a global perspective of suicide and suicide prevention, covering all the regions of the world. The authors are all based in their respective regions. Suicide may be a global problem, but solutions always have to be local.

Clearly, suicide prevention will continue to pose as big a challenge for the foreseeable future as it did 50 years ago. This is particularly so for those countries where lack of resources, poorly established primary and mental health services, and weak political processes make prevention efforts doubly difficult. However, as recent figures from the United States and Scotland show, even high-income countries, with well-established health systems and national suicide prevention programs, are not immune from increases in suicide rates.

In suicide prevention there is no room for complacency. Suicide prevention poses a unique and formidable challenge. Public and mental health professionals, government and nongovernmental organizations, and civil society across the globe need to work together to take up this challenge.

It is hoped that this work will serve as a useful resource for all of us.

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# Suicide and Suicide Prevention From a Global Perspective

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**Abstract.** In this introductory chapter, we provide the background and rationale for the compilation of overviews of national suicide prevention strategies from all geographic regions globally. Currently, suicide is the second leading cause of death among young people aged 15–29 years at global level. 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, but the majority of suicide deaths worldwide occur in LMICs. However, there are ongoing challenges in relation to the accuracy of suicide figures in many countries. The rationale for the global approach to suicide prevention is linked to major strategic documents provided by the WHO, including the Global Mental Health Action Plan, 2013–2020, the WHO report Preventing Suicide: A Global Imperative, in 2014, and the United Nations Sustainable Development Goals (SDGs) for 2030, including a target of reducing premature mortality from noncommunicable diseases by one-third, with suicide mortality rate identified as an indicator for this target. In addition, a review is provided of the evidence base and best practice of suicide prevention programs.

**Keywords:** suicide, prevention, global

Suicide and nonfatal 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 20 times as many episodes of suicide attempts and of self-harm (World Health Organization [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) at 11.2 per 100,000 compared with 12.7 per 100,000 population, respectively, 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).

## Global Policies and Initiatives

The World Health Organization *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 recognize 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 criminalized 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




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global targets, in particular aimed at reaching (a) a 20% increase in service coverage for severe mental disorders, and (b) 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 toward increasing 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 programs at global level (Platt, Arensman, & Rezaeian, 2019). This SIG aims to establish an active forum of international experts who will collaborate with relevant organizations, ministries, and nongovernmental organizations (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 organized many workshops and seminars facilitating professionals and volunteers working in suicide prevention to develop and implement national suicide prevention programs. In addition, annually, both the IASP and the WHO underline the importance of national suicide prevention programs on World Suicide Prevention Day.

The WHO report (WHO, 2014) provides guidance in developing and implementing national suicide prevention programs 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 program can impact positively on surrounding countries and increase prioritization of suicide prevention in countries that do not yet have a national program, a development that is illustrated in the chapters by Pompili, O'Connor, & van Heeringen (2020), Vijayakumar, Daly, Arafat, & Arensman (2020), Silverman, Barnaby, Mishara, & Reidenberg (2020), Osafo, Asante, & Akotia (2020), Rezaeian & Khan (2020), and Pirkis, Amadeo, Beautrais, Phillips, & Yip (2020) this monograph. In terms of the content of a national suicide prevention program, 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 vary (see chapter by Platt & Niederkrotenthaler, 2020).

An encouraging incentive is the fact that the WHO report has been translated into all six United Nations (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 program, including England (Department of Health and Social Care, 2012), Scotland (The Scottish Government, 2013), Ireland (Department of Health, 2015), and the United States (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 Second National Suicide Prevention Strategy.

The ongoing global priority of suicide prevention is highlighted by the UN Sustainable Development Goals (SDGs) for 2030, which include a target of reducing by one-third premature mortality from noncommunicable diseases, with the suicide mortality rate identified as an indicator for this target (UN, 2015). 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 (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).

## Global Survey

During 2013–2014, the IASP and the WHO Department of Mental Health and Substance Abuse conducted a global survey. IASP national representatives of 90 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 (GPs; 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 program on suicide assessment and intervention for GPs was available, and in 20 % of the countries in this region, training programs were available on suicide prevention for non-health professionals. A detailed overview of the survey outcomes for the different geographic regions is provided in the chapters by Pompili et al., (2020), Vijayakumar et al. (2020), Silverman et al. (2020), Osafo et al. (2020), Rezaeian & Khan (2020), and Pirkis et al. (2020).

In addition, information on recent progress in the development and implementation of national suicide prevention programs in the different countries is included.

## Ongoing Challenges

Despite the progress in suicide prevention globally, we still face numerous challenges. The accuracy and reliability of suicide statistics represent an ongoing issue of concern in a considerable number of countries (Tollefsen, Hem, & Ekeberg, 2012). In terms of implementing national suicide prevention programs and the sustainability of interventions, ongoing obstacles are represented by insufficient resources, ineffective coordination, 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 program 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, who have an increased risk of suicide and self-harm; see chapter on future directions by Arensman, De Leo, & Pirkis, 2020).