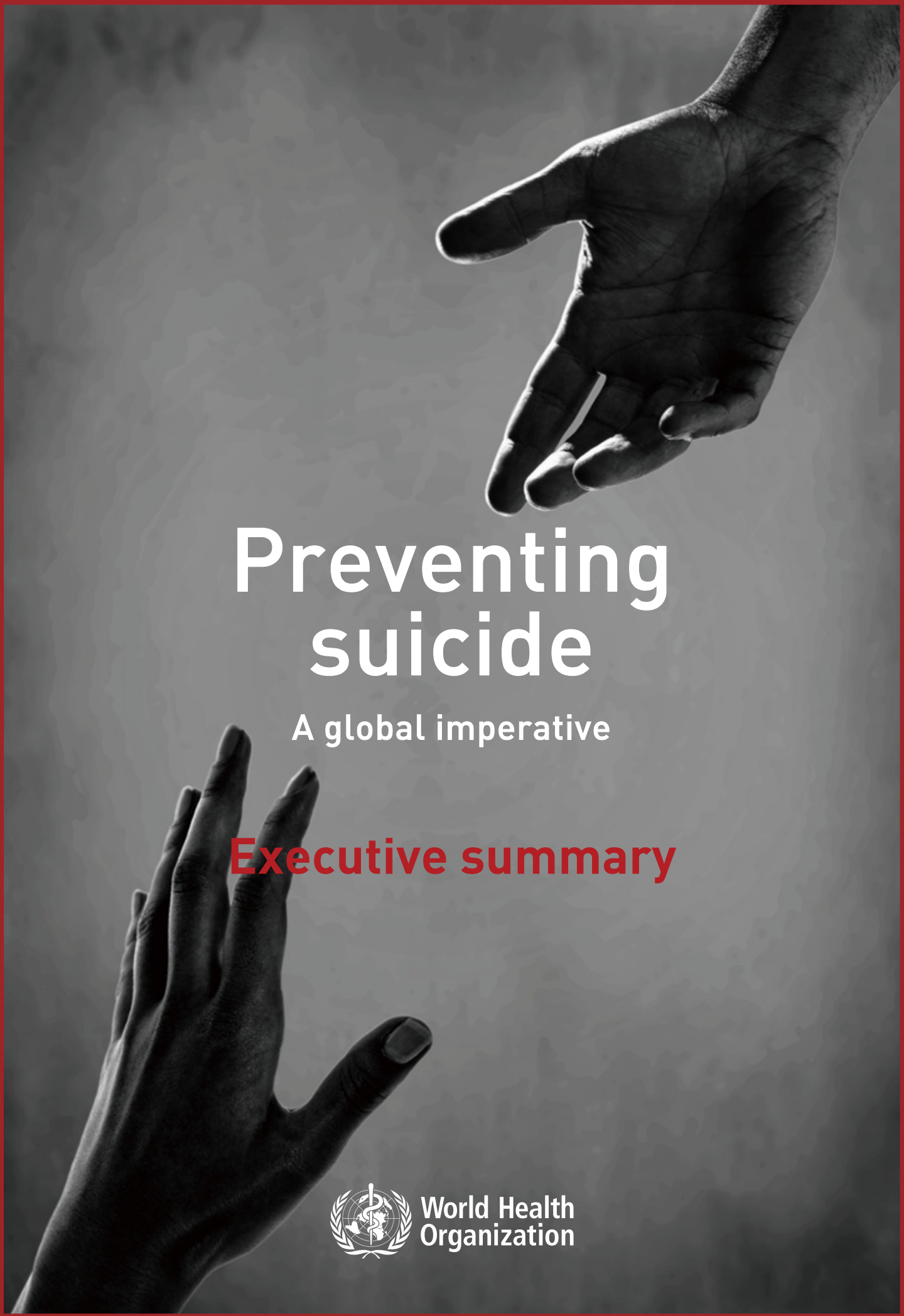

Preventing suicide

A global imperative

Executive summary

World Health Organization

Introduction

In May 2013, the Sixty-sixth World Health Assembly adopted the first-ever Mental Health Action Plan of the World Health Organization (WHO). Suicide prevention is an integral part of the plan, with the goal of reducing the rate of suicide in countries by 10% by 2020 (1). There is no single explanation of why people die by suicide. However, many suicides happen impulsively and, in such circumstances, easy access to a means of suicide – such as pesticides or firearms – can make the difference as to whether a person lives or dies.

Social, psychological, cultural and other factors can interact to lead a person to suicidal behaviour, but the stigma attached to mental disorders and suicide means that many people feel unable to seek help. Despite the evidence that many deaths are preventable, suicide is too often a low priority for governments and policy-makers. The objective of this report is to prioritize suicide prevention on the global public health and public policy agendas and to raise awareness of suicide as a public health issue. The report was developed through a global consultative process and is based on systematic reviews of data and evidence together with inputs from partners and stakeholders.

Global epidemiology of suicide and suicide attempts

An estimated 804 000 suicide deaths occurred worldwide in 2012, representing an annual global age-standardized suicide rate of 11.4 per 100 000 population (15.0 for males and 8.0 for females). However, since suicide is a sensitive issue, and even illegal in some countries, it is very likely that it is under-reported. In countries with good vital registration data, suicide may often be misclassified as an accident or another cause of death. Registering a suicide is a complicated procedure involving several different authorities, often including law enforcement. And in countries without reliable registration of deaths, suicides simply die uncounted.

In richer countries, three times as many men die of suicide than women do, but in low- and middle-income countries the male-to-female ratio is much lower at 1.5 men to each woman. Globally, suicides account for 50% of all violent deaths in men and 71% in women. With regard to age, suicide rates are highest in persons aged 70 years or over for both men and women in almost all regions of the world. In some countries, suicide rates are highest among the young, and globally suicide is the second leading cause of death in 15–29-year-olds. The ingestion of pesticide, hanging and firearms are among the most common methods of suicide globally, but many other methods are used with the choice of method often varying according to population group.

For every suicide there are many more people who attempt suicide every year. Significantly, a prior suicide attempt is the single most important risk factor for suicide in the general population. For both suicides and suicide attempts, improved availability and quality of data from vital registration, hospital-based systems and surveys are required for effective suicide prevention.

Restricting access to the means of suicide is a key element of suicide prevention efforts. However, means restriction policies (such as limiting access to pesticides and firearms or putting barriers on bridges) require an understanding of the method preferences of different groups in society and depend on cooperation and collaboration between multiple sectors.

Risk and protective factors, and related interventions

Frequently, several risk factors act cumulatively to increase a person's vulnerability to suicidal behaviour.

Risk factors associated with the health system and society at large include difficulties in accessing health care and in receiving the care needed, easy availability of the means for suicide, inappropriate media reporting that sensationalizes suicide and increases the risk of "copycat" suicides, and stigma against people who seek help for suicidal behaviours, or for mental health and substance abuse problems.

Risks linked to the community and relationships include war and disaster, stresses of acculturation (such as among indigenous peoples or displaced persons), discrimination, a sense of isolation, abuse, violence and conflictual relationships. And risk factors at the individual level include previous suicide attempts, mental disorders, harmful use of alcohol, financial loss, chronic pain and a family history of suicide.

Strategies to counter these risk factors are of three kinds. "Universal" prevention strategies, which are designed to reach an entire population, may aim to increase access to health care, promote mental health, reduce harmful use of alcohol, limit access to the means for suicide or promote responsible media reporting. "Selective" prevention strategies target vulnerable groups such as persons who have suffered trauma or abuse, those affected by conflict or disaster, refugees and migrants, and persons bereaved by suicide, by training "gatekeepers" who assist the vulnerable and by offering helping services such as helplines. "Indicated" strategies target specific vulnerable individuals with community support, follow-up for those leaving health-care facilities, education and training for health workers, and improved identification and management of mental and substance use disorders. Prevention can also be strengthened by encouraging protective factors such as strong personal relationships, a personal belief system and positive coping strategies.

The current situation in suicide prevention

Knowledge about suicidal behaviour has increased greatly in recent decades. Research, for instance, has shown the importance of the interplay between biological, psychological, social, environmental and cultural factors in determining suicidal behaviours. At the same time, epidemiology has helped identify many risk and protective factors for suicide both in the general population and in vulnerable groups. Cultural variability in suicide risk has also become apparent, with culture having roles both in increasing risk and also in protection from suicidal behaviour.

In terms of policy, 28 countries today are known to have national suicide prevention strategies, while World Suicide Prevention Day, organized by the International Association for Suicide Prevention, is observed worldwide on 10 September each year. Additionally, many suicide research units have been set up and there are academic courses that focus on suicide and its prevention. To provide practical help, non-specialized health professionals are being used to improve assessment and management of suicidal behaviours, self-help groups of bereaved have been established in many places, and trained volunteers are helping with online and telephone counselling.

In the past half-century, many countries have decriminalized suicide, making it much easier for those with suicidal behaviours to seek help.

Working towards a comprehensive response for suicide prevention

A systematic way of developing a national response to suicide is to create a national suicide prevention strategy. A national strategy indicates a government's clear commitment to dealing with the issue of suicide. Typical national strategies comprise a range of prevention strategies such as surveillance, means restriction, media guidelines, stigma reduction and raising of public awareness as well as training for health workers, educators, police and other gatekeepers. They also usually include crisis intervention services and postvention.

Key elements in developing a national suicide prevention strategy are to make prevention a multisectoral priority that involves not only the health sector but also education, employment, social welfare, the judiciary and others. The strategy should be tailored to each country's cultural and social context, establishing best practices and evidence-based interventions in a comprehensive approach. Resources should be allocated for achieving both short-to-medium and long-term objectives, there should be effective planning, and the strategy should be regularly evaluated, with evaluation findings feeding into future planning.

In countries where a fully-developed comprehensive national strategy is not yet in place, this should not be an obstacle to implementing targeted suicide prevention programmes since

these can contribute to a national response. Such targeted programmes aim to identify groups vulnerable to the risk of suicide and improve access to services and resources for those groups.

The way forward for suicide prevention

Ministers of health have an important role in providing leadership and bringing together stakeholders from other sectors in their country. In countries where suicide prevention activities have not yet taken place, the emphasis is on seeking out stakeholders and developing activities where there is greatest need or where resources already exist. It is also important to improve surveillance at this stage. In countries with some existing suicide prevention activities, a situation analysis can show what is already in place and indicate where there are gaps that need to be filled. Countries that already have a relatively comprehensive national response should focus on evaluation and improvement, updating their knowledge with new data and emphasizing effectiveness and efficiency.

While moving forward, two points should be considered. First, suicide prevention activities should be carried out at the same time as data collection. Second, even if it is felt that a country is not yet ready to have a national prevention strategy, the process of consulting stakeholders about a national response often generates interest and creates an environment for change. Through the process of creating the national response, stakeholders become committed, public dialogue on stigma is encouraged, vulnerable groups are identified, research priorities are fixed, and public and media awareness are increased.

Indicators that measure the strategy's progress can include:
- a percentage reduction in the suicide rate;
- the number of suicide prevention interventions successfully implemented;
- a decrease in the number of hospitalized suicide attempts.

Countries that are guided by the WHO Mental Health Action Plan 2013–2020 (1) can aim for a 10% reduction in the suicide rate. Many countries will want to reduce the suicide rate further. In the long-term, importantly, reducing risk will go only part of the way towards reducing suicide. Furtherance of protective factors will help build for the future – a future in which community organizations provide support and appropriate referrals to those in need of assistance, families and social circles enhance resilience and intervene effectively to help loved ones, and there is a social climate where help-seeking is no longer taboo and public dialogue is encouraged.

Key messages

Suicides take a high toll. Over 800 000 people die due to suicide every year and it is the second leading cause of death in 15-29-year-olds. There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide.

Suicides are preventable. For national responses to be effective, a comprehensive multisectoral suicide prevention strategy is needed.

Restricting access to the means for suicide works. An effective strategy for preventing suicides and suicide attempts is to restrict access to the most common means, including pesticides, firearms and certain medications.

Health-care services need to incorporate suicide prevention as a core component. Mental disorders and harmful use of alcohol contribute to many suicides around the world. Early identification and effective management are key to ensuring that people receive the care they need.

Communities play a critical role in suicide prevention. They can provide social support to vulnerable individuals and engage in follow-up care, fight stigma and support those bereaved by suicide.