Suicide prevention from a global perspective

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Suicide facts (1)

- Over 800,000 people die by suicide every year
- More than e.g. malaria, breast cancer, dementia
Suicide rates across countries

WHO estimations

Map 1. Age-standardized suicide rates (per 100,000 population), both sexes, 2012
For each suicide, there are likely to be more than 20 others making an attempt.

For each suicide, there are likely to be hundreds of bereaved persons who suffer.
Suicide facts (3)

- Second leading cause of death among 15-29 year-olds globally
- First leading cause of death among 15-19 year-old girls globally
75% of suicides occur in Low and Middle Income countries.

Rates are higher among the young in LMICs than in HIC.
Suicides by age and income level

Figure 2. Global suicides by age and income level of country, 2012

- Total suicides: 803,900
- Low- and middle-income: 606,700 (75.5%)
- High-income: 197,200 (24.5%)
Age-standardized suicide rates (per 100,000) and total number of suicides, both sexes, 2012

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>Suicide rate</th>
<th>Rank</th>
<th>Country</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Guyana</td>
<td>44.2</td>
<td>1</td>
<td>India</td>
<td>258075</td>
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<tr>
<td>2</td>
<td>Republic of Korea</td>
<td>28.9</td>
<td>2</td>
<td>China</td>
<td>120730</td>
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<tr>
<td>3</td>
<td>Sri Lanka</td>
<td>28.8</td>
<td>3</td>
<td>United States of America</td>
<td>43361</td>
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<tr>
<td>4</td>
<td>Lithuania</td>
<td>28.2</td>
<td>4</td>
<td>Russian Federation</td>
<td>31997</td>
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<tr>
<td>5</td>
<td>Suriname</td>
<td>27.8</td>
<td>5</td>
<td>Japan</td>
<td>29442</td>
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<tr>
<td>6</td>
<td>Mozambique</td>
<td>27.4</td>
<td>6</td>
<td>Republic of Korea</td>
<td>17908</td>
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<tr>
<td>7</td>
<td>Nepal</td>
<td>24.9</td>
<td>7</td>
<td>Pakistan</td>
<td>13377</td>
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<tr>
<td>8</td>
<td>United Rep of Tanzania</td>
<td>24.9</td>
<td>8</td>
<td>Brazil</td>
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<tr>
<td>9</td>
<td>Kazakhstan</td>
<td>23.8</td>
<td>9</td>
<td>Germany</td>
<td>10745</td>
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<tr>
<td>10</td>
<td>Burundi</td>
<td>23.1</td>
<td>10</td>
<td>Bangladesh</td>
<td>10167</td>
</tr>
<tr>
<td>11</td>
<td>India</td>
<td>21.1</td>
<td>11</td>
<td>France</td>
<td>10093</td>
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<tr>
<td>12</td>
<td>South Sudan</td>
<td>19.8</td>
<td>12</td>
<td>Ukraine</td>
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<tr>
<td>13</td>
<td>Turkmenistan</td>
<td>19.6</td>
<td>13</td>
<td>Indonesia</td>
<td>9105</td>
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<tr>
<td>14</td>
<td>Russian Federation</td>
<td>19.5</td>
<td>14</td>
<td>Thailand</td>
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<tr>
<td>15</td>
<td>Uganda</td>
<td>19.5</td>
<td>15</td>
<td>Poland</td>
<td>7848</td>
</tr>
</tbody>
</table>
AMRO/PAHO Region

- AMR LAMICs: 6.1 per 100,000 both sexes; 2.7 females; 9.8 males
- Global: 11.4 per 100,000 both sexes; 8.0 females; 15.0 males

- Each suicide is one too many!
Suicide Facts (5)

- Male: Female ratio is lower in LMICs
Suicide Facts (6)

- Pesticides, hanging and firearms are among the most common means of suicide globally.

- Pesticides account for an estimated $\frac{1}{3}$ of the world's suicides.
Suicide facts (7)

- Suicide causes 57% of all violent deaths
- More than from war and homicide together
Suicide Facts (8)

- Suicide accounted for 1.4% of all deaths worldwide
- 15th leading cause of death in 2012
Preventing suicide
A global imperative

Launched in September 2014
What can be done?
A complex issue with a multitude of factors, there is no one answer to this problem

Governments must assume their role of leadership in suicide prevention

Multisectoral collaboration is key

### A multisectoral approach

<table>
<thead>
<tr>
<th>HEALTH SYSTEMS</th>
<th>Barriers to accessing health care</th>
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<tbody>
<tr>
<td>SOCIETY</td>
<td>Access to means</td>
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<tr>
<td></td>
<td>Inappropriate media reporting</td>
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<tr>
<td></td>
<td>Stigma associated with help-seeking behaviour</td>
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<tr>
<td></td>
<td>Disaster, war and conflict</td>
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<td></td>
<td>Stresses of acculturation and dislocation</td>
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<tr>
<td></td>
<td>Discrimination</td>
</tr>
<tr>
<td></td>
<td>Trauma or abuse</td>
</tr>
<tr>
<td>COMMUNITY</td>
<td>Sense of isolation and lack of social support</td>
</tr>
<tr>
<td></td>
<td>Relationship conflict, discord or loss</td>
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<tr>
<td>RELATIONSHIPS</td>
<td>Previous suicide attempt</td>
</tr>
<tr>
<td></td>
<td>Mental disorders</td>
</tr>
<tr>
<td></td>
<td>Harmful use of alcohol</td>
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<tr>
<td></td>
<td>Job or financial loss</td>
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<td></td>
<td>Hopelessness</td>
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<td></td>
<td>Chronic pain</td>
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<td></td>
<td>Family history of suicide</td>
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<td></td>
<td>Genetic and biological factors</td>
</tr>
</tbody>
</table>
Evidence-based interventions

- Reducing access to means
- Responsible media reporting
- Introducing alcohol policies
- School-based interventions
- Early identification and treatment
- Training of health workers
- Follow-up care and community support
Modelling of optimal implementation

Many thousands of lives could be saved in just one year in the USA

Figure 8. Suicide deaths prevented by proposed interventions approximating a 20% reduction in 2010 suicide deaths in the USA (55)

Separating suicidal individuals from firearm access: 3612
Separating suicidal individuals from carbon monoxide motor vehicle: 600
Psychotherapy provided in emergency care: 2498
## Table 5. Proposed strategic actions for suicide prevention (categorized by current implementation levels)

<table>
<thead>
<tr>
<th>Areas of strategic action</th>
<th>Lead stakeholders</th>
<th>No activity (currently there is no suicide prevention response at national or local level)</th>
<th>Some activity (some work has begun in suicide prevention in priority areas at either national or local level)</th>
<th>Established suicide prevention strategy exists at national level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage key stakeholders</td>
<td>Ministry of Health as lead, or other coordinating health body</td>
<td>Initiate identification of and engagement with key stakeholders on country priorities, or where activities already exist.</td>
<td>Identify all key stakeholders across sectors and engage them comprehensively in suicide prevention activities. Assign responsibilities.</td>
<td>Assess the roles, responsibilities, and activities of all key stakeholders on a regular basis. Use the results to expand sector participation and increase stakeholder involvement.</td>
</tr>
<tr>
<td>Reduce access to means</td>
<td>Legal and judicial system, policy-makers, agriculture, transportation</td>
<td>Begin efforts to reduce access to means of suicide through community interventions.</td>
<td>Coordinate and expand existing efforts to reduce access to the means of suicide (including laws, policies and practices at national level).</td>
<td>Evaluate efforts to reduce access to the means of suicide. Use the evaluation results to make improvements.</td>
</tr>
<tr>
<td>Conduct surveillance and improve data quality</td>
<td>Ministry of Health, Bureau of Statistics, all other stakeholders, and particularly the formal and informal health systems to collect data</td>
<td>Begin surveillance, prioritizing mortality data, with core information on age, sex and methods of suicide. Begin identification of representative locations for development of models.</td>
<td>Put a surveillance system in place to monitor suicide and suicide attempts at national level (including additional disaggregation) and ensure the data is reliable, valid and publicly available. Establish feasible data models that are effective and can be scaled up.</td>
<td>Monitor key attributes such as quality, representativeness, timeliness, usefulness and costs of the surveillance system in a timely manner. Use the results to improve the system. Scale up effective models for comprehensive data coverage and quality.</td>
</tr>
<tr>
<td>Raise awareness</td>
<td>All sectors, with leadership from the</td>
<td>Organize activities to raise awareness that</td>
<td>Develop strategic public awareness campaigns</td>
<td>Evaluate the effectiveness of public</td>
</tr>
</tbody>
</table>

The time to act is now....
Why a National Strategy?

- Recognizes suicide and suicide attempts as a major public health problem.
- Signals the commitment of a government to tackling the issue.
- Recommends a structural framework, incorporating various aspects of suicide prevention.
- Provides authoritative guidance on key evidence-based suicide prevention activities, i.e. identifies what works and what does not work.
- Identifies key stakeholders and allocates specific responsibilities among them. It outlines the necessary coordination among these various groups.
- Identifies crucial gaps in legislation, service provision and data collection.
- Indicates the human and financial resources required for interventions.
- Shapes advocacy, awareness raising, and media communications.
- Proposes a robust monitoring and evaluation framework, thereby instilling a sense of accountability among those in charge of interventions.
- Provides a context for a research agenda on suicidal behaviours.
How does WHO help?

By providing technical assistance
Technical tools for implementation

- mhGAP Intervention Guide: self-harm/suicide module
- mhGAP recommendations for assessment and management of self-harm/suicide
- STEPS survey: module on suicidal behaviours
Preventing Suicide: a resource series

1. for General physicians
2. for Media professionals (updated 2008)
3. for Teachers and other school staff
4. for Primary health care workers
5. in Jails and prisons (updated 2007)
6. How to start a survivors’ group (updated 2008)
7. for Counsellors
8. at Work
9. for Police, firefighters and other first line responders
10. for suicide case registration
11. for registration of non-intentional self-harm

Available in:
Bengali, Bulgarian, Chinese, Dutch, English, Estonian, French, German, Hungarian, Italian, Japanese, Latvian, Norwegian, Polish, Portuguese, Russian, Serbian, Slovenian, Swedish, Spanish, Turkish, Vietnamese
Resources (continued)

- Public Health Action for the Prevention of Suicide: A Framework
- MiNDbank online platform
- Safer Access to Pesticides: Community Interventions
- Clinical Management of Acute Pesticide Intoxication
Better availability and quality of suicide and suicide attempt data

- **Suicide** as a cause of death reported to WHO Mortality Database:
  - Online query tools
- Fatal injury surveillance in mortuaries and hospitals: a manual

- **Suicide attempt** is the single most important risk factor for suicide
- Suicide attempts result in significant social and economic burden for communities
- Monitoring suicide attempts provides important information for development and evaluation of suicide prevention strategies

- Collaboration with National Suicide Research Foundation, Ireland on a Practice manual for establishing and implementing suicide attempt and self-harm surveillance systems
Communities play a critical role in suicide prevention

- Provide social support to vulnerable individuals
- Provide help in crisis situations
- Engage in follow-up care
- Fight stigma
- Support those bereaved by suicide

Collaboration with Mental Health Commission of Canada on a Community Engagement Toolkit for suicide prevention
Objective 3

To implement strategies for promotion and prevention in mental health

Target 3.2:

-- Rates of suicide in countries will be reduced by 10% by year 2020
Post-2015 Agenda

Sustainable Development Goals:

• 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

• Important to include an indicator on Suicide rate
10% reduction in suicide rate will not happen unless we all act together and now!

This workshop and WHO World Health Day 2017 on Depression and suicide, provide excellent and timely opportunities!

World Suicide Prevention Day, 10th September (www.iasp.info/wspd)
World Suicide Prevention Day

10th September

www.iasp.info/wspd
Thank You

www.who.int/mental_health/suicide-prevention