



AN IMPLEMENTATION GUIDE FOR SUICIDE PREVENTION IN COUNTRIES



World Health Organization

LIVE LIFE

**An implementation guide for
suicide prevention in countries**

Live life: an implementation guide for suicide prevention in countries

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FOREWORD

Any death by suicide is a deeply sad occasion. It is extremely painful for close family members and friends left behind who cannot understand why it happened. Inevitably, their sadness is multiplied as they ask themselves what they could have done to prevent the untimely death.

There are more than 700 000 deaths by suicide worldwide every year – each one a tragedy, with far-reaching impact on families, friends and communities. These untimely and unnecessary deaths are the reason why this guide is so important.

We cannot – and must not – ignore suicide. Although some countries have placed suicide prevention high on their agendas, too many countries remain uncommitted. The targets of the United Nations Sustainable Development Goals and the World Health Organization's Mental Health Action Plan for reducing the global suicide mortality rate will not be achieved unless we transform our efforts to implement effective actions to prevent suicide.

LIVE LIFE is WHO's approach to suicide prevention. It details the practical aspects of implementing four evidence-based interventions for preventing suicide, plus six cross-cutting pillars which are fundamental for implementation. Throughout this guide, the LIVE LIFE interventions and pillars are accompanied by case studies from countries across the world. These case studies provide a wide range of inspiring activities in diverse contexts. We hope that decision-makers will consider the lessons learned by countries and communities that have been successful in suicide prevention.

LIVE LIFE recognizes the role that both governments and communities play in implementing actions for suicide prevention. Currently, 38 countries are known to have a national suicide prevention strategy. While a funded national suicide prevention strategy that includes LIVE LIFE interventions and pillars remains the pinnacle of a government-led response to suicide, the absence of such a strategy should not prevent a country from starting LIVE LIFE implementation. By implementing LIVE LIFE, countries will be able to build a comprehensive national suicide prevention response.

This guide serves as a catalyst for governments to take evidence-based actions. It enables countries to protect the lives of people who find themselves in severe distress and are at risk of suicide.

But preventing suicide is not the responsibility of governments alone. Each of us has a role to play, watching out for our friends, families and colleagues and offering them our support when we think they might need it. It can make all the difference.

Dr Tedros Adhanom Ghebreyesus
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EXECUTIVE SUMMARY

INTRODUCTION

Over 700 000 people lose their life to suicide every year. Reducing the global suicide mortality rate by one third by 2030 is both an indicator and a target (the only one for mental health) in the United Nations Sustainable Development Goals (SDGs) and in WHO's Comprehensive Mental Health Action Plan 2013–2030. WHO's 13th General Programme of Work 2019–2023 includes the same indicator with a reduction of 15% by 2023.

The world is not on track to reach the 2030 suicide reduction targets. WHO advocates for countries to take action to prevent suicide, ideally through a comprehensive national suicide prevention strategy. Governments and communities can contribute to suicide prevention by implementing LIVE LIFE – WHO's approach to starting suicide prevention so that countries can build on it further to develop a comprehensive national suicide prevention strategy. The guide is for all countries, with or without a national suicide prevention strategy at present.

PART A. LIVE LIFE CORE PILLARS

The core pillars of LIVE LIFE are as follows:

- Situation analysis
- Multisectoral collaboration
- Awareness-raising and advocacy
- Capacity-building
- Financing
- Surveillance, monitoring and evaluation.

Part A examines each of these core pillars by asking the questions “What?”, “Why?”, “Where?”, “When?”, “Who?” and “How?”. There is a table for each pillar showing what elements should be included, examples from around the world are provided in boxes and each subsection concludes with “tips for implementation”.

Situation analysis provides the background and current profile of suicide and suicide prevention. It is therefore important for informing the planning and implementation of suicide prevention activities. The analysis can be carried out nationally, regionally or locally and should be conducted at the start of suicide prevention efforts by a dedicated working group of specialists, stakeholders and persons with lived experience of suicide. The working group collects data (such as rates of suicide and

self-harm, methods used, precipitating or protective factors, legislation, services and resources), conducts the situation analysis, produces a report and shares it with decision-makers, policy-makers and funders to influence resource mobilization and/or mandate for action. Major issues of concern are to ensure confidentiality, protect people's privacy and avoid encouraging suicides.

Multisectoral collaboration is necessary since the risk factors for suicide are linked with many areas. A whole-of-government or whole-of-society approach works across government sectors or departments and includes nongovernmental and community groups. Under the leadership of government, this approach facilitates knowledge-sharing, exchange of methodologies and lessons learned, and sharing of suicide-related data and research. It also fosters transparency and accountability. This collaboration must start early and both government and partners need to make sure they are prepared. A multisectoral approach relies on a vision for collaboration and an agreed method of engagement with routine evaluations. Problems may arise if non-health sectors consider suicide to be solely a health problem. Each stakeholder's role must be clearly defined and actions agreed in case stakeholders find it difficult to fulfil their responsibilities.

Awareness-raising and advocacy depend on an organized process of communication that targets a public audience. Awareness-raising draws people's attention to facts such as suicide is a serious public health issue. Advocacy aims to bring about changes such as decriminalization or a national suicide prevention strategy. Awareness-raising and advocacy for suicide prevention can range from events in a single community to nationwide public communication campaigns and can be continuous, regular or annual happenings (such as World Suicide Prevention Day), with “champions” leading public campaigns. It is important to decide the message to be communicated, adapt it to the target audience, select the means of communication and test the acceptability and potential impact of the message beforehand. Initiatives should have a clear focus and a call to action, such as linking people with support services rather than addressing suicide in general.

Capacity-building can be coordinated at the national level or conducted in the community. Capacity-building can be delivered by including suicide prevention in pre-service or continued training of health workers, but it can also be triggered when problems such as high rates of suicide or stigma arise.

It may be directed to health workers, emergency service staff, teachers and youth workers, and others such as hairdressers or bartenders who often chat with their clients. For non-specialized health workers and community health workers, the self-harm/suicide module of WHO's *mhGAP Intervention Guide* and associated training materials can be used. A training-of-trainers model is recommended as it increases the human resources available to deliver training. With such a wide range of trainees it is important that training is adapted to the sociocultural context and that it strengthens recipients' knowledge about suicide and its prevention.

Financing for suicide prevention is often meagre because of factors such as poor economic conditions, lack of prioritization of suicide as a serious issue, and lack of recognition that suicides are preventable. Requests for funds should include a focus on the development and implementation of policies, strategies and plans, and not only on development of services. The guide gives advice on how to approach fundraising for suicide prevention, noting that it should be a continuing process. The stages of defining the budget are described, as are researching and identifying potential funders, developing proposals and maintaining relations with funders irrespective of their decision. Concerned groups are encouraged to share stories that demonstrate the impact of well-funded suicide prevention interventions.

Surveillance can provide data on suicide and self-harm to guide LIVE LIFE interventions. Data sources such as civil registration and vital statistics, health and police records, verbal autopsies and population-based surveys are highlighted, though much depends on how much suicide and self-harm surveillance has been done before. Preference should be given to obtaining high-quality data from several representative locations rather than poor-quality data from the entire country. Key findings, including rates and trends in suicides and self-harm, can help guide prevention activities. Consequently, it is important to publish reports regularly to inform action.

Monitoring and evaluation should consider whether an intervention was effective, whether it was delivered as intended, and whether it was efficient in terms of value for money. Detecting changes in suicide rates is challenging but is necessary to assess whether LIVE LIFE is achieving its intended result of reducing suicide and self-harm. Monitoring and evaluation are likely to require a specialized team (including, for instance, epidemiologists, statisticians and data

collectors) and it may be helpful to partner with academic institutions. Outcomes will need to be defined and indicators identified, with the principal goal being a reduction in the rates of suicide and self-harm. The guide emphasizes that without clear goals and indicators it will be difficult to show progress and hence more difficult to justify funding.

PART B. LIVE LIFE: KEY EFFECTIVE INTERVENTIONS FOR SUICIDE PREVENTION

The interventions described in the guide are:

- Limit access to the means of suicide
- Interact with the media for responsible reporting of suicide
- Foster socio-emotional life skills in adolescents
- Early identify, assess, manage and follow up anyone who is affected by suicidal behaviours.

As for the core pillars in Part A, the questions “What?”, “Why?”, “Where?”, “When?”, “Who?” and “How?” are asked for each of the interventions in Part B.

Limiting access to the means of suicide is a universal evidence-based intervention for suicide prevention. Depending on the country, this may mean banning highly hazardous pesticides, restricting firearms, installing barriers at “jump sites”, limiting access to ligature points or taking other measures to make it more difficult to access the means of suicide. Most people who engage in suicidal behaviour experience ambivalence about living or dying, and many suicides are a response to acute stressors. Making lethal means of suicide less easily available gives persons in distress time for acute crises to pass before taking fatal action. This section focuses on pesticides, which are estimated to account for one fifth of all suicides globally. They are a particular problem where there is a large proportion of rural residents working in agriculture.

Restricting access to pesticides requires multisectoral collaboration between all relevant stakeholders, including ministries of health, agriculture, regulators and registrars, as well as community leaders. The same principle of a multisectoral national approach applies to other means of suicide (e.g. the transport sector and the need for barriers). At the personal level, family members may be asked to remove the means of suicide (e.g. pesticides, firearms, knives, medication) from a household where a person is at risk of suicide.

Importantly, evidence shows that restriction of one method of suicide does not inevitably lead to a rise in the use of others.

Interacting with the media for responsible reporting of suicide is significant because media reporting of suicide can lead to a rise in suicide due to imitation – especially if the report is about a celebrity or describes the method of suicide. The aim at country level is to work with national media (and social media) bodies and at local level to work with local media outlets such as local newspapers or radio stations. The guide advises monitoring the reporting of suicide and proposes offering examples of high-profile persons sharing their stories of successful recovery from mental health challenges or suicidal thoughts. It also proposes working with social media companies to increase their awareness and improve their protocols for identifying and removing harmful content.

Fostering socio-emotional life skills in adolescents is the focus of WHO's *Helping adolescents thrive* (HAT) guidelines. While adolescence (10–19 years of age) is a critical period for acquiring socio-emotional skills, it is also a period of risk for the onset of mental health conditions. Rather than focusing explicitly on suicide, the HAT guidelines recommend that programmes employ a positive mental health approach. Other recommendations include training for education staff, initiatives to ensure a safe school environment (such as anti-bullying programmes), links to support services, clear policy and protocols for staff when suicide risk is identified, and increasing parental awareness of mental health and risk factors. Teachers or caregivers should be reminded that talking about suicide with young people will not increase suicide risk but will mean that young people may feel more able to approach them for support when needed. The well-being of staff should also be ensured.

Early identify, assess, manage and follow up anyone who is affected by suicidal behaviours. This advice is intended to ensure that people who are at risk of suicide, or who have attempted suicide, receive the support and care that they need. It applies to health workers and others, including family members, who are likely to come into contact with someone at risk. The advice also applies to health systems which need to incorporate suicide prevention as a core component in order to intervene early when people are found to be at risk of suicide. Additionally, support should be offered to people who have attempted suicide and those who have been bereaved by it. Since suicide prevention is often not a public health priority, the guide recommends advocating for suicide prevention

with policy-makers, raising awareness in the community and providing evidence of the effectiveness and cost-effectiveness of suicide prevention.

A series of four annexes provides: 1) a list of sectors and stakeholders relevant to suicide prevention; 2) 30 boxes describing country activities for suicide prevention (in addition to the 43 descriptive boxes in the text of the guide); 3) the LIVE LIFE indicators framework that lists the goals, outcomes and indicators for LIVE LIFE; and 4) lists of WHO and non-WHO resources on suicide prevention, organized by: Situation analysis, Multisectoral collaboration, Awareness-raising and advocacy, Capacity-building, Financing, Surveillance, Monitoring and evaluation, Limit access to the means of suicide, Interact with the media for responsible reporting of suicide, Foster socio-emotional life skills in adolescents, and Early identify, assess, manage and follow up anyone who is affected by suicidal behaviours.



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INTRODUCTION

BACKGROUND

Over 700 000 people lose their life to suicide every year. People from all socioeconomic backgrounds are affected. Suicide is the fourth leading cause of death in 15–29-year-olds and the third in 15–19-year-old girls. The majority of deaths by suicide (77%) occur in low- and middle-income countries.²

Every suicide is a tragedy, with far-reaching impact on families, friends and communities. Reducing the number of deaths by suicide around the world is a global imperative and global targets have been set. Reducing the global suicide mortality rate by one third by 2030 has been included as an indicator and target (the only one for mental health) in the United Nations Sustainable Development Goals (UN SDGs)³ and in the WHO Comprehensive Mental Health Action Plan 2013–2030. WHO's 13th General Programme of Work (GPW13) 2019–2023⁴ includes the same indicator with a reduction of 15% by 2023.

There has been a small reduction in the global age-standardized rate of suicide since 2010 but the global trend masks regional and country-level variations; not all countries are committed to suicide prevention, and some have seen suicide rates increase. The world is not on track to reach the global targets by 2030. This means that, unless there are accelerated and sustained efforts made to prevent suicide, the global targets will not be met and many more people will unnecessarily lose their life.

Much more needs to be done to reduce the number of people who die by suicide. Consequently, WHO has developed this guide to support countries to implement key effective evidence-based interventions following the WHO LIVE LIFE approach for preventing suicide as a starting point.

WHO advocates for countries to take action in preventing suicide, ideally through a comprehensive national suicide prevention strategy. A government-led comprehensive national strategy is a powerful tool which helps to ensure that the government and other stakeholders are committed to prevent suicide in a country, that there is coordination and monitoring of their efforts, that

suicide prevention is placed high on the political agenda, and that resources are allocated to make it possible to implement the necessary actions. Although there has been progress and some countries have been very active in suicide prevention, only 38 countries were known to have a dedicated national suicide prevention strategy in 2018 (WHO, 2018a). Additionally, governments often underestimate the importance of coordinating implementation after the national strategy has been adopted. In the field of noncommunicable diseases (NCDs), implementation gaps for national action plans have been attributed to inadequate funding, limited capacity, inaction across sectors, and lack of standardized monitoring and evaluation (Tuangratananon et al., 2019). Indeed, evaluations of national suicide prevention strategies are largely lacking.

The absence of a comprehensive national suicide prevention strategy should not stop countries from implementing interventions for suicide prevention. In many countries that have no strategy, a wide range of stakeholders are engaged in suicide prevention activities – from organizing survivors' support groups to awareness-raising and advocacy for at-risk populations. Community stakeholders ([see Annex 1 for a list of sectors and stakeholders](#)) will benefit from implementing any of the LIVE LIFE components; their implementation can form the beginnings of suicide prevention in a country, gaining momentum with the potential to grow into a national response for suicide prevention. Therefore, both governments and communities contribute to suicide prevention when implementing LIVE LIFE through top-down and bottom-up processes respectively.

LIVE LIFE is WHO's approach to get implementation started and to emphasize the scale-up to national level of four key evidence-based suicide prevention interventions, namely:

- limit access to the means of suicide (e.g. ban highly hazardous pesticides);
- interact with the media for responsible reporting of suicide;
- foster socio-emotional life skills in adolescents; and
- early identify, assess, manage and follow up anyone who is affected by suicidal behaviours.

² WHO Global health estimates: leading causes of death. Geneva: World Health Organization (<https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghle-leading-causes-of-death>, accessed 28 January 2021).

³ Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development. New York: United Nations (https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework%20after%202020%20review_Eng.pdf, accessed 28 January, 2021).

⁴ Thirteenth General Programme of Work. Geneva: World Health Organization (<https://www.who.int/about/what-we-do/thirteenth-general-programme-of-work-2019---2023>, accessed 28 January 2021).

The successful implementation and scale-up of these key interventions needs, as a prerequisite, six cross-cutting core foundational pillars, namely:

- situation analysis;
- multisectoral collaboration;
- awareness-raising and advocacy;
- capacity-building;
- financing; and
- surveillance, monitoring and evaluation.

In addition to contributing independently to the reduction of suicide, the combination of implementing all the LIVE LIFE pillars and interventions will have a synergistic effect in which different components interact to produce additional benefits (Harris et al., 2016; Yip & Tang, 2021). For example, an awareness-raising event could increase uptake of training for capacity-building, leading in turn to increased early identification for suicidal behaviours.

There is a need to work towards full implementation of LIVE LIFE in all countries and contexts. LIVE LIFE serves as a starting point upon which countries can build further evidence-based suicide prevention interventions to develop a comprehensive national suicide prevention strategy. All pillars and interventions described in this LIVE LIFE guide are components for a national response and would typically be part of a national suicide prevention strategy. Countries with a national strategy, or where suicide prevention is integrated into existing relevant action plans – such as those for mental health,

alcohol or NCDs – will benefit from ensuring that their strategies or action plans are implemented, prioritizing implementation of these components.

WHO IS THIS GUIDE FOR?

The guide is for:

- all countries, with or without a national suicide prevention strategy;
- national or local focal points for suicide prevention, mental health, alcohol or NCDs; and
- community stakeholders with a vested interest or who may already be engaged in implementing suicide prevention activities.

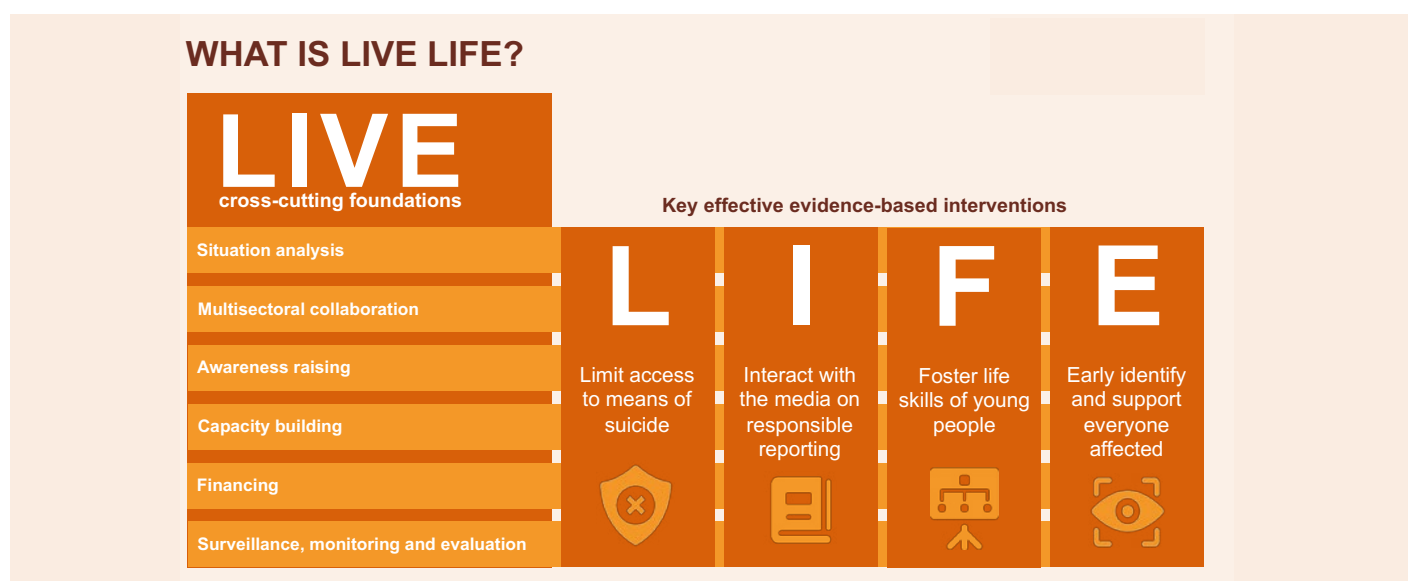
WHAT IS COVERED?

The guide explains how to establish the core foundational pillars and implement the key effective evidence-based interventions of LIVE LIFE (Figure 1).

The guide covers:

- *what* each LIVE LIFE pillar and intervention is;
- *why* it is important for suicide prevention;
- *where* it can be implemented;
- *when* it should be conducted;
- *who* would be responsible for implementation; and
- *how* it can be implemented.

Figure 1. LIVE LIFE cross-cutting foundations and key effective evidence-based interventions



The guide also contains:

- boxes with examples throughout the text and further examples from countries in [Annex 2](#); and
- tips for implementation.

In addition:

- Annex 1 provides a list of sectors and stakeholders who can be involved in LIVE LIFE;
- Annex 2 provides further examples from countries and communities;
- Annex 3 provides an indicator framework which can be used to monitor implementation of LIVE LIFE; and
- Annex 4 provides resources for further information.

WHAT IS NOT COVERED?

This guide does not cover:

- development of a comprehensive national suicide prevention strategy at government level, or examples of strategies, as this is presented in other WHO publications (WHO, 2012; WHO, 2014; WHO, 2018a);
- a step-by-step approach for engaging communities in suicide prevention, as this is available in a WHO publication (WHO, 2018d) and its corresponding e-learning course on community engagement;⁵
- a public health model for suicide prevention or risk and protective factors – covering systemic, societal, community, relationship and individual issues and reflecting an ecological model – which are covered in another WHO publication (WHO, 2014).

Box 1. Forming a Steering Committee and working groups

A Steering Committee (or oversight committee, or task force) is needed to provide leadership and coordination as well as to structure planning, resourcing, implementing, monitoring and evaluating LIVE LIFE.

Working groups (sub-branches of the Steering Committee) would be convened to lead implementation on individual pillars and interventions. One member of the Steering Committee should maintain consistency and facilitate coordination.

At both levels persons should be included who represent authority, administration and technical expertise. Ideally, there should be collaboration between public, private and community groups or individuals ([see Annex 1 for a list of sectors and stakeholders](#)). The following should be included:

- individuals in leadership positions in relevant sectors (e.g. health care, education, employment, social development);
- individuals with expertise in suicide prevention [e.g. academic experts, health sector, nongovernmental organizations (NGOs)];
- individuals with skills and experience specific to the pillar or intervention in question (e.g. a working group for situation analysis should include persons with skills in data collection and analysis, while a working group for interacting with the media should include persons from media regulation bodies or NGOs with experience of engaging with the media); and
- people with lived experience (who have experienced suicidal thoughts, made a suicide attempt, cared for a loved one during a suicidal crisis, or been bereaved by suicide).

The importance of establishing clear leads of the Steering Committee and working groups should not be underestimated. Similarly, explicitly defining roles and responsibilities of group members is necessary to ensure accountability for actions taken. It is not necessary to have 10 separate working groups for LIVE LIFE pillars and interventions as one working group may sequentially address several pillars or interventions, depending on resources and time constraints. Ultimately, the working groups lead the planning and implementation of LIVE LIFE, in coordination with the Steering Committee. Working groups responsible for monitoring the implementation of LIVE LIFE pillars and interventions – e.g. developing a schedule for when actions need to be completed and periodically convening to review progress in order to address difficulties early. Working groups should be prepared to report evaluations to the Steering Committee on the plans that have been put into practice.

⁵ Engaging communities in preventing suicide; e-learning course. Geneva: World Health Organization (<https://accesswho.campusvirtualsp.org/engaging-communities-preventing-suicide>, accessed 28 January 2021).

HOW CAN THE GUIDE BE USED?

- Countries should implement **all** the LIVE LIFE core pillars and key interventions.
- Although all core pillars and key interventions are needed for suicide prevention, each country can adapt its implementation to the availability of resources and the sociocultural context.
- The LIVE LIFE core pillars and key interventions are **not** intended to be implemented in a chronological order. There is no established specific order, although one should ideally begin with a situation analysis and bear in mind that surveillance and monitoring should be ongoing.
- Accordingly, although the chapters of this guide are interconnected, each one could be considered an independent module and countries could start with the module most relevant to them. This decision will be guided by the situation analysis, which should be used as the first step.

- Implementing all the LIVE LIFE pillars and interventions nationally will benefit a national suicide prevention strategy or become part of it.
- In contexts with limited human and financial resources it may be necessary to implement or scale up LIVE LIFE over a longer period and take action on country priorities first.

How the guide is used will vary according to the context and current state of suicide prevention. If the foundational pillars are already up and running, one can tackle the implementation of the key interventions directly. In other circumstances one may need to start with preparing the ground for suicide prevention or on a small scale. At any rate, a Steering Committee and working groups should be established ([see Box 1](#)). For public health emergencies or other emergency situations, some considerations have been compiled, but are not exhaustive ([see Box 2](#)).

Box 2. Suicide prevention in emergencies

Humanitarian crises and emergencies (e.g. natural disasters, armed conflict, public health emergencies) pose a number of barriers to suicide prevention such as structural changes in leadership and systems, change in priorities, issues of safety and resource constraints. Yet risk factors for suicide – such as financial difficulties, unemployment and social isolation – can increase during emergencies and therefore efforts to focus on suicide prevention are vital. Under these circumstances, contexts may need to focus on immediate and feasible priorities for suicide prevention (Gunnell et al., 2020). While a comprehensive discussion of suicide prevention in crisis situations is beyond the scope of this guide, some considerations include:

- Governments should consider the impact of the emergency on risk factors for suicide and should implement mitigation through multisectoral collaboration – e.g. working with the labour and welfare sectors, health sector and humanitarian actors to support individuals in financial distress; restricting access to the means of suicide (such as regulations or guidelines for retailers or camp managers); and facilitating access to mental health support and other emotional or crisis support services.
- Governments hosting persons affected by emergencies, including refugees and migrants, should consider these persons' specific risk factors and needs as part of suicide prevention efforts.
- Identify and provide effective interventions for at-risk populations who may be particularly affected during the emergency – such as young people or older persons who may have lost, or are separated from, family support.
- Engage the media to minimize sensationalized reporting of suicides which occur in the affected community during the emergency.
- Build the capacity of the existing health and community workforce in early identification, assessment, management and follow-up of suicide risk. Community gatekeepers and non-specialist health workers should feel confident to identify, support and refer individuals at risk of suicide, including implementing psychological intervention designed for use in adverse settings (WHO, 2016b). Services where individuals at risk would present can be prioritized, such as primary health care services and programmes focused on addressing concerns about protection (including child protection and gender-based violence).
- Where in-person mental health support is limited, establish systems for remote support (WHO, 2018c). Ensure that staff

receive training and feel comfortable using remote methods of communication, particularly when managing risk.⁶

- To ensure there is adequate coverage to meet needs, prevent the redeployment to non-suicide prevention functions of key persons working in suicide prevention and mental health.
- Provide the affected population with information on mental health self-care and available mental health services.
- Work with humanitarian actors (e.g. in health, protection, education, nutrition, camp management) to facilitate referral of persons from the affected population who may need mental health support.
- Ensure that first responders are provided access to mental health support.

For further information, see the following resources:

- WHO mhGAP Humanitarian Intervention Guide (WHO, 2015).
- Building Back Better: sustainable mental health care after emergencies (WHO, 2013).
- Inter-Agency Standing Committee (IASC) Guidelines on mental health and psychosocial support in emergency settings. Geneva: Inter Agency Standing Committee.⁷



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⁶ Guidance on Operational considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic. Geneva: Inter-Agency Standing Committee (<https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-guidance>, accessed 28 January 2021).

⁷ Guidelines on mental health and psychosocial support in emergency settings. Geneva: Inter-Agency Standing Committee (https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf, accessed 28 January 2021).

PART A

LIVE LIFE CORE PILLARS

The following sections describe the core pillars for suicide prevention. These form the foundation which strengthens successful implementation of the key evidence-based interventions that together contribute to suicide prevention. These include:



situation analysis;



multisectoral
collaboration;



awareness-raising and
advocacy;



capacity-building;

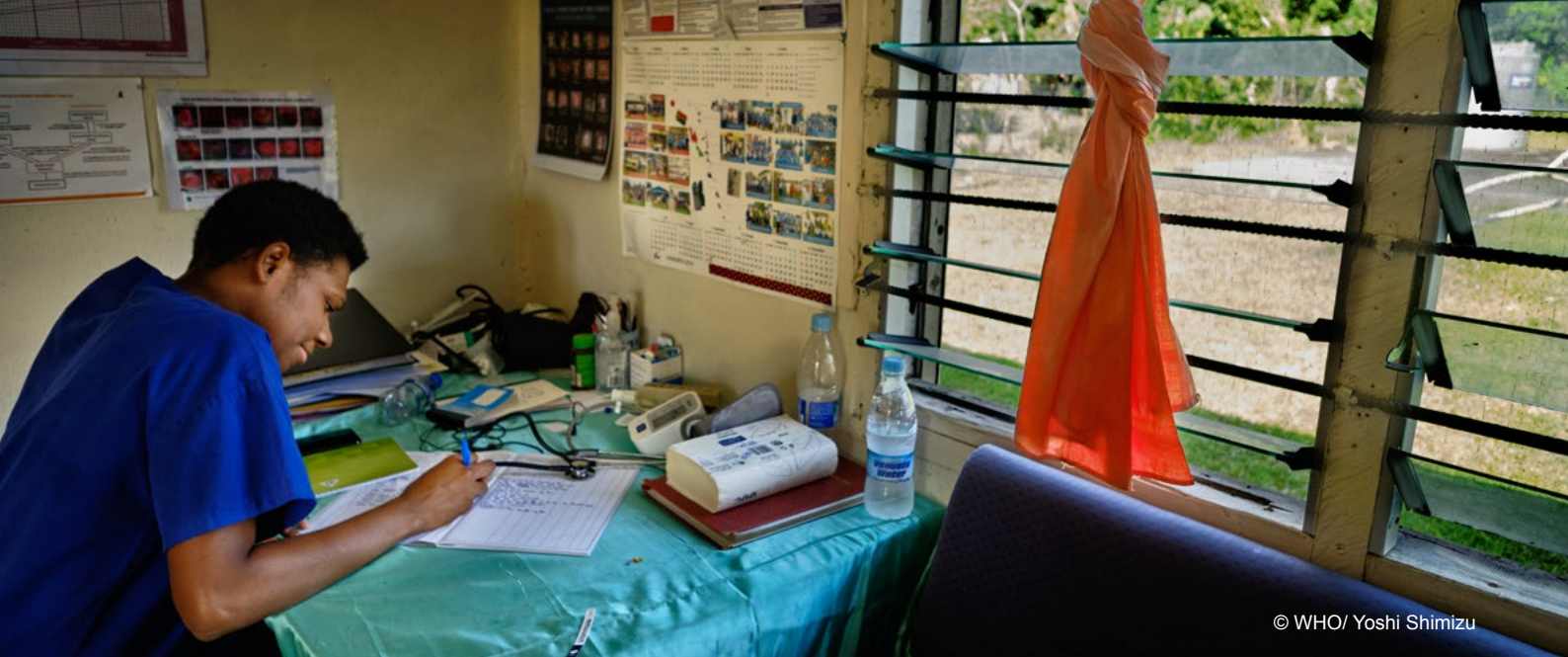


financing;



surveillance,
monitoring and
evaluation.

These pillars are common to other areas of public health. The implementation of each of these pillars is described below in the context of suicide prevention.



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SITUATION ANALYSIS

WHAT?

A situation analysis provides the background to, and current profile of, suicide and suicide prevention in a country using a variety of information.

WHY?

A situation analysis is essential for informing the planning and implementation of suicide prevention activities. The situation analysis can identify where there is most need, where there are gaps or where the benefit will be greatest (e.g. which means or populations to focus on). The analysis can safeguard against duplicate implementation efforts and identify where immediate and feasible actions can be taken.

WHERE?

A situation analysis can be conducted nationally or in a regional or local context – such as a district or other specific setting (e.g. a refugee camp or school). In a national situation analysis, attention should be given to collecting information from different sociodemographic groups and regions to identify specific needs for adapting the implementation of the LIVE LIFE interventions. For example, ingestion of pesticides occurs primarily in agricultural areas of low- and middle-income countries; therefore restricting access to this means of suicide may be less applicable in urban areas.

WHEN?

A situation analysis should be conducted at the start of any suicide prevention efforts in order to inform planning and implementation.

WHO?

A dedicated working group should take the lead in conducting the situation analysis. Mechanisms to ensure transparency and accountability should be in place. The group should involve persons with a range of skills, including:

- leadership and coordination of the situation analysis (e.g. the Ministry of Health) or, for context-specific situation analyses, leadership from the relevant sector (e.g. the education sector for the analysis of life skills programmes in schools);
- experience in conducting situation analyses (e.g. academia);
- experience in conducting data collection and analysis (e.g. Office of Statistics);
- stakeholders who could provide relevant data (e.g. health information systems staff, coroners, medico-legal officers, emergency services or hospital staff);
- community stakeholders with knowledge and experience of a given context (e.g. people with lived experience, gatekeepers, representatives of subpopulations of interest); and
- experts in suicide prevention (e.g. from the health sector or academia).



HOW?

1. Convene a working group to plan and implement the analysis ([see Box 1](#))

- Establish the working group ([see under Who? above](#)).
The working group is also responsible for obtaining any necessary approvals to access data or information which will inform the situation analysis.

2. Decide what information should be collected

- The decision on what information to collect (Table 1) will be influenced by geographical coverage (national or local analysis), the resources available, and the time frame.
- Situation analyses previously conducted by countries with similar populations and resources could be used for guidance.

Table 1. Examples of information to include in the situation analysis

Examples of information	Considerations
Number and rate of suicides	<ul style="list-style-type: none">Obtain data according to: a) context (e.g. national, regions, districts, inpatient services, refugee camp etc.); and b) population groups (e.g. whole population, by sex, age groups, ethnic groups, religious groups, migrant status, urban, rural, socioeconomic status).Calculate rates (deaths or cases per 100 000) in addition to numbers to identify subpopulations disproportionately impacted.Review multiyear data to identify trends.
Number and rate of self-harm cases	
Methods of suicide and self-harm	
Causes or precipitating factors of suicide, and protective factors	
Existing legislation or policy on or related to suicide	<ul style="list-style-type: none">What is the legal status of suicide and suicide attempts and what are the legal consequences for individuals (e.g. judicial sentences)?Where relevant, what is the scope for decriminalization of suicide, suicide attempts and other acts of self-harm?Is there existing legislation or policy relevant to suicide prevention (e.g. mental health, alcohol, employment, insurance, social welfare)?
Ascertainment of suicide	<ul style="list-style-type: none">How and by whom is suicide ascertained?Consider how ascertainment may affect the reporting of suicide and the quality of data available.
Case registration of suicide and self-harm	<ul style="list-style-type: none">How and by whom are suicide and self-harm registered and reported?By which variables are the data disaggregated?
Current implementation and coverage of LIVE LIFE pillars and key interventions	<ul style="list-style-type: none">What is the scope for initiating or improving implementation of these?Have they been evaluated?What adaptation to the country context will be needed? Consider acceptability, feasibility, and (cost-) effectiveness.Consider any previous suicide prevention efforts (and why they are no longer active).



Examples of information (continued)	Considerations (continued)
Current services	<ul style="list-style-type: none"> Existing (public and private) services in the health sector, the community and other relevant sectors – consider the availability, uptake and quality of existing services; What are the gaps in services?
Current resources	<ul style="list-style-type: none"> Financial resources allocated for suicide prevention. Potential financial resources that could be secured. What human resources are available and what capacity-building needs to be addressed for implementation of LIVE LIFE?
Sectors and stakeholders	<ul style="list-style-type: none"> Which sectors are needed for multisectoral collaboration?⁸ Which NGO stakeholders are needed for collaboration? Gaps in leadership, personnel or collaborators.
Knowledge of, or attitudes towards, suicide, suicide prevention, mental health and help-seeking	<ul style="list-style-type: none"> Barriers faced by people (including subpopulations) in seeking help. Barriers faced by the health workforce and related occupations in providing early identification, assessment, management and follow-up, and in reporting self-harm.

3. Decide how this information can be collected

- Consider what information already exists and which sources of information need to be accessed ([see Surveillance](#)). Information should be as recent, high-quality and specific as possible to the context.
- If high-quality information is not available (e.g. in countries without formal health information systems), informal information (e.g. expert opinion, key informant interviews, focus group discussions) is preferable to no information at all.
- If important information is missing, consider what new information can feasibly be collected (or plan to address this in a future situation analysis).
- Think about who can contribute to obtaining the information. This will help in deciding which sectors and stakeholders ([see Annex 1 for a list of sectors and stakeholders](#)) should be involved during the situation analysis. Make sure to include people with lived experience and ensure that they are well trained and supported to bring their lived experience to these discussions.

- Data may have to be gathered from multiple sources to obtain a full picture (e.g. death certificates, emergency department data, health facilities, police data).
- Carry out a desk review to identify reports, policy documents, legislation, and information on services and programmes.⁹ Search for journal publications of research studies in the country.

4. Agree on a plan of action and conduct the situation analysis

- Outline the steps to be taken to conduct the situation analysis.
- For the budget, consider resources that will be needed, such as physical (e.g. technology, locations for working) and human resources.
- Agree which stakeholders will be responsible for conducting each step (e.g. some stakeholders may be able to focus on the desk review, or on data collection from different sources).

⁸ In this document, “multisectoral” refers to multiple government sectors, while “stakeholders” refers to any other nongovernmental group or individuals that may play a role in suicide prevention.

⁹ Joint Action on Mental Health and Wellbeing. European Union; 2015 (https://ec.europa.eu/health/sites/health/files/mental_health/docs/2017_depression_suicide_ehealth_en.pdf, accessed 28 January 2021).



5. Produce a report and share with key

stakeholders to inform planning for implementation

- Produce a written report of the findings, including an analysis of the information obtained, highlighting information which is missing or of low quality and identifying ways towards improvement.
- Produce recommendations from the findings and propose specific short-, medium- and long-term goals as well as the resources required to achieve these. Make sure that people with lived experience are part of the decision-making process.
- Ensure that the written report is agreed upon by all stakeholders who were involved.
- Share the report with key decision-makers, policy-makers and funders to influence resource mobilization and/or mandate for action ([see Monitoring and evaluation](#)).

Box 3. A situation analysis of suicide prevention, Czechia

In line with WHO recommendations (WHO, 2014), a situation analysis was conducted for the National Suicide Prevention Action Plan (Kasal et al., 2019). The work was divided into four activities which were conducted simultaneously and coordinated by the National Institute of Mental Health (NIMH). Situation analysis is a key activity when developing a suicide prevention policy. While following the steps, it allowed the NIMH to: 1) comprehend the existing situation fully; 2) identify problems and needs of the system, as well as existing capacities and possibilities; and establish key partnerships for future implementation by engaging key stakeholders (e.g. Ministry of Health, Ministry of Education, Youth and Sports, representatives of general practitioners, representatives of the mental health sector, people with lived experience). Our situational analysis included both mapping the situation (steps 1 and 2) and identifying and shortlisting suitable interventions (steps 3 and 4).

Four phases of conducting the situational analysis in Czechia

Activity	Identification and analysis of existing data sources	Collection of new data and setting up a platform of stakeholders	Identification of candidate interventions suitable for the local context	Shortlisting of candidate interventions through stakeholders' consensus
Purpose	Utilize the existing data and identify the knowledge gaps	Complement the knowledge gaps with qualitative data	Build on previously published research on effective suicide prevention interventions	Identify priorities among preselected interventions
Action	Identify existing data sources, obtain and analyse the data; engage relevant institutions and make sure that existing data may be utilized regularly to inform and evaluate further steps continuously	Map, contact, interview and engage relevant stakeholders. Analyse and interpret the data obtained	Search for relevant systematic reviews and meta-analyses, extract information on effective interventions	Organize face-to-face or online meeting, facilitate cooperation between stakeholders, gather all relevant comments and arrive at a consensus
Result	Preliminary analysis, interpretation of existing data, identification of knowledge gaps	SWOT analysis and expert platform, which can also be involved in a future implementation of the suicide prevention plan	List of preselected evidence-based interventions	Consensus on shortlisted interventions suitable for the target context among stakeholders and clear priorities for future actions in suicide prevention



Box 4. National suicide study, Namibia

High suicide rates and a lack of evidence-based information on suicide prompted the Ministry of Health and Social Services (MoHSS) of Namibia to conduct a national situation analysis in 2018 to guide prevention and treatment strategies.

The study focused on a number of outcomes, including:

- prevalence of fatal suicides and nonfatal suicide attempts;
- prevalence of suicidal ideation (thoughts);
- causes of suicide;
- knowledge and attitudes towards suicide and suicide prevention and treatment efforts; and
- availability and effectiveness of suicide prevention efforts.

A working group was formed from representatives of the MoHSS, the Namibian Statistics Agency and Sustainable Development Africa (a Namibian socioeconomic research firm). An inception meeting was held to agree on the objectives and methodology of the study. Social workers from the MoHSS were trained as data collection officers and a pilot test was conducted before commencing the full analysis.

The analysis was conducted nationally and involved both qualitative and quantitative research methods, including:

- a review of national and international research, policies and programmes;
- review of suicide records from the Namibian Police;
- quantitative surveys of randomly selected individuals across different regions; and
- qualitative interviews with key informants at national, regional and local levels (e.g. government staff, police, health and social care staff, educational and spiritual leaders); people who had previously attempted suicide; and focus group discussions with randomly selected adults and youth.

The results of the study generated a number of recommendations and were used to inform the development of a Five Year National Strategic Plan on the Prevention of Suicide in Namibia and the development of a policy framework to guide suicide prevention, treatment, management and coordination (Namibian Ministry of Health and Social Services, 2018).



TIPS FOR IMPLEMENTATION

Table 2. Tips for implementation of a situation analysis

Issues	Tips
Limited data	<ul style="list-style-type: none">• A situation analysis can begin using the current data available, and recommendations can be made to improve data in future situation analyses.• If needed, reviews of international reports can be used to supplement missing national information.• Engaging community stakeholders can aid data collection.
Limited resources	<ul style="list-style-type: none">• Focus on existing data and on information priorities to fit within time and resource constraints. Utilize a succinct model such as Strengths, Weaknesses, Opportunities and Threats (SWOT).• Consider consulting with national and international experts on key documents and existing data.• Where human resources are not available (e.g. expertise to analyse data), consider collaborating with individuals, organizations or persons in academia who are working, or have previously worked, on situation analyses in other settings.
Data security and confidentiality	<ul style="list-style-type: none">• The primary ethical consideration in the use of suicide data is to protect the privacy of individuals. This means that no personal data must be disclosed in an identifiable form.• There are known risks in the dissemination of information on the means or common locations of suicide. Stakeholders who have access to sensitive data within the situation analysis must agree to uphold data confidentiality and adhere to an agreed communications plan for dissemination of information.



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MULTISECTORAL COLLABORATION

WHAT?

Suicide prevention cannot be addressed by the health sector alone as risk factors associated with suicide and its prevention cut across many areas. For suicide prevention to be effective, a multisectoral approach is critical. For the purpose of this guide, multisectoral collaboration refers to both multisectoral and multi-stakeholder approaches:

- Multisectoral approaches are sometimes described as “whole-of-government”, “intersectoral” or “cross-sectoral” – i.e. any initiative that includes more than one government sector, such as health, education, labour, transport, agriculture, justice, law, defence, social development.
- Multi-stakeholder approaches are sometimes described as “whole-of society” approaches. Unlike multisectoral approaches, they include collaboration with nongovernmental organizations (NGOs) or community stakeholders, as well as with government sectors.

Implementation of LIVE LIFE requires such collaboration. For instance, in restricting access to the means of suicide, collaboration will be needed between sectors related to the means in question (e.g. Ministry of Agriculture in the case of highly hazardous pesticides) and stakeholders (e.g. registrars, retailers, farmers). Another example would be school-based

interventions where collaboration would include the Ministry of Education and stakeholders such as school heads, teachers, students, parents/caregivers and youth associations.

It is necessary to work across multiple government departments to develop policies, legislation or programmes which have an impact on suicide. For instance, departments responsible for health, mental health, alcohol,¹⁰ service delivery, legislation for violence prevention or social welfare, or fiscal policies¹¹ would need to be aligned with suicide prevention. Legislation which has a direct impact on suicide includes that which criminalizes suicide or suicide attempts. This has systemic ramifications, seriously hampering the implementation of LIVE LIFE pillars and interventions.

¹⁰ About one fifth of suicides are causally attributed to alcohol (WHO, 2018e).

¹¹ Government investment in active labour market programmes between 1970 and 2007 ameliorated the impact of unemployment on suicide mortality in the European Union countries (Stuckler et al., 2009).



Box 5. Decriminalizing suicide, Ireland

Suicide in Ireland was decriminalized in 1993, an act that precipitated Ireland's suicide prevention activities. In the years prior to the decriminalization of suicide in Ireland, there was an increasing public debate about suicide and suicide prevention, supported by emerging research led by a small number of psychiatrists. A member of the Irish Parliament (Dáil Éireann) supported by two psychiatrists had put forward multiple motions to the Government to allow a debate on decriminalizing suicide; up to then suicide had been the "silent taboo" in Irish society. On 1 July 1993, President Mary Robinson signed into law a bill to decriminalize suicide and attempted suicide. The decriminalization of suicide was one of the first steps in Irish society to recognize that suicide and mental health conditions are serious public health issues. It was the beginning of the long road to remove stigma from suicide, self-harm and mental health conditions – a process that is still ongoing. The decriminalization of suicide and opening-up of the discussion on suicide prevention led to the formation of NGOs to raise understanding of the complexity of mental health and suicide. In 1995, the National Suicide Research Foundation was established. In 1996, the Irish Association of Suicidology was formed to provide accurate information and advice on suicide and self-harm to all involved in the prevention and containment of the harm arising from suicide and self-harm. The decriminalization of suicide facilitated the development of Ireland's first National Task Force on Suicide in 1998, which represented the first coordinated response to suicide. This was followed by the first National Suicide Prevention Strategy, *Reach Out*, 2005–2014, supported by the Department of Health. In 2015, the second strategy, Ireland's National Strategy to Reduce Suicide, *Connecting for Life*, 2015–2020, was launched, with an agreed four-year extension until 2024.

Engagement with community stakeholders is essential to multisectoral collaboration ([see Annex 1 for a list of sectors and stakeholders](#)). It helps to build bridges between local needs and national policies, and it helps to ensure that initiatives are adapted to the local context. Community engagement can also foster a sense of participation and collective ownership of

suicide prevention. Multisectoral collaboration in all its forms will not thrive without clear governance and leadership to move the process forward. A successful example, documenting a chronology of actions from government level to engagement of local stakeholders, comes from Sri Lanka (Pearson et al., 2010; Pearson et al., 2015).

Box 6. The influence of circumstances on multisectoral efforts to prevent suicide, Suriname

In response to the high rate of suicide in the country a task force was established, headed by the District Commissioner (the highest representative of the government) to whom the group would report, and chaired by the head of the Medical Psychology department with practical coordination led by a public health specialist. The local departments of the Ministries of Health, Education and Agriculture participated, as did grass-roots organizations, medical doctors and local women's organizations. Many social and educational activities were organized. The group was tasked with developing the first national suicide prevention strategy in line with the National Mental Health Action Plan 2014–2020 that had already been developed. In June 2016 a National Strategy was published that was supported by the Council of Ministers. The focal point for mental health had an important role. The focal point's strength in maintaining relationships and regular persistence meant that pressure was kept on the issue of suicide prevention. However, very soon after publication the country plunged into a deep economic recession, and the focal point who had been instrumental in maintaining government interest in suicide prevention was unable to stay in the post and was not replaced. The recession also affected the infrastructure that had been put in place for suicide prevention, much of which was closed down. The former members of the task force lost enthusiasm and lost executive power to implement the most important aspects of the strategy. Formally, the group was dissolved. Yet, after some time the former chairman expressed concern to the (newly appointed) Minister of Health about the state of the strategy. To everyone's joy in 2018, a new focal point for mental health was appointed and efforts for implementing suicide prevention in Suriname now continue with force.



WHY?

Because suicide is a complex issue, prevention efforts require coordination among multiple sectors and stakeholders, with good governance to facilitate strategic planning. Multisectoral collaboration enables knowledge-sharing, exchanges of methodology and lessons learned from previous work, with sharing of suicide-related data and research (Kolves et al., 2021) and coordination of messaging about suicide. Multisectoral collaboration provides opportunities for the integration of suicide prevention into other programmes (such as mental health, alcohol, NCDs, gender-based violence and child protection). For countries with limited resources, collaboration may provide a starting point to work opportunistically with what is already available. Increased coordination between different groups working on suicide prevention and related areas will make the work more streamlined, resulting in less duplication of effort and pragmatic use of resources.

Multisectoral collaboration fosters transparency and strengthens the accountability of partners involved, while communities are meaningfully engaged to ensure that prevention activities meet the needs of all people. Multisectoral collaboration does not require extensive funds, yet the act of communicating about shared goals and coordinating efforts should result in accelerated progress and improved quality of suicide prevention.

Box 7. Integrating suicide prevention into mental health and substance use policy, Lebanon

The National Mental Health Programme in the Ministry of Public Health of Lebanon, supported by WHO, launched the first National Strategy for Mental Health and Substance Use Prevention, Promotion and Treatment covering the period 2015–2020.¹² As the very first strategy of its kind in Lebanon, suicide prevention was integrated into the strategy. The push for national action was in part enabled by the humanitarian crisis which created an opportunity to build back better for mental health. The success of the strategy development includes a strong participatory development process of all key stakeholders including local NGOs, international NGOs, UN agencies, academic institutions and professional associations. The external mid-term evaluation of the strategy showed that implementation is effectively ongoing through a collaborative approach involving all stakeholders.

Several objectives contribute to suicide prevention in line with LIVE LIFE, namely:

- To enhance responsible media reporting a guide for media professionals on the portrayal of mental health and substance use, including suicide, was developed in a process that engaged media professionals.¹³ Capacity-building will be conducted and the potential for integration of this guide into university curricula will be explored. A roundtable discussion with media professionals on the role of media in suicide prevention was also conducted as another step towards partnering with the media on mental health promotion and suicide prevention in Lebanon.¹⁴
- For awareness-raising and advocacy, annual national awareness campaigns on mental health, including on suicide, were held to increase awareness and decrease stigma. An advocacy brief was launched advocating for a whole-of-society approach.¹⁵
- A national framework for suicide prevention and surveillance was developed in line with WHO frameworks.
- A national helpline for emotional support and suicide prevention was launched jointly by a local NGO, Embrace, and the Ministry of Public Health National Mental Health Programme.

¹² Mental Health and Substance Use Strategy. Beirut: Ministry of Public Health, Lebanon; 2015 (https://www.moph.gov.lb/userfiles/files/Mental%20Health%20and%20Substance%20Use%20Strategy%20for%20Lebanon%202015-2020-V1_1-English.pdf, accessed 28 January 2021).

¹³ Ministry of Mental Health, Lebanon (2019). Practical Guide for Media Professionals on the Coverage of Mental Health and Substance Use. (<https://www.moph.gov.lb/userfiles/files/Practical%20Guide%20for%20Media%20Professionals%20on%20the%20Coverage%20of%20Mental%20Health%20and%20Substance%20Use.pdf>, accessed 28 January 2021).

¹⁴ Video from the National Mental Health Programme, Lebanon (<https://www.facebook.com/watch/?v=720642161857689>, accessed 28 January 2021).

¹⁵ Preventing suicide in Lebanon (infographic). Beirut: Ministry of Public Health, Lebanon (<https://www.moph.gov.lb/userfiles/files/World%20Suicide%20Prevention%20Day%202020-Advocacy%20brief-Eng.pdf>, accessed 28 January 2021).

- An interministerial substance use response strategy was developed to address all substances, including alcohol.
- We are working towards scaling up evidence-based prevention interventions that can help young people develop skills to cope with life's pressures. Life skills education programmes targeting mental health and the prevention of harmful substance use inside and outside schools have been adapted to the Lebanese context in collaboration with the Ministry of Education. A feasibility study of their integration into the curricula will be conducted.
- Mental health service provision is being integrated into primary health care, and community mental health centres are being developed to increase the availability, accessibility and affordability of quality mental health care in order to facilitate early identification and management of self-harm/suicide and priority mental disorders. This development includes building the capacity of primary health care workers using WHO's *mhGAP Intervention Guide* (WHO, 2019b).
- There is capacity-building on mental health (including suicide) for human resources in different sectors, including:
 - » a national training course on mental health, including capacity-building on the identification and management of suicide risk, for social workers and frontline workers in child protection and gender-based violence;
 - » an emotional crisis management protocol and training, including capacity-building on identification and management of suicide risk, for frontline workers in any sector of action.
- Mental health is integrated into programming for responding to sexual and gender-based violence. Within this, questions related to the identification of mental disorders and suicide risk were integrated into the assessment tools of the national standard operating procedures for response to sexual and gender-based violence developed by the Ministry of Social Affairs. A clear protocol for the management of suicide risk was integrated. This also contributes to early identification and management.



WHERE?

Multisectoral collaboration is required both for the core pillars and the key interventions of LIVE LIFE. Leadership should come from the government (usually the Ministry of Health), and it must be complemented by engagement with sectors and stakeholders at all levels, such as national and local authorities, administrators, and individuals/organizations in the community. For example, in the Islamic Republic of Iran, regular intersectoral meetings are led by the governor of each district with key departments represented (health, agriculture, welfare, police, legal medicine, charity, education) to discuss achievements and challenges.

Box 8. Local adaptations for local implementation and priority populations

In settings where local government authorities provide effective leadership, local action plans are one pathway from a national suicide prevention strategy to tailored and coordinated implementation in local and priority population contexts. Local plans should be tailored to the needs and available resources of the local community, which may differ from those identified at the national level.

Japan is an example where, based on the National Suicide Prevention Action Plan, local municipalities and prefectures are required by law to develop local plans for implementing suicide prevention measures. This was considered a desirable approach to accelerate efforts to prevent suicide in Japan as local authorities are closer to residents in a community. Guidance provided has specified the role of prefecture authorities (who cover multiple municipalities) in supporting the work of local municipalities. The government and the Japan Support Center for Suicide Countermeasures (JSSC) support local government planning, both financially and technically.

Public Health England supported all local areas to develop multi-agency suicide prevention plans, with all areas having a plan in place by April 2019. The implementation of the National Health Service (NHS) Mental Health Services Implementation Plan 2019/20–2023/24 includes ring-fenced funding to support delivery of the multi-agency suicide prevention plans. These plans include all key local statutory agencies and the voluntary sector in ongoing local efforts to prevent suicide. The local strategies and plans describe specific actions that will be taken across the respective agencies (based on the English national strategy, guidance from NHS England and NHS Improvement and Public Health England, and national and local data) to reduce suicides in every local area in England. Success of this approach has been attributed to ensuring that detailed plans were submitted prior to the agreement of support funding; aligning local plans with national guidance; and offering learning-days where different sites in receipt of funding can learn from each other and share experiences. National and local efforts on suicide prevention continue to be a high priority for government and a national real-time suicide surveillance system is currently being developed, led by Public Health England. NHS England and NHS Improvement will launch the Mental Health Safety Improvement Programme, focusing support on mental health trusts to reduce the rates of suicide of people in contact with mental health services.

WHEN?

Multisectoral collaboration should be considered as early as possible in the implementation of LIVE LIFE. While some collaboration may be temporary to address a specific need, sustained multisectoral collaboration should be part of all suicide prevention activities to facilitate the benefits discussed above. When initiating potential collaboration, it can be helpful to consider the readiness¹⁶ of the government and of potential partners.

Box 9. How the government facilitated multisectoral cooperation, Bhutan

In 2015, political support for suicide prevention in Bhutan was generated as a result of presenting Cabinet members and parliamentarians, chaired by the Honourable Prime Minister, with a report on the situational analysis of suicide in Bhutan. Considering the magnitude and seriousness of the issue, the government instructed the establishment of a dedicated programme/unit for suicide prevention. Following this, a nationwide study on reported suicide cases was carried out and formed the basis of the National Strategy Action Plan that was developed and was operational in 2016. A national suicide prevention programme was established in the Ministry of Health to coordinate the suicide prevention response across the country and to keep the stakeholders engaged in delivering suicide prevention services. As suicide prevention is multidimensional, involving various key stakeholders, a National Steering Committee was formed to provide thrust to the multisectoral response and to keep the government informed of the challenges, issues and progress of the suicide response. Responsible collaborating agencies from various departments were called upon as stakeholders to implement the suicide prevention action plan and to create a platform to discuss the progress, challenges and issues as well as the way forward. Stakeholders included: the Ministry of Health; Ministry of Education (Department of Youth & Sports); Ministry of Home & Cultural Affairs (Department of Local Government); Royal Bhutan Police; Bhutan Narcotic Control Authority (BNCA); National Commission for Women and Child (NCWC); RENEW (NGO) – Respect, Educate, Nurture and Empower Women; the media (television, national newspapers, radio); Ministry of Agriculture; KGUMSB (Kheser Gyalpo University of Medical Sciences of Bhutan); Bhutan Infocomm & Media Authority (BICMA); and Dratshang (Commission for the Monastic Affairs).



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¹⁶ This involves a group's commitment to change, and belief in their capacity to do so (Weiner, 2020).



WHO?

In national activities such as LIVE LIFE, leadership should come from the government, particularly the Ministry of Health, to identify and bring together stakeholders who may not otherwise collaborate (see [Annex 1](#) for a list of sectors and stakeholders). However, local authorities can also take leadership in the coordination of local stakeholders. For instance, LifeSpan is an integrated suicide prevention approach in Australia, where primary health networks lead a multisectoral collaboration to ensure that initiatives are community-led.¹⁷ Key partners include people with lived experience. Unique examples that drive forward change include public – private partnerships and commitment at the highest levels of government.

Box 10. Forming public–private partnerships, United States of America

The Action Alliance for Suicide Prevention in the USA is a public–private partnership which includes more than 250 partners and coordinates a comprehensive national response to suicide. In 2012, the Action Alliance brought together diverse public–private stakeholders including government representatives, national nonprofit organizations and public sector groups, suicide prevention experts, health-care providers and people with lived experience. The work of the National Alliance includes advancing the National Strategy, prioritizing three areas of work in strengthening care for suicide, strengthening community-based suicide prevention, and changing the national conversation on suicide. The work of the Action Alliance was made possible by several key factors. First, a leader within the federal government recognized the significant contribution that a strong public–private partnership could make to reducing suicide nationally and was willing to be a champion for the effort. Second, there was a willingness to engage multiple federal agencies and departments and to allow them to be equal partners in the initiative. Third, there was a willingness to make an initial investment of federal dollars and maintain that until private funding could also be leveraged. When the Action Alliance was launched on 10 September 2010, the high-level collaboration was vividly demonstrated by the presence of both the Secretary of Health and Human Services and the Secretary of Defence, by the willingness of the Secretary of the Army to serve as the public sector co-chair, and by the willingness of a former United States senator, who had lost his own son to suicide, to serve as the private sector co-chair. This high-level federal involvement also made it possible to engage private-sector leaders from multiple sectors in supporting the effort.

The influence of high-ranking support in government has historically had tremendous impacts on the momentum of multisectoral collaboration for suicide prevention, and thus on the implementation of measures to save lives. A government-led approach signals that suicide prevention requires different government departments to work together, and that suicide prevention is not held only by the health sector. Such influence has been observed by the Presidential Task Force for suicide prevention in Sri Lanka, the Government of Japan, and the (first-ever) appointment of a minister for suicide prevention in the United Kingdom who by now manages the portfolio of suicide prevention, mental health and patient safety.



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¹⁷ Integrated Suicide Prevention, Lifespan (<https://www.health.act.gov.au/about-our-health-system/office-mental-health-and-wellbeing/lifespan>, accessed 28 January 2021)

Box 11. Influence at the highest level, Australia

Australia has had a national approach to suicide prevention since 1997, primarily driven through health portfolios (at the national and state levels). In recognizing the need for a whole-of-government approach, a first-ever National Suicide Prevention Adviser was appointed in 2019, reporting directly to the Prime Minister. To support the work of the Prime Minister's National Suicide Prevention Adviser, a National Suicide Prevention Taskforce was established in August 2019, with joint governance by the Department of Health and the Department of the Prime Minister and Cabinet and staffed by secondees from a range of Commonwealth Government agencies. A Senior Executive Commonwealth Suicide Prevention Interdepartmental Committee was established to facilitate input and advice into the development of suicide prevention initiatives across the government. An Expert Advisory Group was appointed to ensure that the adviser had access to ongoing advice from people with expertise through lived experience of suicide, experts in suicide prevention research, experts in Aboriginal and Torres Strait Islander suicide prevention, and experts from social and community policy associated with suicide prevention.

Box 12. Including people with lived experience

People with lived experience should be included in all aspects of LIVE LIFE. The insights of people with lived experience are crucial and will help to ensure that activities meet the needs of those at risk of suicide. Involving people with lived experience will ensure that the actual needs of the people requiring support are met. Their expertise is critical to informing, influencing and enhancing all aspects of suicide prevention. Furthermore their involvement can help to provide models of hope for others who are experiencing or being affected by suicidal behaviours or who have lost someone to suicide. Every working group for each pillar and intervention should include people with lived experience who are actively involved in the planning, development, implementation and evaluation. All working groups should follow a participatory process which equally takes into account the voices of people with lived experience.

This involvement is not tokenistic, and the views of people with lived experience are heard and valued through integration of their feedback into programme design, policy reform, and service enhancement or re-design. Sufficient time and resources should be allocated during planning of LIVE LIFE activities for engagement with people with lived experience. Involvement may be emotive and sometimes challenging for persons with lived experience, and care should be taken when discussing some aspects (e.g. details of suicide methods). There should be provisions to ensure that individuals are adequately supported during their involvement¹⁸ and measures to retain anonymity should be considered.

In the field of suicide prevention, the term “people with lived experience” refers to people who have previously engaged in suicidal behaviours, including having experienced thoughts of suicide, and people who have been bereaved by suicide, such as family members, friends and colleagues (also called survivors or suicide loss survivors). The LifeSpan Lived Experience Framework¹⁹ provides a framework for integrating lived experience across an organization. *Roses in the Ocean*²⁰ provides best practice for how to go about such integration effectively and safely for people with lived experience. An example on meaningful engagement in Scotland is provided in [Annex 2](#).

¹⁸ Storytelling for suicide prevention checklist. National Suicide Prevention Lifeline (USA) (<https://suicidepreventionlifeline.org/wp-content/uploads/2018/10/Lifeline-Storytelling-Checklist.pdf>, accessed 28 January 2021).

¹⁹ LifeSpan lived experience framework. Black Dog Institute (Australia) (https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/bdi_lived-experience-summit-2018_final.pdf, accessed 28 January 2021).

²⁰ *Roses in the Ocean* (Australia) (<https://rosesintheocean.com.au/>, accessed 28 January 2021).

HOW?

1. Form a steering group and develop a vision for collaboration (see Box 1, Introduction)

- Identify individuals who will play a key role in the development and monitoring of collaborations. Decide on leadership that will be able to convene collaborators and coordinate activities. It is key to involve relevant budget holders, and national/local government leaders.
- Consider the aims and scope of collaboration, understand what you hope to achieve through the collaboration, and establish what success will look like (see also [Annex 3](#) and [Monitoring and evaluation](#)).
- Plan for financing of the collaboration, taking into account, for instance, time, transport and activities.

2. Identify collaborators and decide on a method of engagement

- Perform a collaborator mapping exercise (e.g. during situation analysis) considering the following items for potential collaborators:
 - » role in LIVE LIFE;
 - » current engagement with, and attitudes to, suicide prevention;
 - » potential reasons/aversion to engaging in suicide prevention;
 - » cultural or religious beliefs, social and economic circumstances and usual channels of communication;
 - » relationships with other sectors/stakeholders;
 - » power/influence to ensure there is engagement from all partners and that recommended changes are put into action;
 - » what they can contribute to the collaboration effort (e.g. resources, skills);
 - » benefits for them of their involvement (that could be highlighted when attempting to engage them);
 - » any issues related to their involvement (possible conflicts, barriers, constraints).
- Decide on techniques for engaging collaborators, such as:
 - » memorandums of understanding or cooperation (e.g. between government departments);
 - » public meetings;
 - » focus groups;

- » workshops;
- » individual meetings/interviews;
- » awareness-raising events;
- » Internet (questionnaires, consultations, emails).

3. Engage collaborators

- When engaging with collaborators, discuss the following points:
 - » the importance of suicide prevention;
 - » the role of collaborators in suicide prevention;
 - » potential benefits of their involvement for themselves and for LIVE LIFE implementation;
 - » use of appropriate language;
 - » respect for different perspectives;
 - » any concerns they may have about being involved.

4. Hold an initial collaboration meeting

- Agree on the shared aims of collaboration.
- Consider what each partner can bring to the collaboration (resources, skills, relationships/areas of influence), and whether collaborators have any requirements/constraints to be negotiated.
- Define the roles and responsibilities of each collaborator.
- Develop clear guidelines/rules for the collaboration and define procedures to follow should these not be met.
- Formulate a plan of action: identify a set of short- and medium-term actions that can be prioritized initially, with a timeline for completion in the long-term. Include SMART goals²¹ and consider how actions will be financed.
- Put in place accountability mechanisms to strengthen transparency: a plan of action and stakeholder commitments should be clearly defined and made publicly available.

5. Begin collaboration and monitor and evaluate progress (see [Monitoring and evaluation](#))

- Create a calendar for regular meetings with collaborators to review progress on the plan of action and make adjustments/develop new actions. Agree a timeline in which actions should be completed.
- Discuss any challenges and lessons learned.
- Routinely conduct formal evaluations of collaborator engagement; if possible, evaluations should be carried out by independent parties.

²¹ SMART goals are actions that are specific, measurable, achievable, relevant, and time-bound (<https://www.mindtools.com/pages/article/newstool102.htm>, accessed 28 January 2021).

Box 13. Saving lives, led by the community, India

In Chennai, south India, a nondescript building in a narrow tree-lined lane houses an organization that has saved uncountable lives. The volunteers of this NGO, SNEHA, themselves would not know how many they have brought back from the precipice of suicide. As students of psychiatry we had little to offer for other conditions, but for something which was preventable like suicide, nobody was doing anything and this prompted the start of SNEHA.

At the beginning of SNEHA in 1986, suicide was a subject tainted with social stigma. The going was initially tough as the concept of volunteerism, emotional support and suicide prevention was poor – so much so that finding a place to rent was difficult. Slowly and steadily the work of SNEHA came to be recognized by the public, media and mental health professionals. Over the decades, SNEHA branched out beyond being a suicide helpline to raising awareness in the community, addressing policy issues and developing innovative community interventions to reduce suicides. In the early 2000s, SNEHA volunteers began noticing that every year in June, the number of callers increased. Volunteers were running 24-hour shifts to manage the distress calls from students who were suicidal due to failure in examinations during this period. Most students who died by suicide had failed in only one or two subjects. Yet, it was not enough to listen with compassion – policy needed to be changed if young lives were to be saved. We lobbied very hard with the state government of Tamil Nadu to bring in supplemental examinations whereby students could re-take the examination within two months and not lose an academic year. There was extensive support from the media.

In late 2002, the Tamil Nadu government announced the introduction of special supplemental examinations for students who had failed in up to three subjects. This was implemented in 2003, although the new policy was not publicized until late 2004. Once the state created awareness of the supplemental exams, the number of student suicides reduced by almost 50%. Just the fact that they had a second chance seemed to make a vast difference. Hope, it seems, worked wonders and several other states have followed suit.

The increasing numbers of suicides within the population of Sri Lankan refugees living in Tamil Nadu prompted another NGO to approach SNEHA to address this issue. A low-cost peer delivered intervention called Contact and Safety Planning (CASP) was designed. At the end of the first year, suicidal behaviour was significantly reduced in the intervention refugee camp (Vijayakumar et al., 2017). SNEHA's community intervention strategies have always been low-cost, non-labour intensive and based on peer support. In effect, these strategies can be successfully replicated all over the world.

In 2017, after decades of lobbying by SNEHA with the Indian government on the need to decriminalize attempts to take one's life, the colonial era law was finally made redundant by the passage of the Mental Health Act. SNEHA has also advocated ceaselessly for a national suicide prevention strategy at the highest government levels, including the Ministry of Health. As a result of these efforts, a committee was formed, and a National Action Plan has been drafted. The story of SNEHA is at the same time a story of how the loss of young lives to suicide is not ignored, and immediate and urgent action to save lives is taken. It shows how far community action can reach.

Box 14. Presidential task force for suicide prevention, Sri Lanka

In 1995, Sri Lanka was highlighted by the international community as having the highest suicide rate in the world. Hence, the then President appointed a Presidential Task Force to combat suicide in Sri Lanka in 1997. A crucial factor in the success of the Task Force was the authority of the President in appointing it resulting in all sectors collaborating with the utmost degree.

The multisectoral Task Force comprised representatives from health, education, agriculture, social development, social services, universities and NGOs which provided community services. The main reasons for success of this multisectoral collaboration were the composition of the Task Force, the enthusiasm of the chair and the authority appointing it. In addition there was a balance of administrative authorities involved (such as the pesticide registrar, the director of the Samurdhi (development finance) authority, and the director of the health education bureau) along with technical experts (such as public health officials, sociologists and psychiatrists). The Task Force based its recommendations on evidence and consensus.

The Task Force not only recommended interventions to prevent suicide, but also continued to monitor implementation of the recommendations at the grassroots level for several years thereafter. Key ingredients of success of the implementation at community level included the collaborative approach between the Task Force and communities, a dedicated programme to address the determinants of suicide in villages, and monitoring and evaluation.

In Sri Lanka, it was important to tap into the resources of the political authority at the right moment in order to get things done. For other countries similar to Sri Lanka, public health professionals should be prepared to advocate at the highest levels of authority, basing their actions on the best available evidence adapted to cultural contexts.

TIPS FOR IMPLEMENTATION

Table 3. Tips for implementation of multisectoral collaboration

Issues	Tips
Suicide prevention is not a priority for other sectors/ stakeholders and/or national leadership. They think suicide prevention belongs only in the health sector	<ul style="list-style-type: none"> • Use advocacy to show that suicide prevention goes beyond the health sector and requires collaboration. • Recognize suicide prevention as an issue in its own right, allowing for consideration of all underlying risk factors and not just mental health conditions. • Engage in regular meetings with other sectors and stakeholders to emphasize the ethical, political and economic value of suicide prevention, and involve them in awareness-raising. • Increase the budget for suicide prevention in other sectors to enable their participation. Allocate specific budgets to specific LIVE LIFE pillars and interventions so that these can be adequately resourced, rather than being considered a routine activity of the sector in question. • Provide regular feedback to stakeholders on successful prevention activities to retain engagement and momentum. • Consider incorporating suicide prevention in other public health policies and programmes which are prioritized (e.g. mental health, alcohol, violence prevention). • Where there is stigma, engage partners in awareness-raising discussions, provide information and dispel myths about suicide. • Find champions (i.e. people who care a lot about suicide prevention and are willing to take a leadership role) who can help to engage peers. It is preferable to have more than one champion because people's roles change over the course of implementation.

Issues (continued)	Tips (continued)
Conflicting interests (both in terms of actions and funding)	<ul style="list-style-type: none"> • Define mutual goals and objectives to be worked towards. • Define the role of collaborators and develop transparency and accountability mechanisms to ensure that their contribution is in line with this role. This should include transparent management of the assigned budget. • Regularly evaluate the collaboration and address any issues that arise. • Ensure that the efforts of collaborators are thoroughly acknowledged in internal and external communications. • Work to identify shared funding or resourcing opportunities to ensure that stakeholders are not competing for the same resources.
Lack of teamwork and coordination	<ul style="list-style-type: none"> • Clearly identify each stakeholder's role. • Organize regular meetings to maintain relationships and review actions. • Establish between-meeting channels of communication for different stakeholders and share information in a timely manner to reduce duplication of efforts. • Identify shared goals that can serve to unite individuals for joint achievement. • Develop systems of governance and accountability; make plans publicly available; and agree on actions to take if stakeholders have difficulties fulfilling their responsibilities.
Absent or ineffective leadership	<ul style="list-style-type: none"> • Learn how to communicate and work with a range of stakeholders. • Understand the traits of effective and ineffective leadership, thus helping to avoid pitfalls and to strengthen leadership abilities.²² • Where there is a high turnover in leadership, consider mechanisms that will help to maintain continuity – e.g. persons who can fulfill the role in times of transition, or joint leadership. • Ensure that planning and actions include input from all levels of collaborators, rather than relying on a top-down approach. • Endeavour to have funding over several years to give initiatives time to be developed and evaluated.

²² Leadership and legacy wheel. Oklahoma City (OK): Suicide Prevention Resource Center (<https://www.sprc.org/grantees/core-competencies/leadership>; <https://www.sprc.org/resources-programs/legacy-wheel>, accessed 28 January 2021).



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AWARENESS RAISING AND ADVOCACY

WHAT?

Awareness-raising and advocacy are crucial activities for often-neglected public health problems such as suicide prevention. Public health awareness-raising is an organized process of communication that targets a public audience to increase knowledge and change attitudes, beliefs or behaviours on a public health topic of importance. Advocacy can be combined with awareness-raising to advocate for necessary changes to address a problem.

By improving awareness, both communities and countries will observe an increase in the demands for services and support. This means that people leading efforts on awareness-raising should be prepared for such an increase (see [Early identify, assess, manage and follow up](#), and [Capacity-building](#)).

Awareness-raising draws attention to suicide prevention with messages such as:

- Suicide is a serious public health issue.
- People affected can seek help.
- How to identify and support someone at risk of suicide.
- How to open a conversation about suicide and respond appropriately if someone is suicidal.

Advocacy tries to bring about change, usually at the policy level, by advocating for:

- more funding to be allocated to suicide prevention measures;
- changes in legislation, such as decriminalization;

- integration of suicide prevention into schools, workplaces, health systems;
- a national suicide prevention strategy;
- improved suicide and self-harm surveillance systems; and
- resources and support for at-risk groups.

It is important to note that the language used in awareness-raising does not normalize or stigmatize suicide (see [Resources](#) for advice on language use). While it can be acknowledged that suicidal thoughts may occur over the life course, the importance of providing and seeking support needs to be emphasized. Consider not only **what** you communicate but also **how** you communicate it. Ensure that messaging addresses myths and misconceptions, and that it uses language which is neither sensational nor inflammatory.

WHY?

Awareness-raising and advocacy are strategic actions which contribute to overall suicide prevention efforts by influencing decision-makers and public opinion, attitudes and behaviours.

For decision-makers, advocacy can:

- contribute to increased political commitment and increased resource allocation for suicide prevention measures; and
- be used to influence non-health stakeholders about their role in suicide prevention, including, but not limited to, agriculture, transport, judiciary, the community, and the private and labour sectors.



For the public, awareness-raising can:

- inform that suicide is a serious public health issue which warrants attention;
- reduce stigma for suicide by dispelling myths or misconceptions and addressing attitudes or beliefs about mental health and suicide, including attitudes towards people who have attempted suicide and bereaved family members;
- increase awareness about individuals' roles in supporting those at risk;
- encourage by offering help and help-seeking behaviours; and
- provide knowledge on where to seek help.

Box 15. Raising awareness creates demand for services, Kenya

Working in the absence of a national strategy for suicide prevention, Befrienders Kenya has a vested interest in suicide prevention. Through the provision of listening services for people experiencing high distress, coordinating efforts on World Suicide Prevention Day, working with the media, and conducting gate-keeper training, Befrienders Kenya has observed an increase in requests for awareness sessions and training. The requests are a clear indication of the interest that is generated by Befrienders Kenya's efforts in awareness creation on suicide and suicide prevention. In response, Befrienders Kenya provides training such as that for gate-keepers at the community level to equip specific community groups with the necessary knowledge and skills which contribute to reduction of stigma and promotion of help-seeking behaviour – thus contributing to suicide prevention efforts. The awareness creation conducted by Befrienders Kenya also forms a platform for advocacy efforts on suicide prevention in the country.

WHERE?

Awareness-raising and advocacy for suicide prevention can range from events conducted in a single community location (such as a village or workplace) to nationwide public communication campaigns. Advocacy for change can be integrated in awareness-raising (such as joint meeting events with government and NGOs). Messaging can be disseminated through a widely accessible and commonly used channel for a community (such as a radio broadcast, or in a community or faith meeting), or through multiple channels to reach diverse audiences and improve geographical reach in a country (such as social media, printed media, television, radio, press briefings, conferences or workshops, printed advertisements or billboards).

WHEN?

Awareness-raising can be implemented continuously using static communication methods such as billboards, regular printed news, advertisements or posters in community locations which are accessed by people who are seeking help or who may be at risk of suicide (e.g. in schools, police stations, public transport, health services). It is important that the impact of efforts is evaluated and disseminated to decision-makers to demonstrate the benefit of resourcing continued activity. Local or national suicide prevention focal points can continue to advocate for suicide prevention in related agendas.

Box 16. National suicide awareness month, Japan

To concentrate efforts and resources, countries may choose to dedicate a specific period of time to awareness-raising. For example, in 2010 Japan selected March as its National Suicide Prevention Awareness Month. This was selected as a meaningful date due to the increased rate of suicides observed in March in Japan.²³ More recently, posters have been used on transport systems in Japan to raise awareness.

²³ Japan turning a corner in suicide prevention (https://www.who.int/mental_health/suicide-prevention/japan_story/en/, accessed 28 January 2021).



Countries and communities can use the opportunity of global public health days to amplify awareness-raising efforts through campaigns. Such campaigns can target a whole population and/or be used as opportunities to target selected groups.

Notable annual dates for suicide prevention are:

- 10 September: World Suicide Prevention Day (WSPD).
- 10 October: World Mental Health Day.
- November (variable date every year): International Survivors of Suicide Loss Day.

The benefit of using global days is that large-scale efforts go into developing resources which can be shared and utilized by many others. World Suicide Prevention Day is organized by the International Association for Suicide Prevention (IASP). Country efforts are supported by IASP through the collection, sharing and provision of resource materials and activities. Hundreds of activities in over 70 countries have been conducted on this day since its inception in 2003. These include educational and commemorative events, press briefings, conferences, and extensive social media coverage.²⁴ Follow-up activities (e.g. for two weeks after these global dates) can be an effective way to strengthen the sustainability of the messages from the campaign days.

WHO?

Awareness-raising and advocacy requires collaboration between multiple stakeholders. At the national level, leadership can come from a collaboration between the Ministry of Health and the media. The media are a crucial partner in awareness-raising. A partnership with the media should be viewed as a key component in ongoing awareness-raising and advocacy efforts (see [Interaction with the media for responsible reporting of suicide](#)).

At the community level, leadership may come from individuals or organizations with a vested interest in suicide prevention. Stakeholders may include people with lived experience, representatives of the target audience or NGOs. Persons with experience in awareness-raising (e.g. in other areas of public health) should be included.

Box 17. See Me – addressing stigma, Scotland

One of the key strategic aims of the Scotland Government's suicide prevention action plan is to ensure that suicide is no longer stigmatized. Wider efforts to reduce the stigma and discrimination around mental health support this aim, as well as two other strategic aims – i.e. that people at risk of suicide feel able to ask for help, and that people affected by suicide are not alone. Removal of the stigma around asking for help for a mental health problem or when in distress is vital to ensure that people can speak about how they are feeling before they reach a point where suicide feels like an option. See Me, Scotland's programme to end mental health stigma and discrimination, focuses its work on the reduction of inequalities and a mental health inclusion approach in three core areas. In education, young people and the adults in their lives are offered a common language to speak about mental health, so that young people are not scared to speak out. In workplaces, employers work with See Me to improve policies and practices which can cause discrimination, as well as changing cultures so that employees feel able to say they are struggling and can have reasonable adjustments put in place to support them. In health care, See Me has worked to promote the involvement of people with lived experience of distress in the training of health-care staff so that the latter are aware of the negative impact of giving a noncompassionate and dismissive response. This work is supported by partners in local areas, intersectoral partners and those focusing on high-risk groups who, together with a growing social movement of people all across Scotland, are changing the culture around mental health in Scotland so that people do not feel alone and can ask for help when in distress.

Suicide prevention champions can accelerate awareness-raising and advocacy efforts. Champions can be influential or recognized members of a community (such as a faith leader, or local politician) or national or global celebrities who have demonstrated commitment to, and interest in, mental health and suicide prevention – such as Heads Together led by The Royal Foundation of the Duke and Duchess of Cambridge in the United Kingdom of Great Britain and Northern Ireland.

²⁴ Suggested activities by the International Association for Suicide Prevention (IASP) (<https://www.iasp.info/wspd2019/suggested-activities/>, accessed 28 January 2021).



Identifying champions with lived experience can help capture the attention of the population or can give impetus to a large-scale increase in suicide prevention initiatives, such as the Garrett Lee Smith Memorial Act²⁵ in the USA. This Act has subsequently supplied youth suicide prevention grants to all states in the USA, including academic institutions and more than 50 indigenous tribes. Research evidence showed that areas in receipt of grant-funded activities experienced decreases in youth suicide (Godoy Garraza et al., 2019).

Champions for awareness-raising and advocacy also include persons or organizations with an interest in preventing suicide – such as NGOs, or health, social care and scientific leaders, or suicide prevention advocates, including family members.



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Box 18. Determined and committed champions, United States of America

In 1996 the United Nations issued a document entitled *Prevention of suicide: guidelines for the formulation and implementation of national strategies*. This document called on governments to formulate a national strategy for suicide prevention and to establish a coordinating body responsible for the prevention of suicidal behaviour. This call to action was heard by Jerry and Elsie Weyrauch of Marietta, Georgia who had lost their 34-year-old physician daughter Terri to suicide. They led a movement of survivors of suicide loss and allies and created a nonprofit organization called the Suicide Prevention Advocacy Network USA (SPAN-USA) that has changed the response to suicide in the USA. The advocacy of this one couple from Georgia and the countless others who joined their crusade was instrumental in the development of the United States' first national strategy. By bringing suicide to the attention of national legislators by engaging the voices of these many survivors, grief turned to action, pain to promise, and hurt to hope. In 1997, after US Senator Harry Reid shared his own story of having lost his father to suicide many years earlier, the Weyrauchs contacted his office to ask for his support in introducing a Resolution (S.Res.84) calling for acknowledgement of suicide as a national problem that warranted a national response and calling for the development of a National Strategy for Suicide Prevention. This Resolution passed unanimously the day it was introduced, being approved by all 100 United States senators, and launched the country's current movement to address suicide as a leading cause of death. In 1998 a national meeting was held in Reno, Nevada which called together survivors, academics, policy-makers, clinicians and others to lay the groundwork for our first national strategy for suicide prevention. After an initial Call to Action released in 1999, the first strategy was released in 2001, was revised in 2012, and the coordinating body was established in 2010. As Margaret Mead once said, "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has." It is championship like that of Senator Harry Reid, Jerry and Elsie Weyrauch and Senator and Mrs Gordon Smith that have lifted the veil of secrecy from suicide and sparked a nation to take critical steps to commit to addressing this public health challenge. Because of their tireless efforts and selfless service, there is now a national strategy for suicide prevention, a coordinating body to oversee its implementation, a national suicide prevention resource centre, a national lifeline, an infrastructure to address suicide across the country and grants being distributed to assist communities in addressing suicide in their localities. These persons will always be remembered for their catalytic efforts, coming from their own losses of loved ones, to ensure that a country responds to the health challenge of suicide.

²⁵ Unfortunately, the impact of tragedy brought about change for suicide prevention. Garrett Lee Smith, son of Senator Gordon and Sharon Smith, died by suicide in 2003, which led to the passage of the Garrett Lee Smith Memorial Act.



Box 19. Turning grief into action against suicide, Iraq

Some people say that time heals all wounds. We believe that it is both time and action that help us heal after loss. In the midst of the grief that we faced after losing our younger son Taba to suicide, we started reaching out to fellow survivors – people suffering after the loss of a loved one to suicide like us. We strived to provide them with whatever limited support we could in order to guide them in their journey through grief and their efforts to fight off social stigma, while reminding them that they were not alone.

Taba's death transformed us completely. We realized that through sharing our own experience that we could help those who had experienced a similar loss to our own by showing them that they were not alone or abandoned. We soon learned through research and reflection that, contrary to local discourse, suicide is in fact preventable. In the absence of specialized governmental help and NGOs focused on the systematic prevention of suicide and the support of survivors, we decided to take action ourselves through the founding of Azhee.

A few months after the official registration of Azhee as a nonprofit NGO in 2019, with support from the International Organization for Migration (IOM), we organized a national conference that coincided with World Suicide Prevention Day attended by approximately 100 suicide survivors, academics, national and international NGOs, diplomats, government representatives, and United Nations agencies. The conference succeeded in its objective of bringing heightened media and academic attention to the issue of suicide and the dire urgency of adopting efforts to prevent it. During the event, we reaffirmed the importance of finalizing a much needed, yet shelved, draft of the National Strategy for Suicide Prevention.

In order to mark World Suicide Prevention Day this year, we hosted a remote workshop to launch the review process aimed at finalizing the draft strategy for government endorsement. Building on Azhee's efforts, the Iraqi Council of Ministers' Secretariat and IOM co-hosted Azhee and senior ministerial representatives in a two-day conference in Baghdad in November 2019 to consolidate our efforts towards finalizing the suicide prevention strategy. Though we have made progress since our inception, we continue to face challenges such as stigma at the personal and community levels, and the lack of funds at the organizational level. We remain committed to overcoming them in the years to come.

Our son's story ended, but ours did not. We founded Azhee (a Kurdish word that means s/he lives) because we are here celebrating the lives of the loved ones we lost to suicide and honouring the time they spent with us. We want others to appreciate and cherish their lives, live with happiness, and use their time on this planet to benefit both themselves and others. As the founders of Azhee²⁶ we advocate, in the name of our love for Taba and countless others, for the expansion of our society's understanding and recognition of the importance of mental health.

HOW?

1. Convene a working group (see [Box 1, Introduction](#))

- Establish the group (see under [Who? above](#)).
- Ensure that stakeholders (see [Annex 1 for a list of sectors and stakeholders](#)) are engaged throughout the planning and implementation process, as they and their partners will be vital for dissemination efforts.

2. Decide the objective

- Consider the aims and whether they support other LIVE LIFE interventions and pillars. Examples could be to draw attention to suicide as a serious public health problem, to raise awareness of available support services, or to advocate for resources for specific suicide prevention interventions
- Decide on the target audience. For awareness-raising, utilize an available situation analysis or related source

²⁶ See: www.azhee.org, accessed 28 January 2021.



of information to identify priority target groups (i.e. those with disproportionately high rates of suicide, or low help-seeking). For advocacy, consider the appropriate decision-maker or funder to meet the aim of the advocacy. Communications are most effective when they target specific audiences (e.g. policy-makers, adolescents). Where communities hold very strong views on suicide, it is important that discussions with key stakeholders are held in order to maintain partnerships before actions are taken.

- Decide on the timing of implementation. Options include a continuous initiative, a campaign, a designated national awareness month, a designated global awareness day, or other important dates (e.g. times of high stress such as school or college examinations). Make sure that objectives can be achieved within the timeline.
- Consider whether objectives can be achieved with the resources available. Consider whether efforts and resources can be integrated into related awareness-raising for other public health issues.
- Decide how impact will be assessed and communicated. A mechanism for monitoring and evaluating the impact of awareness-raising or advocacy should be planned in advance (see point 5 below and also [Monitoring and evaluation](#)).

3. Decide the delivery methods and the messaging for the activity or communications

- Assess which method of delivery will: 1) meet the aims; 2) be suitable for the target audience; and 3) ensure sufficient impact and coverage for the investment effort.
- Ensure that the information content is evidence-based.²⁷
- Adapt the methods and messages to the target population. Consider age groups (e.g. adolescents may prefer different communication methods from other age groups), gender (e.g. adapt language or images), sociodemographic composition of a community (e.g. messaging in predominant languages; images and language representing the community, for instance in terms of ethnicity, migrant status, religion); literacy of the population (e.g. verbal or image-based messaging); context (e.g. radio or community events may be preferable when there is no Internet access).

- Plan for multiple methods of delivery and multiple messaging, particularly for populations with different sociocultural backgrounds.

4. Check acceptability, comprehensibility and feasibility of the delivery methods and messages

- Engage relevant stakeholders to test acceptability and potential impact of the initiative in a small sample of the target audience.
- This can also include determining whether advocacy directed towards decision-makers will be acceptable and will have the intended impact.
- Revise, if needed, and prepare stakeholders for the dissemination phase.

5. Conduct the initiative and evaluate its effectiveness (see also [Monitoring and evaluation](#))

- Consider how to assess whether awareness-raising has been successful. Think about the aims. If feasible, administer a baseline survey to determine knowledge, attitudes and behaviours in the target audience before conducting awareness-raising efforts.
- Use the lessons learned to inform changes for the next initiative.
- A report evaluating the initiative should be disseminated to all the stakeholders and decision-makers involved. Such a report can serve as a form of advocacy by highlighting the impact of awareness-raising.

²⁷ See, for example, the WHO fact sheet at: <https://www.who.int/news-room/fact-sheets/detail/suicide>, accessed 28 January 2021).



TIPS FOR IMPLEMENTATION

Table 4. Tips for implementation, LIVE LIFE awareness-raising and advocacy

Issues	Tips
Lack of time for planning	<ul style="list-style-type: none"> • Reduce the number of activities and the messaging to fit reasonably within the timeline. Keep ideas for another dissemination date. • Prioritize the messaging on the target group and the timeline. • Use SMART goals²⁸ to plan.
Concerns about addressing suicide in contexts where there is stigma and/or lack of support services	<ul style="list-style-type: none"> • Awareness-raising should discuss stigma. Support should be available for persons in need. • Involve the public in generating awareness-raising content. For example, create an online/local challenge, engaging the public to share how they take care of their mental health.²⁹
Limited funding and/or resources which affect coverage and activities	<ul style="list-style-type: none"> • If it is not possible to obtain more funding, aim to work within the available budget. • Reduce geographical coverage and the number of activities. • Prioritize one target population (to reduce requirements for multiple methods of delivery and development of multiple adaptations of messages). • Prioritize which methods of delivery will be most cost-effective and will have the intended impact for the objective. • Consider if resources can be pooled with stakeholders or consider if awareness-raising on suicide prevention can be integrated into related campaigns (e.g. for mental health). • Consider leveraging other initiatives, or partnering with local stakeholders, to add suicide prevention messages to their events and observances. • Engage with media outlets that may be able to donate empty advertising space they need to fill. • Communicating the evaluation of a single campaign to prospective funders may help to secure future financial resources.
Lack of clear outcomes	<ul style="list-style-type: none"> • Initiatives should have a clear focus and a call to action, such as linking people with support services rather than awareness-raising about suicide in general.

²⁸ SMART goals are goals that are specific, measurable, achievable, relevant and time-bound.

²⁹ See the Campaign to Change Direction at: <https://www.changedirection.org/a-week-to-change-direction/>, accessed 28 January 2021.



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CAPACITY BUILDING

WHAT?

Capacity-building for suicide prevention is strategically intended for anyone delivering the implementation of LIVE LIFE pillars or interventions (see Table 5). This means training to improve the knowledge and skills of people both inside and outside the health sector.

Table 5. Examples of capacity-building for LIVE LIFE interventions and pillars

LIVE LIFE interventions and pillars	Capacity-building examples
Situation analysis	Persons identified with this task (in desk review, interviewing, interpretation of quantitative and qualitative analyses)
Multisectoral collaboration	Stakeholders (in building partnerships, leadership)
Awareness-raising and advocacy	Persons identified with these tasks (in communications skills)
Financing	Identified person (in writing a proposal or a budget for financing)
Surveillance, monitoring, evaluation	Data collectors, data managers, medico-legal staff, coroners. Capacity-building to increase and strengthen research in low- and middle-income countries (Chibanda et al., 2020)
Limit access to the means of suicide	Pesticide registrars and regulators; legislators in the area of firearms control; judges; architects
Interact with the media for responsible reporting	Media professionals (e.g. journalists, filmmakers, those working on stage and screen); students of media professions
Foster socioemotional skills in adolescents	Health workers, education providers or facilitators (to deliver socioemotional skills programmes in schools)
Early identify, assess, manage and follow up	Health workers (also in clinical management of acute pesticide ingestion, where relevant); community gatekeepers.

WHY?

Capacity-building is important so that people may obtain, improve and retain the skills and knowledge needed to do their jobs competently. Health services are often the entry point for people in distress where management and follow-up care are provided. Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship.³⁰ Given that many people do not have sufficient access to health care (WHO, 2018b), it is also important to build the capacity of local gatekeepers, whose knowledge of and access to the community enables them to identify at-risk individuals and to mobilize support.

Box 20. Scale-up of multisectoral gatekeeper training, Malaysia

Government leadership, public–private local and international partnerships, and volunteers from NGOs and patient advocacy groups have contributed to the upscaling of gatekeeper training for suicide prevention among frontline health workers, educators and the general public at regional and national levels in Malaysia within the past decade. The evidence base is gradually expanding in terms of improved awareness of suicide prevention in the short term (Siau et al., 2018). Future work is needed to establish and evaluate sustainable models of gatekeeper training for longer-term capacity-building in specific populations in the community.

WHERE?

Capacity-building can be coordinated at the national level (e.g. training of national health, education, police workforce) or conducted in the community (e.g. training coordinated by a local body and directed towards specific community stakeholders). Training can be conducted face-to-face or digitally – using, for instance, suicide prevention e-learning courses on the virtual

campus of the Pan American Health Organization (PAHO)^{31, 32} or the WHO e-mhGAP application for non-specialized health workers in the assessment and management of self-harm/suicide.³³

WHEN?

This work should be continuous throughout LIVE LIFE implementation. There may be strategic times to deliver capacity-building, such as by including suicide prevention in pre-service or continued training of health workers which is regularly reviewed during their employment. Capacity-building may also be triggered when problems arise, such as high rates of suicide in a particular occupational sector (such as construction) or stigma in the judicial sector.

Before commencing initiatives, a care pathway for ongoing management and follow-up must be established (see [Early identify, assess, manage and follow up anyone who is affected by suicidal behaviours](#)). Capacity-building should be sustainable rather than having one-time training after which the effects of training effects may decline. Models which promote sustainability are the training-of-trainers model, the provision of supervision for health workers, or planning of training that is regularly repeated in the community.

³⁰ Universal health coverage. Geneva: World Health Organization (https://www.who.int/health-topics/universal-health-coverage#tab=tab_1, accessed 17 February 2021)

³¹ Preventing self-harm/suicide: empowering primary health care providers. Washington (DC): Pan American Health Organization (<https://www.campusvirtualsp.org/en/course/preventing-self-harmsuicide-empowering-phc-providers>, accessed 28 January 2021).

³² Engaging communities in preventing suicide. Washington (DC): Pan American Health Organization (<https://www.campusvirtualsp.org/en/course/virtual-course-engaging-communities-preventing-suicide-2020?language=es>, accessed 28 January 2021).

³³ See: mhGAP-IG 2.0 App (e-mhGAP) (<https://apps.apple.com/gb/app/mhgap-ig-2-0-app-e-mhgap/id1291414206>, accessed 28 January 2021)

Box 21. Capacity-building for judges, Ghana

In Ghana, the need for training judges started when the media highlighted that courts were punishing survivors of suicide attempts. In response, the Centre for Suicide and Violence Research (CSV) organized stakeholder meetings to discuss the need to expand awareness and knowledge of suicide to staff of the judiciary and related security services. To encourage the involvement of the judiciary, CSV partnered with the Ghana Mental Health Authority to plan a training programme. A personal connection facilitated access to and buy-in from the judiciary services, who then joined planning discussions. Logistical arrangements for the training were made collaboratively. The training content included education on suicide, warning signs, stigma and the need for decriminalization of attempted suicide.

- other community gatekeepers (persons likely to come into contact with at-risk individuals, or with influence in a community (see [Annex 1 for a list of sectors and stakeholders](#)). Unique examples include:
 - » Queen Mothers in Ghana who have large community influence;
 - » public transport workers in the United Kingdom to identify individuals at-risk near jump sites;³⁴
 - » taxi drivers in Ireland who may drive past jump sites;
 - » health administrative staff in Scotland, who are often the first point of contact for patients;
 - » hairdressers in the United Kingdom, who have opportunities to talk to their clients, particularly men;
 - » bartenders in the USA who are likely to come into contact with at-risk men;³⁵
 - » financial officers and debt collectors in the Netherlands, who are likely to encounter individuals with financial problems.

WHO?

Capacity-building stakeholders should be considered in terms of: 1) the persons to develop and/or deliver capacity-building training; and 2) the recipients of training.

For example, capacity-building for early identification, assessment, management and follow-up can be directed towards:

- health workers, including mental health workers and non-specialists (such as emergency medical workers, general physicians, nurses, community health workers, or social workers);
- emergency service workers (such as police, firefighters, ambulance or crisis line personnel);
- those working with:
 - » young people (e.g. teachers, youth workers);
 - » older people (e.g. care staff in residential homes, pension service staff);
 - » the judicial system (e.g. prison or jail officers, judges);
 - » social welfare recipients;
 - » people in workplaces (e.g. occupational groups with high suicide rates);

HOW?

1. Convene a working group (see [Box 1, Introduction](#))

- Establish the group (see Who? above and [Annex 1 for a list of sectors and stakeholders](#)). Capacity-building is likely to involve collaboration between the health sector, local authorities and community stakeholders.
- Determine where there is a need to build capacity and what the aim of capacity-building will be. In resource-limited contexts, consider where suicide prevention training will have the largest impact. The need for capacity-building needs should be identified in collaboration with stakeholders. The situation analysis may have revealed gaps in capacity and training needs.
- Determine who will develop/deliver the training. Training should be developed/delivered by people with expertise in suicide prevention and skilled in training methods.
- Determine how the training will be delivered. It could be face-to-face or virtual training, or delivered through digital methods such as online video conferencing.
- Plan to ensure continuity and sustainability of the training. For health workers, ongoing supervision is important; for stakeholders who may not require ongoing clinical supervision, plan for repetition of the training

³⁴ Suicide prevention on the railway. London: NetworkRail (<https://www.networkrail.co.uk/communities/safety-in-the-community/suicide-prevention-on-the-railway/>, accessed 28 January 2021).

³⁵ Bartenders as gatekeepers. Ventura County (CA): NotAlone (<https://www.notalonevc.org/bartenders-as-gatekeepers/>, accessed 28 January 2021).

and refresher sessions. Consider if a training-of-trainers model can be used.

- Consider inserting capacity-building for suicide prevention into the curricula of professional education.

2. Develop or select and adapt a training package

- For non-specialized health workers and community health workers, the self-harm/suicide module of the WHO *mhGAP Intervention Guide* (WHO, 2019b) and associated training materials can be used.³⁶
- For gatekeepers, training should be evidence-based and adapted to the needs of the gatekeepers. Awareness-raising and stigma reduction should be incorporated into all suicide prevention capacity-building. Training should ensure that gatekeepers know what to do once risk is identified (e.g. referral).
- Training should provide trainees with opportunities to practise skills they have learned (e.g. through role play). Following training, ongoing systems of supervision and refresher training should be put in place to facilitate continued learning and opportunities to discuss issues that have arisen.
- Training content may require cultural adaptation for delivery in a new context. The training developers can advise on how best to make adaptations without impacting effectiveness.

3. Train the workforce and provide ongoing supervision or plan refresher training

- Supervision must be seen as an essential component of training to ensure sustained change, particularly for health workers.
- Regular supervision sessions should be planned to strengthen the transfer of knowledge to practice, and to give trainees an opportunity to resolve problems they face.
- Plan for refresher training for gatekeepers or others outside the health sector.

4. Evaluate the training

- Plan in advance how training programmes will be monitored and evaluated (see [Monitoring and evaluation](#)).

- For capacity-building training, assess and evaluate the competency of trainees – i.e. the ability to apply the knowledge and skills learned. For nonspecialist providers of psychosocial interventions, the Enhancing Assessment of Common Therapeutic Factors (ENACT) assessment tool can be used. A digital version of ENACT is available (in multiple languages) on the WHO Equip Platform.³⁷
- Assess confidence and qualitative experiences of the trainees and trainers. It is not sufficient to report only the numbers of people who receive training, as this does not indicate if trainees gained skills or knowledge, or if they changed their behaviour.
- To assess the impact of training on the routine work of trainees, indicators may include the number of contacts with at-risk persons and the number of referrals made.
- Monitor the proportion and distribution of health workers that have been trained and meet competency requirements. Aim to increase training coverage.



³⁶ mhGAP training manuals. Geneva: World Health Organization (https://www.who.int/mental_health/mhgap/training_manuals/en/, accessed 28 January 2021).

³⁷ EQUIP: Ensuring Quality In Psychological Support. Geneva: World Health Organization (https://www.who.int/mental_health/emergencies/equip/en/, accessed 28 January 2020).

Box 22. Strengthening the health workforce to prevent suicide, Guyana

Prompted by having one of the highest suicide rates in the world, the Government of Guyana made suicide prevention a priority. With technical support from PAHO/WHO, the National Mental Health Action Plan 2015–2020 and the National Suicide Prevention Plan 2015–2020 were developed and published in 2014. In May 2016, The Ministry of Public Health, established the Mental Health Unit to lead implementation of both plans and to organize the delivery of mental health services. One of the four strategic areas for the plan is to address the health system response to suicidal behaviour.

mhGAP, developed by WHO for low- and middle-income countries, aims to scale up services for people with mental, neurological and substance use disorders. The mhGAP module on suicide and self-harm aims to train general health workers – such as those in primary care – in identifying and managing risk for suicide and providing appropriate follow-up care. In 2015, the Mental Health Unit of PAHO/WHO implemented the online course “Integration of mental health into primary care” based on the WHO *mhGAP Intervention Guide*, using PAHO’s Virtual Campus for Public Health platform. Seven physicians from Guyana successfully completed the first online course. One of the mhGAP trainees reported being “*better able to manage depression, using not only medication but also psycho education*”. This included identifying and understanding the stresses her patients were experiencing and exploring their social support system. Since then, more than 300 health-care workers have been trained to assess, manage and follow up common mental health conditions and suicide/self-harm. More than 100 of these are doctors located in primary health care. Additionally, 70 persons were also trained in the substance use module as alcohol and substance abuse are major risk factors for suicide in Guyana. In addition, teachers are being trained to recognize mental health issues in children and adolescents and to refer appropriately. Guyana’s next aspirations for gatekeeper training include a programme to involve non-health-care persons in suicide prevention.

Box 23. Building capacity for workplace suicide prevention, Australia

The MATES in Construction (MATES) programme was developed in Queensland, Australia, in 2007. The programme was established with seed capital from the Building Employees Redundancy Trust (BERT), an employee entitlement fund jointly owned by construction employer associations and employee unions. The decision to establish an industry suicide prevention programme followed a report from a WHO Collaborating Centre in Brisbane – the Australian Institute for Suicide Research and Prevention – demonstrating significantly higher suicide rates amongst Queensland building industry workers (Heller, Hawgood & De Leo, 2007).

MATES was established as an independent industry-based charity for the purpose of reducing suicide among construction workers. MATES is a multimodal programme (Gullestrup, Lequertier & Martin, 2011) based on four principles:

- raising awareness among workers;
- building resilience in the workplace;
- connecting workers to help and support; and
- informing industry about best practice in partnerships with researchers.

The MATES programme is based on a community development model of continual improvement. MATES does not provide clinical services but seek to connect workers to the right resources at the right time. The basic building blocks of the MATES on-site programme related to capacity-building include:

- General Awareness Training (GAT) – a one-hour programme designed to engage workers in suicide prevention and provided to all workers on site. Workers are provided with a white hard-hat sticker.



- Connectors – a four-hour programme training workers to connect workmates to support. The programme is provided to volunteers on site. Connectors are recognized by a green hard-hat sticker.
- ASIST workers – a 16-hour programme training workers on site to intervene when a co-worker is at risk of suicide. Key workers are trained as ASIST workers who are recognized by a blue hard-hat sticker.
- Site accreditation – worksites meeting the minimum training requirements receive site accreditation.

In addition, the basic building blocks include: 1) promotion of information material on sites for engagement (e.g. on World Suicide Prevention Day); 2) field officers to support the volunteer network; 3) on-site volunteers who inform management on site about mental health and suicide risk; 4) case management; 5) a 24/7 support line; and 6) national policy advocacy such as the Australian Building and Construction Industry Blueprint for Better Mental Health and Suicide Prevention which is a framework for better mental health endorsed by all major construction unions and employer associations in Australia.

MATES has reached more than 220 000 workers across Australia and has more than 18 000 connectors and 2500 ASIST workers across more than 1000 worksites in Australia. The programme receives approximately 30% of its funding from government and 70% from industry. The programme is available at no charge to both employers and workers in the construction industry. The programme has demonstrated high social validity in the construction industry, improving help-offering and help-seeking skills, and reducing stigma. A health economic evaluation demonstrated a return on investment of A\$4.60 per Australian dollar invested, primarily to government (Doran et al., 2016).



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TIPS FOR IMPLEMENTATION

Table 6. Tips for implementation of capacity-building

Issues	Tips
Funding	<ul style="list-style-type: none"> • Use existing evidence-based and freely available training packages such as WHO mhGAP (WHO, 2019b). • Emphasize to decision-makers that capacity-building is beneficial where resources are limited because it upskills the existing workforce. • Integrate suicide prevention into other existing training programmes (e.g. case management of gender-based violence or pre-service and in-service training of health workers).
Limited human resources and/or large geographical reach	<ul style="list-style-type: none"> • Employ a training-of-trainers model to increase human resources available to deliver training. • Prospective trainers may be selected strategically, such as those working in high-risk geographical areas or those able to deliver capacity-building in rural or hard-to-reach areas.
Health workers may not be prepared or competent to identify and manage suicidal behaviours. In addition, the quality of care provided may be inadequate and inconsistent	<ul style="list-style-type: none"> • Train specialized and nonspecialized health workers in the assessment, management and follow-up of suicidal behaviours and mental, neurological and substance use disorders and ensure these workers meet competency requirements. • Involving health workers in adapting the training to the local context can enhance motivation and the effectiveness of the training. • Understand the context-specific factors which hinder the management of suicidal behaviours, thus enabling training to be modified so that staff can be prepared to manage such challenges.
Stigma or legal status of suicide may make trainees reluctant to participate	<ul style="list-style-type: none"> • Capacity-building should be accompanied by awareness-raising (see Awareness-raising and advocacy). When planning training programmes it is important to empower and engage communities in discussions on suicide prevention.
Content of gatekeeper training does not always match gatekeepers' level of expertise or readiness to change	<ul style="list-style-type: none"> • Ensure that training is adapted to the recipients and extend introductory sections of training to strengthen knowledge about suicide and its prevention. • Ensure that training is adapted to the sociocultural context. • Include interactive activities to address readiness to change or to shift beliefs about suicide. • Include experiential exercises such as role-plays to ensure that trainees feel confident to respond to a range of situations. • Following training, ensure that trainees feel sufficiently supported by supervision.



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FINANCING

WHAT?

Financing allows for LIVE LIFE pillars and interventions to be translated into action through the allocation of resources. Financing can originate from various public and private sources, such as government funding or philanthropic grants by private individuals, foundations, community groups or corporations.

WHY?

Unfortunately, dedicated funding for suicide prevention is scarce. Factors such as poor economic conditions, lack of prioritization of suicide as a serious public health issue, and lack of recognition that suicides are preventable result in a belief that funding for other areas is more important to society (see [Awareness-raising and advocacy](#)). One should not be disheartened by this, but instead should take a solution-focused approach by tailoring suicide prevention activities to the realities of the funding situation. This could mean taking an integrated approach (with mental health or other sectors) to qualify for multisectoral funding and increase likelihood of obtaining funds. It could also mean focusing efforts on cost-effective interventions with maximal reach, such as national bans on highly hazardous pesticides (Lee et al., 2021). Additionally, financing should be conceptualized to include a focus on the development and implementation of policies, strategies and plans, and not only on development of services. This is vital because LIVE LIFE includes pillars which are infrastructural and interventions that lend themselves to national policy

and regulation (such as means restriction) as well as service development (such as early identification, assessment, management and follow-up).

WHERE?

Financing for suicide prevention can be provided towards implementation at the:

- *geographical level*: national-level financing (e.g. for nationwide campaigns) or local-level financing (e.g. for delivering mental health services in a specific district);
- *stakeholder level*: financing that targets specific at-risk populations or specific sectors or providers (such as schools, agriculture, community gatekeepers);
- *systems level*: financing that targets broad-based activities that build the knowledge, capability and infrastructure of the sector at large (such as research, technology and capacity-building).

Funders' approaches may also involve a combination of the above levels, such as financing state-level research on suicide prevention in schools. Ultimately, LIVE LIFE implementers should understand the various sources of funding available and advocate to funders to align mutual values between implementers and financiers.



WHEN?

Funding needs and budgets should be clearly defined well before reaching the implementation phase of a suicide prevention pillar or intervention. Ideally, implementers would first build high-level strategic plans (to articulate goals and priorities for action), followed by detailed operational plans (to specify interventions to be carried out, costs, and the process for securing funds), fundraising or allocation of funds, and then implementation. The lack of well-defined plans can potentially lead to a perception that the work is not strategic, resulting in low success in acquiring funds no matter whether from government or other sources.

While fundraising can be an ongoing activity, many funders have fixed grant cycles – a window of time within which they select grantees and disburse funding. For corporate bodies that donate a proportion of their revenue towards social activities, the end of the financial year is typically a time when they consider programmes to which they direct their funding. For foundations, grant cycles may vary and should be checked through their websites. Similarly, individual governments have their own budget cycles. Fundraising should not be a one-time or static effort. Once initial funding is secured, implementers can leverage this momentum towards mobilizing additional funds from a wider range of funders. There is no single approach to obtaining funds – all funders have their own process, structure and guidelines that must be individually researched and understood.

WHO?

Financing for LIVE LIFE pillars and interventions may come from various public and private players. National governments, as well as state or local governments, typically have some portion of their budget allocated to mental health programmes of which suicide prevention may be a component. Foundations often have greater appetite to fund innovative projects and to provide flexible and long-term capital. Many family foundations or individual philanthropists who focus their giving on suicide prevention are driven by personal experience. Initial private funding can be used to demonstrate effectiveness of an innovative intervention, which can then be leveraged to enabling the government to adopt the programme and scale its impact.

HOW?

1. Define budgets and articulate the need for funding

- The national steering committee, or equivalent, will be the responsible body [see [Box 1](#), [Introduction](#)].
- Develop an operational plan or implementation plan that highlights details about interventions to be implemented, programme timelines and milestones, and human resources and funds required to carry out the work (see [Annex 3](#)).
- Determine whether available financial resources will meet the needs and, if not, how much funding needs to be raised and over what period of time.
- When defining budgets, clearly delineate personnel costs (salaries) and programme costs (travel, equipment, etc.) with clear and realistic cost figures against each. Also consider outlining not just direct costs of the programme but also indirect or overhead costs (utilities, rent, etc.), where relevant.

2. Research the landscape of funders

- Research which government sector or local and international funders support work on suicide prevention. Map funders who are supporting related work (e.g. mental health care, youth, pesticide-related programmes); many of these funders may not clearly present themselves as funders of suicide prevention work but could be interested in funding such programmes.
- Approach philanthropy advisors or intermediary organizations who can help you navigate the landscape of funders of suicide prevention or related work.
- Find out how your government's funding works. Do government budgets for suicide prevention rest with national or regional governments, and within which departments?
- Speak with nonprofit organizations and other implementers to understand their successes in obtaining funding.
- Create a database of potential funders on the basis of your research.

3. Identify government funding or suitable funders

- Identify the government department and budget holder, or determine the type of funder, that would be most suitable given the nature of the intervention.



- Identify which funders most strongly align with your vision, objectives and priorities. For instance, if you are seeking funding for suicide prevention for adolescents, seek funders who prioritize adolescent well-being and who have a history of funding similar programmes, or identify the budget holder in the relevant ministry or government department for education.
- Check for alignment of the funders through websites and conversations. Make sure to identify potential conflicts of interest.
- Understand the approximate size of grant that the funder would be ready to give. This can be gauged by researching the funder's previous funding or having an initial conversation with the funder.
- Identify and prioritize funders with whom you may already have built a strong relationship or professional connection.
- Diversify your efforts to reaching out to multiple funders of various types.

4. Develop proposals

- On the basis of the funder's requirements, you may need to use a fixed template provided by them or have the flexibility to create your own format for the proposal.
- A proposal should cover the following: 1) information about you and your organization or government department; 2) the "why" (i.e. the context of the problem you are trying to address and why it is important); 3) the "what" (i.e. proposed objectives, interventions and activities); 4) the "how" (i.e. programme budget, timelines and key milestones); 5) the "who" (i.e. the team and partners who will be leading and implementing the work); 6) expected outcomes of the intervention with specific and measurable short-, medium- and long-term outcome indicators; and 7) the funding ask (i.e. how much funding, for what aspect of the work and over what duration).
- Tailor the language and positioning of your proposal as closely as possible to the priorities of the funders.
- If you have already secured some funding, share this information transparently with the funder. Funders often see value in investing in programmes and interventions that bring other resources to the table.
- Preferably, send the proposal to the representative responsible for making decisions, rather than to a generic mail address.

Box 24. Checklist: asking for funds from national and local budgets

- Identify the key policy-maker responsible for decisions.
- Identify the officials or systems responsible for implementing the policy decisions.
- Seek an appointment at an appropriate place and time.
- Keep the interaction focused and precise with a clear, concise and contextual message that speaks directly about prevention (do not discuss only the problem of suicide). Highlighting the burden of suicide as compared to that of other issues (e.g. road injuries) for which investment may be significantly greater can help call attention to the need for greater investment in suicide prevention.
- Policy-makers usually have limited time and several competing priorities. To get their attention, do not give them a lengthy proposal with pages of data; deliver a understandable and brief (maximum two pages) note with sharp messaging focused on concrete results.
- Offer your experience and expertise in suicide prevention.
- Be persistent and maintain regular contact.
- Define the costs involved and highlight the lives and costs saved.
- Messaging should have both scientific data and stories of people with lived experience.
- The message should emphasize the intersectoral relevance of suicide prevention and highlight how it is linked to physical and mental health, education, the economy and other areas.

5. Present to funders

- Ensure that team members who can speak effectively and in detail about the implementation work are present at the meeting with the funder.
- Plan your key messages and structure your presentation to be succinct, specific and inspiring, with accompanying visuals and data. Policy-makers often have limited time and competing priorities, so a well-rehearsed, engaging and concise pitch is important.
- Focus not only on the details of the programme or intervention, but also on why you think this is a significant mission-aligned opportunity for the funder to support the work. Also stress your history of success in suicide prevention.



- Keep the presentation conversational, invite the funder's thoughts and build a relationship with them through the course of the presentation.

6. Maintain relationships with funders, irrespective of their funding decisions

- If you were successful in securing funding, do not assume that the hard work is finished; in fact, it has just begun. To maximize the chance of the funder providing more funding to you in the future and to increase credibility among other potential funders, instil trust and confidence in the funder through regular, transparent and thoughtful communication. This may take place through frequent meetings, telephone calls, reports or progress updates that evaluate the implementation to show the impact that the funding has had.
- If you were unsuccessful in securing funding, talk to the funder about what to improve for a future proposal. Stay in touch with the funder by providing regular updates on your work; continue looking for new opportunities. Just because you were unsuccessful in obtaining funding this time does not mean they will not fund you in future.

Box 25. Philanthropists, Ghana

Suicide is stigmatized in Ghana and remains a crime. Consequently, the Centre for Suicide and Violence Research (CSVR) in Ghana struggled to obtain any funding from official sources to support its activities in providing education on suicide prevention. One of the key staff members at CSVR maintained a high media presence in order to strengthen awareness-raising and advocacy for suicide prevention and noticed that a philanthropic organization had been following his efforts. Persistent and determined, the CSVR repeatedly submitted its budget to the organization in the hope of garnering support. Even though they were not always successful, this persistence paid off, and the philanthropists saw the importance of the capacity-building work that CSVR engaged in. Crucially, to maintain the relationship, the CSVR continues to provide feedback to the philanthropists on the impact that their funding contributed to building capacity to prevent suicides in the country.

Box 26. National Suicide Prevention Trial, Australia

The National Suicide Prevention Trial (NSPT) is an Australian Government, Department of Health initiative. A total of A\$60 million has been provided to 12 identified trial sites across Australia for the NSPT over five years from 2016–2017 to 2020–2021. This funding was provided through relevant primary health networks (PHNs) as partner organizations at a total of A\$5 million per site.

PHNs were established in July 2015 to increase the efficiency and effectiveness of medical services, particularly for patients at risk of poor health outcomes, and to improve coordination of care to ensure that patients receive the right care in the right place at the right time. As regional planning and commissioning bodies, PHNs were selected to lead trial activity to ensure it could be responsive to local needs.

Aims

The Australian Government funded the NSPT to gather evidence on suicide prevention activities in local geographical areas of Australia, and to improve understanding of the most effective strategies in preventing suicide at local level and in at-risk populations. More specifically, its objectives were to provide evidence of how a systems approach to suicide prevention might best be implemented in Australia and to identify new learning about suicide prevention in at-risk populations.

The NSPT was designed to allow trial sites to be flexible. Each trial site was required, at a minimum, to select one or more focus population groups in their region, to trial an evidence-based systems approach and to participate in the evaluation.

Focus populations

Seven of the 12 sites focused on Aboriginal and Torres Strait Islander peoples as a target population. Six focused on men, two on young people, two on lesbian, gay, bisexual, transgender and intersex (LGBTI) people, and one each on ex-ADF members and older adults. Some focused on specific subgroups in their chosen focus population (e.g. fishermen, farmers and miners, LGBTI youth, and Aboriginal and Torres Strait Islander youth).



Box 26. National Suicide Prevention Trial, Australia cont.

Systems-based approaches

Systems approaches to suicide prevention can implement a suite of interventions aimed at different elements of the system to reduce suicide and suicidal behaviour.

Trial sites drew on a range of evidence and frameworks to determine their approach to suicide prevention. Eight of the 12 trial sites chose to implement the LifeSpan model, and two sites chose the European Alliance Against Depression (EAAD) model. Adaptations were made where necessary to suit the local needs of the trial site.

Two sites, which focused exclusively on Aboriginal and Torres Strait Islander peoples, adopted an approach guided by the principles set out in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP). The ATSISPEP outlines a set of principles or success factors for suicide prevention grounded in a social and emotional well-being approach.

Example activities

Trial sites implemented a wide range of individual services and community-based activities. These included:

- aftercare services for people following a suicide attempt or who presented in suicidal crisis;
- suicide and mental health awareness-raising, including through media and social media campaigns and community events;
- cultural strengthening activities for Aboriginal and Torres Strait Islander peoples;
- training to build capacity of community members, and training resources for general practitioners and other service providers on suicide prevention and culturally safe support;
- school-based activities for young people, including specific programmes for Aboriginal and Torres Strait Islander young people and LGBTI young people.
- small grant programmes for local community activities;
- engagement activities such as targeted workshops, camps and events;
- developing self-harm and suicide prevention and postvention response protocols;
- peer work and mentoring programs.
- supporting tailored research (e.g. on outcome measurement for Aboriginal and Torres Strait Islander peoples; on peer support for LGBTIQ people; and research related to traumatic brain injury for veterans).

Next steps

Funding for the NSPT ceases on 30 June 2021. An evaluation of the NSPT is now completed and is being considered by the Australian Government.

The Australian Government is also funding a project to analyse the findings of the NSPT evaluation alongside evaluations from other suicide prevention trials across the country – namely the LifeSpan trials and the Victorian place-based suicide prevention trials.

Together, the findings of these projects will build the evidence base about systems-based approaches to suicide prevention in Australia.



TIPS FOR IMPLEMENTATION

Table 7. Tips for implementation of financing

Issues	Tips
Resource limitations	<ul style="list-style-type: none">• Attempt to find approaches that can work with government structures that are already in place. This can be particularly important where funds are not available to establish new institutions or departments to carry out the work.
Lack of recognition among funders that suicides are preventable and suicide prevention is a priority	<ul style="list-style-type: none">• Engage in awareness-raising and advocacy, demonstrating data which indicate the magnitude of the problem and illustrate that, with the right investments, suicides are preventable.• Share stories that demonstrate the impact of well-funded suicide prevention interventions, involving professionals, people with lived experience, and advocates to make your message compelling.• Raise smaller funds from a greater number of funders, moving towards a pooled or collaborative funding model.• Consider leveraging funds from related programmes (e.g. for mental health, education).





SURVEILLANCE

WHAT?

Up-to-date data from established surveillance systems of suicide and self-harm are essential in informing LIVE LIFE pillars and interventions. Data on the number of suicides and cases of self-harm should be disaggregated at a minimum by gender, age and method (WHO, 2011; WHO, 2016a).

These data can be collected from a number of different sources, such as:

- **Civil registration and vital statistics (CRVS) system:**³⁸ Many countries have a CRVS system which formally records the occurrence and characteristics of deaths (and births). This provides continuous and comparable data, although it includes less detail about the circumstances of the death.
- **Health and police records:** This involves collecting data from hospital- and mortuary-based records, and/or police, coroners and judicial records. In some contexts this will need to be done manually (e.g. by examining medical notes). While this approach takes time and money, it can provide accurate data. Where it is possible to utilize

routinely collected data, this system can be relatively inexpensive and provides continuous and detailed information. However, hospital data capture only self-harm and deaths that happen in hospitals and may not identify well the means of suicide (e.g. the type of poison involved). Data on self-harm could also be obtained from outpatient, primary health care and community services.

- **Verbal autopsy:**³⁹ Such data can be collected through community-based reporting systems whereby health-care workers ask the family and friends questions about the circumstances surrounding the death. This is particularly helpful where vital registration systems or access to formal medical care are limited; it can also be used to validate information collected from other data sources and to provide more detailed information. Community surveillance involves a system for community members to report suicidal behaviour and can also be considered for collecting information on defined geographical areas or evaluations of a particular intervention. However, sufficient standardization is needed and there may be a risk of bias.
- **Population-based surveys:** nationally representative surveys can be conducted specifically on suicidal behaviour or can be embedded in larger national or

³⁸ See: Civil registration and vital statistics. Geneva: World Health Organization ([https://www.who.int/data/data-collection-tools/civil-registration-and-vital-statistics-\(crvs\)](https://www.who.int/data/data-collection-tools/civil-registration-and-vital-statistics-(crvs))), accessed 28 January 2021).

³⁹ Verbal autopsy standards: ascertaining and attributing causes of death. Geneva: World Health Organization. (<https://www.who.int/standards/classifications/other-classifications/verbal-autopsy-standards-ascertaining-and-attributing-causes-of-death-tool>), accessed 28 January 2021).



international surveys.⁴⁰ While surveys (including those for a specific catchment area or community) also capture suicide attempts and self-harm that occur outside of hospital settings (e.g. because no medical attention was sought), they may be limited by non-response bias and unwillingness to report due to fear of stigmatization, and will not provide continuous data.

Comprehensive surveillance may combine data collected from a range of sources, although where resources are limited it is usually most feasible to start by focusing on existing

areas of routine data collection (e.g. CRVS, hospital-based records). In fact, a comprehensive surveillance system for recording suicides and attempted suicides in rural India has been developed and utilizes data from community surveillance systems, hospital and police records (Vijayakumar et al., 2020).

How surveillance is implemented will also depend on the current stage of suicide prevention in the country:

Table 8. Implementation of surveillance based on the country context

Issues	Tips
Countries where there is currently no, or little, surveillance	It can be helpful to begin by developing data collection in representative locations or pilot sites (e.g. in one region or district), by prioritizing core information (e.g. suicide mortality data, age, sex, methods of suicide), conduct basic analyses (e.g. suicide rates), and work towards scaling up to the whole country and having a CRVS system.
Countries where there is already some surveillance	Systems can be scaled up to monitor suicide (through CRVS) or self-harm at the national level (e.g. national hospital-based self-harm registry ^{41, 42}) and can include more detailed information and wider analyses (e.g. changes in risk factors, information about repeated self-harm). The priority should be to begin with monitoring suicide mortality and then incorporating surveillance of self-harm. For countries which have poison centres, encouraging the sharing of data on intentional poisoning cases by individual centres to a central collection point may be informative: 1) for certain methods of suicide; and 2) to identify trends and new methods which may be amenable to means restriction. Situation analysis can be used to assess the current quality of surveillance and areas for improvement [see Situation analysis].
Countries where a comprehensive surveillance system and CRVS are established	It is important to monitor key attributes such as data quality, coverage, timeliness and costs of the surveillance system in order to make improvements. In contexts with a strong infrastructure for surveillance, real-time surveillance can be introduced where data are available for analysis immediately after a case of suicide or self-harm is recorded.

⁴⁰ STEPwise approach to surveillance (STEPS) mental health/suicide module. Geneva: World Health Organization (https://www.who.int/ncds/surveillance/steps/riskfactor/STEPS_Mental_Health_Suicide_module.pdf, accessed 28 January 2021).

⁴¹ National Self-harm Registry Ireland. Dublin: National Suicide Research Foundation (<https://www.nsrif.ie/our-research/our-systems/national-self-harm-registry-ireland/>, accessed 28 January 2021).

⁴² Multi-Centre Study of Self-harm in England. Oxford: University of Oxford (<https://www.psych.ox.ac.uk/research/csr/ahoj>, accessed 28 January 2021).



WHY?

Surveillance systems help to inform LIVE LIFE implementation, for instance by highlighting trends in suicidal behaviour, subpopulation groups at risk, clusters of cases, or the emergence of new methods or contagion methods of suicide that would need prompt action (Thomas, Chang & Gunnell, 2011). Data on suicide and self-harm also inform service provision, resource deployment and guidelines for managing suicidal behaviour by, for instance, ensuring that medical teams in specific locations are trained to manage the effects of certain means of suicide (e.g. pesticides), or employing specialized nurses in areas where many suicides occur. Data are used to monitor progress (e.g. indicator of reduced suicide rates) and contribute to the evaluation and research of ongoing prevention strategies and interventions, such as long-term cohort studies of self-harm cases presenting to hospitals in Oxford, United Kingdom.⁴³

Box 27. Surveillance, Sri Lanka

The South Asian Clinical Toxicology Research Collaboration (SACTRC) set up a long-term prospective cohort of patients with intentional self-poisoning in 2002, focusing on pesticide poisoning. Staff saw all poisoned patients on their admission to the study hospitals and aimed to identify the poison involved, test treatments, and record outcome. The pesticide was typically identified from the history; in a nested sample, mass spectrometry in a laboratory was used to check the accuracy of identification based on history alone (>80%). The cohort now numbers over 80 000, of whom 35 000 have ingested pesticides, and has provided novel data on the relative toxicity of a number of pesticides in humans (Buckley et al., 2021). As a result of the cohort, three particularly toxic pesticides (Dawson et al., 2010) were identified and data were presented to the Registrar of Pesticides and the Pesticide Technical Advisory Committee. These pesticides were banned from agriculture in 2008–2011, contributing to the continued reduction in total and pesticide suicide numbers in Sri Lanka (Knipe et al., 2017).

WHERE?

Ideally countries should aim to collect data nationally to develop a full understanding of suicidal behaviour in the population. However, preference should be given to obtaining high-quality data from several representative locations rather than poor-quality data that cover the entire country. Surveillance may begin with smaller data sets that are representative of the national population (e.g. across a few key hospitals) and that can later be scaled up using the lessons learned. This may be particularly useful in large countries or where data are coordinated at a federal or regional level. Data collection may take place in a dedicated registry for self-harm, or it be part of a wider system of national data on mortality or injuries. Where data are collected nationally, it is important to aim for consistency between regions/localities on what data are collected and how this is reported.

WHEN?

Sustained surveillance should be included as a priority and should be set up before or at the beginning of LIVE LIFE implementation as it will allow countries to evaluate the effectiveness of the interventions implemented. Data need to be collected continuously over the long term in order to provide timely, up-to-date (or where possible real-time) information on suicidal behaviours, and to enable the identification of changing patterns and persons at risk of repeated self-harm. However, where resources are very limited, surveillance may begin as an individual study of suicidal behaviour over a time-limited period in a specific area/population, which can then be scaled up to collect data continuously.

WHO?

Whether the surveillance system is national or local, representatives of the Ministry of Health should be involved, as should persons from other relevant offices such as a national statistics office or office responsible for civil registration and vital statistics, who might help to provide guidance and the resources for long-term sustainability. Stakeholders should include

⁴³ The Oxford Monitoring System for Self-Harm. Oxford: University of Oxford (<https://www.psych.ox.ac.uk/research/csr/research-projects-1/the-oxford-monitoring-system-for-self-harm>, accessed 28 January 2021).



organizations or individuals that are best placed to collect and process the target data (e.g. medical professionals, mortuary staff, police, local health workers), and those with skills to plan and implement the system (e.g. health information system specialists and public health academics – including epidemiologists, statisticians, data system managers, data collectors). It can also be helpful to engage with academics who may already be working with relevant cohort data in the target population.

Box 28. Self-harm surveillance, Russian Federation

The Russian Federation is one of the European Region countries where the national authorities recognize suicide as an important public health issue. To tackle this challenge and to enhance suicide monitoring and prevention within the mental health system, key health experts in Russia started collaboration with WHO's Regional Office for Europe and the WHO Country Office in the Russian Federation, the results of which can be beneficial to other countries in the eastern part of the European Region. WHO's self-harm surveillance approach has already been deployed in a number of English-speaking countries, such as Ireland, where it has shown its effectiveness in identifying vulnerable populations and enhancing access to needed health services. The pilot project in the Russian Federation aims to analyse positive practices at the national level and in parallel fine-tune and adapt the tool and methodology.

As part of WHO, the Russian Federation's collaboration under the Country Collaboration Strategy (CCS) is in line with the objectives of creating a comprehensive environment for prevention, for promoting health through a life-course approach and for strengthening capacity for global and regional cooperation in health. In consultation with the Serbsky Center, nominated as the key mental health institution in the Russian Federation and under Ministry of Health leadership, in 2018 experts from three Russian regions (the Ural Federal District, North Caucasian Federal District and Far Eastern Federal District) shared their experiences and expressed their readiness to

showcase pilot sites on how they adapt and use a WHO tool and manual for improving monitoring and surveillance systems for self-harm and suicide attempts in hospitals.⁴⁴ The tool is based on a set of WHO-recommended procedures that a trained health worker can follow to identify self-harm cases in hospitals and specialized health-care institutions. The initiative is aimed at creating a multicentred surveillance system on the basis of the Russian language version of the WHO tool to apply an online monitoring platform that can be used to gather and analyse high-quality data on self-harm and suicide attempts. The online software is currently being modified by health professionals in Stavropol Krai, North Caucasian Federal District. Setting up such a monitoring system can serve as a key step towards the enhancement of suicide prevention in any health system.

As another result of the collaboration, WHO's Regional Office for Europe and Russian health professionals have created training courses for facilitators of the surveillance and monitoring system. Use of the materials will facilitate the training health workers and data collectors who are needed to scale up the initiative to national and international levels. This set of WHO-recommended tools is harmonized with Russian health service standards at subnational level and has the capacity to be scaled up further. This initiative is intended to become an integral part of suicide and self-harm prevention infrastructure in the European Region, helping to improve access to mental health and other services for people at risk of suicidal behaviours. Success of the initiative is attributed to the commitment and motivations of all participants, good collaboration between partners and commitment to the prevention of suicides as an important element of the Sustainable Development Agenda.

⁴⁴ Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/208895>, accessed 17 February 2021).



HOW?

1. Convene a working group (see [Box 1, Introduction](#))

- Establish the group (see under [Who?](#) above and [Annex 1 for sectors and stakeholders](#)).
- Consider a steering committee to provide continuing support; a technical advisory group to provide guidance on planning, implementation and evaluation; and a surveillance management team to conduct the surveillance.
- Inform key stakeholders about the necessity for surveillance of suicide and self-harm, and the need for continued support to maintain the system.

2. Plan the surveillance system

- Define the goals, objectives and scope of the system. Address, for instance, what information needs to be collected, how the information will be used for prevention, whether there are any pre-existing systems collecting similar information, and where the system should be situated.
- Consider stepped implementation, beginning with a pilot phase and then scaling up to the national level.
- Prepare a realistic budget of costs and resources required (e.g. for personnel, systems equipment, training, maintenance) and allocate primary and secondary funding options to sustain the system over time.
- Identify processes for data collection, management and analysis. Address, for instance, what data will be collected, by whom, and where and how data will be stored. Develop standard operating procedures to maintain consistency.
- For suicide mortality, aim for a CRVS system. For self-harm, aim at including it into routine medical records. As necessary, obtain required ethical approval from an ethics committee and permissions (e.g. from hospital management) for data collection from relevant data sources. Put safeguards in place to maintain confidentiality (i.e. no reporting of identifiable data).

3. Prepare resources

- Develop a data registration form or electronic data entry system, utilizing data coding and enabling the recording of data by event (as well as by person for suicide attempts). Include space for demographic details to enable identification of at-risk groups.

- Prepare a manual to guide data collection and guarantee consistency over time.
- Conduct training with data collectors, highlighting the importance of consistent definitions of suicidal behaviour, and practicing coding and data entry (particularly where available information may be ambiguous).
- Meet and brief staff from whom data will be obtained (e.g. health-care managers) to encourage detailed assessment and record-keeping when they are managing people with suicidal behaviour.

4. Pilot and implement the system

- Pilot the data registration and collection in one or two locations to identify and resolve any issues.
- Begin using the system in more locations.
- Analyse the data periodically (ideally quarterly) to enable up-to-date summaries.

5. Communicate findings

- Write, publish and disseminate annual reports or smaller evidence briefs on a regular basis. Plan the release of annual reports at strategic times to increase visibility, such as on national or international suicide prevention days.
- When designing reports of the data, consider the needs of stakeholders and the objectives of the surveillance system. Consider what type of reports should be generated, how often reports should be written, and who should receive them. Stakeholders may include policy-makers, health-care services, the general public, and the media (though caution will need to be used when reporting in the media; see [Interact with the media for responsible reporting of suicide](#)).
- Communicate key findings, including rates and specific trends in suicides and self-harm, and provide recommendations to inform prevention.

6. Review and evaluate

- Create a calendar for regular meetings and provide supervision to ensure that data collection is conducted according to operating procedures. It is important to make emotional support available to data collectors who will be exposed to emotive/graphic information on suicide.
- In addition to ongoing monitoring, a detailed evaluation should be conducted periodically to determine how well



the system is meeting objectives, to assess the accuracy of the data and quality of reporting, and to assess the usefulness of reports (see [Monitoring and evaluation](#)).

Monitoring can include quality control exercises to compare the consistency of data collection between sites/collectors.

- Based on review, make changes to standard operating procedures as necessary.
- It is recommended that the surveillance system is also independently reviewed to enhance quality and efficiency.
- Scale up the surveillance system to include additional sites/regions in order to build a national surveillance system.
- Review the budget and sources of funding regularly to ensure the system is sustained.

Box 29. The self-harm and suicide registration system, Islamic Republic of Iran

The Islamic Republic of Iran possesses a well-developed national self-harm and suicide registration system operating under the governance of the Ministry of Health and Medical Education (MOH). According to system requirements, all medical universities countrywide are responsible for routine collection and registration of self-harm and suicide data related to their districts and catchment areas. This system was officially established as a stand-alone data gathering system in 2009 by the Department for Mental Health and Substance Abuse of the MOH in order to collect data on self-harm and suicide in a uniform manner. The system was modified in 2017 on the basis of the *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm* (WHO, 2016a).

In 2009, an experienced mental health expert from each university participated in a national training meeting. Subsequently, data were collected from the medical universities after one mental health officer from each had been trained. A case report questionnaire in the form of a software with a users' manual was prepared to ensure systematic and uniform portal data collection. The most important epidemiological correlates for designing suicide prevention interventions were covered. The questionnaire included demographic characteristics of the subjects such as gender, age, marital status, occupational status and educational level, previous history of mental and physical disorders, method of suicide and its outcome (adopted from previous related studies).

The main sources of data on self-harm and suicide are official medical records from general hospitals and outpatient health facilities in cities and also from health houses and public health centres in villages. In rural areas some cases may be based on reports of local health workers who are aware of suicides in the area although they are otherwise not reported officially. Data from these sources is gathered in the district health centres, which are branches of medical universities in defined catchment areas of the provinces. Each university has access only to the data of its own district health centres while national data can be obtained only by the Department for Mental Health and Substance Abuse of the MOH which has responsibility of monitoring the data entry. According to official reports, some suicide cases may not be referred to health or medical centres. In these cases, corpses are referred to local forensic medicine headquarters for verification of the cause of death and the data are then compiled and officially reported to medical universities. These data are also added to the MOH data on a seasonal basis.



Box 30. Surveillance, White Mountain Apache Tribe, USA

Currently, Native American communities struggle with the highest rates of suicide of any US ethnic group, particularly young people aged 15–24 years. In response to this public health concern, the White Mountain Apache Tribe (WMAT) has developed an innovative approach to promote mental health and resiliency. Powered by their local tribal member workforce of community mental health specialists, the Celebrating Life model integrates referral, surveillance, prevention, crisis care and case management (Cwik et al., 2014; Cwik et al., 2016).

Surveillance has been recommended as part of the US National Strategy for Suicide Prevention, but many challenges have precluded widespread and timely implementation of reporting. The WMAT, with technical support from the Johns Hopkins Center for American Indian Health, is the first community to establish and implement a comprehensive system which has been able to address these limitations and can serve as a model for other communities.

The WMAT government passed a tribal resolution in 2001 mandating that any suicidal incident occurring on the Fort Apache Indian Reservation — including suicidal ideation and suicide attempts — should be reported to a tribal suicide surveillance system (episodes of non-suicidal self-injury and binge substance use were later added as reportable incidents).

The Johns Hopkins Center for American Indian Health worked with the WMAT to revise the referral form, develop an in-person follow-up form, design a computerized data gathering system, and employ and train the Celebrating Life team, a local workforce of community mental health specialists. The Celebrating Life staff track, monitor and maintain the surveillance system which has received awards from the American Academy of Psychiatry, the Indian Health Service, and the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, the Celebrating Life staff help to analyse data and provide regular reports to the WMAT leaders on trends within the community.

Over the past two decades, the community surveillance system has provided a foundation for prevention programming and evaluation. Although national rates remained stable or have increased slightly, the overall White Mountain Apache suicide death rates decreased when their suicide surveillance system and comprehensive programming were active. Suicide attempts have also decreased by 53% and the proportion of at-risk individuals seeking treatment nearly doubled from 39% to 71%.





TIPS FOR IMPLEMENTATION

Table 9. Tips for implementation of surveillance

Issues	Tips
Under-reporting	<ul style="list-style-type: none">• Because of the stigma attached to suicide in many countries, many suicides and suicide attempts go unreported or are reclassified. Awareness-raising and changes to the legal status of suicide (i.e. decriminalization) are key to tackling stigma. It is important that surveillance systems maintain confidentiality and foster trust.• Under-reporting can also be a consequence of limited access to health care and restrictions on health insurance coverage, therefore limiting the number of people who seek medical support for attempted suicide. The provision of universal health coverage is vital in addressing this barrier in particular and suicide prevention overall.
Incomplete and inaccurate data	<ul style="list-style-type: none">• In low-resource settings data may not be easily accessible. It will be important to draw upon other sources of information (e.g. verbal autopsy/community surveillance) and to implement a basic system for registering suicide mortality (e.g. by working with people who register deaths in the community such as the police and medical centres).• In many countries there is poor surveillance of health-care data. Advocacy for the improvement of health information systems is an important part of awareness-raising.• The registration and classification of suicidal behaviour is complex, and sufficient training, practice and ongoing monitoring is required to support data collectors. Advocacy and awareness-raising among those reporting on suicides (such as police and first responders) is important to avoid misreporting; it is key that these services are trained in detailed record-keeping and assessment of suicidal intent.• Where more than one organization is responsible for gathering suicide data, differences in practice may lead to discrepancies. It is important that representatives from different organizations are included in planning, and that common guidelines are developed to guide data collection and recording in different areas.• Where possible, national guidance on data collection should be developed to enable data from different jurisdictions to be aggregated.
Lack of data and information hinders prioritization and resource allocation by decision-makers. Inadequate data collection throughout the implementation process can lead to resources being wasted on ineffective interventions.	<ul style="list-style-type: none">• Establish and strengthen surveillance systems for suicide and self-harm; surveillance is a core pillar of suicide prevention.• Monitor the effectiveness of primary outcomes with accurate data collection, thus enabling subsequent adjustments to be made to enhance effectiveness.• Work with interested academics to set up surveillance systems that can advise public policy.
Sensitivity of data	<ul style="list-style-type: none">• Ensure that safeguards are in place to maintain confidentiality of the data (e.g. by using case identifier numbers and not using identifiable information).• Caution should be employed in the use of data, its availability and how it is communicated. Include consideration of the impact that suicide data can have on those at risk (see Interact with the media for responsible reporting of suicide).



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MONITORING AND EVALUATION

WHAT?

Monitoring and evaluation are essential for assessing whether suicide prevention is working. Monitoring involves planned and continuous or regular measurement of information that will help to assess the progress of LIVE LIFE implementation. This should be followed by evaluation, which is a periodic review of whether LIVE LIFE has achieved its desired results. Monitoring and evaluation should be part of all interventions, and this information can be combined to evaluate the overall effectiveness of LIVE LIFE.

Evaluation should consider the following:

- **Effectiveness.** Does the intervention provide the desired outcome; did it deliver what it set out to do? Working with academics to design and interpret robust studies of effectiveness for interventions would be beneficial before implementing them widely (Kolves et al., 2021). Such studies may need to be large to provide clear and relevant evidence for policy decisions.
- **Implementation.** Were services delivered as intended and how well were they delivered? What had a positive impact on implementation and what were the barriers/challenges?
- **Efficiency (cost-effectiveness).** Does the intervention provide sufficient value for the costs? Are the costs sustainable/how can they be sustained in future?

The principal goal of all suicide prevention activities is a reduction in rates of suicide and self-harm [see [Surveillance](#)].

However, detecting changes in suicide rates that could be attributed to prevention activities is challenging and can be assessed only in the long-term.

Given these challenges, it is important that other indicators of progress are monitored and evaluated. Indicators need to have a clear and direct relationship with the principal goal. Examples may include:

- enforced restriction of access to means of suicide;
- more responsible reporting of suicide in the media;
- more young people trained in emotional life skills;
- an increased number of people utilizing and accessing support and services;
- enhanced knowledge, attitudes and practice of health workers with regard to people who engage in suicidal behaviours.

Measurement of progress must be planned in advance using specific, achievable, relevant and time-bound indicators (see [Annex 3](#) for indicators for LIVE LIFE). This process should be informed by existing evidence about factors that influence suicidal behaviour in the target population. Indicators may be measured using a variety of sources (see [Surveillance](#)), including routinely collected data (e.g. CRVS, service attendance data, client demographics, referral sources) and purpose-designed data collection (e.g. interviews with stakeholders and project workers, population surveys, focus groups, research studies).



WHY?

Monitoring and evaluation are necessary to assess whether LIVE LIFE is achieving its desired result of reducing suicide and self-harm. Monitoring and evaluation can indicate whether LIVE LIFE is working in the country context, whether it provides feedback about which interventions have the largest impact, and where changes are needed. It is important that, in addition to identifying areas for improvement, evaluations consider factors that may have had a positive or negative impact on implementation (e.g. design issues, changes in funding, community engagement, economic conditions) in order to develop helpful recommendations for improvement.

Reporting of evaluations ensures that information and lessons learned from the process are shared and informs other services or areas that plan to adopt similar interventions. Informing key stakeholders and the public of progress can also help to foster accountability and community support. These data can be a powerful tool to seek and secure additional resources to support ongoing efforts.

WHERE?

In addition to monitoring and evaluation at the national level, data at the local level should also be included (e.g. data on service provision, feedback from key personnel).

WHEN?

Monitoring and evaluation needs to be planned and agreed in advance to ensure involvement by all relevant stakeholders. Include inputs from key personnel involved in the implementation of interventions, as well as feedback from service users and members of the general population. This should form a continuous feedback loop to allow for refinement of interventions as they progress.

WHO?

It is recommended that a dedicated group should be specifically responsible for monitoring and evaluating LIVE LIFE. This should include persons with the skills to plan and implement monitoring and evaluation (e.g. health epidemiologists, statisticians, data collectors). It can also be helpful to partner

with academic institutions where possible to support data collection, analysis and evaluation.

HOW?

1. Convene a dedicated working group for planning monitoring and evaluation (see [Box 1, Introduction](#))

- Establish the group (see under Who? above and [Annex 1 for a list of sectors and stakeholders](#)).
- Include persons with the skills to plan and implement monitoring and evaluation.
- Assign roles and responsibilities to group members and plan a calendar of regular meetings.

2. Plan for measurement of the principal goal

- The principal focus of suicide prevention is a reduction in rates of suicide and self-harm (see [Surveillance](#)).

3. Identify outcomes

- On the basis of the situation analysis, identify desired outcomes and what the implementation of interventions is hoping to achieve. These outcomes should contribute to the principal goal of reducing suicide. (See [Annex 3](#)).

•

4. Identify indicators for each outcome

- Identify indicators that can be used to assess each outcome. For example, if a desired outcome is responsible reporting by the media, indicators may include the number of media establishments providing training, and the quality of reporting on suicide.

5. Plan data collection

- Plan how data will be collected for each indicator (e.g. a survey of media establishments to identify who has received training, assessment of a random sample of media reports).
- When planning interventions, request that personnel involved provide regular progress reports with up-to-date data.

6. Collect the data

- Where possible, collect data continuously to allow for continued feedback.
- Aim to summarize the data regularly (ideally quarterly) with monitoring reports to inform ongoing activities.



7. Evaluate the data

- Analyse the data periodically (ideally every 1–2 years) and use this to evaluate whether the interventions have achieved the desired outcomes.

8. Communicate findings and respond to lessons learned

- Produce reports of the findings that are appropriate for different audiences; stakeholders may include policy-makers, other services who could adopt the intervention, and the public.
- Communicate key findings, including the effectiveness of different interventions, enablers and barriers to implementation, and recommendations for improvement.
- Use lessons learned to improve the design and implementation of interventions where necessary or to scale them up.

9. Review and plan for improved monitoring and evaluation

- Create a calendar of regular meetings of the task force to review progress.
- One of the objectives of monitoring and evaluation is likely to be to improve data on suicide. Such data can be used to monitor progress periodically and identify areas where data availability or quality could be improved and where additional indicators that may be relevant.
- Based on the review, make necessary changes to monitoring and evaluation.

Box 31. Monitoring and evaluating a national suicide prevention strategy, Ireland

In 2014 the Department of Health and the National Office for Suicide Prevention of Ireland began to develop a new suicide prevention strategy – *Connecting for Life* (2015–2020; extended until 2024).⁴⁵ The strategy began with a focus on outcomes, a vision that measurable improvements could be made in relation to the incidence of suicide and self-harm against which the impact of the strategy and its component parts could be evaluated in the future.

A wide-ranging consultation and engagement process was undertaken to capture the voices and opinions of a range of stakeholders, including service providers, the general public, people affected by suicide, government departments and state bodies. A wide range of evidence and data was also examined when developing the strategy in order to identify risk and protective factors affecting specific population groups and to develop effective initiatives to support them.

On the basis of this information, several goals and primary and intermediate outcomes were developed, with an accompanying outcomes framework in place to allow progress to be tracked and the impact of the strategy to be measured objectively against baseline indicators.⁴⁶ A plan was made to conduct proportionate evaluations of all major activities conducted under the aegis of *Connecting for Life*, and to disseminate findings and share lessons learned with programme practitioners and partners. In addition to measuring indicators of primary and intermediate outcomes, process evaluations of the quality of implementation of major activities were also planned to facilitate understanding of elements that contributed to the successes and failures of the strategy.

⁴⁵ Connecting for Life. Dublin: Health Service Executive (<https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/>, accessed 28 January 2021).

⁴⁶ Implementation progress reports. Dublin: Health Service Executive (<https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/strategy-implementation/implementation-progress-reports/>, accessed 28 January 2021).



TIPS FOR IMPLEMENTATION⁴⁷

Table 10. Tips for implementation of monitoring and evaluation

Issues	Tips
Lack of planning	<ul style="list-style-type: none">• Monitoring and evaluation should be included as a key part of initial planning and should happen simultaneously with the implementation of interventions.• During planning it is key to define the goals of the interventions, which indicators will be used to assess progress and how these can be measured (see Annex 3).
Insufficient data for evaluation	<ul style="list-style-type: none">• Incorporate monitoring and evaluation as a key objective of LIVE LIFE. According to the situation analysis informing of the current status of suicide-related data, develop a plan to improve data availability, comprehensiveness and quality.• Provide regular progress reports as a part of the funding process for interventions.• Establish and strengthen surveillance systems for suicide and self-harm (see Surveillance).
Lack of funding and resources	<ul style="list-style-type: none">• Highlight the importance of effective monitoring and evaluation in conversations about suicide prevention with key stakeholders.• Incorporate funds and resources needed for monitoring and evaluation into planning of all prevention activities.• Engage academic institutions that may have access to data or may be able to assist with data collection, research studies, analysis and interpretation.
Lack of capacity (people working on suicide prevention may not have experience/knowledge in monitoring and evaluation)	<ul style="list-style-type: none">• Involve people with experience in monitoring, evaluation and planning of data collection (such as experts in public health or community development), particularly in identifying indicators which can be measured.

⁴⁷ Further challenges and recommendations specific to different types of intervention are discussed here (<http://www.sprc.org/sites/default/files/resource-program/ChallengesRecommendationsEvaluatingSPPPrograms.pdf>, accessed 28 January 2021).

PART B

LIVE LIFE: KEY EFFECTIVE INTERVENTIONS FOR SUICIDE PREVENTION

The following sections present the four key evidence-based interventions for suicide prevention:^{48, 49}



Limit access to the means of suicide.



Interact with the media for responsible reporting of suicide.



Foster socio-emotional life skills in adolescents.



Early identify, assess, manage and follow up anyone affected by suicidal behaviours.

The cross-cutting foundational pillars must be established in parallel to implement these key interventions (LIFE).

⁴⁸ Evidence-based recommendations for management of self-harm and suicide in non-specialized health settings. Geneva: World Health Organization (https://www.who.int/mental_health/mhgap/evidence/suicide/en/, accessed 28 January 2021).

⁴⁹ Guidelines on mental health promotive and preventive interventions for adolescents. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/item/guidelines-on-mental-health-promotive-and-preventive-interventions-for-adolescents>, accessed 28 January 2021).



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LIMIT ACCESS TO THE MEANS OF SUICIDE

WHAT?

Restricting access to lethal means of suicide is a key universal evidence-based intervention for suicide prevention. The restriction of means involves:

- restricting access to the means (e.g. limiting, banning or regulating access to the means through national legislation and policy) by:
 - » banning acutely toxic highly hazardous pesticides, as has been successful in e.g. Bangladesh, Jordan, Republic of Korea, Sri Lanka (Gunnell et al., 2017), and India (Bonvoisin et al., 2020);
 - » restricting and regulating firearms, which has been successful in Australia (Chapman et al., 2006), Israel (Lubin et al., 2010), Switzerland (Reisch et al., 2013) and the United Kingdom (Haw et al., 2004);
 - » installing barriers at potential jump sites such as bridges or rail transport locations, which has been successful in Australia at the Gateway Bridge where barriers were introduced (Law et al., 2014) and in the Republic of Korea after screens were installed at subway stations (Chung et al., 2016);
 - » limiting access to ligatures or modifying ligature points in detention or other institutional settings (e.g. prisons, inpatient mental health); and
 - » restricting the prescription of high-toxicity medicines, particularly those where safer alternatives exist (such as barbiturates (Oliver & Hetzel, 1972) and co-proxamol (Hawton et al., 2009).
- reducing availability of the means by:
 - » limiting the quantity of individual sales for medications and other poisonous substances, such as reducing the size of medication packages and using blister packaging which makes it harder to access each medicine, as performed successfully in the United Kingdom (Hawton et al., 2001).
- reducing lethality of the means (e.g. increasing availability of low-risk alternatives) by:
 - » introducing natural gas in households which contains less poisonous carbon monoxide compared to coal, as in the United Kingdom (Kreitman, 1976);
 - » reducing the lethality of pesticides.
- increasing availability and effectiveness of antidotes and improving clinical management following acute intoxication or injury related to commonly-used means of suicide (WHO, 2008a).

Complete removal of a means of suicide will have the greatest impact, although this may encounter the greatest resistance from related stakeholders.

Effective means restriction should focus on methods that:

- » cause most deaths and/or have a high case fatality (the most lethal means);
- » and the most commonly used.



Preference should be considered for means with the highest case fatality as the removal of common means that are less lethal may drive individuals towards more lethal means.

Methods will vary geographically and between different sociodemographic groups (e.g. urban versus rural, age, sex) and can change over time. Surveillance is necessary to identify the means used by the population or subpopulations and any means that are newly emerging. Initially, this can be ascertained through a situational analysis (see [Situation analysis](#)).

This section focuses on the example of pesticides, which are estimated to account for one fifth of all suicides globally, particularly in countries with a large proportion of rural residents and agricultural work (Mew et al., 2017). Pesticides are estimated to have prematurely killed as many as 14 million people since being introduced into poor rural communities during the Green Revolution in agriculture (Karunaratne et al., 2020). Pesticides vary significantly in their toxicity, with some being highly acutely toxic when ingested while others are much less likely to be lethal. The intervention is intended to address acutely toxic highly hazardous pesticides – i.e. those with the acutest risk to health – and not to restrict access to all pesticides used in agriculture.

Key actions include banning the sale and use of acutely toxic highly hazardous pesticides whilst facilitating the use of low-risk alternatives, including organic/non-chemical pesticides; increasing research for low-risk alternatives; increased regulation of products; and encouraging proper disposal of hazardous products (Food and Agriculture Organization of the United Nations (FAO) & WHO, 2016; WHO & FAO, 2019). Measures to facilitate safe storage of pesticides such as household lockboxes and community storage facilities have not shown clear evidence of effectiveness (Pearson et al., 2017; Reifels et al., 2019).

WHY?

WHO advocates national bans of highly hazardous pesticides as a cost-effective intervention for reducing suicide mortality in countries where pesticides are a common means of self-harm and suicide (WHO, 2021). The estimated reduction in suicide mortality after banning highly hazardous pesticides equates to 20% progress towards the UN SDG target 3.4 (Lee et al., 2021).

Restricting access to means not only reduces suicide related to those means, but also has been found to reduce overall suicide rates in some countries (indicating that substitution of method of suicide does not compensate for the primary reduction, as people revert to less lethal alternatives). Most people who engage in suicidal behaviour experience ambivalence about wanting to live or die, and many suicides happen impulsively as a response to acute stressors (often after much less than 30 minutes of thought). Making lethal means of suicide less easily available can provide individuals in distress with the time for acute crises to pass before fatal action is taken. A suicide attempt can be the first occasion when other people are made aware of an individual's distress, and survival enables that person to receive support. Removing highly hazardous pesticides from agricultural practice (so that people ingest pesticides that are much less toxic) and improving the clinical management of pesticide ingestion reduces the number of people who die, regardless of their level of intent.

Box 32. Ban on highly hazardous pesticides, Sri Lanka

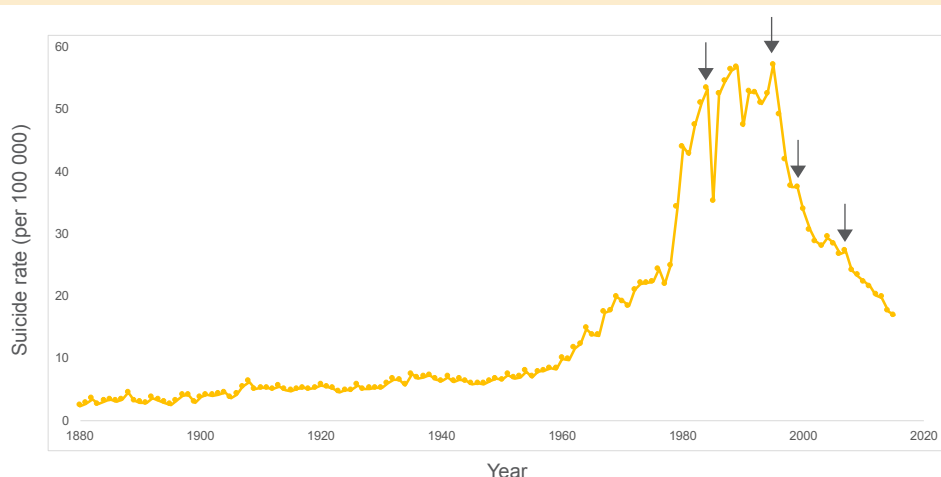
By 1980, Sri Lanka was known to have one of the highest suicide rates in the world, predominantly from ingestion of pesticides. The then Registrar of Pesticides recognized the problem and in 1983, in view of limited resources, placed the primary focus on prevention, banning two key pesticides for self-harm – the organophosphorus (OP) insecticides parathion and methyl parathion. Ten years later, the registrar banned all remaining highly hazardous WHO Class I pesticides, particularly monocrotophos and methamidophos, resulting in a remarkable drop in overall suicide numbers from 1995 onwards. Over the next 20 years, with another ban in 2008-2011 of paraquat and two further OP insecticides, the overall annual suicide rate fell from 57 per 100 000 people over 8 years of age in 1995 to 17 per 100 000 in 2016, a 70% reduction. The bans are estimated to have saved 93 000 lives at a direct government cost of US\$ 50 per life saved (Knipe, Gunnell & Eddleston, 2017) without affecting agricultural output (Manuweera et al., 2008). Method substitution has been modest (Gunnell et al., 2007). This work benefitted from an interest in the issue by the country's President, which was key for interagency collaboration and programme sustainability, and also active interactions between regulators, academics, agriculture extension and industry (Pearson, Anthony, & Buckley, 2010; Pearson et al., 2015).



Box 32. Ban on highly hazardous pesticides, Sri Lanka cont.

Efforts were made to address suicide as an issue of national interest in which industry could be part of the solution. Transparency, openness, consistency, predictability and inclusiveness were the key ingredients for stakeholder engagement. Since 1983, the process and mechanisms to achieve success have been iterative, evolving over time with each successful ban.

Figure 2. Incidence of suicide in Sri Lanka, 1880-2015



Down arrows show the timing of pesticide bans (1984: parathion, methylparathion; 1995: all remaining WHO class I pesticides, including methamidophos and monocrotophos; 1998: endosulfan; 2008: dimethoate, fenthion, paraquat). Suicide data obtained from police records.

Source: Knipe, Gunnell & Eddleston, 2017.

WHERE?

A national-level response is critical for the effective regulation of means such as pesticides, particularly in countries with a high burden of suicide related to pesticides. Collaboration at a regional level may also be needed to implement regional regulations and find effective solutions for crop protection in countries with similar agriculture.

WHEN?

When pesticide self-poisoning is identified as one of the most common and/or most lethal methods of suicide – i.e. through situation analysis, surveillance or other country-specific research – ongoing monitoring is necessary to identify changes or trends over time – i.e. changes as to which pesticides are used and in which communities.

WHO?

Restricting access to pesticides requires multisectoral collaboration between all relevant stakeholders, including ministries of health, agriculture, regulators and registrars. Means restriction may be considered intrusive by the stakeholders of agricultural communities. Collaboration with, and endorsement by, community (agricultural) leaders is essential for increasing buy-in, awareness of the problems associated with highly toxic substances, and the availability and benefits of low-risk alternatives. The media can be an important partner in raising awareness and in using responsible reporting to limit contagion effects (see [Interact with the media for responsible reporting of suicide](#)).

The same principle of a multisectoral national approach applies to other means of suicide (e.g. the transport sector and the need for barriers). Communities can play a role in advocating to restrict means which have affected a local community.



Community-level implementation of means restriction is also an option where this is feasible and effective (e.g. local implementation of national bans). At the individual level, family members may be asked to remove the means of suicide (e.g. pesticides, firearms, knives, medication) from a household where a person is at risk of suicide.

HOW?

1. Convene a working group (see [Box 1, Introduction](#))

- Establish the group (see under [Who?](#) above).

2. Establish the most common and lethal means in a population

- Establish through surveillance, monitoring or existing research the most common and lethal means of suicide and suicide attempts in a population.
- Understand if there are differences between different sociodemographic groups (e.g. between rural and urban areas).
- For pesticides, ascertain which pesticides contribute to most deaths. This may be difficult from medical records and may require targeted surveys of suicide deaths or hospital-presenting cases of pesticide poisoning. Where feasible, collaboration with forensic toxicology laboratories will allow the most important pesticides to be identified for restriction.
- It is important that lethal means are the focus of restriction as there is a potential danger that restricting common low-lethality methods may drive people to use higher-lethality alternatives.

3. Engage with relevant government sectors and other stakeholders related to the means of suicide

- Restriction of the means will require collaboration with sectors related to the method identified under point 2 above.
- In the case of pesticides this will involve the health and agricultural sectors and pesticide regulators/registrars.
- Use data to advocate to the relevant sector (e.g. the number of deaths by suicide or the number of suicide attempts related to pesticides).
- Be aware of the different interests of stakeholders in the pesticide industry and among users of pesticides (WHO & FAO, 2019).
- Expect to engage in advocacy over a period of time.

- Ensure that the discussions are two-way: gain a better understanding of the concerns that the sector or stakeholders may have for not taking action to ban highly hazardous pesticides. Use this information to tailor advocacy efforts. For instance:
 - » if there is concern that changing pesticides may reduce crop yield, demonstrate the evidence that shows this is not the case and identify alternative agricultural approaches to crop protection (Gunnell et al., 2017; Manuweera et al., 2008);
 - » bring national attention to the issue in collaboration with the media to generate advocacy efforts through public pressure.
- For other methods of suicide consider the following stakeholders:
 - » (for firearms) legislators, firearms retailers, locations or occupations where firearms are used (e.g. shooting ranges, military services, police services);
 - » (for medications or poisonous substances) regulatory agencies, authorities responsible for dispensing or prescriptions, the ministry that deals with toxic fuels such as some gases. It is also important to also consider the regulation of (online) sales of such products;
 - » (for jump sites such as bridges, high-rise buildings, railways, subways) transport and construction ministries and agencies;
 - » (for ligatures/ligature points) judicial ministry, prisons and detention facilities, and institutions (such as long-term care facilities).

4. Agree policy or legislative action required to ban or restrict access to the means of suicide

- For pesticides, this may include the following actions:
 - » identification of highly hazardous pesticides for withdrawal through review of pesticides currently in circulation (FAO & WHO, 2016);
 - » regulatory actions to ban the sale and use of acutely toxic highly hazardous pesticides, including penalties for importation of lethal pesticides and violation of pesticide regulations;
 - » risk assessments for the registration of new products;
 - » strengthened inspection and control of pesticide use;
 - » facilitation of the registration and use of low-risk pesticides;
 - » increased funding and opportunities for research on lower-risk alternatives; and



- » supporting the use of no-pesticide agriculture and agroecology.
- The acceptability of policy actions should also be considered, and steps taken to increase public support – e.g. in the case of pesticides, working with stakeholders (farmers/pesticide retailers) to increase awareness of the need for regulation and viable alternatives.

5. Agree community actions required to restrict access to means of suicide

- Collaboration with local authorities will be required to monitor and enforce national regulations and policies.
- For pesticides this can involve collaboration with local agricultural authorities (particularly agriculture extension services) to strengthen inspection and control, as well as working closely with farmers and pesticide retailers to provide education on the rationale for withdrawal of products and the benefits of using alternatives.
- Ensure there is capacity in the health sector and guidelines for the clinical management and reporting of pesticide poisoning (WHO, 2008a).

6. Evaluate the effectiveness of initiatives (see [Monitoring and evaluation](#))

- Monitor the impact of means restriction on rates of suicide, review information gathered from inspections, and schedule regular reviews of initiatives with national and local stakeholders. In particular, identify any method substitution to methods of higher lethality or changes in the pesticides that contribute to most deaths.
- Use lessons learned to inform further changes to policy and local initiatives. For instance, if inspection reveals that banned pesticides are still in use, focus groups could be convened to establish the reasons for this and to devise more effective remedies.
- Evaluations can be disseminated to stakeholders to encourage further restriction of means and implementation of lessons learned.

7. Ensure that good surveillance is in place to assess changes in means and in suicide

- It is important to ensure that ongoing monitoring of the methods of suicide and suicide attempts is carried out and that interventions respond to changing patterns in the means of suicide.

Box 33. A story of success, Republic of Korea

Suicide mortality in the Republic of Korea has been high compared to other high-income countries and to countries in the WHO Western Pacific Region in general. Suicides by pesticide accounted for around one fifth of all suicides in the Republic of Korea during 2006–2010. Efforts to control and minimize the harmful impact of pesticides in the country prior to 2011 had no meaningful impact as the pesticides that accounted for the majority of deaths were not adequately controlled.

In 2011, the Republic of Korea enacted the Suicide Prevention Act, cancelling the re-registration of paraquat and banning its sale in 2012. These actions resulted in an immediate and clear decline in suicides by pesticide poisoning and contributed to an overall decline in suicide rates. The intervention appeared to reduce suicide rates among all population groups, including men, women, all age groups, and persons living in both urban and rural areas.

More than half of the overall reduction in the suicide rate between 2011 and 2013 could be attributed to the paraquat ban. Notably, this was achieved without any impact on crop yield. Given the magnitude of suicide by pesticide self-poisoning around the world, tens of thousands of lives could be saved every year if effective regulation of pesticides were enforced worldwide. Ensuring safer access to pesticides will require an intersectoral approach, including pesticide bans and other related policies, as well as community interventions, improved health care, and training and surveillance activities. The successful approach taken by the Republic of Korea provides an encouraging model for other countries aiming to reduce suicide deaths.



TIPS FOR IMPLEMENTATION

Table 11. Tips for implementation of access to the means of suicide

Issues	Tips
Stakeholders may be reluctant to invest in means restriction due to a concern that the population will switch to another method and that people determined to die by suicide cannot be stopped	<ul style="list-style-type: none"> • Share information with stakeholders about the evidence base: <ul style="list-style-type: none"> » Inform stakeholders that restriction of one method of suicide does not inevitably lead to a rise in the use of others (Yip et al., 2012). » Where substitution has been observed, individuals have often been seen to use less-toxic pesticides, resulting in lower rates of fatality and fewer total suicides (Gunnell et al., 2007). » Most people who engage in suicidal behaviour experience ambivalence about wanting to live or die. Restricting access to means can provide the time for acute crises to pass before fatal action is taken.
Resistance from stakeholders due to the convenience/financial implications associated with means	<ul style="list-style-type: none"> • Increase recognition of the problems associated with specific means through education and mitigate concerns. For example, educate stakeholders about the benefits of low-risk alternatives and advocate that the use of low-risk alternatives has no negative impact on crop yield (WHO, FAO 2019).
One of the main methods of suicide involves ingestion of pesticides; however, in many contexts this remains unacknowledged and little or no action is taken	<ul style="list-style-type: none"> • Encourage existing poison centres to share data on intentional pesticide poisoning cases in order to identify the scale of the problem. • Monitor the use of pesticides in suicide or attempted suicide in order to understand the problem; engage regulatory bodies and relevant government sectors (e.g. agriculture) in the national regulation of access to pesticides. • Build a strong awareness and advocacy campaign directed at stakeholders linked to the means of suicide. • Decriminalize suicide and suicide attempts to reduce barriers to reporting poisoning cases as suicide/suicide attempts.
The most commonly used means of suicide is not easily amenable to restriction (e.g. hanging outside of closed institutional settings in the community; self-immolation)	<ul style="list-style-type: none"> • Ensure continued focus of efforts to restrict access to means of suicide in institutional settings; reduce the likelihood of imitation of these means through collaboration with the media (to remove descriptions of the method when reporting on a suicide); improve capacity for clinical management of near-hanging or burns; improve help-seeking in the community (Gunnell et al., 2005); improve early identification of people at risk of suicide (see Early identify, assess, manage and follow up).
Inadequate data collection can hinder attempts to identify the means of suicide on which to focus interventions	<ul style="list-style-type: none"> • Establish or strengthen surveillance systems for suicide and self-harm which accurately record the method used and are as timely as possible. This may involve education to encourage reporting of suicides and suicide attempts.



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INTERACT WITH THE MEDIA FOR RESPONSIBLE REPORTING OF SUICIDE

WHAT?

There is evidence that media reporting of suicide can lead to a rise in suicide due to imitation, particularly in cases of celebrity suicide and where suicide methods are described (Niederkrotenthaler et al., 2020). Conversely, stories demonstrating help-seeking in adverse circumstances which include information about where to seek help contribute to suicide prevention (Niederkrotenthaler et al., 2014). The media (e.g. journalists, film-makers) play an important role in shaping public opinion and attitudes and are an important stakeholder in raising awareness and reducing the stigma of suicide. Working with the media can include collaboration in developing guidelines (such as recently in India; Vijayakumar, 2019) and regulating responsible coverage of suicide, which may include collaboration with the technology sector to identify articles which fail to meet reporting guidelines.⁵⁰ Interactions will include building the capacity of media professionals to report responsibly. They may also include policies for monitoring user content on digital media platforms.

WHY?

Repeated glamorized coverage of high-profile suicide cases may include detailed descriptions of a suicide and fictional portrayals of suicide that do not accurately represent reality

Box 34. Media monitoring, Lithuania

The main goal of media monitoring is to reach a common understanding with the media regarding responsible reporting of suicides and suicide attempts. The Suicide Prevention Bureau reviews nearly 700 reports of suicide or suicide attempts in the online media every working day. This is achieved by using specially selected keywords and a media monitoring search engine. The title, text, video and photo material are then analysed. The analysis is based on the WHO resource booklet for media professionals (WHO, 2017) and guidance from the Lithuanian Psychologists' Association. If the Code of Ethics for Public Information is violated by the publication, the editor of the online media is contacted and requested to correct the publication. The Suicide Prevention Bureau also provides short seminars for media professionals on how to report suicides and suicide attempts responsibly.

influence suicide rates (WHO, 2017). This contributes to public misunderstanding of suicide, hindering effective prevention. The increasing use of digital media means that it is becoming ever more difficult to monitor these problems, as information can be spread quickly between users. However, portrayals of suicide written in accordance with media guidelines show potential to help prevent suicide.

⁵⁰ See the beta version of a data science tool developed to screen text automatically for its adherence to reporting guidelines for suicide (<https://reportingonsuicide.cisco.com>, accessed 28 January 2021).

WHERE?

Collaboration with the media is ideally conducted with a nationally positioned media body, including media regulators. Should this not be possible, collaboration can be established with local or more specialized media outlets that may have access to specific geographical or sociodemographic groups. In the case of cross-national media, such as social or digital news media, collaboration at headquarters (international) and national levels may be required to facilitate a country-specific approach to the management of suicide-related content online. Collaboration is also needed within the stage and screen industries.

WHEN?

Work with the media can begin at any time. It may be triggered by harmful media coverage which requires a response. Preferably, however, collaboration should begin pre-emptively, to prevent such coverage. Building good relationships with media stakeholders, such as through actively involving them in awareness-raising, can help create a more welcoming relationship in preparation for training or policy development on responsible reporting and its monitoring. Training can be delivered at strategic times such as during the education curriculum for media professionals or at the beginning of established recruitment cycles. Opportunities for increased focus on suicide prevention can be utilized to promote collaboration, such as on World Suicide Prevention Day or World Mental Health Day.

WHO?

This work requires collaboration between multiple stakeholders. At the national level, leadership can come from collaboration between the Ministry of Health and ministries related to media, national media, media regulators (e.g. press ombudsman) and cross-national media organizations such as social media companies. In the community, leadership may additionally

come from stakeholders with interest in suicide prevention (and who may have experience of, or links to, work with the media). NGOs can be influential in engaging with the media. For example, the Samaritans (United Kingdom) and SAVE (USA) have developed media guidelines and training on responsible coverage of suicide, in addition to providing individual advice to journalists reporting on suicide.^{51, 52, 53}



⁵¹ Guest Blog: Samaritans Media Advisory Service and guidelines. London: Independent Press Standards Organisation (<https://www.ipso.co.uk/news-press-releases/blog/guest-blog-samaritans-media-advisory-service-and-guidelines/>, accessed 28 January 2021).

⁵² Samaritans' media guidelines. Epsom: UK Samaritans (<https://www.samaritans.org/about-samaritans/media-guidelines/>, accessed 28 January 2021).

⁵³ Journalist and media training. Bloomington (MN): Suicide Awareness Voices of Education (SAVE) (<https://save.org/what-we-do/training/journalists-and-media/>, accessed 28 January 2021).

Box 35. The Papageno-Media Prize, Austria

The dissemination and application of the guidelines on media coverage of suicide are a success story in suicide prevention, both nationally and internationally. Meanwhile, it has also been demonstrated that a certain form of reporting not only prevents imitation suicides (the “Werther effect”) but can have a general suicide-preventive effect (the “Papageno effect”). The Papageno effect refers to the character of Papageno from Mozart’s opera *The magic flute*. In the opera, Papageno is able to overcome his initial suicidal thoughts with the help of others. In Austria, the Austrian Press Council established suicide-preventive reporting in its code of ethics in 2012. Media articles which are not in line with responsible reporting receive admonitions by the National Press Council. In order to further disseminate the media guidelines and promote suicide prevention reporting in Austria, in 2019 the Federal Ministry of Social Affairs, Health, Care and Consumer Protection established – in cooperation with the Austrian Society for Suicide Prevention, the Wiener Werkstätte for Suicide Research and the Kriseninterventionszentrum – the “Papageno-Media-Prize”.⁵⁴ Each year a single winner is selected out of a pool of professional journalists from Austrian print and digital media. Media articles are assessed for their positive thematization of suicide in line with the guidelines, as well as on journalistic criteria (e.g. quality of the writing itself). Good collaboration with the media is exemplified through the selection of the winner who is elected by a jury consisting of five journalists (nominated by the Press Council/Journalists’ Union/ Presseclub Concordia/ Association of Austrian Newspapers) and five suicide prevention experts. These experts include experts by experience and bereaved (nominated by the advisory board of Austria’s national suicide prevention programme SUPRA which awards the “Papageno-Media-Prize”). The winner of the 2020 “Papageno-Media-Prize” for suicide-preventive media reporting was awarded on 10 September by the Federal Minister to Ursula Theirezbacher from ORF (the Austrian Broadcasting Corporation) for her radio story about suicidality in *Journal Panorama*.

HOW?

1. Convene a working group (see [Box 1, Introduction](#))

- Establish the group (see under [Who?](#) above).

2. Develop an understanding of current media reporting and media regulatory frameworks

- Assess the current reporting of suicide by media and identify examples of responsible reporting and examples of problematic reporting that require intervention.
- Identify existing policies, guidance or training opportunities on responsible reporting on suicide for media professionals (if not already identified in the situation analysis).
- If none are specifically available, consider whether new policy, guidance or training are required or whether these can be integrated into existing practices.
- Identify whether there are ethical regulations for the media and if these include the responsible reporting of suicide. The body responsible for regulation should be included as a key stakeholder.

3. Meet with media professional bodies

- If it is not possible to meet with a national or regional representative body, collaborate with individual media organizations (such as one radio broadcasting company or one print newspaper which serves a local area). However, it can be helpful to first meet with multiple (local) media outlets as a group to foster a sense of collective responsibility.
- Cross-national media companies such as digital social media may be included as a stakeholder alongside national media organizations. They may require a separate collaborative arrangement, depending on their legal status in your country.

4. Convey the importance of responsible reporting and discuss collaborative efforts

- Ensure that all stakeholders are aware that the aim of the collaboration is to implement the evidence-based intervention of responsible reporting of suicide in the media.
- An important discussion point to focus on is the understanding of the contagious effects of sensationalized reporting of suicide.

⁵⁴ Papageno media award for suicide prevention reporting. Vienna: Federal Ministry of Social Affairs, Health, Care and Consumer Protection (<https://www.sozialministerium.at/Ministerium/Preise-und-Guetesiegel/Papageno-Medienpreis-fuer-suizidpraeventive-Berichterstattung.html>), accessed 28 January 2021).



- Ensure that information is adapted for media stakeholders and is evidence-based – e.g. utilize existing WHO resources (WHO, 2017; WHO, 2019a).
- Decide the area of media focus such as journalism, entertainment or social media.

5. Agree strategies that will be used to increase responsible reporting of suicide; for example:

- Develop policies and guidelines on responsible reporting, plus an accountability mechanism to monitor and manage problematic reporting.
- Collaborate on sustainable training for media professionals or media students in educational courses. Include the impact of sensationalized media coverage on suicide and give practical guidance on responsible reporting, increasing coverage of positive narratives on coping and including information on resources and where readers/viewers can seek help.
- Develop a system of recognizing good practice (e.g. by nominating individuals or organizations for existing awards for excellence in reporting or by establishing new recognition schemes).
- Agree to provide resources (e.g. a press information kit) or contact details of suicide prevention experts for media professionals to use when covering a story on suicide,
- For social media, consider:
 - » policies and mechanisms for managing user-created content in social and digital media;
 - » referral pathways or access to resources which are specific to the local context of the users.
- Additional considerations to enhance collaboration with the media include:
 - » using the media in awareness-raising and advocacy campaigns and events (see [Awareness-raising and advocacy](#));
 - » providing support for media professionals who themselves may have been affected by suicide.

6. Agree a plan of action

- Outline the steps that need to be taken to develop and implement each activity. Agree which stakeholders will be responsible for carrying out each step of the plan of action.
- Consider strategically important times to implement different actions (e.g. training could be part of the induction of new employees, and refresher workshops could be held at regular intervals).

- Agree the coverage of the work. For instance, coverage could be national, regional or for a specific media type (e.g. all print news) or for a single media company (e.g. a local radio broadcaster).

7. Conduct the initiatives and carry out evaluation

- Plan in advance how the effectiveness of each initiative will be evaluated, using indicators of interest (e.g. change in sensationalized or responsible reporting of suicide) (see [Monitoring and evaluation](#)).
- Create a calendar for regular review of training, guidelines and policies to ensure that these reflect updated research and practice-based evidence.
- Implement a monitoring process to collect information about appropriate coverage of suicide and provide timely constructive feedback on harmful depictions.
- Evaluations can be disseminated to wider media outlets to encourage further uptake of initiatives and implementation of lessons learned.

Box 36. Successes and challenges in engaging the media, Malaysia

The Malaysian Ministry of Health organized a national-level seminar and workshop for media professionals during the 2004 World Suicide Prevention Day in conjunction with the theme of “Media as Partners in Advocacy for Suicide Prevention”. This led to the development of the Malaysian guidelines for media reporting on suicide which were updated in 2011. However, a framing analysis of Malaysian newspapers seemed to suggest a lack of adherence to media guidelines up to 2018 (Victor et al., 2019). Consequently, responsible reporting efforts from governmental, nongovernmental and international organizations – such as public talks, media interviews, capacity-building workshops and social media interactions – have intensified over the past two years. Stakeholder engagement has been encouraging, albeit at varying levels regionally and nationally. To address this, efforts have been made to break down silos between health professionals, people with lived experience, media professionals, academics and industry regulatory bodies. Further evaluations are required to ascertain the degree of guideline implementation by the media and its impact on suicidal behaviour in Malaysia.



Box 37. Media guidelines, Trinidad and Tobago

Suicide is an important public health problem in Trinidad and Tobago. As part of a strategy to reduce the suicide rate in the country, the Ministry of Health of Trinidad and Tobago, together with PAHO/WHO, held an awareness-raising workshop with representatives of local news media. The workshop involved journalists, reporters, editors, radio announcers and bloggers, among others, in a national conversation on the media's role in suicide prevention. During the workshop, experts shared evidence on the impact of responsible and irresponsible articles on suicides and shared good practices in media coverage of the issue. A senior producer said the workshop taught her that the media should not make assumptions about the cause of death: "We should provide the facts, not make speculations, not sensationalize... let people know that there are signs that indicate suicidal behaviour and help them identify those warning signs and offer advice on asking for help."

The Ministry of Health, with support from PAHO, developed guidelines with 11 best practices for responsible coverage of suicide and self-harm. The draft document underwent a series of reviews by stakeholders, including an international panel of experts, to ensure consistency with best practice and to assess the likelihood of compliance by the media. The guidelines were shared with relevant stakeholders and further feedback was obtained before they were finalized and circulated.

To measure the impact of the guidelines, a framework for monitoring and evaluation was developed to evaluate how the media adhered to guidelines. This tool assesses compliance and identifies gaps and opportunities for further development. It rates all suicide-related news reports accessible online (deaths, attempted suicide, self-harm, suicide prevention articles etc.) on the number of guidelines violated and the number of helpful information included in the report e.g. suicide hotline, coping strategy. Media houses are then contacted on the basis of their score, are reminded of the guidelines and are informed of additional resources where required.

A formal research study into the changes that have happened since the guidelines were circulated has not yet been done. However, there has been a noticeable change in the tenor of reporting, especially with regard to the placement of stories and omission of the more explicit details of suicide. A comprehensive review is planned to assess the qualitative and quantitative changes that have occurred since the guidelines became available. This is necessary for evaluating the guidelines. One challenge is combined murder-suicide which still attracts occasional irresponsible reporting.



TIPS FOR IMPLEMENTATION

Table 12. Tips for implementation, LIVE LIFE interaction with the media

Issues	Tips
Sensational headlines benefit media outlets, resulting in a lack of adherence to agreed guidelines for responsible reporting	<ul style="list-style-type: none"> Engage stakeholders in collaborative, non-punitive, discussions around the ethical implications and responsibilities regarding the reporting of suicide. Emphasize the evidence linking reporting with suicide. Highlight the audience preference of non-sensationalism using voices of people with lived experience (including the media community). Offer examples of engaging high-profile persons in sharing their stories of successful recovery from mental health challenges/suicidal thoughts.
Lack of structural support for responsible reporting (e.g. short deadlines; changes made after editing)	<ul style="list-style-type: none"> Engage media professionals at all levels of the organization, including management and editorial positions. Cultivate champions for suicide prevention within the media (e.g. journalists with lived experience). Strengthen monitoring of responsible reporting and discuss regulation with the relevant stakeholders.
Limited collaboration between different stakeholders, particularly where profit-making stakeholders may be competing	<ul style="list-style-type: none"> Regularly convene to maintain relationships and to foster a sense of collective responsibility. Establish channels of communication between different stakeholder between meetings. Once good practice has been established in an organization, use learning points to foster initiatives in other target organizations.
Difficulties regulating publicly-generated content (e.g. on social media)	<ul style="list-style-type: none"> Work with social media companies to increase their awareness and develop/improve protocols for identifying and removing harmful content. Create mechanisms for public reporting of harmful content (such as Stigma Watch⁵⁵).

⁵⁵ StigmaWatch, Sane Australia (<https://www.sane.org/get-involved/stigmawatch>, accessed 28 January 2021).



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FOSTER SOCIO-EMOTIONAL LIFE SKILLS IN ADOLESCENTS

WHAT?

For suicide prevention in adolescents, WHO's *Helping adolescents thrive* (HAT) guidelines (WHO, 2020) and menu of cost-effective interventions for mental health (WHO, 2021) recommend the implementation of socio-emotional life skills training in schools. The guidelines include mental health awareness training (i.e. mental health literacy) and skills training (such as problem-solving and coping with stress). Rather than focusing explicitly on suicide, it is recommended that programmes employ a positive mental health approach.⁵⁶

To strengthen the implementation of evidence-based socio-emotional life skills programmes in schools, complementary areas of work can be considered, such as:

- Provide gatekeeper training for education staff on how to create a supportive school environment, how to recognize risk factors and warning signs of suicidal behaviour, how to provide support to distressed young people and how to refer collaboratively for additional support.
- Facilitate a safe school environment (e.g. anti-bullying programmes, initiatives to increase social connection, staff training on creating a supportive environment).
- Create and strengthen links to external support services and provide this information to students.
- Establish specific support for students at risk, such as those who have previously attempted suicide, have been bereaved by suicide or are from groups at risk of suicide (e.g. because of sexual orientation or gender minority);
- Provide a clear policy and protocols for staff when suicide risk is identified; for communication of an attempt or suicide among staff or students; and for supporting a student to return to school following a suicide attempt.
- Promote staff mental health. Include training for their own mental health and access to support.
- Involve parents to increase parental awareness of mental health and risk factors.
- Educate on healthy use of the Internet and social media (e.g. safe Internet use; use of social media to build healthy social support; and recognizing and responding to unhealthy online activity such as bullying).
- Develop initiatives to address other risk factors for young people (e.g. parental violence, family trauma, substance use).

⁵⁶ A positive mental health approach involves a focus on fostering students' strengths and abilities, and helping them to develop new skills to improve overall mental well-being rather than focusing specifically on suicide.



Box 38. World Health Organization's *Helping adolescents thrive* (HAT)

WHO's *Helping adolescents thrive* (HAT) guidelines (WHO, 2020) provide evidence-informed recommendations on psychosocial interventions to promote mental health, prevent mental health conditions, and reduce self-harm and other risk behaviours among adolescents. The guidelines are designed to be delivered across various platforms such as schools, health or social care, the community or digital media. The guidelines are intended to inform a package of interventions – the HAT toolkit – which is being developed to support the operationalization of the HAT guidelines with the aim of bringing together a core set of evidence-based strategies to advance efforts to promote and protect adolescent mental health. The HAT toolkit will describe programmes that show evidence of promoting mental health in adolescents or reducing risk factors for mental illness, substance use and self-harm. The toolkit focuses on: 1) improving laws and policies; 2) improving environments within schools, communities and online to promote and protect adolescent mental health; 3) supporting carers; and 4) improving adolescents' psychological skills. The toolkit also refers users to additional sources of information for implementation tools and experiences. A UNICEF and WHO HAT comic series for enhancing the socio-emotional learning of young adolescents in schools and an accompanying teacher's guide will be available in 2021.

WHY?

Adolescence (10–19 years of age) is a critical period for the acquisition of socio-emotional skills which are the foundation for later health and well-being. However, adolescence also marks a period of risk for the onset of mental health conditions, with half of all cases occurring by the age of 14 years. The formation of socio-emotional skills associated with positive mental health is the foundation of young peoples' development into mentally healthy adults (WHO, 2015; Sánchez Puerta et al., 2016). Increased mental health literacy may help to reduce stigma and increase knowledge of mental health (Milin et al., 2016), while helping young people notice warning signs in themselves and

others can encourage help-seeking (Burns & Rapee, 2006). Given that educational settings are a main point of contact for young people in many countries, implementing suicide prevention in these settings is a viable way to reach this group.

WHERE?

Coordination of socio-emotional life skills training for adolescents in educational settings can be conducted at national or district levels. Activities can range from a programme conducted in a school or partnership of schools, in youth centres/activities, and in educational programmes for displaced young people, to nationwide investment in introducing socioemotional life skills interventions in educational curricula. There is increasing evidence of such skills programmes being adapted for digital use. It is advisable to pilot-test in a district or smaller set of schools before scaling up.

Box 39. Evidence-based application for adolescent Aboriginal and Torres Strait Islander Australians, Australia

iBobbly⁵⁷ is a self-help app for social and emotional well-being designed with and for young Aboriginal and Torres Strait Islander Australians aged 15 years and over. The app uses strategies from acceptance and commitment therapy and cognitive behavioural therapy. iBobbly was first tested in a randomized controlled trial involving 61 Aboriginal people from Kimberley, Western Australia (Tighe et al., 2017). Users reported significantly lower levels of depression and psychological distress. iBobbly was well received by people who tried it and feedback from users was positive (Tighe et al., 2020). A second, large-scale trial concluded in August 2019 and involved six locations around Australia and over 400 participants. Preliminary results were positive. Importantly, everything that is seen, heard and experienced in the app is shaped by Aboriginal and Torres Strait Islander community members to ensure that iBobbly is culturally informed and safe. Most of the artwork within the iBobbly app was designed by local artists. The language used in the app was chosen in

⁵⁷ iBobbly. Black Dog Institute (Australia) (<https://www.blackdoginstitute.org.au/resources-support/digital-tools-apps/ibobbly/>, accessed 28 January 2021).



consultation with the young people, and other suggestions on the type of language that young people would respond to were incorporated into the app. In addition, most of the local voice-over was recorded by a local Aboriginal media agency. iBobbly was developed in close coordination with local Aboriginal and Torres Strait Islander Australians and was guided by an advisory group to inform and shape project activity associated with the implementation and quality assurance of the iBobbly app. The group ensures that iBobbly continues to meet cultural standards and is informed, shaped and directed by those for whom the app is designed – Aboriginal and Torres Strait Islander peoples.

WHEN?

Before commencing initiatives, care pathways which have capacity to support young people (such as child and adolescent mental health services) should be established between schools and local health and social protection services. The implementation of the training may be prompted by timing, such as delivering skills programmes in advance of periods of high stress (such as examinations). However, it is not advisable to start suicide prevention activities immediately after a suicide (although psychosocial support should be available and provided to school members).

WHO?

School-based suicide prevention works best where there is collaboration between multiple stakeholders. Leadership can come from collaboration between the Ministry of Health and the Ministry of Education. In the community, leadership may come from individual schools or organizations with a vested interest in suicide prevention or young people's well-being. For optimal implementation it is important to consider the support of local politicians, schools, staff (including teachers and school counsellors/nurses), parents and caregivers, local health and protection services and/or organizations that work with young people (e.g. sports or youth groups). It is important that young people are integrated into the design of school prevention programmes. Young people are well-placed to advise on how best to engage their peers and to identify risk factors specific to their community.

HOW?

1. Convene a working group to plan and implement school-based programmes (see [Box 1, Introduction](#))

- Establish the group (see under Who? above).
- Before implementation of the programme, ensure that schools have an adequate plan of action in place to support students and adequate links to mental health services to which they can refer students at risk. Ensure that school staff are aware of these processes and are confident and competent to carry them out.
- Plan to implement the work in a selected area or select a number of schools for piloting prior to scale-up.

2. Select an evidence-based intervention for young people

- An expert in young people's mental health and suicide prevention should be engaged to ensure that the selected programmes are evidence-based.
- Determine which programme will fit the needs of the target population, community, or school; this will depend on the needs of the young people in addition to the resources available. If support is needed to identify an evidence-based programme, the working group is recommended to consult a research expert, an agency specializing in suicide prevention or a person familiar with this area of knowledge.
- Preference should be given to previously-evaluated programmes which indicate the resources required for implementation and their strengths and limitations.
- Adapt the programme for the target population as there may be cultural differences in students' attitudes to suicide – or in how they communicate warning signs and help-seeking behaviours – compared with the original programme.
- Seek advice from the developer of a programme on how best to make adaptations without reducing effectiveness, or identify other areas or schools with a similar student population who have already adapted a programme successfully.

3. Agree a plan of action and plan for the resources required

- Plan for the human resources and capacity-building required for implementation (e.g. the need to train a facilitator or school staff).
- Determine who will deliver the programme (e.g. mental health providers, school welfare staff, health providers).



Ensure that a supervision mechanism is arranged between the schools and local mental health services. There may also be opportunities to engage youth peers or parents.

- Decide on the timeline in which each action will be carried out. Consider when it will be most effective to implement the programme and how often it will be repeated.
- Arrange a time to reconvene regularly to review progress and decide on new actions.

4. Develop a plan for evaluation

- Plan in advance how the effectiveness of the programme will be evaluated (see [Monitoring and evaluation](#)). Guidance can be taken from the existing validation processes of the programme creators and may include:

- » pre- and post-programme questionnaires on knowledge of and attitudes towards mental health/ suicide and measures of self-esteem and other skills;
- » the impact on suicidal behaviour;
- » feedback from students and staff on their experiences and opinions of the programme and its resources.

- Use the lessons learned to inform any changes for future implementation of the programme.
- Decide on a plan to scale up the intervention (e.g. to a wider number of students within a particular school, in another district, or in all schools in the country).

Box 40. Youth Aware of Mental Health (YAM), from research to implementation, Sweden

Saving and Empowering Young Lives in Europe (SEYLE) was a research project developed to evaluate three school-based programmes for mental health promotion and suicide prevention. The randomized controlled trial was conducted on 11 110 adolescents from 168 randomly selected schools in 10 European Union (EU) countries. The SEYLE study showed that Youth Aware of Mental Health (YAM) was successful in significantly improving young people's mental health compared to the other two programmes and the control group. Compared to the control group, young people who participated in YAM showed a reduction of 50% in new suicide attempts and severe suicidal ideation (Wasserman et al., 2015) while new cases of moderate and severe depression were reduced by about 30%.

The five-hour YAM programme, delivered by a specially trained instructor and a helper over three weeks, provides young people in their classroom with a safe and nonjudgemental space to explore mental health topics. The emphasis is on empathy towards others' experiences and peer support, while empowering young people to reflect on their own mental health needs (Wasserman et al., 2018). Role-play activities are supported by an interactive talk given by an instructor, booklets on the topic given to each participant, and posters hung on the walls of the classroom that provide information that includes contacts of local health-care and youth support services.

In interviews after YAM, young people have expressed feeling more confident in supporting a friend in need. They also indicate using skills and strategies acquired during the programme to help them through adverse life events. Perhaps most importantly, YAM helps young people recognize the need for support as they encounter challenges. To meet this need, information about local physical and mental health care options as well as youth-serving organizations in their communities is shared with them.

The YAM programme is a novel, effective and cost-effective (Ahern et al., 2018) school-based intervention in suicide prevention that improves coping skills, increases empathy, help-seeking behaviour and peer help, and encourages a positive classroom climate. The YAM programme has been taken up by countries around the world. The Mental Health in Mind International, a research and development enterprise created with support from Karolinska Institutet Innovations, is implementing the results from the SEYLE project. Current implementation and evaluation programmes are taking place in Europe (Austria, France, Norway, Sweden, United Kingdom) Australia, India and the USA. To date, more than 100 000 students worldwide have participated in the YAM programme.



Factors which have been instrumental to the implementation of YAM include: 1) a readily available package has been developed to implement YAM and the intervention developers offer collaboration with new sites, including training and quality assurance measures; 2) all sites implementing YAM have infrastructure in place to allow for supervision and continued training; 3) there are protocols for translation and cultural adaptation of the programme; 4) the process is participatory and always includes young people; 5) advice is provided to support sites in obtaining funding for implementation; and 6) the programme works best where people are committed and dedicated to implementing suicide prevention with developing young people's skills in YAM.

TIPS FOR IMPLEMENTATION

Table 13. Tips for implementation of fostering socio-emotional life skills in adolescents

Issues	Tips
Reluctance to address mental health among other topics at school; reluctance (of leaders, schools or parents/caregivers) to discuss mental health issues, emotional distress and suicidal behaviours with young people	<ul style="list-style-type: none">• Work closely with the education sector on the need for prevention activities and emotional and life skills training, given the risk of suicide in younger age groups; provide gatekeeper training for teachers; provide awareness-raising and/or training for parent/caregiver representatives in the community; meaningfully include young people in the design of any prevention programme.• Remind teachers or caregivers that talking about suicide with young people will not increase suicide risk but will mean that young people may feel more able to approach them for support when needed.• Where reluctance may stem from previous experience of suicide within a school, it is important that those affected are provided with adequate support (such as postvention counselling) and that prevention work is sensitively encouraged to prevent future incidents.• Engage champions/celebrities to encourage participation.
Resistance from staff	<ul style="list-style-type: none">• It is essential to secure the well-being of staff prior to initiating student programmes so that they are well-placed to support those at risk. This will involve providing a safe school environment where staff are encouraged to access support, and where they have adequate training to increase their confidence in communicating with distressed students and managing risk.• It is also important to ensure good cross-sector collaboration for students who require services/support outside the school setting.
Lack of time and resources for planning and implementation, or it is not seen as a priority compared to traditional academic classes	<ul style="list-style-type: none">• Prevention programmes can be integrated into existing school initiatives (e.g. health classes or other health programmes) or peer leadership programmes.• Existing events in the school calendar can provide a good opportunity to launch prevention programmes, such as healthy school weeks and mental health awareness days/weeks.



EARLY IDENTIFY, ASSESS, MANAGE AND FOLLOW UP ANYONE WHO IS AFFECTED BY SUICIDAL BEHAVIOURS

WHAT?

Early identification, assessment, management and follow-up ensure that people who are at risk of suicide, or who have attempted suicide, receive the support and care that they need. Health systems need to incorporate suicide prevention as a core component in order to intervene early when people are identified as being at risk of suicide. Health-care workers should be trained in early identification, assessment, management and follow-up (WHO, 2019b). Non-health actors who come in contact with at-risk individuals (e.g. in the community) should be competent in early identification and follow-up. Health-care systems should coordinate care pathways for the referral of individuals to follow-up support in the community or specialist mental health care. At-risk individuals may experience risk factors and care needs that cannot be addressed by the health sector alone. For example, a person may require support in accessing employment or financial opportunities in addition to support from the health system. Likewise, in the example of Japan, people presenting to the social welfare department with financial difficulties are automatically referred to the health sector for simultaneous care.

Postvention support⁵⁸ should be available for people who have attempted suicide and those who have been bereaved by suicide. In addition to support provided by health services, community-led follow-up can pertain to survivors' groups of people bereaved by

suicide (WHO, 2008b), self-help groups facilitated by persons with lived experience, or volunteer services.⁵⁹ Crisis services such as crisis community treatment teams or crisis lines should also be available to provide immediate support to individuals in acute distress (WHO, 2018c).

Box 41. Case management for people who have attempted suicide, Republic of Korea

In the Republic of Korea, case management was implemented in 2013 for suicide attempters who visit emergency departments, with the support from the central government. The National Action Plan for Suicide Prevention, which was released in January 2018 by the relevant government ministries, presents specific action tasks that strengthen counselling and follow-up management for suicide attempters. The emergency department-based post-suicide attempt case management started with 25 locations in 2013, had been expanded to 85 locations in 2020 and will continue its expansion. Case managers, who contact patients within 24 hours of their presentation to the emergency department with a suicide attempt, have weekly meetings to discuss all active cases. All hospitals are supervised and the evaluation of the programme is ongoing.

⁵⁸ Postvention refers to an intervention conducted following a suicide attempt or suicide.

⁵⁹ Befrienders Worldwide (<https://www.befrienders.org/>, accessed 28 January 2021).



WHY?

Health systems are currently failing to meet the mental health needs of their populations, and the scarcity and unequal distribution of services means that many people do not receive the care they need (WHO, 2018b). It is essential to aim for universal health coverage⁶⁰ to ensure that all people are able to access quality care.⁶¹ Implementing mental health service recommendations – including providing 24-hour crisis care, local policies for patients with dual diagnoses, and providing multidisciplinary reviews after a suicide – was associated with reduced suicide rates in clinical populations over time in England and Wales (While et al., 2012). There is also scope to provide management and follow-up digitally.

As people experiencing physical and mental health conditions are at increased risk of suicide (WHO, 2018b; WHO, 2019b) and may already be in contact with health services, health-care workers are well-placed to identify people at risk. Therefore, health workers should be trained to identify, assess, manage and follow up people at risk of suicide and should feel confident to do so. Following contact with health services, people can feel isolated and are at substantially increased risk of further suicide attempts. Consequently, prompt and systematic follow-up care is essential as this has been shown to reduce suicides and suicide attempts following discharge (Goldman-Mellor et al., 2019; Fontanella et al., 2020). Families and friends affected by suicide can also be at risk and may experience feelings of guilt, shame and stigmatization which make it difficult to access social support. Proactive follow-up should be provided to this group.

WHERE?

Initiatives to promote early identification, assessment, management and follow-up should be coordinated at the national level but adapted to meet the needs of local communities. Implementation should be piloted in a single health service or in district health services prior to scale-up. Activities should be conducted across all levels of health care – particularly primary care services which may be the principal source of (mental) health care in many countries, and

emergency units where persons may present after a suicide attempt (which is an important risk factor for suicide).

WHEN?

Before commencing activities that may identify people at risk (such as training health workers), care pathways for management and follow-up should already be established. The training of health workers or actors in the community should be strategically timed (see [Capacity-building](#)).

WHO?

The Ministry of Health should lead the work with local health services – i.e. activities may target specific health departments or units likely to come into contact with at-risk individuals such as those dealing with emergencies, mental health, alcohol use disorders, chronic pain or chronic diseases. The work will require collaboration with stakeholders in the community who have a role in early identification or follow-up (e.g. social care, social welfare, education, police and other gatekeepers).

HOW?

1. Convene a working group (see [Box 1, Introduction](#))

- Establish the group (see under Who? above).
- The group should include people with a knowledge of the local health system and public health principles, plus health professionals who understand the current challenges within the system.
- The group may also include people from other sectors (e.g. police, teachers, social care workers) depending on the care pathways or follow-up in the context.

2. Map current resources

Map resources (see [Situation analysis](#)) within the health and other sectors that are providing early identification, assessment, management and follow-up to people affected by suicide (e.g. social care, education, judiciary, service user groups).

⁶⁰Universal health coverage. Geneva: World Health Organization (https://www.who.int/health-topics/universal-health-coverage#tab=tab_1, accessed 19 February 2021).

⁶¹WHO QualityRights initiative. Geneva: World Health Organization (<https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools>, accessed 28 January 2021).



3. Coordinate care pathways

- Organize pathways that will enable identified at-risk individuals to be assessed in health care and referred for support either in the community or in specialized mental health care (WHO, 2019b).
- Create uniform referral documentation and agree on pathways, procedures and standards for making referrals between all departments and sectors in the care pathway.
- Support the development of clear guidance to enable at-risk individuals identified in other sectors to be referred to health care for assessment, management and follow-up.

where available or by creating additional mechanisms.

Indicators may include, for example: 1) proportion of facilities with non-specialists trained in suicide prevention; 2) number of new and follow-up cases; 3) number of referrals in each health facility; 4) service user outcomes and feedback on interventions and support (see [Annex 3](#)).

- Use lessons learned to improve service provision and care pathways, and plan for scale-up.
- Use further situation analyses to identify any gaps in services and make plans for further provision.

4. Train non-specialized health workers

- Build the capacity of non-specialized and community health workers to manage people at risk of suicide, to make referrals, and to link with specialists and non-specialists who have been trained in suicide prevention and in delivering psychological interventions (see [Capacity-building](#)).
- Where gaps have been identified in the situation analysis, make plans to provide adequate local services for intervention (including crisis management) and follow-up, utilizing community sources of support.⁶²

5. Train gatekeepers and stakeholders relevant to early identification and follow-up in the community

- This should include: 1) an awareness of the common presentations of self-harm/suicide in order to identify at-risk individuals; 2) the principles of assessment and management of self-harm, including in crises (e.g. how to ask about self-harm; recognizing self-inflicted injuries or self-poisoning); 3) psychosocial interventions (e.g. providing psychoeducation about suicide; mobilizing sources of social support); and 4) referral to specialists, and follow-up.

6. Monitor, evaluate and scale up (see [Monitoring and evaluation](#))

- Monitoring and evaluation should be planned in advance and conducted alongside the implementation.
- Develop indicators to monitor progress using existing data-collection mechanisms in the health system

⁶² WHO mhGAP training manuals. Geneva: World Health Organization (https://www.who.int/mental_health/mhgap/training_manuals/en/, accessed 28 January 2021).



Box 42. Aboriginal-specific aftercare, Australia

South Australia established Australia's first Aboriginal-specific Aftercare model delivered by and co-designed with the local Aboriginal community. In 2017 Country South Australia Primary Health Network (CSA PHN) worked with the Black Dog Institute on a series of indigenous community forums. Consultations indicated that people were keen for follow-up services for people leaving hospital after a suicide crisis, identifying this as a gap in local services. An Aboriginal working group was established in collaboration with the local community, including people with lived experience and representatives from the local health network and Aboriginal Community Controlled Health Organisation (ACCHO). The group spent eight months documenting the co-design process and developing a model, followed by four months of stakeholder consultation.

CSA PHN commissioned the Pika Wiya Health Service Aboriginal Corporation to deliver the Aboriginal Aftercare Service in Port Augusta. Pika Wiya Health Service Corporation recruited an aftercare team comprising the clinical team leader, who is a social worker, and two Aboriginal health workers. The aftercare team sits within the social and emotional well-being team (SEWB) and has internal supports from a psychologist and visiting psychiatrist.

The project has produced two sets of guidelines – for use in the emergency department and for the community mental health team. These are the Aboriginal Aftercare Service Design and the Guidelines for Integrated Suicide-Related Crisis and Follow-Up Care. Each offers a comprehensive staged approach to maintaining contact through admission and after discharge with a mix of psychosocial, clinical and healing approaches with a strong focus on family and community.

An unanticipated positive outcome has been greater collaboration between clinical and cultural workers across the spectrum of mental health services. Mental health plans and referrals overseen by the visiting psychiatrist now frequently include a recommendation for healing alongside other supports. Aftercare workers have been invited to participate in traditional healing with ngangkari (defined as an Indigenous practitioner of bush medicine). Hospital mental health staff are similarly reported to be more comfortable referring people post-discharge to social and emotional well-being services and general practitioner services knowing that these services can draw on the expertise of the aftercare team. Ongoing clinical management, including medication support, is now with the Pika Wiya Health Service and not the hospital, thus continuing to build capacity within the health service.

The Aftercare Service is also working with established postvention services that include the National Indigenous Critical Response Service and Beyond Blue's service, The Way Back.



Box 43. Scaling up mental health services and suicide prevention, Islamic Republic of Iran

The integration of mental health services into primary health care in the Islamic Republic of Iran is considered one of the major turning points in scaling up public mental health services, including the suicide prevention programme. Enhanced access to mental health care services, and early recognition of depression and other mental health conditions (which are associated with suicide) are mainly sought by delivering primary mental health care by general practitioners (GPs), multipurpose general health-care workers and clinical psychologists in the primary health care field in both rural and urban areas countrywide. Multipurpose general health-care workers perform initial screening for any mental health problems according to the client's age group and in parallel with the assessment in other health fields. If the screening result is positive, the client is assessed for suicidal ideation or history of suicide attempt and, if detected to have any suicide risk, will be referred to the GP for further assessment.

According to the GP risk assessment and clinical judgement, patients are referred to the nearest hospital if they are considered high-risk. A previously-prepared workflow guides the GP when dealing with cases who are uncooperative. For low-risk individuals, management is initiated by the GP in accordance with the Mental Health Guide for management of mental disorders in primary health care. If a specialist consultation is needed at any stage, the patient is referred to the local psychiatrist.

All suicidal patients are introduced to clinical psychologists who work in urban health centres. The patients receive concurrent telephone follow-up, psychoeducation and/or brief psychological interventions along with other treatment modules if they have been referred to the hospital or the psychiatrist. At another level, patients admitted to hospital after suicide attempts are also referred to health centres upon discharge to be placed in this cycle.

Follow-up service packages to support of survivors (bereaved by suicide) have also been developed and clinical psychologists will be trained to deliver this postvention service. Capacity-building for providing these services is based on obligatory pre-service training and in-service booster training sessions for all service providers. The National Suicide Prevention Programme of the Ministry of Health and Medical Education has six strategic objectives. The programme has been operating officially since 2005 and was scaled up in 2018 after feedback from national and international consultants.



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TIPS FOR IMPLEMENTATION

Table 14. Tips for implementation of early identification, assessment, management and follow-up of anyone affected by suicidal behaviours

Issues	Tips
Suicide prevention is not a public health priority	<ul style="list-style-type: none">• Advocate for suicide prevention with policy-makers and raise awareness in the community. Seek out advocates from other sectors (e.g. education) and strengthen advocacy groups to be leaders for suicide prevention in the community.• Provide evidence of effectiveness and cost-effectiveness of suicide prevention.
Only limited resources are available	<ul style="list-style-type: none">• Work with regional and national policy-makers in reallocating budgets.• Use a cascade training model (training-of-trainers) to maximize the numbers of trained workers who can then train others and share knowledge and skills. Facilitate the development of community resources such as self-help and survivor groups.
Lack of confidence/knowledge in managing suicide risk	<ul style="list-style-type: none">• Ensure that adequate training is provided on what to do next when suicide risk is identified (both management of imminent risk and referral to care).• Develop clear policies and step-by-step guidance for management and care, and make sure these are easily available for individuals to refer to.
Hard-to-reach individuals at risk	<ul style="list-style-type: none">• Extend awareness-raising and capacity-building to reach a range of sectors that may be in contact with hard-to-reach communities.• Ensure that general health-care staff (e.g. general practitioners, community health workers) and staff from other disciplines (e.g. police, teachers) are trained to identify persons at risk.

ANNEX 1. SECTORS AND STAKEHOLDERS IN SUICIDE PREVENTION

Government sectors:

- Ministry of Health;
- Ministries of: Agriculture, Education, Judiciary, Labour/employment, Media, Minority Affairs, Planning and Development, Social Affairs/Welfare, Transport, Youth, Defence;
- politicians, parliamentarians or representatives;
- local governments, local decision-makers;
- policy-makers and opinion leaders.

Stakeholders (individuals and organizations):

- **Everyone**
- people with lived experience of suicide;
- mental health service user organizations;
- mental and general health workers, health promotion officers, health administrative authorities, substance use services, social workers, community development services;
- teachers, education staff, youth workers, schools, youth clubs and centres;
- police, firefighters, ambulance personnel/paramedics;
- people working with older adults, care providers, nursing homes, day centres;
- religious, faith or spiritual leaders, organizations, community places of worship/convening;
- traditional healers or community elders;
- media outlets (print, television and film, web, social media), journalists, journalism associations;
- gender-based violence services, child protection services;
- sexual orientation and gender identity groups;
- retailers related to risk or means of suicide, such as pharmacists, bartenders, alcohol retailers
- workplaces, trade unions, professional associations, occupational health sectors, business leaders;
- people working in unemployment bureaus, job centres, social welfare services;
- military;
- secure services such as mental health inpatient wards and prisons;
- financial services, debt collection services, pension services;
- NGOs, including international groups or charities that are concerned with welfare and well-being or that provide services for vulnerable people;
- scientific community, academic experts;
- celebrities and influencers; and
- many more, as listed throughout the guide.

ANNEX 2. FURTHER EXAMPLES FROM COUNTRIES

SITUATION ANALYSIS

Box 44. Data analytics and insights system, Australia

A major challenge hampering suicide prevention efforts in Australia has been a lack of detail about the scale and extent of the issue. In collaboration with the Australian National University and SAS (a software company), the Black Dog Institute continues to develop the data analytics and insights system to gain insights and help local communities develop more targeted and evidence-based suicide prevention initiatives. The system is currently being deployed as part of Black Dog Institute's LifeSpan trials.

Components of the system include the following:

Suicide Data Analytical Reports (SDARs)

Local-area audits are used to monitor trends, identify high-risk groups vulnerable to suicide, and inform the development and implementation of local strategies to minimize risk. These reports deliver regionally-specific information in a way that has meaningful implications for translating findings into practical outcomes.

Geospatial analysis

The audits and the intelligence system can visualize data sources and show the importance of spatial resolution. Visualizing data geospatially helps to depict where concentrations of suicide deaths are occurring in local areas. This analysis allows decision-makers to better consider factors such as social and economic advantage and disadvantage, availability of services and specific hotspot locations.

Means restriction

Means restriction is one of the most effective strategies for reducing suicide. The system helps determine if there are patterns for methods and their availability, and variations in the geospatial distribution that could help inform a targeted means restriction strategy for a region and determine specific means restriction activities and interventions based on local need.

Resource atlas

The *LifeSpan resource atlas* is an online interactive resource that researchers and policy-makers can use to create maps and analyses. The atlas helps answer questions about, and improve coordination of, suicide prevention. It allows users to discover community characteristics and share information.

A team of eight data officers, geographers and postdoctoral fellows were responsible for designing and setting up the data platform, applying for data acquisition from primary data custodians, and drawing up data management procedures. Maintaining operation of the system and producing the outputs specified above requires a minimum of two full-time data officers, a data manager and the equivalent of one full-time geographer.

Currently, the system is set up to provide highly specific information for New South Wales (one of the major states in Australia). However, it also provides data on suicide deaths at national level. A major end-goal is to scale up the self-harm data to national level. However, meeting this goal will require substantially more resources (a minimum of three additional data officers and one geographer) to have appropriate capacity to navigate ethics requirements for data acquisition and use and to undertake the complex data management needed to ingest multiple sources of data into the system in a harmonized manner.

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Box 45. The national study of suicide, Iraq

The Mental Health Office at the Iraqi Ministry of Health initiated a national study of suicide from 2015 to 2016 in collaboration with international researchers (Abbas et al., 2018). The Ministry of the Interior facilitated the distribution of a data collection forms to police stations in the 13 provinces covered by the study. Police personnel completed the forms in relation to individual deaths in their jurisdiction which had been ruled as suicide from 2015 to 2016, and followed up with families where data were missing data from the legal notes. The data collection form included variables on demographics, method of the suicide, medical, mental health and suicide attempt history, and potential causes. The results were used to identify the population and subpopulation suicide rate (e.g. age and gender), common methods of suicide, and the profile of medical, mental health, suicide and precipitating factors related to deaths by suicide. Comparisons were also conducted between different demographic groups to identify at-risk groups. Lessons learned from implementation of the first national study have informed planning for the development of a national register of suicide in Iraq. This includes improvement of data quality – which in this study relied on legal reports and family which may have contributed to under-recognition or under-reporting – and the inclusion of additional expertise to inform design and data collection (e.g. epidemiologist and forensic medicine specialist). The study also indicated the need to implement means restriction for firearms and kerosene (related to self-immolation) in future suicide prevention efforts in Iraq.

Box 46. Situation analysis, Syrian Arab Republic

The impact of the protracted emergency on the lives of people living in North West (NW) Syria, including the impact of COVID-19, has led to several areas of concern for suicide prevention. The months of April–June 2020 saw a 57.7% increase in attempted suicide compared to January–March 2020, as indicated by mental health and psychosocial support (MHPSS) service mapping. Within a similar period, social media reports from journalists claimed an increase in the number of deaths by suicide. However, mortality data were not recorded in the existing health information systems, reflecting a significant challenge for the surveillance of suicide and self-harm in NW Syria.

WHO's Gaziantep hub, with the support of the Inter-Agency Standing Committee's thematic working group on MHPSS, saw an urgent need to address suicidal behaviour inside NW Syria. The thematic working group set up a Suicide Prevention Ad Hoc Task Force with six members who agreed that a situation analysis was required in order to inform planning and provide evidence that would facilitate donor requests. This was the start of a "suicide questionnaire" which was developed by the working group. The aim of the survey was to better understand suicide inside NW Syria over the previous 12 months and therefore identify actions for suicide prevention in NW Syria as of the fourth quarter of 2020. The questionnaire included 36 questions which were related to health workers' experiences with people who had died by suicide or attempted suicide/self-harm in the previous six months. It included questions about the providers' capacity and skills for working in suicide prevention. Questions from the *Assessing mental health and psychosocial needs and resources* toolkit were also translated and adapted to the NW Syrian context (WHO & UNHCR, 2012). For logistical reasons, a digital survey methodology was agreed as the most feasible method of collecting the necessary data. KoBo Toolbox⁶³ – a free open-source tool for digital data collection – was used. The toolbox provides users with features such as graph-generation, making it ideal for use in humanitarian contexts.

In September 2020, invitations to take the survey were offered to physicians in both primary health care and hospitals, MHPSS staff (psychosocial support workers, psychiatrists and psychologists), gender-based violence and child protection staff and paramedic workers in NW Syria a total of 534 respondents (including 206 females). For six months during the COVID-19 pandemic, 1748 attempted suicides and 246 deaths by suicide were reported by respondents. Of those who died by suicide, 76% were Internally Displaced Persons (IDPs), as were 86.6% of those who attempted suicide. Of those who attempted suicide, 42.2% were 21–30 years of age, 25% were aged 31–40 years and 18.1% were 16–20 years of age. Among the methods of suicide reported, 21.4% ingested insecticides at home, 16% used a knife and 11.5% jumped from buildings. The precipitating factors for suicide were thought to be: relationship/marriage problems (26.3%), financial problems (23.7%), relationship problems with parents (12.7%) and unemployment (10.4%). The survey results also indicated barriers to discussing suicide in the health sector, barriers in the community – specifically stakeholders with the largest concern for discussing suicide (such as religious leaders) – and assessed respondents' limited current knowledge and requests for capacity-building. A series of key recommendations were produced following analysis of the survey which will be the focal area of work for suicide prevention in NW Syria.

⁶³ See: <https://www.kobotoolbox.org/> (accessed 18 February 2021).

MULTISECTORAL COLLABORATION

Box 47. An example of bottom-up multisectoral collaboration, Brazil

A mid-sized town (population 140 000) in the countryside of São Paulo State has in the last 10 years had a suicide rate that was twice the national rate. In March 2016, following an open invitation in the local media by a local social worker, about 100 people met at the local office of the Industry Federation. Those people came from diverse origins: health-care workers, educators, religious leaders, housewives, police officers and firemen, politicians and politicians-to-be, media professionals, hotline operators, justice officers, local celebrities and others.

This town was and is exceptionally gifted with mental health resources – both public (a university hospital with a psychiatric ward, a psychiatric hospital, a hospital specialized in the care of people with substance use disorders, several outpatient services and day-centres) and private (the third largest proportion of psychiatrists per population in the country and several therapeutic communities for people with substance use disorders). However, the public services were administratively and financially dependent on a variety of federal, state and municipal agencies, with limited coordination between them. The stakeholders' meeting decided to put in place a Life Protection Network (LPN) using their own resources and acting as volunteers.

A four-person Coordinating Committee was elected by those present and eight working groups were established, namely: 1) supporters (composed of people without a professional mental health background but actively engaged in social media, usually housewives, commerce employees and students); 2) spiritual supporters (religious leaders); 3) assessment (health workers, mostly psychologists); 4) mental health professionals (psychologists, therapists, psychiatrists); 5) educators (teachers, school principals); 6) local authorities (city mayor, city councilors, relevant county secretaries [Health Education, Social Welfare, Culture, Sport and Public Safety], directors of mental health services); 7) local media; and 8) ambassadors (young people specially trained by the LPN).

An important requirement for becoming a volunteer member of the LPN is to undergo a four-hour training by the coordinators using the self-harm/suicide module of the WHO *mhGAP Intervention Guide*. Given the wide support from volunteers, the LPN now has a waiting list of professional and caregiver volunteers. There are also regular monthly supervision meetings open to all volunteers to discuss issues of their interest, particularly in dealing with more complex cases. The network started to be operational two weeks after the initial meeting and soon after the training sessions for all specific volunteer groups.

People can contact the LPN via the site www.precisodeajuda.org ("I need help", in Portuguese) either for themselves or for someone they identified who is in distress. Primary health care workers and emergency care services can also contact the LPN. Several activities have been developed by the LPN volunteers: some are of a supportive nature (social and spiritual support), psychological enhancement (life skills training) or clinical care (integrative community therapy, complementary therapies recommended by the Ministry of Health, psychotherapy, follow-up and referral, and postvention), and some are related to universal promotion and prevention (such as awareness-raising at community level). All members of the LPN act as volunteers and occasional costs (room meeting rental, printed materials etc.) are covered by the local commerce and industries.

Although the specific impact of the LPN is awaiting measurement, one clear result is that the previous lack of coordination among the several types of health-care services has been overcome. Through the LPN, early identification and care are now promptly provided by competent and trained people, with a smooth and rapid transition between different levels of care when needed.

Box 48. Multisectoral collaboration, Canada

Federal Coordinating Committee

The Government of Canada supports collaborative approaches to suicide prevention in order to improve information-sharing and facilitate opportunities for partnership. In late 2016, the government released the Federal Framework for Suicide Prevention, which establishes strategic objectives and guiding principles to align federal suicide prevention efforts. To help improve collaboration between federal government departments, the Public Health Agency of Canada chairs the Federal Coordinating Committee for Suicide Prevention, which meets quarterly. This Committee comprises representatives from federal departments and agencies working in the area of mental health and suicide prevention, including representatives from ministries and agencies of health, Indigenous services, economic development, transport and statistics. The Committee meets quarterly and is focused on identifying suicide prevention priorities and developments across the federal government, aligning efforts where possible; sharing information and expertise on suicide prevention, including on suicide-related surveillance; and supporting the development of the biennial progress reports.

National collaborative for suicide prevention

The National Collaborative for Suicide Prevention is a pan-Canadian collective of individuals (e.g. survivors of suicide attempt and survivors of suicide loss) and organizations that provide leadership, resources and information-sharing for suicide prevention, intervention and postvention initiatives. Formed in June 2012, the members of the Collaborative promote mental health, build resiliency, foster hope, and work to reduce the impact of suicide on all Canadians. The work of the Collaborative is structured and championed with the support of an Executive Committee, three working groups (the Communications Working Group, the National Strategy Action Plan Working Group and the Data and Research Working Group) and a Secretariat. The purpose of the Collaborative is: to facilitate discussions and knowledge exchange between organizations on life promotion, mental wellness and suicide prevention; to act as a catalyst for collaboration between members; and to advocate and provide a forum for a collective voice on issues related to suicide prevention.

Box 49. Alcohol policy and legislation, Russian Federation

The privatization and deregulation of the alcohol market in the Russian Federation in the 1990s may have contributed to the escalation of alcohol-related problems, with alcohol consumption contributing substantially to increased morbidity and mortality levels.⁶⁴ In 2004, the government began a process of strengthening alcohol-control policies (Levintova, 2007), followed by a series of amendments to the law governing regulation of the production and trading volume of alcohol products. This was then followed by amendments to other laws and regulations related to alcohol. Between 2007 and 2016, total (recorded and unrecorded) alcohol consumption was reduced by 3.5 litres of pure alcohol per capita. During the period 2005–2015, the death rate from alcohol use also declined, especially in males. Similar patterns were observed among patients diagnosed with alcohol dependence and other alcohol-related diseases, along with an important reduction in total adult mortality – all of which are likely to be a result of the downward trends in general alcohol consumption. Many of the policies implemented have been evidence-based in line with the WHO Global strategy to reduce the harmful use of alcohol (WHO, 2010) and were introduced in a stepwise manner. It is therefore likely that restrictive alcohol policies have contributed to the reduction of suicide seen in the Russian Federation.

⁶⁴ Interpersonal violence and alcohol in the Russian Federation: Policy briefing. Copenhagen: WHO Regional Office for Europe; 2006 (http://www.euro.who.int/_data/assets/pdf_file/0011/98804/E88757.pdf, accessed 28 January 2021).

Box 50. Meaningful participation of people with lived experience in suicide prevention, Scotland

The Lived Experience Panel (LEP), established in September 2019 by Scotland's National Suicide Prevention Leadership Group (NSPLG), supports delivery of the Scotland's Suicide Prevention Action Plan.⁶⁵ The LEP comprises 14 people from diverse professional and social backgrounds who responded to a national advertisement and who give their time as committed volunteers. Each panel member has a different connection to suicide: some are survivors of bereavement from suicide, others have been suicidal in the past or have been carers of family members or friends living with suicidal thoughts and behaviours. They are supported with respect and sensitivity by a coordinator hosted by the Scottish Association of Mental Health. A wider network of over 100 people across the country with lived experience of the impacts of suicide is also involved in supporting the work of the NSPLG through a range of activities.

Based on the learning from the establishment of the LEP and its collaborative partnership with the NSPLG, 13 key ingredients have been identified that have proved essential to achieving meaningful and authentic participation of those with lived experience of suicide in the delivery of Scotland's Suicide Prevention Action Plan:

- **Recruitment of volunteers** – There are fixed criteria for volunteering (suggested gap of two years since prior suicide attempt or bereavement by suicide). This enables safer participation and reduces potential distress.
- **Recruitment of a designated Lived Experience Coordinator** – To manage volunteers, liaise with stakeholders and implement safeguarding protocols.
- **Steering Group** – Establish a partnership Steering Group to support the coordinator role and to use learning to update policy and processes.
- **Agree outcomes and set expectations** – Ensure that volunteers are aware of programme outcomes and that activities are aligned to these; manage volunteer expectations.
- **Methods of engagement and deliberation** – Promoting respectful and honest conversations helps to nurture openness between volunteers and build trusting relationships. Non-polemical methods of sharing lived experiences helps volunteers to prioritize key issues and identify areas for improvement.
- **Engagement planning and preparation** – Professionals and volunteer coordinators should agree session plans and share information with volunteers in advance of each session.
- **Gathering feedback** – Deploy a range of ways to gather feedback (written, audio, focus groups, digital) to maximize opportunities for participation. Smaller groups have proved to be the most effective and safest way for volunteers to share personal stories.
- **Virtuous feedback cycle** – Agreeing feedback mechanisms with volunteers avoids tokenistic participation. It ensures that those taking action produce evidence of using knowledge while also assuring volunteers that their views are being taken seriously.
 - » Hold follow-up meetings with volunteers about progress.
 - » Agree timescales for feedback.
 - » Incorporate views into reports.
 - » Ensure that volunteers attend programme meetings.
- **Seeking permission at every turn** – Volunteers must be consulted at every turn on sharing personal information. They have the final say on information-sharing; checking for consent should be ongoing.
- **Emotional support and safeguarding** – Welfare check-ins with volunteers must routinely take place before, during and after engagement sessions.
- **Volunteer agreement and handbook** – There should be clearly recorded responsibilities and boundaries for volunteers, including a list of crisis support services.
- **Debriefing after sharing lived experiences** – Open channels are essential: the impact of sharing can be cathartic but also may trigger painful memories and difficult emotions.
- **Self-care** – This is not an optional extra. Well-being sessions are vital.

⁶⁵ Suicide prevention action plan: every life matters. Edinburgh: Scottish Government (<https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters/>, accessed 28 January 2021).

Box 51. Roses in the Ocean – an organization for those with lived experience of suicide, Australia

Roses in the Ocean is an organization for lived experience (LE) of suicide founded in 2008 and fully staffed by people with an LE of suicide. The organization was established at a time when suicide was barely spoken about in Australian communities and it was apparent that the government and services needed to hear from people who had walked in the shoes of suicide. It has grown to become a driving force behind significant reform in suicide prevention in Australia where genuine integration of lived experience expertise is now deemed central to all suicide prevention initiatives.

Roses in the Ocean defines the lived experience of suicide as having experienced suicidal thoughts, made a suicide attempt, cared for someone through suicide crisis, or been bereaved by suicide.

The work of Roses in the Ocean began by raising community awareness through lived experience story-telling at community and corporate events, but it was soon realized that its role needed to be far more than a speaker's bureau. The organization soon developed a suite of capacity-building workshops for people with an LE of suicide to build their skills and knowledge in order to engage in suicide prevention at their local community and at national level in a variety of ways.

The need to work at both grassroots level in the community building an LE workforce and at strategic level with the suicide prevention sector and government was critical to actively inform, influence and enhance all aspects of suicide prevention from service design and delivery, to research, to policy etc.

No funding was forthcoming for the first eight years, so Roses in the Ocean relied on the generosity of volunteers, some of them full-time, to make progress. Some key people in suicide prevention began to listen and lent their credibility to open the right doors in government and to help the organization grow. As the organization was a registered charity with a board of directors, it provided the government with a vehicle through which – tentatively at first and then much more deliberately – to support the voice of lived experience.

In 2018, the Australian Government provided core funding for Roses in the Ocean through the National Suicide Prevention Leadership and Support Program. The rest of Roses in the Ocean's income is generated through fee-for-service work and specific project funding from various Primary Health Networks, State and Territory Health Departments, and sector organizations.

Today, Roses in the Ocean is involved in a wide range of activities, such as the delivery of capacity-building workshops for people with LE of suicide, national LE mentoring services, integration of people with LE of suicide into organizations, communities of practice, building capacity through training local persons with LE to deliver LE-informed "lifekeeper" training, co-designing nonclinical safe spaces, developing the emerging specialist Suicide Prevention Peer Workforce, and working with research institutes and researchers to integrate LE into research and to guide new research focus.

Steps to establish an LE workforce are:

- Build on what has already been learned and developed around the world.
- Support and fund the establishment of an LE organization that will:
 - » engage people with LE of suicide who are keen to inform and influence suicide prevention;
 - » invest in building LE capacity to share people's stories and insights and meaningfully participate in local and national suicide prevention conversations and work;
 - » grow an LE network with varied LE perspectives and skills;
 - » work to embed an LE framework across organizations and government with LE representation at all levels of governance;
 - » identify specific local and national areas of key focus.

Box 52. Integrating an all-of-nation, whole-of-government approach, USA

The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS),⁶⁶ established a three-year action plan to address suicide in the USA, with a focus on veteran populations. PREVENTS was created with the full support of the White House as well as senior leadership from every US federal agency. To lead the effort, a seasoned mental health expert from the nongovernmental sector with 15 years of experience creating and coordinating large multisectoral coalitions was chosen as Executive Director. PREVENTS has been able to leverage the convening power of the White House to ensure that government – as well as nongovernmental leaders – participated fully in the building and implementation process. In addition, the Executive Director brought organizations and partnerships to the initiative who were committed to adding their resources and expertise to the effort. This combination of significant political support, adequate resources provided by government and nongovernmental partners, and strong and effective leadership to drive the initiative has been key to the success of PREVENTS.

Over 150 subject matter experts from 15 federal agencies collaborated in a year-long process to develop the PREVENTS roadmap. This created a plan for suicide prevention grounded in public health with goals of culture change, seamless access to care, a connected research ecosystem and robust community engagement. This action plan emphasizes an all-of-Nation, whole-of-government approach that will continue to leverage a network of partners and champions consisting of more than 1000 individuals, including national PREVENTS ambassadors, and organizations representing federal/state/local/tribal government, faith-based communities, nonprofits, academia, veteran and military service organizations, and other private industry partners working collaboratively to implement best practices to improve health and prevent suicide. Implementation of the PREVENTS roadmap began a multi-year process that includes a significant focus on programme evaluation to measure efficacy and impact of each strategic area as well as the overall approach.

PREVENTS has created a comprehensive model to enlist all Americans to work together to:

- change the conversation about mental health and advance the understanding of the underlying risk and protective factors associated with suicide through a robust public health campaign (The REACH⁶⁷ public health campaign was launched in 2020, providing people with the tools and resources to REACH out for help when they are suffering and to REACH to help others who are struggling);
- design and support effective programmes to provide veterans with the services they need;
- build a research ecosystem that encourages data-sharing and coordination; and
- working across federal agencies, foster a culture and develop initiatives that support a person's ability to thrive throughout the entire life cycle.

PREVENTS has elevated the national conversation around mental health and suicide by: 1) adopting a national public health approach aimed at educating all Americans about the importance of mental health and suicide prevention; 2) developing a robust coalition of partners inside and outside of government; and 3) facilitating collaboration and coordination for this first of its kind all-of-nation effort to prevent suicide.

⁶⁶ Washington (DC): United States Department of Veterans Affairs (<https://www.va.gov/prevents/>, accessed 28 January 2021).

⁶⁷ Washington (DC): United States Department of Veterans Affairs (<https://www.reach.gov/>, accessed 28 January 2021).

Box 53. Suicide prevention and management, occupied Palestinian territory, including east Jerusalem

Since 2016, annual police reports in the West Bank have indicated an increase in the rates of suicide and suicide attempts compared to previous years.⁶⁸ In the Gaza Strip, data also show that suicide rates continue to increase, especially among young people and adolescents.⁶⁹ However, data on suicide and attempted suicide in the occupied Palestinian territory, including east Jerusalem are scarce, with most cases being covered up, condoned, undocumented or simply undiscovered. Many factors contribute to the lack of studies and registers on suicide in the occupied Palestinian territory, including east Jerusalem, including social stigma, religious misconceptions (haram/sin), and the lack of capacity and coordination between major actors on the ground. From this context, efforts were joined in 2017 to establish the National Committee of Suicide Prevention in the occupied Palestinian territory, including east Jerusalem. The committee, led by the Ministry of Health with technical support from WHO, proposed the first National Suicide Prevention Strategy for 2021-2026. The strategy signals the commitment of committee members and key stakeholders in the occupied Palestinian territory, including east Jerusalem (government actors, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), WHO, national NGOs, and the international NGO Médecins du Monde (MdM-CH) to address the issue of suicide in the occupied Palestinian territory, including east Jerusalem. The committee has also worked on increasing data collection, has set-up an action plan for different sectors, and has encouraged stakeholders to allocate funds for planning implementation. Nonetheless, efforts have been stalled by the many challenges imposed, including: the limited number of mental health professionals; the gap in service provision, detection and prevention between key providers (health, education and protection); the scarcity of accurate data; and the presence of stigma. As a result, different members of the committee have worked to raise awareness of the topic through national multimedia campaigns and have worked with media on responsible reporting. Additionally, MdM-CH conducted a 2019 study on the risk factors of attempted suicide in the West Bank.⁷⁰ Based on the findings of this study, a training plan for emergency-room departments and community mental health centres was established and rolled-out in partnership with the Ministry of Health. WHO and other actors have also conducted WHO mhGAP training to respond to the lack of capacity among key professionals to address the issue of suicide. Religious leaders and military medical service providers will also be trained in suicide prevention. Despite these recent efforts, there is a need to continue the collaboration between different sectors to set up a comprehensive system of promotion, detection, referral and treatment of suicide in the occupied Palestinian territory, including east Jerusalem.

⁶⁸ See: <https://www.palpolice.ps/annual-statistics>, accessed 28 January 2021.

⁶⁹ Geneva: United Nations Office for the Coordination of Humanitarian Affairs, Reliefweb (<https://reliefweb.int/report/occupied-palestinian-territory/brink-gaza-s-youth-are-turning-suicide-amid-growing>, accessed 28 January 2021).

⁷⁰ Neuchâtel: Médecins du Monde (https://medecinsdumonde.ch/wp-content/uploads/2020/03/2019_MdM-Suisse_Attempted-Suicide-Patients-Risk-Factors-Suicide-Prevention-Strategies-in-Palestine_Study_EN-002.pdf, accessed 28 January 2021).

AWARENESS-RAISING AND ADVOCACY

Box 54. Awareness-raising and advocacy, Canada

Being without an active suicide prevention strategy in Québec for 15 years, the Association québécoise de prévention du suicide (AQPS) in Quebec, Canada, saw an opportunity to advocate for a new strategy and moved to create a collective to mobilize stakeholders to this goal. Formed in 2019 with approximately 35 member organizations, the collective brought together organizations with an interest in suicide prevention and mental health in order to convince the Government of Quebec to adopt a dedicated national suicide prevention strategy. Guided by their mobilization plan, the group aimed at creating a sense of purpose and belonging. The collective gained support by publishing open letters, requesting meetings with government officials, holding a press conference on World Suicide Prevention Day, requesting support from the general population, hosting information meetings and conducting consultations across Quebec. Concrete actions were planned and carried out over the course of 10 months. In October 2019, the Health Minister of Quebec announced the creation of a comprehensive national suicide prevention strategy.

Box 55. World Mental Health Day and World Suicide Prevention Day

Suicide prevention was selected as the theme for the 2019 World Mental Health Day (WMHD) on 10 October. Given that World Suicide Prevention Day is exactly one month earlier, it was decided that a month-long initiative should take place. Seven months were scheduled for preparation for World Suicide Prevention Day. The objective was to highlight the problem of suicide in relation to key global data – that one person dies every 40 seconds from suicide. Animated videos were developed to target key gatekeeper populations (e.g. teachers,⁷¹ emergency responders,⁷² employers,⁷³ health workers⁷⁴) and additional resource handouts were developed.⁷⁵ Talinda Bennington, co-founder of 320 Changes Direction⁷⁶ and an influencer with lived experience, was identified as a champion for suicide prevention. She engaged in multiple social media activities, such as a Twitter live and three Facebook Lives, and an Instagram takeover. Her engagement also included a meeting with the Director-General of WHO and a joint call for participation in the initiative. A core planning group of intergovernmental and nongovernmental organizations dealing with suicide prevention and mental health was established to coordinate efforts on an advocacy activity (40 seconds of action) between WHO, the International Association for Suicide Prevention (IASP), the World Federation for Mental Health and United for Global Mental Health.⁷⁷ This led to further dissemination of the key messages of the campaign as high-profile global influencers engaged in the activity. The success of the initiative was monitored through the number of website visits to the resources, number of views and shares on social media, and geographical location of website visitors. A 160% increase in website visits was observed from after the launch of the campaign.

⁷¹ See: https://www.youtube.com/watch?v=Le7n6i0dpTI&feature=emb_logo, accessed 28 January 2021.

⁷² See: https://www.youtube.com/watch?v=ECarCNxgM-4&feature=emb_logo, accessed 28 January 2021.

⁷³ See: https://www.youtube.com/watch?v=C0iQLwABpc&feature=emb_logo, accessed 28 January 2021.

⁷⁴ See: https://www.youtube.com/watch?v=Fy7n8SfwS_A&feature=emb_logo, accessed 28 January 2021.

⁷⁵ What emergency workers, health workers, teachers, prison officers, media professionals and employers can do to help prevent suicide. Geneva: World Health Organization (<https://www.who.int/health-topics/suicide/campaign-materials-handouts>, accessed 28 January 2021).

⁷⁶ See: <https://www.changedirection.org/320-changes-direction/>, accessed 28 January 2021.

⁷⁷ World Mental Health Day 2019 flyer. Geneva: World Health Organization (https://www.who.int/docs/default-source/mental-health/suicide/flyer-40seconds-web.pdf?sfvrsn=5ba643c_2, accessed 28 January 2021).

CAPACITY-BUILDING

Box 56. LGBTIQ adaptation of evidence-based gatekeeper training, Australia

The Australian Government has outlined a range of suicide prevention policy reforms that combine strong national leadership with systematic regional efforts that recognize local differences. Key among these is the National Suicide Prevention Trial (NSPT), a major initiative that involves 11 Primary Health Networks (PHNs) taking a systems-based approach to commissioning enhanced services for people at risk of suicide. The Australian Government established PHNs to increase the efficiency and effectiveness of medical services, reduce fragmentation of care and improve health outcomes for everyone, especially the most vulnerable.

North Western Melbourne Primary Health Network (NWMPHN) is the only PHN in Victoria taking part in the NSPT. NWMPHN is the biggest of Victoria's six primary health networks with a catchment of about 1.6 million people covering highly diverse communities from Melbourne's Central Business District and inner city to the rapidly growing suburbs in the north and west Department of Health Primary Health Network locator.

The vulnerable population that is the focus of NWMPHN NSPT is the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) communities. LGBTIQ Australians have significantly poorer mental health outcomes and suicidality and a large proportion of LGBTIQ Australians reside in the North Western Melbourne area. Activities within the NSPT are led by the LGBTIQ taskforce, which consists of representatives from LGBTIQ organizations and advocacy bodies, representatives from the broader LGBTIQ community, and those with a voice of lived experience. The taskforce identified a need for education and training to build the capacity of the LGBTIQ specialist services sector and others working with the LGBTIQ community in order to develop skills to identify the warning signs of poorer mental health and suicide for LGBTIQ people.

LivingWorks Australia has begun work with representatives from the taskforce and LGBTIQ community to adapt existing evidence-based methods of suicide prevention and intervention (ASIST and safeTALK). All LivingWorks programmes have gone through extensive design and development and are regularly updated to reflect the latest evidence and best practice knowledge about suicide prevention. The training programmes were adapted through an extensive co-design process with LGBTIQ stakeholders, with an aim to make the workshops feel safe and inclusive and to build capacity of the LGBTIQ and the broader mainstream sectors to respond to LGBTIQ community members who need suicide intervention support.

As at the end of 2020, a total of 206 people had been trained in LGBTIQ ASIST & safeTalk, including 33 LGBTIQ community leaders, with 10 ASIST trainers and seven safeTALK trainers through a train-the-trainer model. A number of these trainers are now registered ASIST and safeTALK trainers, who will continue to deliver adapted training and support the sustainability of the project post the end of the trial in June 2021.

In addition, the *Essential understanding guide for delivering LivingWorks education training to LGBTIQ populations* has been developed with the LGBTIQ community. This is designed to complement the ASIST trainer manual and acts as a guide for trainers delivering the LGBTIQ version of ASIST, as well as providing guidance for existing trainers on how to ensure that their training is always safe and inclusive for participants within the LGBTIQ community.

Impacts of the project include:

- creating inclusive and safe training workshops for LGBTIQ communities, by LGBTIQ communities; and
- strengthening the capacity of LGBTIQ organizations to become suicide-safer communities.

One workshop participant said that:

"Having all queer people in the workshop made it feel very safe and was one of the best parts of the training."

Box 57. Community gatekeeper training project, Canada

The Community Gatekeeper Suicide Prevention Training Project in British Columbia was created to develop a formally-trained network of people who could identify and support persons who are exhibiting signs of distress or suicide risk and connect them with available services. The 9466 individual gatekeepers involved in the project were identified on the basis of their frequent direct contact with members of their community, being in a position of responsibility and trust, being aware of community resources, and being comfortable with encouraging help-seeking in others. These gatekeepers received LivingWorks' safeTALK or ASIST training and the project added over 40 trainers to the province's overall training capacity. This project began in 2015 with a one-time investment of 3 million Canadian dollars from the British Columbia Ministry of Health to the British Columbia division of the Canadian Mental Health Association. Although the work concluded in 2018, future work that builds on the successes of the gatekeeper training project will be supported by a sustainability fund that was generated through workshop fees.

Box 58. Capacity-building, Islamic Republic of Iran

With the aim of managing the social harms, including suicide behaviours, among all 136 universities/colleges belonging to Ministry of Science Research and Technology, a consulting centre has been established to provide consultation and mental health services. The "Comprehensive Programme for Suicide Prevention in Universities" was established in 2007 and was most recently updated in 2018. The programme encompasses two elements of for capacity-building. One provides an administrative structure in each university/college, including the main officials of universities/colleges to intervene in crisis situations such as suicide attempts. The second element is the establishment of a supportive committee by students – the Student Association of Mental Health Helpers (SAMHH) – who are trained in the BTE programme. B stands for Bepors (ask), T for Targhib (encourage) and E for Erja (refer). Multiple workshops have been conducted to train and retrain the members, and each year a national meeting is held by SAMHH.

Box 59. IOM Mental Health and Psychosocial Support Programme: suicide prevention and response, Iraq

In line with the *Manual on Community Based Mental Health and Psychosocial Support in Emergencies and Displacement* of the International Organization for Migration (IOM), the IOM Iraq Mental Health and Psychosocial Support (MHPSS) programme has included suicide prevention and response as one of the strategic activities in its Community Stabilization portfolio after ascertaining the priority of this topic in the involved communities.

In 2019, IOM Iraq organized focus group discussions in different camp and out-of-camp settings to understand the community perceptions and risk factors associated with suicide among displaced persons. IOM identified that the lack of information about risk and protective factors and the lack of awareness of possible community support are key challenges that contribute to the stigma around suicide and the lack of adequate response. IOM's MHPSS team developed an awareness-raising package that addressed different audiences such as health-care workers, people working in schools, families who had lost someone to suicide. A leaflet outlining common misconceptions about suicide targeted the general public. The leaflets were made available in English, Arabic, Sorani and Bahdini Kurdish. The electronic versions were circulated with all members of the MHPSS Technical Working Group in Iraq and IOM has donated thousands of copies to the Ministries of Health in Baghdad and Erbil in addition to many local and international NGOs that requested printed copies.

IOM Iraq's MHPSS team recognized the lack of trained human resources who could engage the community to raise awareness on a topic that they consider to be very sensitive. Between 2019 and 2020, IOM organized a series of training-of-trainers courses to provide participants (e.g. health-care workers, people working in schools, families who lost someone to suicide) with the knowledge and skills needed to raise the community's awareness about suicide and overcome the barriers of stigma and sensitivity around the topic. Some 200 people from 10 governorates in different parts of Iraq were trained to communicate to their communities the risk factors, protective factors, possible ways to prevent suicide, and how to provide brief support to individuals and families at the community level until professional help is available. IOM supported some of the participants in organizing community awareness-raising sessions in camps for internally displaced persons, informal settlements and villages. These sessions were a chance for "on the job" supervision and coaching to ensure the effectiveness of the training. It was also a good opportunity to pilot the awareness-raising materials and make them more user-friendly.

Box 60. Gatekeeper training evaluated, Netherlands

The Dutch gatekeeper training programme is a four-hour course delivered by two trainers. The programme includes an introduction to suicide, risk factors and prevention, repeated role-plays to practice skills and to build understanding of how to refer people for additional support. The organization 113 Suicide Prevention evaluated the effectiveness of the training between 2015 and 2016, during which time 42 training sessions were conducted with 526 individuals (Terpstra et al., 2018). Gatekeeper trainees were from the health-care, education and socioeconomic sectors, as well as from security and justice, transport, churches and mosques. The gatekeeper training demonstrated effectiveness in increasing knowledge and skills for suicide prevention and building confidence in gatekeepers. Interestingly, there was no effect on the number of people that were identified as at-risk by the gatekeepers, or the number of onward referrals made.

Box 61. Suicide prevention, Turkey

National suicide prevention work in Turkey was restructured in line with the National Mental Health Action Plan (2011-2023). In 2019, all provinces in Turkey were asked to identify a focal point to lead suicide prevention work. These professionals were trained by the Ministry of Health on the development of local plans for the prevention of suicide in their provinces, as well as post-intervention referrals and the importance of rapid psychiatric evaluation. Because risks may be different between regions, these trained professionals were asked to identify regional risk factors for suicide in their province and the sources of support for people with suicidal thoughts or attempts. For this purpose, “Provincial Committees for Suicide Prevention” were established under the coordination of each Provincial Health Directorate. Members of the committees are representatives of the Provincial Security Directorate, Provincial Gendarmerie Command, Provincial Directorate of Family, Labour and Social Services, Provincial Mufti Office, Provincial Directorate of National Education, the municipality and NGOs. These committees work in collaboration with all units that can provide services in the field. By the end of 2018, all provinces have developed their own Suicide Prevention Provincial Action Plans to implement activities effectively. Activities are reported to the Ministry of Health twice a year. Examples of activities include the adaptation of the WHO suicide prevention resource booklets to Turkish context in 2015. The booklets are used throughout the country in capacity-building training given to five separate professions: family physicians, primary care nurses, teachers, journalists, and prison employees. Since 2015, the training has been provided to 155 426 people. The Ministry of Health has been successful in ensuring mutual cooperation between law enforcement, academics, NGOs and health professionals. This has included the development of training for police staff who have a primary role in suicide prevention in the country.

SURVEILLANCE

Box 62. The Queensland Suicide Register, Australia

The Queensland Suicide Register (QSR) is a suicide mortality surveillance system managed by researchers at the Australian Institute for Suicide Research and Prevention (AISRAP) at Griffith University and funded by the Queensland Mental Health Commission. It involves close collaboration with the Queensland Police Service (QPS) and the Coroners Court of Queensland (CCQ). Because of the need for real-time information, AISRAP established an interim QSR (iQSR) in 2011.

The QSR contains a broad range of information on suicides in Queensland since 1990. Information comes from four primary sources, including police reports of death to a coroner, postmortem autopsies, toxicology reports and coroners' findings. AISRAP receives the police forms from the QPS and the CCQ. AISRAP accesses the National Coronial Information System (NCIS) to obtain the other reports. Additional cross-checks occur with the Queensland Registry of Births, Deaths and Marriages. Each suspected suicide is entered in two stages, resulting in the iQSR and the QSR. In the first stage, information from electronic police reports for all suspected suicides is added to the iQSR three times a week. In the second stage, a coronial investigation finishes and cases close in the NCIS and then move from the iQSR to the QSR with additional information from different reports being entered and double-checked by trained research assistants.

Using a decision-tree, QSR staff code all deaths into one of four probabilities: unlikely, possible, probable or beyond reasonable doubt. Only deaths falling into the categories of probable or beyond reasonable doubt are reported.⁷⁸ The QSR is the primary data source, informing Queensland suicide prevention strategies and other suicide prevention activities and evaluations.

Box 63. Surveillance of intentional injuries, Brazil

Awareness-raising, financial investment and the inclusion of suicide prevention in the health agenda were key ingredients of success in Brazil's surveillance of intentional injuries which is integrated to the country's Violence and Accident Surveillance System. In 2006 the Brazilian Ministry of Health launched a ministerial ordinance (Portaria 1.876, August 2006) which established national guidelines for suicide prevention to be implemented in all levels of governance (federal, state, municipality). From 2006 to 2008, the Ministry of Health implemented the Violence and Accidents Surveillance System, including mandatory reporting of self-injuries by emergency and specialized services (e.g. women's centres or reference centres for violence) as well as funding for implementing the surveillance system at state and municipality levels. In 2011, the Ministry of Health launched a new ministerial ordinance that makes surveillance reporting of self-injuries and suicide attempts mandatory for all health services (not only specialized and emergency services), and established criteria and responsibilities for health professionals and health services. In 2014, the Ministry of Health launched a new ministerial ordinance that obliged municipalities' health secretaries to report suicide attempts within 24 hours. In 2019, a law was passed that established the National Policy for the Prevention of Self-mutilation and Suicide, to be implemented by the federal government in cooperation with the States, the Federal District and the municipalities.

⁷⁸ <https://www.griffith.edu.au/griffith-health/australian-institute-suicide-research-prevention/research/qsr>, accessed 28 January 2021.

Box 64. Observatory of Suicidal Behaviour, Central America and the Dominican Republic

The Observatory of Suicidal Behaviour in Central America and the Dominican Republic,⁷⁹ which has been cosponsored by PAHO and the Council of Ministers of Health in Central America and the Dominican Republic (COMISCA), was created in 2013 as an interdisciplinary and intersectoral space for the collection of data and production of information on suicidal behaviour in Central America and the Dominican Republic. The purpose of the observatory is to have official and timely epidemiological information that allows for characterization of suicidal behaviour in countries in order to strengthen national capacities for decision-making on the creation and design of evidence-based plans and programmes.

Mortality data in Latin America have been described as “irregular”, especially when compared with data from European countries (Bertolote & Fleischmann, 2002). There are additional problems, of which one of the most significant is the delay in reporting data (PAHO, 2014). On the other hand, there are marked disparities in suicide rates between different countries, even between some with similar levels of development (Liu, 2009), which probably reflect problems of method (PAHO, 2016). The proposal to establish a Subregional Observatory of Suicidal Behaviour was made in order to strengthen the information systems in mental health and to improve the analysis of problems and decision-making based on reliable epidemiological data. Data on completed suicides has been collected from the beginning but has recently been extended to include data on suicide attempts.

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⁷⁹ Virtual office for health management, information, and communication of Central American Integration and the Dominican Republic (http://comisca.net/content/observatorio_suicidio, accessed 28 January 2021).

Box 65. The Aga Khan University Hospital Self-Harm Monitoring System (AKUH-SHMS), Pakistan

The Aga Khan University Hospital (AKUH) is a 700-bedded private teaching hospital centrally located in Karachi, Pakistan's largest city with a population of approximately 22 million. The hospital uses the hospital information and management system (HIMS) for its medical records. The hospital receives an average of 60-65 cases of self-harm annually. Self-harm cases consist of three groups: medically serious attempts that are admitted to the hospital; those discharged after medical treatment in the emergency room; and those who leave against medical advice (LAMA). All self-harm patients are referred to the on-call psychiatry team for evaluation and details are documented in the patients' medical records. Training workshops are held periodically for medical, psychiatry and nursing staff on the assessment and recording of vital information of self-harm cases.

In 1990, the Department of Psychiatry set up a registry for cases of self-harm presenting to AKUH. Data are retrieved from the medical records and recorded on a specially devised data extraction form (including details of sociodemographics, methods used, type of substance, accessibility, intent, reason for self-harm, psychiatric diagnosis, disposal and follow-up) and are entered into a computerized database by a research officer. Quarterly meetings are held to review the data and quality of the database. Currently, most of the information is captured electronically.

Although AKUH receives a relatively small number of self-harm cases that take place in Karachi, the database has provided useful information on the pattern of self-harm and has led to several publications. Some of the seminal research findings on self-harm in Pakistan are the result of information generated by the AKUH self-harm management system (SHMS) database (e.g. high rates of self-harm in young married women, low rates of repetition of self-harm or suicide, high use of benzodiazepines, low use of analgesics in acts of self-harm) (Khan & Reza, 1998; Syed & Kahn, 2008; Zakiullah et al., 2008).

Some critical factors contributing to the sustainability of the monitoring system include departmental leadership, the presence of a dedicated research person, training and education of medical and nursing staff, documentation and medical record-keeping, information systems and quality control.

The AKUH-SHMS remains the only database for self-harm in the country and provides an excellent example of a low-cost, low-resource intensive health facility-based system on data collected routinely. This is particularly useful for low- and middle-income countries that lack national surveillance systems for self-harm.

LIMIT ACCESS TO THE MEANS OF SUICIDE

Box 66. Pesticide bans, Bangladesh

In 2000, the pesticide registrar in Bangladesh removed all WHO Hazard Class I pesticides from agricultural use, including the highly toxic organophosphorus insecticides dichlorvos, parathion, methyl parathion, monocrotophos and phosphamidon. Over the following years, the pesticide suicide rate fell dramatically, from 6.3 per 100 000 in 1996 to 2.2 per 100 000 in 2014 – a 65.1% reduction (Chowdhury et al., 2018). As rates of death by hanging stayed the same during this period, it appears that these bans reduced the overall number of suicides. At the same time, there was no evidence that these focused insecticide bans had any effect on agricultural output.

Box 67. Limiting access to means in the community, Canada

In the community of La Ronge in the northern part of the province of Saskatchewan (Canada), the means safety working group is implementing medication safety programming throughout the community as a strategy to restrict access to lethal means of suicide. Taking a multifaceted approach, the community coordinator in La Ronge is adapting a booklet on Creating a Safer Home with local support information; offering virtual education programming in partnership with the local pharmacist; and distributing medication lockboxes to persons identified as being at higher risk for suicide. The medication lockboxes are distributed by clinicians at key health service sites in the community to caregivers of persons who have experienced thoughts of suicide or a suicide attempt. Lessons learned in La Ronge are directly supporting communities elsewhere in Saskatchewan where local coordinators are adapting the programme to fit the needs in their own communities. Moving forward, the means safety working group in La Ronge has identified alcohol use as another important area to explore for means safety programming in the future.

Box 68. Restricting access to pesticides, Fiji

The Government of Fiji implemented a ban on the importation, sale and use of two types of pesticides (paraquat and imidacloprid) from 1 January 2020. Paraquat has been linked to a number of suicides in Fiji and has been shown to have a negative impact on the environment. Government buy-in was essential for the pesticide ban to be passed. The importance of the ban was highlighted to the government through: 1) a multisectoral approach combining the Ministry of Agriculture, the Ministry of Health and organic farming NGOs to showcase reasons behind the ban; and 2) leveraging media coverage of suicide to showcase the importance of the ban.

The Ministry of Health National Committee on Suicide Prevention petitioned for restriction of pesticides to prevent suicides. The Ministry of Agriculture recommended the pesticides bans due to the negative impacts on the environment (animals, waters supply, human health). At the same time, NGOs and communities pushed for organic farming using natural pesticides in Fiji because of the negative impact of paraquat and imidacloprid on the land. Looking after land and environment is integral to the Fijian identity and culture.

Media coverage was used to highlight the importance of suicide prevention, and hence the ban on pesticides. Media coverage included campaigns on suicide prevention led by the National Committee on Suicide Prevention, personal stories of suicide shared by high-ranking community members over social media, and police force data on suicides.

Resistance to the ban was seen from farmers who regularly used these pesticides, and sellers of the pesticides. To overcome these barriers, the Ministry of Agriculture and NGOs involved in organic farming engaged directly with farmers and sellers to educate them on the dangers of these pesticides and where to find alternatives. Awareness-raising focused on the benefits to climate change and health. To allow farmers and sellers time to adjust to the impending changes, advocacy work began six months before the ban came into practice.

The top-down nature of the government ban meant that the ban is adhered to, emphasizing the importance of government buy-in.

"We cannot do it alone, in isolation"

Ms Tavaita Sorovanalagi Matakaca, National Suicide Prevention Project Officer, Ministry of Health, Fiji.

The National Committee on Suicide Prevention has used this opportunity to promote mental well-being as a way to prevent suicides (e.g. raising community awareness of managing stress). The government is monitoring the numbers of suicides in the country to assess the impact of the pesticide ban. Initial data from January–May 2020 suggested a slight decrease in suicide rates when compared to 2019.

Box 69. Banning paraquat, Malaysia

Pesticide poisoning is the second leading method of suicide in Malaysia. The country commenced a total paraquat ban on 1 January 2020. Paraquat is a herbicide that is associated with particularly high lethality when ingested as there is no antidote or effective treatment for paraquat poisoning. Paraquat poisoning rates had increased 5.5 times by 2015 compared to rates in 2006 when restricted use was allowed after the initial decision to ban paraquat in 2002 (Leong et al, 2018). Real-world implementation of a ban on paraquat to reduce access to lethal pesticides requires addressing the accessibility of sustainable alternatives to paraquat in farming communities.

INTERACT WITH THE MEDIA FOR RESPONSIBLE REPORTING OF SUICIDE

Box 70. Adaptation and implementation of guidelines for responsible media reporting on suicide, Slovenia

In 2010 the National Institute for Public Health, the UP Institute Andrej Marusic (the Slovene Centre for Suicide Research), the National Organization for Quality of Life (OZARA) and the Slovene Association for Suicide Prevention collaborated to adapt media guidelines to the Slovenian context and to implement them. The WHO publication on *Preventing suicide: a resource for media professionals* was translated into the Slovenian language. The working group collaborated with media professionals to gather feedback on the usefulness and clarity of the text and the guideline was further adapted to include their feedback. The working group released the final version of the Slovenian media guidelines on World Suicide Prevention Day (2010) at a launch event that included prominent media professionals. Dissemination was coordinated by the National Institute of Public Health. Media representatives from each health region of Slovenia were invited to be advocates for the guidelines, and local media representatives were encouraged to attend 90-minute training workshops. These workshops aimed to facilitate an exchange of opinions between suicide prevention experts and the media rather than adopting a confrontational or didactic-expert approach. Copies of the guidelines were also sent to media associations which were asked to disseminate them to their members.

A research study was designed to evaluate whether the intervention (the guideline and workshops) was effective in improving the quality of reporting on suicide (Roškar et al., 2017). Print media articles were retrieved via a media monitoring agency over two 12-month periods – one prior to the introduction of the guidelines, and one following their dissemination. Articles were assessed for the presence of key qualitative indicators of responsible reporting based on the guidelines. The study found that the overall number of suicide-related articles had significantly decreased following the intervention. For six out of the 11 recommendations in the guideline, significant changes were observed in the expected direction. However, no significant reductions were seen in reporting of the method and location of suicide, and there was some increase in the use of inappropriate photographic material. The researchers suggested that in future promotion of the guidelines would benefit from workshops with editors, journalists and photographers separately in order to meet their different needs and work demands.

EARLY IDENTIFY, ASSESS, MANAGE AND FOLLOW UP ANYONE WHO IS AFFECTED BY SUICIDAL BEHAVIOURS

Box 71. Suicide bereavement group support facilitators network, Canada

Following a national outreach effort, the Canadian Association for Suicide Prevention (CASP) identified growing interest in creating a dynamic movement specifically addressing suicide bereavement and postvention concerns, needs and initiatives. In response, the organization launched a Suicide Bereavement & Postvention Alliance to address this gap. One of the Alliance's key priorities is to establish a network for suicide bereavement group support facilitators. The aim of the network is to bring together people providing bereavement support in a group setting for the purpose of exchanging knowledge, identifying and promoting best practices, reducing isolation and increasing support. The primary roles of the network are: 1) to create a space for mutual support and the sharing of experiences (challenges and celebrations) and best practices for facilitators providing suicide loss services; and 2) to reduce isolation among individual facilitators in urban and rural locations in Canada. The network will be formally launched in early 2021.

Box 72. Following up people who have attempted suicide, Islamic Republic of Iran

In line with planning and implementing the suicide prevention programme of the Islamic Republic of Iran a new programme was launched in 2017 in one of the country's western provinces – West Azerbaijan (WA) which has a high rate of suicide. The programme was based on: 1) a register of suicide attempters in emergency departments; 2) provision of continuity of care by following up the attempters by telephone and providing brief counselling; and 3) encouraging persons who have attempted suicide to use the mental health services. As a first step a steering committee was formed with participation of the Police Department, the Welfare Organization, a representative of the Women's Department of the Office of the President of Iran, the Legal Medicine Department, the Iranian Scientific Society for Suicide Prevention (IRSSP) as an NGO, the Television Governing Organization and the Education Department. The steering committee was led by Ministry of Health's mental health bureau. The IRSSP was responsible for conducting the programme in the Health and Treatment Department of the WA Medical University. At provincial level a steering committee had similar representation with each participant having their own duties in the WA province. Each participant had his/her own responsibilities regarding raising public awareness through the television organization, providing social support through the Welfare Organization, and providing security for suicidal persons. The Legal Medicine Department provided real-time data on cases of suicide, the Education Department referred students who were screened positive for self-harm behaviours, and the Health and Treatment Department had the main role in the programme, registering cases, following up and providing brief counselling. After one year of the programme, the rate of suicide has been reduced from 7.9 to 6.1 per 100 000 population (23%). The IRSSP had a key role in coordinating the work of the collaborators to ensure successful implementation of the programme.

Box 73. Recovery assistant as an emerging profession, Poland

People with mental health problems and suicidality often feel that they are alone, a burden to their family and community and that they will never recover. Recovery assistants give them hope. Recovery assistants are experts with lived experience who support people in mental health crises, with or without suicidal thoughts, following a suicide attempt. They also support people bereaved by suicide – led by their own experience of mental health problems and/or suicidal behaviour, treatment, rehabilitation and recovery. Recovery assistants work in part-time jobs or as volunteers in NGOs. In accordance with the Regulation of the Minister of Health of 2019, recovery assistants can be employed as part of the core activities of mental health centres throughout Poland. Recovery assistants work in inpatient and outpatient clinics, community treatment teams, patients' self-help clubs and family support groups, and are organized through the Association of Recovery Assistants (Stowarzyszenie Asystentów Zdrowienia). The role of a recovery assistant is to support the person's recovery process. In the mental health centres, recovery assistants participate in meetings and psychotherapy sessions, support patients, and accompany them during community visits (including as part of mobile outreach teams). They also empower people in problem-solving, daily functioning tasks, accessing social support and supporting others with their own interests and passions. Recovery assistants are peer role-models who can strengthen the sense of healing during the recovery process. They are trained to refer patients to specialists when required. Recovery assistants also play a role in awareness-raising and advocacy by providing training, doing public speaking and media interviews, engaging with employers, participating in research projects, and advocating to decision-makers on behalf of mental health services.

ANNEX 3. LIVE LIFE INDICATORS FRAMEWORK

The vision of LIVE LIFE is a world where suicide is no longer a leading cause of death and where people who are attempting or thinking about suicide feel comfortable to seek help which is provided capably and respectfully to all.

To assist with making this vision a reality, a template indicator framework for LIVE LIFE has been included in this guide. The indicator framework is a tool to assist planners to establish the necessary actions in order to meet the intended outcomes and goal of LIVE LIFE. The framework can be used to monitor progress towards the goal.

The components can be described as:

- **GOAL:** The overall result which the programme aims to achieve (or overall problem to be addressed).
- **OUTCOME:** The change(s) the programme needs to reach, so the GOAL can be achieved (sometimes referred to as Objectives or Results).
- **OUTPUT:** A specific deliverable which contributes to the OUTCOME. There may be many individual actions (activities) necessary to deliver an output (sometimes referred to as Deliverables). In this framework, the OUTPUTS rows are left blank, as these will largely vary and depend on the context. However, examples of the tasks that can be included under OUTPUTS can be found in the corresponding chapters of the LIVE LIFE implementation guide, under the “How” subsections.
- **INDICATORS:** Quantitative or qualitative data which assess whether the OUTCOME and GOAL have been delivered or the extent to which change has occurred.
- **ASSUMPTIONS:** The conditions necessary for the GOAL, OUTCOMES and OUTPUTS to be achieved, which may be out of the programme’s control.

Table 15. Goals, outcomes and indicators for LIVE LIFE

GOAL: a) Reduced country suicide mortality rates: by 15% (2019–2023); by one third (2015–2030). b) Improved monitoring of self-harm presentations.	GOAL INDICATORS: a) % change to country suicide mortality rate, 2019–2023; % change to country suicide mortality rate 2015–2030. b) National self-harm surveillance system established.	Means of verification: a) Country suicide mortality rate, per year. b) Country self-harm surveillance system.	GOAL ASSUMPTIONS: a) That countries have high-quality data for suicide based on: <ul style="list-style-type: none">Country Civil Registration and Vital Statistics (CRVS) system;Country suicide surveillance system;Ministry of Health/Ministry of Statistics records. b) That countries have capacity to develop, implement and sustain hospital-based self-harm surveillance systems.
OUTCOME 1: A situation analysis is available to inform country planning for suicide prevention.	OUTCOME 1 INDICATORS: <ul style="list-style-type: none">National, regional or situation-specific (e.g. schools) situation analysis is conducted, analysed and published.	OUTCOME 1 ASSUMPTIONS: <ul style="list-style-type: none">That there is technical competency available to develop, conduct and analyse the necessary data.	
OUTPUTS 1: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections.			
OUTPUTS 1 INDICATORS: OUTPUTS should have corresponding indicators.			
OUTCOME 2: Suicide prevention is integrated into relevant non-health sectors, and governance and multisectoral collaboration (which includes both government sectors and other stakeholders in the community) are established and strengthened.	OUTCOME 2 INDICATORS: <ul style="list-style-type: none">Full-time national suicide prevention focal person introduced and salaried.Appointment of a national suicide prevention multisectoral steering committee (governance group).⁸⁰Appointment of a national or local suicide prevention working group to plan and implement LIVE LIFE pillars and interventions.Number of meetings of the national suicide prevention steering committee (governance group) related to LIVE LIFE pillars and interventions.Number of meetings of each national or local suicide prevention working group for the LIVE LIFE pillars and interventions.[Frequency of] reporting to accountability mechanisms on the activities of the collaboration.	OUTCOME 2 ASSUMPTIONS: <ul style="list-style-type: none">Leadership in suicide prevention is required to establish working relationships.Advocacy required within government (or from the community) to promote establishment of the working group; the political will in government is recognized for suicide prevention.	
OUTPUTS 2: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections.			
OUTPUTS 2 INDICATORS: OUTPUTS should have corresponding indicators.			

⁸⁰ Suggestions for membership of the steering committee and the working groups are covered in Multisectoral collaboration.

OUTCOME 3: Improved knowledge and attitudes (and reduced stigma) about suicide, self-harm and mental health in the population, in at-risk groups, and in national representatives or heads from other sectors. Improved awareness of available services for self-harm and mental health.	OUTCOME 3 INDICATORS: <ul style="list-style-type: none"> • % or number of the population and at-risk groups targeted by awareness-raising. • [Proportion] of change in knowledge, attitudes, help-seeking behaviours in population and in at-risk groups. • Change in # of people at risk presenting to health services (for mental health conditions, suicidal thoughts or self-harm). 	OUTCOME 3 ASSUMPTIONS: <ul style="list-style-type: none"> • Increased awareness-raising should be accompanied by or preceded by ensuring availability of services. • Health information records can be disaggregated by sociodemographic data which may be commensurate with risk (e.g. age, ethnicity). • Health information records are available.
OUTPUTS 3: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections. <p>OUTPUTS 3 INDICATORS: OUTPUTS should have corresponding indicators.</p>		
OUTCOME 4: Capacity-building in the health sector and the community is strengthened for suicide prevention.	OUTCOME 4 INDICATORS: <ul style="list-style-type: none"> • % or number of non-specialized health workers and specialist mental health workers (or % or number of primary health, secondary health and community facilities or services where health staff are located) trained in early identification, assessment, management and follow-up of self-harm/suicide (every 6 months, or annually). • Number of non-specialized health workers and specialist mental health workers, who are assessed for competency in early identification, assessment, management and follow-up of self-harm/suicide (every 6 months, or annually). • % pre-service health worker training curricula which include training in early identification, assessment, management and follow-up. • % or number of community gatekeepers trained in early identification of the risk of suicide, referral and follow-up in the community (annually). 	OUTCOME 4 ASSUMPTIONS: <ul style="list-style-type: none"> • Training of competency is developed and delivered by technically competent persons in self-harm/suicide identification, assessment, management and follow-up.
OUTPUTS 4: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections. <p>OUTPUTS 4 INDICATORS: OUTPUTS should have corresponding indicators.</p>		

OUTCOME 5: Budgets are articulated and funds secured to implement LIVE LIFE pillars and interventions.	OUTCOME 5 INDICATORS: <ul style="list-style-type: none"> • % increase in annual budget allocations for suicide prevention activities. • National budget earmarked for suicide prevention is systematically allocated annually. 	OUTCOME 5 ASSUMPTIONS: <ul style="list-style-type: none"> • There is willingness to fund suicide prevention.
OUTPUTS 5: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections. OUTPUTS 5 INDICATORS: OUTPUTS should have corresponding indicators.		
OUTCOME 6: Surveillance systems for suicide/self-harm are established or strengthened. Monitoring and evaluation contributes to national and programme-specific knowledge on LIVE LIFE implementation.	OUTCOME 6 INDICATORS: <ul style="list-style-type: none"> • Civil registration and vital statistics (CRVS) system is established in the country. • % or number of hospitals or regions participating in self-harm surveillance system. • Data on suicide deaths and self-harm are disaggregated by at least age, sex and means. • Data provided by functioning surveillance systems is of high quality. • Monitoring of LIVE LIFE framework indicators reported annually. • Publication of evaluations on LIVE LIFE implementation (in agreed time period). 	OUTCOME 6 ASSUMPTIONS: <ul style="list-style-type: none"> • There is technical capacity to implement the work; health information systems available in context, and advocacy to engage health information systems; potential to integrate with existing surveillance mechanisms (e.g. for communicable diseases).
OUTPUTS 6: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections. OUTPUTS 6 INDICATORS: OUTPUTS should have corresponding indicators.		
OUTCOME 7: Suicide deaths are reduced by restricting access to the means of suicide.	OUTCOME 7 INDICATORS: <ul style="list-style-type: none"> • % change (reduction) in suicide deaths by method (adapted to country context). • Number of measures implemented to restrict access to means of suicide. 	OUTCOME 7 ASSUMPTIONS: <ul style="list-style-type: none"> • Countries have surveillance systems in place which include monitoring of the means of suicide/self-harm. • Countries have registration, licensure or monitoring mechanisms in place in relation to the means of suicide. • The method is amenable to restriction (e.g. pesticides, firearms).
OUTPUTS 7: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections. OUTPUTS 7 INDICATORS: OUTPUTS should have corresponding indicators.		

OUTCOME 8: Responsible reporting of suicide by the media.	OUTCOME 8 INDICATORS: <ul style="list-style-type: none"> • Number or % reporting which does not meet country standards or guidelines. • Number or % reporting which includes resources for where to seek help. • Number or % reporting which includes stories of coping with life stressors or suicidal thoughts, and how to get help. 	OUTCOME 8 ASSUMPTIONS: <ul style="list-style-type: none"> • Countries have media monitoring mechanisms in place. • Countries have established guidelines or reporting standards on responsible reporting and accountability mechanisms, in collaboration with the media.
OUTPUTS 8: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections. OUTPUTS 8 INDICATORS: OUTPUTS should have corresponding indicators.		
OUTCOME 9: Young people’s life skills are fostered through provision of universally delivered psychosocial interventions.	OUTCOME 9 INDICATORS: <ul style="list-style-type: none"> • Number or % of schools or educational settings which are delivering universally evidence-based psychosocial interventions to adolescents. • % change in suicide deaths in adolescents aged 15–19 years or young people. 	OUTCOME 9 ASSUMPTIONS: <ul style="list-style-type: none"> • There is coordination with national education curriculum planners. • There is capacity and competency to deliver the universal psychosocial interventions in educational settings. • Countries have CRVS or surveillance systems in place which include sociodemographic data (age) along with cause of death. • Countries have mechanisms for data collection in educational settings (including for establishing baseline socio-emotional life skills data).
OUTPUTS 9: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections. OUTPUTS 9 INDICATORS: OUTPUTS should have corresponding indicators.		

<p>OUTCOME 10: Health and community settings (which include public, private and nongovernmental or civil society services, and may include other sectors such as education) are able competently to deliver early identification, assessment, management and follow-up of suicide attempters and for risk of suicide.</p>	<p>OUTCOME 10 INDICATORS:</p> <ul style="list-style-type: none"> • Number of self-harm cases competently identified. • Number of self-harm cases competently assessed. • Number of self-harm cases competently managed. • Number of functioning referral pathways which are 1) documented, 2) disseminated and 3) applied by health and community workers. • % of self-harm cases presenting to primary health, secondary health or community facilities or services who are followed up in the community. • % bereaved persons provided with timely postvention support. 	<p>OUTCOME 10 ASSUMPTIONS:</p> <ul style="list-style-type: none"> • Assessment of competency is developed and delivered by technically competent persons in self-harm/suicide identification, assessment, management and follow-up. • Countries have health information systems which include coherent record-keeping between different health and community systems such as health and social care records. • Health workers are able to follow up after discharge. • Self-harm is recorded on health records – i.e. surveillance for self-harm is in place.
<p>OUTPUTS 10: [ADAPTATION TO COUNTRY CONTEXT]: Include outputs which will lead to the achievement of a single or multiple OUTCOME(s). Examples of the outputs which can be included can be found in each corresponding chapter in the LIVE LIFE implementation guide, under the “How” subsections.</p> <p>OUTPUTS 10 INDICATORS: OUTPUTS should have corresponding indicators.</p>		

ANNEX 4. RESOURCES

SITUATION ANALYSIS

WHO resources

- Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings. Geneva: World Health Organization; 2012 (https://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/, accessed 1 January 2021).
- Assessment Instrument for Mental Health Systems (AIMS). Geneva: World Health Organization; 2005 (https://apps.who.int/iris/bitstream/handle/10665/70771/WHO_MSD_MER_05.2_eng.pdf?sequence=1, accessed 1 January 2021).
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External resources

- Arensman E, Khan M (2017). Evaluation of National Suicide Prevention and Suicide Registration Programs in Iran. Tehran: World Health Organization and Ministry of Health and Medical Education; 2017 (https://iums.ac.ir/files/irssp/files/%D8%A7%D8%B1%D8%B2%D8%B4%DB%8C%D8%A7%D8%A8%DB%8C_%D8%A8%D8%B1%D9%86%D8%A7%D9%85%D9%87_%D9%87%D8%A7%DB%8C_%D9%85%D9%84%DB%8C_%D9%BE%DB%8C%D8%B4%DA%AF%D-B%8C%D8%B1%DB%8C_%D8%A7%D8%B2_%D8%AE%D9%88%D8%AF%DA%A9%D8%B4%DB%8C_%D9%88_%D8%AB%D8%A8%D8%AA_%D8%AE%D9%88%D8%AF%DA%A9%D8%B4%DB%8C_%D8%AF%D8%B1_%D8%A7%D-B%8C%D8%B1%D8%A7%D9%86.pdf, accessed 1 January 2021).
- Data infrastructure: recommendations for state suicide prevention. Oklahoma City (OK): Suicide Prevention Resource Center; 2019 (<http://www.sprc.org/sites/default/files/StateInfrastructureDataSupplement.pdf>, accessed 1 January 2021).
- Instructions for Conducting a SWOT Analysis. Oklahoma City (OK): Suicide Prevention Resource Centre (https://www.sprc.org/sites/default/files/migrate/library/swot_0.pdf, accessed 1 January 2021).
- KoBo Toolbox. Cambridge (MA): Harvard Humanitarian Initiative (<https://www.kobotoolbox.org/>, accessed on 1 January 2021).
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MULTISECTORAL COLLABORATION

WHO resources

- NCD map tool. Geneva: World Health Organization (<https://apps.who.int/ncd-multisectoral-plantool/home.html><https://apps.who.int/ncd-multisectoral-plantool/home.html>, accessed 1 January 2021).
- Preventing suicide: a community engagement toolkit. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/bitstream/handle/10665/252071/WHO-MSD-MER-16.6-eng.pdf?sequence=1>, accessed 1 January 2021).
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External resources

- #308conversations. Ottawa: Mental Health Commission of Canada (<http://www.mentalhealthcommission.ca/English/initiatives/11884/308conversations>, accessed 1 January 2021).
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- Engaging people with lived experience. Oklahoma City (OK): Suicide Prevention Resource Center (<https://www.sprc.org/keys-success/lived-experience>, accessed 1 January 2021).
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- Lived experience. Zero Suicide Institute (<https://zerosuicide.edc.org/toolkit-taxonomy/lived-experience>, accessed 1 January 2021).
- Partner engagement tool. Oklahoma City (OK): Suicide Prevention Resource Centre (<http://www.sprc.org/statewide-partnerships>, accessed 1 January 2021).
- Partnerships and collaboration. Oklahoma City (OK): Suicide Prevention Resource Centre (<https://www.sprc.org/keys-success/partnerships-collaboration>, accessed 1 January 2021).
- PREVENTS: The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide. Washington (DC): Department of Veteran Affairs; 2020 (https://www.va.gov/PREVENTS/docs/PRE-007-The-PREVENTS-Roadmap-1-2_508.pdf, accessed 1 January 2021).
- Prompts and suggestions for speaking with local leaders on suicide prevention. London: Department of Health; 2012 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/137641/Prompts-for-local-leaders-on-suicide-prevention.pdf, accessed 1 January 2021).
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- The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience. Oklahoma City (OK): Suicide Prevention Resource Center; 2014 (<https://www.sprc.org/resources-programs/way-forward-pathways-hope-recovery-and-wellness-insights-lived-experience>, accessed 1 January 2021).
- Lived experience. Washington (DC): National Action Alliance for Suicide Prevention (<https://theactionalliance.org/our-strategy/lived-experience>, accessed 1 January 2021).

AWARENESS-RAISING AND ADVOCACY

WHO resources

- Campaign materials: animations. What emergency workers, health workers, teachers and employers can do to help prevent suicide. Geneva: World Health Organization (<https://www.who.int/health-topics/suicide/campaign-materials-animations>, accessed 1 January 2021).
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External resources

- #308conversations. Ottawa: Mental Health Commission of Canada (<https://www.mentalhealthcommission.ca/English/308conversations>, accessed 1 January, 2021).
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- 320 Changes Direction Campaign, USA (<https://www.changedirection.org/320-changes-direction/>, accessed 1 January 2021).
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- See Me campaign. Glasgow, Scotland (<https://www.seemescotland.org/>, accessed 1 January 2021).
- Stichting 113, Netherlands (<https://vimeo.com/291877756>, accessed 1 January 2021).
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WHO resources

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EARLY IDENTIFY, ASSESS, MANAGE AND FOLLOW UP ANYONE WHO IS AFFECTED BY SUICIDAL BEHAVIOURS

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LIVE LIFE

Cross-cutting foundations:

- Situation analysis
- Multisectoral collaboration
- Awareness raising
- Capacity building
- Financing
- Surveillance, monitoring and evaluation

Key effective evidence-based interventions:

- Limit access to means of suicide
- Interact with the media on responsible reporting
- Foster life skills for young people
- Early identify and support everyone affected



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