National suicide prevention strategies

Progress, examples and indicators

World Health Organization

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Foreword

Suicide is a global public health concern. Close to 800 000 people lose their life to suicide every year. Suicide knows no boundaries and cuts across every sociodemographic level and all regions of the world. A suicide attempt is a crucial risk factor for subsequent suicide. Families, friends, school friends, work colleagues and communities affected or bereaved by suicide or suicide attempts are often left without assistance. Silence and stigma prevent those in need from seeking help. Suicide remains the second leading cause of death in 15–29-year-olds and the majority of suicides (79%) occur in low- and middle-income countries, where resources for identification and management are often scarce. These concerning facts highlight an ongoing tragedy which can no longer be ignored.

National suicide prevention strategies are essential for elevating suicide prevention on the political agenda. A national strategy and associated action plan are necessary to push forward the implementation of suicide prevention. Without these, efforts are likely to abate and suicide prevention will remain neglected. It is fundamental for governments to take the lead in developing comprehensive multisectoral suicide prevention strategies for the population as a whole and vulnerable persons in particular.

This document aims to support countries in continuing the progress that is being made in preventing suicide and to inspire governments and policy-makers to establish or revise national suicide prevention strategies that are adapted to engage local communities. The document highlights the fact that governments are in a position to lead coordination between multiple stakeholders who may not otherwise collaborate. Governments have a crucial role in developing and strengthening surveillance for both suicide and suicide attempts at the national level. High-quality surveillance for suicide prevention must be perceived as a necessity in order to provide the data to inform necessary action. Without high-quality surveillance, the safety of a population is compromised.

The document presents examples from each region of the World Health Organization (WHO), showing the variety of approaches undertaken in national suicide prevention strategies and the indicators that have been chosen. The elements for developing, implementing and evaluating a national suicide prevention strategy are described and actions to overcome common barriers are presented.

National suicide prevention strategies are essential for working towards the ultimate goal of suicide reduction. The Member States of WHO have committed themselves in the Mental Health Action Plan 2013–2020 to work towards the global target of reducing the suicide rate in countries by 10% by 2020. The suicide rate is also one of the indicators for health target 3.4 of the United Nations Sustainable Development Goals. The target is to reduce premature mortality from noncommunicable diseases by one third by 2030 through prevention and treatment and the promotion of mental health and well-being. The targets are unlikely to be achieved unless governments actively engage in efforts to prevent suicide.

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1. Introduction

1.1 Background

Globally, close to 800 000 people die by suicide every year; nearly one third of all suicides occur among young people. Suicide is the second leading cause of death among 15–29-year-olds and the second leading cause of death for females aged 15–19 years. These data correspond to an overall global age-standardized suicide rate of 10.5 per 100 000 population in 2016 – 13.7 and 7.5 per 100 000 for males and females respectively (WHO, 2018a).

Suicide continues to be a serious problem in high-income countries. However, 79% of all suicides occur in low- and middle-income countries which bear the larger part of the global suicide burden (WHO, 2018a). Although in high-income countries three times as many men die by suicide as women, the male-to-female ratio for suicide is more even in low- and middle-income countries, at 1.6 men to each woman. Suicide rates for both men and women are lowest in persons under 15 years of age and highest in persons aged 70 years or older in almost all regions of the world. In some regions, suicide rates increase steadily with age, while in others there is a peak in suicide rates in young people. In low- and middle-income countries, young adults and elderly women have much higher suicide rates than their counterparts in high-income countries, while middle-aged men in high-income countries have much higher suicide rates than those in low- and middle-income countries (WHO, 2014).

It is estimated that for each person who dies by suicide, more than 20 others attempt suicide. In fact, suicide attempts are an important risk factor for subsequent suicide (WHO, 2014).

When the family members, friends, colleagues and communities of those who attempt suicide or die by suicide are taken into consideration, many millions of people worldwide are affected by suicide every year (Pitman et al., 2014; Cerel et al., 2018). Because suicide remains a sensitive issue, it is very likely that it is under-reported due to stigma, criminalization and weak surveillance systems.

Social, psychological, cultural and many other factors can interact to increase the risk of suicidal behaviour, but the stigma attached to suicide means that many people who are in need of help feel unable to seek it. Risk factors for suicide include previous suicide attempts, mental health problems, harmful use of alcohol, drug use, job or financial loss, relationship breakdown, trauma or abuse, violence, conflict or disaster, and chronic pain or illness (WHO, 2014).

Unfortunately, suicide prevention is too often a low priority for governments and policy-makers. Suicide prevention needs to be prioritized on global public health and public policy agendas and awareness of suicide as a public health concern must be raised by using a multidimensional approach that recognizes social, psychological and cultural impacts (WHO, 2014).

A national suicide prevention strategy is important because it indicates a government's clear commitment to prioritizing and tackling suicide, while providing leadership and guidance on the key evidence-based suicide prevention interventions (WHO, 2014).

1.2 Global action to prevent suicide

In 2013, the WHO Mental Health Action Plan 2013–2020 was adopted by the World Health Assembly (WHO, 2013). The action plan describes suicide prevention as an important priority for achieving the global target of reducing the rate of suicide in countries by 10% by 2020. This action plan highlights that suicides are a serious public health problem worldwide and that, with appropriate efforts, suicides are preventable. National responses to suicide with comprehensive multisectoral suicide prevention strategies are essential to achieving this target. In 2015, the Sustainable Development Goals (SDGs), which are focused on what can be achieved by 2030, were adopted by the United Nations (UN) General Assembly. Far broader in scope than the Millennium Development Goals, the third goal of the SDGs is to ensure healthy lives and promote well-being for

all ages. Target 3.4 of the SDGs is to reduce premature mortality from noncommunicable diseases by one third by 2030 through prevention and treatment and the promotion of mental health and well-being. The suicide rate is an indicator for target 3.4. The prevention of suicide is not only important for individuals and families but also benefits the well-being of society, the health care system, and the economy at large.

1.3 National suicide prevention strategies in the historical context

In the early 1990s, the seminal document entitled *Prevention of suicide: guidelines for the formulation and implementation of national strategies* was published by the UN following consultation with a variety of experts and with technical support from WHO. The document emphasized the need for intersectoral collaboration, multidisciplinary approaches, and continued evaluation and review, and also identified key elements as a necessary means of increasing the effectiveness of suicide prevention strategies (UN, 1996). Further, the document emphasized that nations seeking to address suicide require both a national suicide prevention strategy and a coordinating/leading body to develop, implement and monitor the strategy.

Knowledge about suicidal behaviour has increased greatly since the UN document was published. Research, for instance, has shown the importance of the interplay between biological, psychological, social, environmental and cultural factors in determining suicidal behaviours. At the same time, epidemiology has helped us to identify many risk and protective factors for suicide both in the general population and in vulnerable groups – such as indigenous peoples, young pregnant women, immigrants, prisoners, military personnel and lesbian, gay, bisexual, transgender and intersex (LGBTI) persons. Cultural variability in suicide risk has become more apparent, with culture and religion playing roles both in increasing risk of suicide and in protecting from suicidal behaviour (WHO, 2014). In 2012, the UN document was followed by WHO's *Public health action for the prevention of suicide: a framework* which identified components and clear steps for developing a national suicide prevention strategy (WHO, 2012).

In 2014, WHO published its first-ever world suicide prevention report *Preventing suicide: a global imperative* (WHO, 2014). In this report, WHO's Director-General made a call to action for countries to employ a multisectoral approach which addresses suicide in a comprehensive manner, which brings together different stakeholders, and which is based on their current resources and contexts. Since then, the number of requests that WHO has received from countries for technical assistance in suicide prevention or to review and comment on their new or revised national suicide prevention strategies has increased. WHO is working at headquarters, regional and country levels, together with collaborators and partners, including the International Association for Suicide Prevention (IASP), to respond to such requests.

When the UN guidelines were initially prepared, only Finland was known to have a government-supported systematic response to developing a national programme for suicide prevention. Today, some 40 countries at all income levels have adopted a national suicide prevention strategy, with some countries already developing or implementing further revision(s) of their national strategy. However, only a few countries in the low-income and middle-income categories have adopted a national suicide prevention strategy, even though 79% of suicides occur in these settings.

The WHO MiNDbank[1] online platform was created to provide quick and easy access to international resources and national/regional-level policies, strategies, laws and service standards for mental health and related areas such as suicide, substance abuse, disability, general health and human rights. The available national strategies for suicide prevention are included in this repository and are searchable and accessible by country (see Annex 1 for an overview).

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[1] http://www.mindbank.info, accessed 8 November 2018

Another global effort to address suicide is the creation of World Suicide Prevention Day, organized by IASP. This day has been observed worldwide on 10 September each year since 2003, providing an important opportunity for countries to raise awareness about suicide and its prevention. For some countries this event has facilitated the development of a national suicide prevention strategy. Furthermore, some countries have extended this day to a week or month in which to observe this important public health issue. In 2017, IASP launched a Special Interest Group on the development of effective national suicide prevention strategy and practice.

1.4 Objectives of this document

While a lot has been achieved since the UN report was published in the 1990s, there are still significant improvements to be made. This document encourages countries to continue the work where it is already ongoing, to strengthen suicide prevention efforts, and to place suicide prevention high on the political agenda, regardless of where a country stands currently in terms of suicide rate or suicide prevention efforts. By focusing on selected examples, this document aims to serve as a resource and inspire governments and policy-makers to establish their own national suicide prevention strategy adapted to their local situation. It is essential that governments assume a leadership role for a national suicide prevention strategy, as they are able to bring together stakeholders who may not otherwise collaborate. Governments are also in a unique position to develop and strengthen surveillance, and to provide and disseminate the data that is necessary to inform action (WHO, 2014).

Much of this document contains examples of national suicide prevention strategies by country. The examples reflect diverse approaches and backgrounds and aim to inform the reader by outlining the variety of ways to implement national suicide prevention strategies. An attempt has been made to include at least one example from each WHO region, without peer-review of the content of the strategies or indicators. Prior to the examples, key elements of a strategic approach to developing, implementing and evaluating a comprehensive multisectoral national suicide prevention strategy are presented and are brought together in the LIVE LIFE approach. Common barriers to developing a national strategy are discussed, as are possible actions for addressing such barriers. A list of the countries known to have stand-alone national suicide prevention strategies is presented in Annex 1. Indicators reported for national strategies are contained in Annex 2.

Box 1. National suicide prevention strategy success stories: England

The Cross-Government Suicide Prevention Strategy for England was published in 2012, revised from the original 2002 strategy. It is comprehensive, based on evidence and places an emphasis on cross-sectoral collaboration across national government, its agencies and voluntary and charitable organizations. The strategy has seven key areas for action to reduce suicides across all sectors, including health and social care, justice and public health.

The suicide rate in England is currently close to the lowest on record and is low by European standards. After a rise following the global recession, it is now back on a downward trend. The male suicide rate has fallen for four consecutive years. The suicide rate in people using mental health services is also falling and the number of suicides by inpatients has reduced by half.

A number of factors have been important to this apparent success, namely: 1) broad support from professions, charities, academics and government departments; 2) advocacy by bereaved families whose personal experiences have engaged political leaders and the media; 3) reliance on up-to-date data and evidence; 4) national oversight that allows the strategy to evolve to address emerging priorities; 5) partnership with national agencies such as the National Institute for Health and Care Excellence (NICE), which published clinical guidance on depression and self-harm, and Public Health England which published suicide prevention guidance for local government; and 6) links to wider mental health policy (e.g. on community care, psychological therapies and reduction of stigma).

Suicide prevention in England has risen up the political agenda and has achieved cross-party consensus. A national ambition was set in 2016 to reduce suicides by 10% by 2020. The prime minister published an update to the strategy in 2017 with an emphasis on young people and self-harm. Every local authority area in the country has a multi-agency suicide prevention plan in place and there is a national programme to improve suicide prevention in the National Health Service, supported by an investment of £25 million, with a zero-suicide ambition for inpatient care.

The most important current focus is young people. The suicide rate in 15–19-year-olds is rising, in contrast to the general downward trend, and the rate of non-fatal self-harm in young people is also going up. The highest rates are in middle-aged men, a group that is reluctant to seek help. Additionally, there are widespread concerns about online safety, stress on health professionals, gambling addiction and social media. The aim is to ensure that national policy, cross-government working and local suicide prevention plans reflect these new priorities.

2. Developing, implementing and evaluating a comprehensive multisectoral national suicide prevention strategy

2.1 Why national suicide prevention strategies are important

The importance of developing a national suicide prevention strategy has been comprehensively explored. The numerous benefits include (WHO, 2012):

- A national strategy not only outlines the scope and magnitude of the problem but, more crucially, recognizes that suicidal behaviour is a major public health problem.
- A strategy signals the commitment of a government to addressing the issue.
- A cohesive strategy recommends a structural framework, incorporating various aspects of suicide prevention.
- A strategy provides authoritative guidance on key evidence-based suicide prevention activities – i.e. it identifies what works and what does not work.
- A strategy identifies key stakeholders and allocates specific responsibilities to them. Moreover, it outlines the necessary coordination among these various groups.
- A strategy identifies crucial gaps in existing legislation, service provision and data collection.
- A strategy indicates the human and financial resources required for interventions.
- A strategy shapes advocacy, awareness-raising and media communications.
- A strategy proposes a robust framework of monitoring and evaluation, thereby instilling a sense of accountability among those in charge of interventions.
- A strategy provides a context for a research agenda on suicidal behaviours.

2.2 How to get started

A country that decides to work on its national response to suicide prevention has an opportunity to tackle suicide prevention in a way that is meaningful to that country's context. Regardless of a country's current commitment to and resources for suicide prevention, the very process of establishing a national response can itself improve prevention (WHO, 2014). In countries where suicide prevention activities have not yet taken place, the emphasis is on identifying stakeholders and developing activities where the need is greatest or where resources already exist. It is also important to improve surveillance. In countries with some existing suicide prevention activities, a situation analysis can show what is already in place and where gaps need to be filled. Countries that already have a relatively comprehensive national response should focus on evaluation and improvement, updating their data and emphasizing effectiveness and efficiency (WHO, 2014). Resources should be allocated to achieve both short-to-medium- and long-term objectives; there should be effective planning, and the strategy should be regularly evaluated, with findings feeding into future planning.

2.3 A strategic approach

A national suicide prevention strategy needs to be multisectoral, involving not only the health sector but also sectors such as education, labour, social welfare, agriculture, business, justice, law, defence, politics and the media. The strategy should be tailored to each country`s cultural and social context. When conceptualizing and implementing a national suicide prevention strategy through an action plan, it is necessary to specify clear objectives, targets, indicators, timelines, milestones, designated responsibilities and budget allocations. The government needs a strategic and systematic approach. Without an action plan, it is likely that progress will fall short. The following elements, which are in no particular order, are key to the success and sustainability of the national strategy (WHO, 2012). Some of these elements may need to occur before or simultaneously with others. Context-informed decisions are needed in order to establish a preferential order in any given context.

Identify stakeholders
It is important to identify the key stakeholders in suicide prevention when developing a national strategy. Suicide prevention needs to involve different actors and disciplines working on suicide prevention – such as different ministries, health administrations, nongovernmental and nonprofit organizations, universities and civil society at different levels (national, regional, state or provincial, and community). Lead stakeholders are listed according to strategic actions for suicide prevention in WHO's Preventing suicide: a global imperative (WHO, 2014). Potential stakeholders at community level can be found in WHO's *Preventing suicide: a community engagement toolkit* (WHO, 2018b).

Undertake a situation analysis
A thorough situation analysis, starting with the data available, identifies the extent of the problem in a particular geographical area (whether an entire country or a specific subregion of a country). The identification of barriers to implementation is an important part of the situation analysis in which all the barriers are listed and solutions are proposed to remove them systematically. Without barrier identification, national strategies may face challenges when implementing activities.

Assess resources
The availability of and access to both human and financial resources, for both development and implementation, are central to the success of any public health intervention, as is the willingness of policy-makers to engage with the key issues. The assessment of resources can also be included in the situation analysis.

Achieve political commitment
Without political commitment, strategies are likely to remain only on paper, being implemented only partially or not at all. Political commitment is essential for ensuring that suicide prevention receives the resources and attention that it requires from national, state and local leaders. Achieving political commitment that is sustainable and which transcends changes in the government is a long and arduous process, but it has the potential benefit of reaching the population and showing impact in the long term.

Address stigma
Stigma related to suicide remains a major obstacle to suicide prevention efforts. Those who are left behind or who have attempted suicide often face considerable stigma within their communities, which may prevent them from seeking help. Stigma can subsequently become a barrier to accessing suicide prevention services. This is of particular concern in countries where suicidal acts are criminalized. Furthermore, high levels of stigma may negatively affect recording and reporting of suicide and suicide attempts.

Increase awareness
The process of developing a suicide prevention strategy offers opportunities to increase awareness about suicide. It is not necessary to wait until the implementation phase of a suicide prevention strategy to seek the media's support in highlighting the importance of suicide prevention. For an intervention to be successful, the public requires an understanding of the issue and the need for the intervention. Awareness efforts can also generate greater and more sustained involvement from stakeholders and buy-in from communities that recognize the importance of suicide prevention.

State clear objectives
An effective suicide prevention strategy should have several parallel and interconnected objectives that need to be stated clearly.

Identify risk and protective factors
The identification of relevant risk and protective factors at individual, family, community and societal level for both suicide and suicide attempts can help to determine the nature and type of interventions required in a given context (see also WHO, 2014; Hawton et al., 2016; Zalsman et al., 2016).

Select effective interventions
Based on relevant risk and protective factors, as well as the situation analysis and resources allocated, a national strategy and its action plan for implementation can propose the most suitable type and combination of effective evidence-based interventions – universal, selective and indicated (see also WHO, 2014). Universal interventions target the general population with coverage of the population as a whole. Selective interventions focus on subpopulations that have an elevated risk and can be employed on the basis of sociodemographic characteristics, geographical distribution or prevalence of mental and substance use disorders (e.g. according to the contribution of these factors to the overall burden of suicide). Indicated interventions are aimed at persons who are already known to be vulnerable to suicide or who have attempted suicide. A comprehensive suicide prevention programme typically employs a combination of universal, selective and indicated interventions.

Improve case registration and conduct research
As suicide often remains misclassified, un- or under-reported, surveillance systems are needed to improve the availability and quality of data. Suicide attempt data are equally important as presented in the *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm* (WHO, 2016), as a prior suicide attempt is the strongest predictor of subsequent suicide in the general population. A systematic approach for gathering data in a sustained manner is key (see also WHO, 2014). Research is important for understanding the risk and protective factors and vulnerable persons for a given context and can be used to identify the link between intermediate outcomes of a strategy's action plan e.g. enhanced practice of health workers, and the primary outcomes of interest, i.e. suicide and suicide attempts.

Conduct monitoring and evaluation
Monitoring and evaluation need to be planned and agreed upon in advance to ensure the involvement of all relevant stakeholders, including inputs from key personnel involved in the implementation of interventions as well as feedback from community members. Evaluations are important for indicating whether changes need to be made to an intervention or whether it can be scaled up. While evaluating the strategy as a whole, the evaluation of individual interventions that are being implemented offers opportunities to examine critically the outcome and impact of these interventions in terms of the stated objectives. Intermediate outcomes, which are influenced by suicide prevention efforts in the short term, provide evidence of the impact of the strategy and action plan with regard to achieving the goal of reducing the rate of suicide and suicide attempts in the long term, which is the key primary outcome. Examples of intermediate outcomes include: more responsible reporting of suicide in the media; enhanced knowledge, attitude and practice of health workers towards people who engage in suicidal behaviours; an increased number of people utilizing and accessing support and services; and increased awareness and understanding of suicidal behaviours. The emphasis remains clearly on the primary outcomes of reducing suicides and suicide attempts. Intermediate outcomes can be useful only if a clear and direct relationship with the primary outcomes can be established. Monitoring the quality of the implementation of the action plan through intermediate outcomes and their impact on primary outcomes can indicate which aspects of the implementation plan have the largest impact on the primary outcomes of suicide and suicide attempts and which aspects of the implementation plan require further improvement. This can also facilitate an understanding of changes that may affect implementation, such as reduced funding or lack of commitment to the process by stakeholders (see also WHO, 2014).

Monitoring and evaluation should be seen as part of a continuous feedback loop that is designed to allow refinements to be made to improve the strategy as it progresses. More information about approaches to monitoring and evaluation are provided in the next section.

2.4 Measuring the success of national suicide prevention strategies

Measuring the success of a national strategy not always easy but there are ways to ensure that evaluations of national strategies are as robust as possible. One of the main concerns is that, by design, national strategies have multiple components and are rolled out on a large scale. Another concern is that a variety of factors influence a country's suicide rates and there will be fluctuations over time. Both of these factors mean that it may be difficult to detect changes in suicide rates that could be attributed to the national strategy. The best evaluations address these issues by adopting a "programme logic" approach and using multiple indicators of success.

A programme logic approach is a way to systematize the theory of action of the given national strategy. The approach usually involves developing a hierarchy of objectives that operationalize the stated objectives of the strategy. Typically, the lowest-level objectives relate to ensuring that the structures and processes are in place for the strategy to achieve its aims, the next level relates to immediate and intermediate outcomes, and the highest level relates to the ultimate, longer-term primary outcomes. The logic asserts that, if the lowest-level objectives are met, then this augurs well for the intermediate objectives, and if these are met then this stands the strategy in good stead for meeting its highest-level objectives. Often the hierarchy is arranged in streams that align with the action areas of the strategy, and different indicators will be used to assess whether the objectives within each stream have been achieved. Thus, for example, if one of the key components of a given national strategy is about improving media reporting of suicide, the lowest-level objectives might relate to guidelines being developed and journalists being trained in good reporting practices, the next level might relate to improved reporting of suicide, and the higher levels might relate to reductions in suicide and suicide attempts. Similarly, if another key component was to improve access to and quality of care for suicidal persons, the lowest-level objectives might relate to resourcing and equipping the general health workforce to assess and manage suicidal behaviour, the intermediate-level objectives might relate to increased uptake of and satisfaction with care by suicidal individuals, and the higher levels might relate to reductions in suicide and suicide attempts. The streams will often converge at the higher points on the hierarchy because the ultimate aim will be to reduce rates of suicide and suicide attempts.

Assessment of the extent to which the various objectives are achieved relies on using indicators that are clear and measurable. Ideally, multiple data sources and multiple methods will be used to gauge the strategy's success against these indicators. Some data will come from routine sources, such as death registers or hospital admissions data; other data will be collected in a purpose-designed way, possibly through surveys or interviews. Wherever possible, the full range of perspectives on the success of the strategy should be sought, including the views of those who have engaged in suicidal behaviour themselves, as well as those who have been bereaved by suicide. The collection and analysis of data from these various sources will involve qualitative and quantitative approaches.

The benefits of taking a programme logic approach and using multiple data sources and methods to evaluate national strategies are manifold. First, this approach ensures that key stakeholders agree what the strategy is trying to achieve and how it will get there. Second, it provides a framework for evaluating not only the strategy as a whole but also its component parts. And third, it provides a clear picture of the pathways by which the strategy's overarching goals will be achieved, providing early insights into structures and processes that might need to be re-addressed and strengthening the conclusions that can be drawn about causality, including the relationship between intermediate and ultimate primary outcomes.

2.5 LIVE LIFE

The elements of a strategic approach for suicide prevention (WHO, 2012) along with core effective interventions (WHO, 2014) are embodied by LIVE LIFE for preventing suicide. LIVE stands for leadership, interventions, vision and evaluation and builds the pillars of LIFE – i.e. the core interventions, which are: less means (i.e. restricting access to means of suicide), interaction with the media for responsible reporting, formation of the young in their life skills, and early identification, management and follow-up (Figure 1). LIVE LIFE establishes the key ingredients on which the formulation of a national suicide prevention strategy should be based. The components of LIVE LIFE are as follows:

LIVE

Leadership. National governments are instrumental in providing leadership through the mobilization and coordination of multiple stakeholders, including governmental and nongovernmental sectors, civil society and communities. Governments are in a position to define a culturally adapted response through a national suicide prevention strategy which aims for a reduction in suicide and suicide attempts. Leadership is essential for conducting a situation analysis, raising awareness, and developing, adapting and enacting policies across sectors relevant to suicide prevention, such as those on mental health, pesticides and alcohol.

Intervention. The core effective evidence-based interventions for implementation are described in LIFE (see below). This also means providing services and care for persons in need, including suicide attempters and family, friends and colleagues around them and after bereavement.

Vision. Having a vision is essential to keep steering towards the goal of reducing suicide and suicide attempts while overcoming changes and barriers. A vision is needed for financing and resource allocation as well as for identifying new funding opportunities and partnerships. A champion in suicide prevention may help drive the process forward. A vision is also important for introducing innovations and for creativity in testing new delivery platforms.

Evaluation. Strategies and interventions must be continuously monitored and evaluated to ensure that suicide prevention goals and objectives are met with interventions that have the desired impact. Monitoring and evaluation are assured by functioning and high-quality case registration and surveillance systems that allow for evaluation, provide feedback to inform improvements (including in effectiveness and efficiency) and are ultimately the cornerstone of research activities.

LIFE

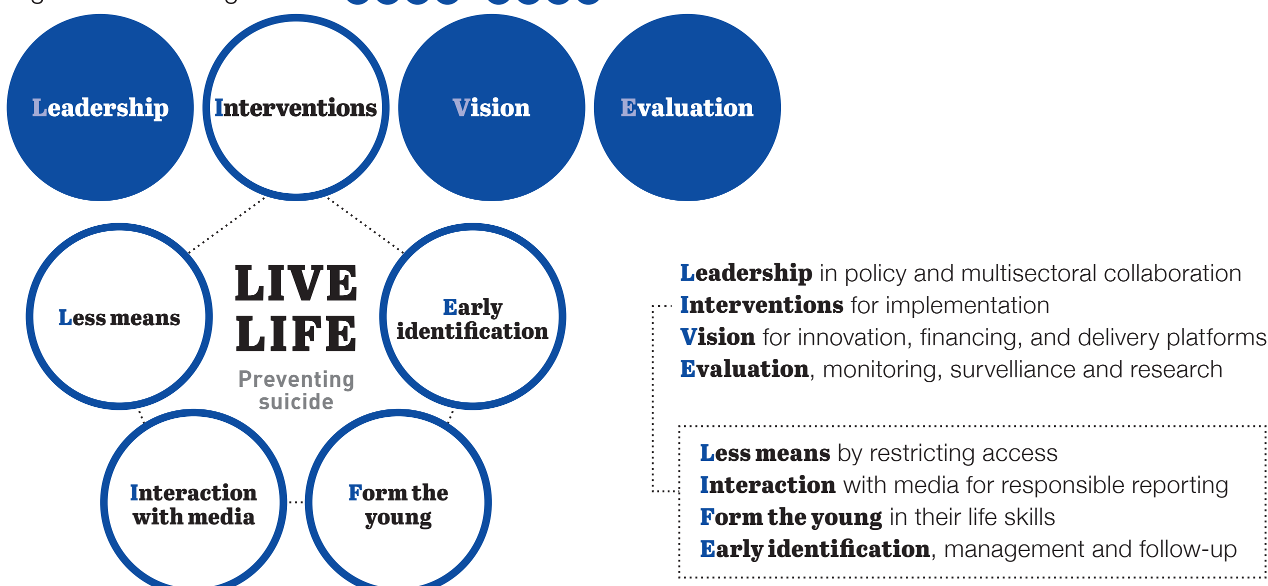
Less means. Restricting access to means (e.g. pesticides, firearms) is the key universal intervention for suicide prevention. Well-established surveillance systems are important to identify and target the most common means in a country or specific context.

Interaction with media. Responsible reporting by the media is an essential component of suicide prevention. Media professionals should not only refrain from the glamorized presentation of cases of suicide and thereby avoid imitation by vulnerable people, but should also communicate stories of someone coping successfully, seeking and receiving help. In addition, the media can play a role in raising awareness about suicide, its prevention and mental health more generally, as well as about stigma reduction.

Form the young. Enhancing young people's problem-solving, coping and life skills has been shown to be an effective intervention for suicide prevention among the young. Corresponding sessions can be delivered through different platforms (e.g. school-based programmes).

Early identification. Early identification, assessment, management and follow-up ensure that people who may be at risk of suicide, or who have attempted suicide, receive the support and care that they need. Health-care systems need to incorporate suicide prevention as a core component, and health workers, including those at community level, need to be trained and equipped to deliver these services. As vulnerable people are often at the heart of suicide prevention strategies, universal health coverage needs to ensure that all people are able to access care.

Figure 1. Preventing suicide: LIVE LIFE



Box 2. National suicide prevention strategy success stories: Scotland

Over the past 17 years the Scottish Government, working in liaison with a range of partners – including the National Health Service, NHS Health Scotland, social services, Police Scotland and the third sector (voluntary and community organizations) – has prioritized efforts to reduce and prevent suicide through the *Choose Life strategy and action plan* (2002–2013)[1] and the *Suicide prevention strategy* (2013–2016).[2] The Scottish Government's new Suicide Prevention Action Plan *Every life matters*[3] was published in August 2018, setting out ambitious actions for a major change in how services and communities respond to suicide.

Between 2002–2006 and 2013–2017 the Scottish suicide rate fell by 20%. Over much of the last 30 years the suicide rate in Scotland has been consistently lower than the average across the 53 countries of the WHO European Region. Key ingredients of success include:

- a 10-year national strategy and action plan (*Choose Life*), (partially) evaluated and refreshed, generating a sustained focus on suicide prevention actions and outcomes;
- a devolved government, with key national partners having ease of access to the suicide prevention policy team and Government ministers; and the creation of a new post of Minister for Mental Health in 2016;
- dedicated leadership and a common vision from the Scottish Government and national agencies, which have positively influenced suicide prevention action involving public and third-sector agencies at local government level;
- commitment to a broad public health approach to suicide prevention, combining population-based action and a focus on equity with interventions targeted at high-risk groups and individuals, incorporating but going beyond traditional (mental) health service responses;
- improvement of the capability of the health and social care system to respond effectively and compassionately to individuals in emotional distress/at risk of suicide, via the provision of training (STORM, ASIST, safeTALK and Scottish Mental Health First Aid) and other learning materials;
- collaborative working across national agencies in gathering, analysing, disseminating and acting on research and experiential evidence about what works in suicide prevention;
- raising awareness in the general population through agreed branding (*Choose Life*), national campaigns, and national and local activities for Suicide Prevention Week;
- tackling problem drinking, especially through alcohol brief interventions delivered in primary care, accident and emergency services and antenatal care settings, and increased attention to the identification and treatment of depression in primary care;
- improvements in local patient safety introduced on the basis of evidence developed by the United Kingdom-wide *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (in particular the work on discharge planning).

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[1] http://www.gov.scot/Publications/2002/12/15873/14466, accessed 16 November 2018.

[2] http://www.chooselife.net/Home/index.aspx , accessed 16 November 2018.

[3] https://www.gov.scot/Publications/2018/08/8874, accessed 16 November 2018.

Elements that could be improved, or that remain to be achieved in the future include:

- further reach into communities in order to improve support to those in emotional distress/at risk of suicide and those with direct and indirect experience of suicide, via a range of channels, including face-to-face and digital technology;
- improvement of capacity and capability to deliver trauma-informed practice[4] (which addresses the barriers often experienced by those affected by trauma when accessing the care, support and treatment they need to live a healthy life); and incorporation of this into new learning resources proposed under the recently published *Action Plan*;
- incorporation of suicide prevention action into local (community) planning and other strategic documents;
- improvement of the access of suicide prevention agencies to data (both real-time and historical) on the epidemiology and characteristics of suicidal behaviour at local level;
- development of appropriate reviews/audits into all deaths by suicide (i.e. those occurring in the community as well those in service settings) and ensuring that findings are shared and acted upon;
- undertaking more sophisticated evaluation studies in order to identify the essential components of complex national multilevel suicide prevention interventions such as *Choose Life*.

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[4] https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx, accessed 16 November 2018.

3. Barriers to implementing national suicide prevention strategies

Even with a well-designed suicide prevention strategy, barriers (see examples in Table 1) can arise that threaten its success and sustainability. Overcoming barriers is vital. Actions need to be well-defined and structured, taking into account the stakeholders involved, the resources available and the characteristics of the national and local contexts. Considering this in advance may help to avoid barriers and reduce their consequences.

3.1 Identifying barriers

Without the early identification of their potential setbacks or barriers, prevention strategies are likely to be harder to implement or will fail altogether. When planning the implementation of each strategic action, possible barriers should be considered and preparation should include additional strategies for addressing identified barriers.

3.2 Overcoming barriers

It is important to understand the factors that create a barrier in order to overcome or circumvent it. The problem generated by the barrier needs to be defined, discussed among stakeholders, and potential solutions need to be proposed. Once actions are taken to overcome a barrier, an assessment is needed of whether the problem was successfully resolved.

Table 1. Barriers to consider when implementing national suicide prevention strategies

Barrier	Description of the barrier	How to overcome the barrier
Management and logistics		
Understanding the problem	A poor understanding of suicide in the national or local context makes it difficult to develop clear goals and actions adjusted to the communities' needs.	Gain a thorough understanding of the problem by recording the means, number and rate of suicides and suicide attempts; identify relevant risk and protective factors and vulnerable groups; assess the health-care infrastructure and resources available for services and care; define the problem properly to allow for efficient implementation with adequate timelines and use of resources.
Actions and interventions	A poor description of actions and interventions – including, for instance, objectives, resources required, responsibility for implementation, and timeline – can leave the strategy disorganized and ineffective.	Define clear objectives for each action and intervention, expected results, persons in charge of implementation, resources allocated, infrastructure and timeline.
Stakeholders		
Leadership and management	Suicide-relevant stakeholders should be well versed in working with the wide range of government leaders with whom they may be involved. Absent or ineffective leadership, particularly leadership that is not accepted by stakeholders, can make it difficult to achieve goals.	Learn how to communicate and work with a range of stakeholders; adapt to contexts where there is a frequent turnover in leadership; understand the traits of ineffective leadership, thus helping to avoid pitfalls and strengthen leadership abilities; government leadership with good management skills needs to be put in place.

Barrier	Description of the barrier	How to overcome the barrier
Teamwork and collaboration	Poor teamwork and lack of cohesion and collaboration result in following one's own interests or approaches, rather than working towards common objectives in a unified manner.	Clearly identify each stakeholder's role; establish channels of communication among different stakeholders; share information in a timely manner and create synergies among different agents; these can serve to unite individuals for joint achievement of the objectives; designate a national resource centre for suicide prevention to provide briefings and reports and to engage internationally.
Legislation and policies	Legislation and policies that are not in line with suicide prevention efforts can hinder implementation.	Increase awareness about suicide and its prevention, helping to align legislation and policies with suicide prevention efforts.
Financial resources		
Budget for implementing the action plan	Lack of political support can result in a lack of funding. Inadequate estimation of funding required can hinder the full implementation of interventions.	Estimate the full cost of the interventions and monitor the funding as this can help to keep implementation sustainable over time; maintain a reserve fund as this can provide stability and reduce uncertainty; clearly demarcate the funding allocation because, without this, interventions are less likely to be implemented or evaluated.
Human resources		
Training	Health workers may not be prepared or competent to identify and manage suicidal behaviours. Additionally, the quality of care provided may be inadequate and inconsistent.	Train specialized and non-specialized health workers in the assessment and management of suicidal behaviours and mental, neurological and substance use disorders and ensure these workers meet competency requirements; involving health workers in the adaptation of the training to the local context can enhance motivation and the effectiveness of interventions; understand the context-specific factors which hinder the implementation of evidence-based interventions, thus enabling training to be modified so that staff can be prepared to manage such challenges.
Multisectoral involvement		
Restricting access to means	One of the key methods of suicide involves self-ingestion of pesticides; however, in many contexts this remains unacknowledged and little or no action is taken.	Monitoring the use of pesticides in suicide or attempted suicide facilitates an understanding of the problem; engage regulatory bodies and relevant government sectors (e.g. agriculture) in the national regulation of access to pesticides.

Barrier	Description of the barrier	How to overcome the barrier
Responsible media reporting	Ongoing sensationalizing of suicide in the media.	Actively monitor media reports in order to intervene promptly if there are sensationalist articles; provide ongoing training and awareness sessions for media professionals; work with media regulatory bodies to manage the reporting of suicide; include the media in positive reporting (e.g. success or resilience stories and anti-stigma and awareness campaigns).
School-based interventions	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.	Work closely with the educational 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; include young people in the design of any prevention programme.
Access to services	Limited health or social care coverage reduces the ability to implement the interventions or follow-up needed for those who have attempted suicide, or for those bereaved by suicide.	Train community workers; establish self-help groups and peer support; explore digital platforms.
Continuity of care in the health-care system	Different services and health workers who are not linked and not in communication with each other cannot keep track of persons seeking help and therefore continuity of care may be interrupted.	Promote follow-up, referral, exchange, meetings and joint training, which can strengthen the care provided; promote integration of services and multidisciplinary treatment as this can promote the continuity of care.
Data		
Data collection	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.	Establish and strengthen surveillance systems for suicide and suicide attempts; surveillance should be considered a core element of suicide prevention; monitor the effectiveness on primary outcomes with accurate data collection, enabling subsequent adjustments to enhance effectiveness.
Stigma		
Stigma	Persons who attempted suicide, their families and those who are left behind after a suicide are all stigmatized. Stigma negatively influences the willingness to utilize health-care resources, it affects the quality of care provided by health-care workers, and it may have an impact on the effectiveness of national strategies, if not addressed.	Conducting awareness campaigns and providing information are important elements in fighting stigma, discrimination and other inequities, such as the lack of access to care associated with suicidal behaviours.

Box 3. National suicide prevention strategy success stories: Sweden

In 2008, the Swedish parliament decided on a National Action Programme for Suicide Prevention, the "Vision Zero Policy". The vision of the programme is that no one should be in a situation of such vulnerability that suicide is seen as the only way out.

The first national suicide preventive programme in Sweden, described in the report Support in suicidal crisis was established in 1995 by the Swedish National Council for Suicide Prevention, guided by the National Institute of Public Health, the Swedish National Board of Health and Welfare and the National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP). This programme was never presented to the Swedish parliament for ratification, and this fact could be seen as a drawback for implementation since the preventive activities had to rely on the goodwill of public authorities and various organizations and individuals.

The second national suicide preventive programme was created by the National Institute of Public Health (now called the Public Health Agency of Sweden) and the National Board of Health and Welfare with support of experts from NASP. This programme was ratified by the Swedish Parliament in 2008 and put in force by the Swedish Government which announced the Vision Zero policy for suicide. The policy sends a strong signal to the whole population that the topic is important and, for the first time, suicidal persons and their families felt that priority was finally being given to them.

Parliamentary ratification not only gave legal status to the national action programme for suicide prevention but also contributed to implementation of the following nine areas of action:

1. Promote good life opportunities for less privileged groups
2. Reduce alcohol consumption in the population and in groups at high risk for suicide
3. Reduce access to means and methods of suicide
4. View suicide as a psychological mistake
5. Improve medical, psychological and psychosocial initiatives
6. Distribute knowledge about evidence-based methods for reducing suicide
7. Raise skill levels among staff and other key individuals in the care services
8. Perform "root cause" or event analyses after suicide
9. Support voluntary organizations

The Public Health Agency of Sweden received a mandate from the government in 2015 to coordinate suicide prevention at national level. Accordingly, the agency developed the coordination and cooperation between relevant government agencies and stakeholders in order to monitor the implementation of suicide preventive activities throughout the country.

Since it was approved, the second national suicide prevention programme has been a success in terms of increased awareness within Swedish society and among bodies in the health-care and public mental health systems. Because of the increased awareness in society, attitudes to suicidal persons have changed. When the stigma surrounding suicide is lifted, it becomes less of a taboo subject. There is a deeper understanding about the risk factors that prompt suicidal behaviours and how they can be reduced by social, medical/psychiatric and psychological measures.

Moreover, there is a greater understanding of protective factors which help individuals cope with suicidal behaviours and improve their mental health. Subsequently, over time, the view that suicidal behaviours are impossible to prevent and treat has diminished. The idea that most suicidal acts arise in situations in which life is unbearable and everything seems out of the individual's control is emphasized, as opposed to the view that suicidal acts represent control over one's life situation and freedom.

Similarly, a Vision Zero policy was introduced for road accidents in Sweden in 1997. This led to increased public awareness and a substantial increase in funding for the relevant parties. Road safety improvements and changes to the traffic laws, resulted in a 50% reduction in deaths due to motor vehicle accidents over a 20-year time period. It is hoped that the Vision Zero policy for suicide will have a similar effect.

Following the ratification of the Vision Zero policy for suicide, financial resources were provided for some time-limited projects. However, financial support to the Vision Zero policy for suicide has been greatly insufficient compared to the Vision Zero policy for traffic accidents. More funding is needed for permanent activities. To ensure that the best possible prevention and treatment are provided, there needs to be an increase in adequately trained human resources in the health-care and public mental health systems, backed by continuous development and dissemination of evidence-based methods which reduce suicidal behaviours.

The Vision Zero policy may sometimes be misinterpreted. However, this policy does not mean that suicide is forbidden. The policy's goal is to ensure that everybody does everything within their power to provide the best prevention, care, treatment and rehabilitation to at-risk and suicidal persons. This should be feasible as research shows that suicidal behaviours are preventable.

4. Country examples

In recent decades, and particularly since 2000, many national suicide prevention strategies have been developed. As of 2017, almost 40 countries were known to have a stand-alone national strategy that had been adopted by the government (WHO, 2018c), demonstrating commitment to suicide prevention. The number of national strategies is increasing steadily. Close to 10% of low-income and lower-middle-income countries have a national strategy, while approximately one-third of upper-middle-income and high-income countries report having such a strategy. In addition, some countries have a national suicide prevention framework, national programmes for specific subpopulations, or the integration of suicide prevention into national plans for mental health or other health areas (WHO, 2018c).

This section aims to provide examples of national suicide prevention strategies in order to help countries that are in the process of developing or revising their own strategy. The descriptions and indicators below have not been subject to peer review; rather, they are intended to provide examples across a range of geographical regions. The country examples have been summarized directly from the national strategy documents and indicators to which they pertain. In total, 10 country examples are described (Table 2). Sociodemographic information and suicide estimates by country can be found in the country profiles[1] of the *Mental health atlas 2017* and WHO's suicide prevention webpages.[2]

The country examples are structured in several sections: first, the context for suicide prevention is provided; second, the key components of the strategy, such as the vision, mission, time frame, annual budget, goals, objectives and guiding principles are presented; and, third, the implementation of the strategy and its monitoring/evaluation are described.

The vision that the strategies have in common is usually less or no suicide (e.g. a country free of suicide) and/or improved mental health and well-being.

Among the typical components that can be found in national suicide prevention strategies are means restriction, responsible media reporting, access to services, treatment, crisis intervention, training, postvention, surveillance, awareness raising, stigma reduction, and oversight and coordination (WHO, 2014), all of which should reflect universal, selective and indicated interventions.

Table 2. Overview of country examples

1. Bhutan (South-East Asia Region)	**6. Namibia (African Region)**
2. Guyana (Region of the Americas)	**7. Republic of Korea (Western Pacific Region)**
3. Iran, Islamic Republic of (Eastern Mediterranean Region)	**8. Switzerland (European Region)**
4. Ireland (European Region)	**9. USA (Region of the Americas)**
5. Japan (Western Pacific Region)	**10. Uruguay (Region of the Americas)**

[1] http://www.who.int/mental_health/evidence/atlas/profiles-2017/en, accessed 8 November 2018.

[2] https://www.who.int/mental_health/prevention/suicide/suicideprevent/en, accessed 8 November 2018.

Example 1. Bhutan (South-East Asia Region)

The following information was summarized from the National Suicide Prevention Strategy of the Royal Government of Bhutan, called "Suicide prevention in Bhutan". For further details and references please refer to the original source.
Source: http://www.mindbank.info/item/6176

Context for suicide prevention

Before the three-year action plan was formulated in 2015 by the Royal Government of Bhutan, there had been no stand-alone comprehensive suicide prevention programme in Bhutan. However, some forms of integrated services were available through primary care mental health services, domestic violence prevention and de-addiction strategies for alcohol and drugs. Mental health screening or suicide risk identification was not routine practice and most rehabilitation services were concentrated in a few districts. Consequently, many people were unable to access crucial resources.

Key components of the strategy

Vision	A nation with zero deaths by suicide
Mission	Promoting, coordinating and supporting appropriate intersectoral action plans and programmes for the prevention of suicidal behaviours at national, dzongkhags (district), gewogs (group of villages) and community levels
Time frame	2015–2018
Annual budget	BTN 9.6 million

Goal	Preventing premature deaths due to suicide across the lifespan, among the Bhutanese population.

Objectives

Specific objectives

1. Improving leadership, multisectoral engagement and partnerships for suicide prevention in these communities.
2. Strengthening governance and institutional arrangements to effectively implement comprehensive suicide prevention plans.
3. Improving access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide (including those with suicidal ideation, history of self-harm or a non-fatal suicide attempt).
4. Improving the capacity of health services and gate keepers to provide suicide prevention services.
5. Improving community resilience and societal support for suicide prevention in communities, including schools and institutions.
6. Improving data, evidence and information for suicide prevention planning, and programming.

Guiding principles

- Suicide prevention is to be a broad and coordinated system working with a wide range of partners, organizations and sectors, including people who have been affected by suicide.
- Suicide prevention will address a wide range of factors related to suicidal behaviour, including social support, mental illness, substance abuse, economic factors, and community and personal risk and resilience.
- Suicide prevention will be a comprehensive targeting of the population, building supportive community systems and focusing on individual-level risks for suicide.
- Suicide prevention will employ a combination of public health and individual clinical approaches focusing on risk identification and the provision of individually tailored services.

Strategies
The action plan proposes three levels of interventions: universal suicide prevention strategies, designed to reach an entire population; selected suicide prevention strategies, specifically targeting vulnerable individuals within the population; and indicated suicide prevention strategies, targeting those who have engaged in non-fatal suicidal behaviour or are left behind.

Universal strategies: promoting responsible media reporting on suicide; religious beliefs and cultural practices; schools providing parenting education and awareness programmes, guidance counsellors, etc.; mental health services by training of health workforce, infrastructure of the hospitals and psychiatric wards, etc.; and means restriction, limiting the availability and supply of pesticides.

Selective strategies: for vulnerable women and children; addiction and substance abuse prevention, established programmes, drop-in centres, outreach centres, rehabilitation services; community resilience and support programmes; and counselling, such as peer counsellors, health and social counsellors.

Indicated strategies: access to services and care for individuals at higher risk of suicide such as crisis helplines, health information services, etc.; survivor postvention services that include reducing further risk of suicidal behaviour, prevent suicide contagion by identifying other members at high risk of suicide etc.; and referral services and standardisation of health services.

Implementation
The Government of Bhutan recognized that the action plan had to be realistic and implemented it through a financially sustainable model. Each activity was graded on a 10-point scale in five domains – effectiveness, cost, feasibility, public health benefits and cultural acceptability of the action – in order to ensure an effective cross-sectoral implementation and governance. A Suicide Prevention Steering Committee was established, comprising Ministry of Health representatives and other key stakeholders to advise on the national suicide prevention response. The committee meets every six months and its main function is to provide thrust to the multisectoral response in suicide prevention.

Implementation of the suicide prevention workplans was designed to take place in the dzonkhakgs (districts) and local governments, ensuring that suicide prevention activities were embedded within the Government Performance Management System. The Dzongdag Suicide Prevention Response Team is composed of appropriate representatives of relevant agencies with the Royal Bhutan Police (RBP) and health representatives, is also established in all 20 dzongkhags (districts). The team's key function is to ensure effective rescue responses to suicide attempts and deliberate self-harm incidents occurring in communities.

Monitoring and evaluation
The monitoring and evaluation is conducted under the direction of the Suicide Prevention Steering Committee. The Committee and the Ministry of Health are responsible for evaluation and management, including the appointing of teams and coordination during the field work.

The monitoring and evaluation framework follows a set of input and output indicators to show accomplishments or progress in the strategy (Annex 2.1). The implementing partners will submit six-monthly implementation reports, using standard reporting forms. The overall trend of the suicide reduction will be monitored through national data on suicide collected through the national registry for suicide and deliberate self-harm. Finally, an annual progress report will be published.

Example 2. Guyana (Region of the Americas)

The following information was summarized from the National Suicide Prevention Strategy of the government of Guyana, called the "National Suicide Prevention Plan: A National Suicide Prevention Strategy for Guyana". For further details and references please refer to the original source.
Source: https://www.mindbank.info/item/6321

Context for suicide prevention
Guyana is facing high suicide rates, and conclusions from situation analyses have indicated that there were not enough primary health care centres with adequately trained personnel. Moreover, similar gaps existed in other sectors. The media, for instance, presented sensationalized reports on cases of suicide and suicide attempts, potentially enhancing the "copycat" phenomenon. Also, the quality of data on suicide attempts and suicide was depicted as poor. To tackle these challenges, a National Suicide Prevention Plan was developed in 2014.

Key components of the strategy

Vision	Improving and contributing to the mental and social well-being of all peoples in Guyana
Mission	Addressing the health determinants and constraints in the health system to achieve mental health for all in Guyana, which reflects the experience gained in the country and expresses the government's commitment to the establishment of priorities and management to prevent and control suicide in Guyana
Time frame	2015–2020
Annual budget	The health budget is GYD 23 455 957 000; of this, the mental health budget was GYD 105 550 000 in 2018

Goal	To reduce the incidence of suicide mortality and attempted suicide (by 20%), thereby preventing premature death from suicide or disability from attempted suicide, across the life span from 2015–2020.

Objectives

General objectives

1. To promote a healthy lifestyle and implement culturally-sensitive approaches, to reduce the risk of suicidal behaviour, especially in high-risk groups.
2. To reduce the availability, accessibility and attractiveness of the means to suicide (e.g. pesticides, medications, firearms).
3. To develop multidisciplinary effective interventions and actions to prevent suicidal behaviour and implement new initiatives to help those affected by suicide.
4. To promote the use of mental health services and services for the prevention of substance abuse and suicide.
5. To promote the quality and timeliness of national data on suicide and suicide attempts and support the establishment of an integrated data collection system.

Strategies
1. Risk factor reduction, health promotion and prevention
To develop comprehensive interventions for the promotion of healthy lifestyles and prevention of suicidal behaviour, especially in high-risk groups.

Specific objectives:

- Provide evidence-based information about the magnitude, risks and consequences of suicidal behaviour.
- Promote healthy lifestyles within the general population including the reduction of substance abuse and alcohol intake as a component of suicide prevention.
- Communication through a specialized social communication strategy focused on suicidal behaviour.
- Reduce the risk of suicide in key high-risk groups.

2. Reduce access to the means of suicide:
Develop interventions to reduce access to means of suicide.

Specific objectives:

- Restrict access to means of self-harm/suicide.
- Reduce the number of suicides as a result of self-poisoning.
- Reduce the number of suicides as a result of overdose of medications.
- Reduce the number of suicides as a result of hanging and strangulation.
- Reduce the number of suicides at high-risk locations.
- Reduce the number of suicides occurring on the road.
- Response to new methods of suicide.

3. Health system response to suicidal behaviour:
Improve the quality of health services to treat and manage people with mental disorders.

Specific objectives:

- Improve the capacity and quality of the health system response.
- Increase access to the management and interventions for treatment, control and rehabilitation of persons who attempted suicide.
- Strengthen human resources in the health system and communities to provide care, treatment and support in cases of suicidal behaviour.
- Train gatekeepers to identify individuals at risk, the level of risk and how to refer at-risk individuals for treatment.
- Mobilize communities and develop interventions to address the factors that influence suicide risks (trauma or abuse, discrimination and relationship conflict).
- Develop interventions to support survivors.

4. Suicide Surveillance and Research:
Improving data collection on the incidence of suicidal behaviour, research and evaluation of effective interventions.

Specific objectives:

- Improve case registration.
- Conduct researches on suicidal behaviour.

Implementation
A situation analysis was conducted in order to assess the severity of the problem, resources available and community needs. The development of the action plan took into consideration governance, roles and responsibilities within the Ministry of Public Health, as well as with potential partners. Key stakeholders were made responsible for specific tasks and ways to coordinate these effectively among themselves. The action plan provides leadership and clarity on the main evidence-based suicide prevention interventions and their prioritization. Much is carried out locally, adjusted to local circumstances and building on existing initiatives. The

establishment of health and well-being boards supports the setting up of effective local partnerships and helps in the development of creative ways to utilize local resources and assets.

Monitoring and evaluation

Evaluation of the components of the national strategy examines the outcome and impact of interventions vis-à-vis the stated objectives. The monitoring and evaluation plan was planned and agreed upon in advance to ensure the involvement of all relevant stakeholders. The evaluation has a set of specific, measurable, achievable, relevant and time-bound indicators which can measure the input, process, impact and outcome of individual interventions as well as of the strategy as a whole (Annex 2.2).

The main objectives of the evaluation component of this plan are:

- monitoring the incidence and prevalence of suicidal behaviour in the 10 regions of the country, ascertaining and recording the number of attempted suicides and suicides;
- evaluating the catchment, recording and processing of data collected in all levels of the surveillance system through the review of documents and procedures;
- evaluating the management and treatment of suicidal behaviour in all levels of the health system (emergency, inpatient and outpatient services, mental health services, communities) and assessing the quality and effectiveness of interventions.

Example 3. Iran, Islamic Republic of (Eastern Mediterranean Region)

The following information was summarized from the National Suicide Prevention Strategy of the Government of the Islamic Republic of Iran, called “National suicide prevention and suicide registration programmes”. For further details and references please refer to the original source.
Source: Strategy document shared by WHO Collaborating Centre, Tehran, Islamic Republic of Iran.

Context for suicide prevention
Over the last decade and a half, the Islamic Republic of Iran has implemented a pilot suicide prevention programme based on the early identification and treatment of depression in a region called Khoramabad, with successful results. In 2009, the programme was piloted in two districts and the rate of suicide was significantly reduced. Based on this, in 2010 a national suicide prevention programme was released for implementation in the public health-care system in the Islamic Republic of Iran.

Key components of the strategy

Vision	[not available]
Mission	[not available]
Time frame	2010 - [not available]
Annual budget	[not available]

Goal	Reducing suicidal behaviours in populations covered by the primary health care systems.

Objectives

Specific objectives:

1. Improve the accuracy of statistics of suicide and suicide attempts (non-fatal self-harm).
2. Reduce stigma relating to suicidal behaviour and mental health, and increase awareness of suicide, attempted suicide, and improve positive mental health promotion.
3. Improve accessibility and consistency in care pathways for the assessment and management of people vulnerable to suicidal behaviour.
4. Enhance engagement and collaboration with the media in relation to media guidelines, training and adherence to improve the reporting of suicidal behaviour and to disseminate information on positive mental health promotion.
5. Reduce access to frequently used and highly lethal methods of suicide and attempted suicide (non-fatal self-harm), including pesticides and frequently-used drugs, and to address other highly lethal methods such as hanging and self-immolation.
6. Improve and maintain the response to suicidal behaviour within health and community-based services and ensure continuity of care.
7. Improve and maintain the capacity of suicide bereavement support services and specialist interventions for people with prolonged and complicated grief.
8. Reduce the stigma of mental disorders and promote help-seeking behaviours in students.
9. Develop a national monitoring and evaluation system, promote relevant research that supports national innovation, promote the suicide prevention programme and address knowledge gaps.

Strategies
Service strategies: inclusion of suicide prevention programmes in the health-care system; reinforcing the referral system by training the staff and gatekeepers; reinforcing the support and treatment services; and providing counselling services in the community.

Executive strategies: assigning the person in charge; establishment of a national multisectoral group at national and provincial levels.

Educational strategies: public education on how to cope with daily stresses and enhancing life skills; preparing educational literature for health-care personnel at different levels; holding educational workshops; preparing educational literature for influential family members and gatekeepers in the community; and preparing guidelines for the media.

Therapeutic strategies: detection of individuals at risk of suicide and suicide survivors; providing counselling services; and follow-up of counselling and therapeutic services in persons who attempt suicide after their discharge.

Research strategies: epidemiologic evaluation of national suicide status; etiological study of suicide in the Islamic Republic of Iran; evaluation of incidence and etiology of suicide; evaluation of the effects of each intervention; evaluation of knowledge and attitude of health-care personnel and of the public towards suicide.

Action areas (separated by population level, community level, health systems and services)

- legal status of suicide and attempted suicide;
- registration of suicide and attempted suicide;
- awareness and stigma reduction;
- treatment;
- the media;
- restriction of access to means;
- crisis intervention;
- suicide bereavement/postvention;
- mental health promotion among young people.

Implementation

The first year of implementing the national prevention programme was 2010. The action plan adopted a cross-sectoral approach, with the Ministry of Health being the lead interlocutor but working in collaboration with other relevant government departments and stakeholders. The implementation of the action plan was divided into three levels: population level, community level, and health systems and services level.

Monitoring and evaluation

For the monitoring of the implementation of the national action plan, both processes and outcomes were evaluated. Alongside the process evaluations, the quality of the implementation of the actions were assessed, the progress of the implementation of actions monitored, and the outcomes measured to help determine whether the strategic actions produced the changes they intended to achieve (Annex 2.3).

Example 4. Ireland (European Region)

The following information is summarized from the government strategy called "Connecting for Life: Ireland`s National Strategy to Reduce Suicide 2015–2020". For further details and references please refer to the original source.
Source: http://www.mindbank.info/item/5640

Context for suicide prevention
Suicide prevention in Ireland was guided by "Reach Out", the first national suicide prevention strategy 2005–2014[1]. This strategy brought a focus on suicide prevention work and guided activities in this area. Reach Out set out a vision and guiding principles for suicide prevention. During that period, 96 actions and identified lead agencies were outlined. Since Reach Out, there have been significant developments in the areas of research, policy and service delivery relating to suicide prevention. The new strategy 2015-2020 Connecting for Life is very much based on Reach Out.

Key components of the strategy

Vision	An Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and well-being
Mission	[not available]
Time frame	2015-2020
Annual budget	US$ 13 073 535 in 2016

Goal	Reducing suicide and suicide attempts rate in the whole population and among specified priority groups.

Objectives

1. Improving the nation's understanding of, and attitudes to, suicidal behaviour, mental health and well-being: The language relating to suicide and mental health is often stigmatizing or misleading. By working with people and organizations across society, including the media, a greater understanding of suicide can be achieved and stigma reduced.

Specific objectives:

- Improving population-wide understanding of suicidal behaviour, mental health and well-being, and associated risk and protective factors.
- Increasing awareness of available suicide prevention and mental health services.
- Reducing stigmatizing attitudes to mental health and suicidal behaviour at population level and within priority groups.
- Engaging and working collaboratively with the media in relation to media guidelines, tools and training programmes to improve the reporting of suicidal behaviour within broadcast, print and online media.

2. Supporting local communities' capacity to prevent and respond to suicidal behaviour: Well-structured and coordinated community-based initiatives can translate into protective benefits for families and individuals, which contribute to reduced risk of suicidal behaviour.

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[1] Health Service Executive, the National Suicide Review Group and Department of Health and Children (2005) Reach Out: National Strategy for Action on Suicide Prevention http://health.gov.ie/wp-content/uploads/2014/03/reach_out.pdf, accessed 8 November 2018.

Specific objectives:

- Improving the continuation of community-level responses to suicide through planned, multi-agency approaches.
- Ensuring that accurate information and guidance on effective suicide prevention are provided for community-based organizations (e.g. family resource centres, sporting organizations).
- Ensuring the provision and delivery of training and education programmes on suicide prevention to community-based organizations.

3. Targeting approaches to reduce suicidal behaviour and improve mental health among priority groups: Considering young people aged 15–24 years, people with mental health problems of all ages, persons with alcohol and drug problems, the bereaved, prisoners and suicide, sex workers, people with chronic illness or disability, etc.

Specific objectives:

- Improving the implementation of effective approaches for reducing suicidal behaviour among priority groups.
- Supporting, in relation to suicide prevention, the Substance Misuse Strategy, to address the high rate of alcohol and drug misuse.
- Enhancing supports for young people with mental health problems or vulnerable to suicide.

4. Enhancing accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour: guaranteeing a sustained approach to preventing and reducing suicide, easy access to services, integrating care pathways across both statutory and non-statutory services.

Specific objectives:

- Improving psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour.
- Improving access to effective therapeutic interventions (e.g. counselling, dialectical behaviour therapy, cognitive behavioural therapy) for people vulnerable to suicide.
- Improving the uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide.

5. Ensuring safe and high-quality services for people vulnerable to suicide: agencies need to have good-practice guidelines, clear care protocols, and appropriate training and supervision mechanisms. All services must promote an ambition for recovery, restoring the individual's independence built on self-worth and self-belief.

Specific objectives:

- Develop and implement national standards and guidelines for statutory and non-statutory organizations contributing to suicide prevention.
- Improve the response to suicidal behaviour within health and social care services, with an initial focus on incidents with mental health services. Reduce and prevent suicidal behaviour in the criminal justice system.
- Ensure best practice among health and social care practitioners through the implementation of clinical guidelines on self-harm and the delivery of accredited education programmes on suicide prevention.

6. Reducing and restricting access to means of suicidal behaviour: implementation of strategies to restrict means can occur at the national level, via legislation and regulations, and at the local level.

Specific objectives:

- Reducing access to frequently used drugs in intentional drug overdose.
- Reducing access to highly lethal methods used in suicidal behaviour.

7. Improving surveillance, evaluation and high-quality research relating to suicidal behaviour: having real-time and better-integrated data surveillance systems for suicidal behaviour as well as accelerating the transfer of research findings into practice

Specific objectives:

- Evaluating the effectiveness and cost-effectiveness of *Connecting for Life*.
- Improving access to timely and high-quality data on suicide and self-harm.
- Reviewing (and, if necessary, revising) current recording procedures for death by suicide.
- Developing a national research and evaluation plan that supports innovation aimed at early identification of suicide risk, assessment, intervention and prevention.

Guiding principles

- collaborative: achieve together to deliver our goals;
- accountable: clear governance structures and openness in implementing the strategy;
- responsive: providing high-quality service responses;
- evidence-informed and outcome focused: action targeted to identify need and based on international best-practice recommendations;
- adaptive to change: responsive to new and emerging circumstances.

Implementation

In order to develop and implement the strategy, five supporting advisory groups were appointed, covering the areas of research, policy, practice, engagement and communications/media. The strategy was developed through an evidence-based approach and its implementation was based on knowledge of the best practice in terms of policy and services.

For an effective implementation, four incremental stages were created, each requiring different conditions and activities. These were: exploring and preparing, planning and resourcing, implementing and operationalizing, and full implementation. Multiple evidence-informed interventions were included throughout the strategy. Communication and resource plans were formulated to support the implementation of the strategy.

Connecting for Life depends fundamentally on coordination across government departments and agencies. Formal accountability, budgetary management, capacity development and evaluation structures, with clearly delineated roles and responsibilities, are central requirements for effective implementation. For government strategies with a relatively short time frame, having solid implementation structures in place facilitates monitoring of activities and puts a clear decision-making process in place, thus avoiding decisions being made hastily without clarifying accountability and implications. Five key implementation structures for *Connecting for Life* represent the different stakeholder groups involved in delivery and provide forums for engagement, facilitate monitoring and clear decision-making, and are designed to make the best use of existing structures to ensure efficient working.

Monitoring and evaluation

Monitoring and evaluation are embedded in the implementation process, 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 (Annex 2.4). These indicators measure principal outcomes to assess the achievement of the main goals, and intermediate outcomes to provide preliminary evidence of the effectiveness of the suicide prevention strategy in the shorter term. In addition to the measurement of principal and intermediate outcomes, evaluation of this strategy will include assessment of process variables. This involves assessment of the activities undertaken and of the causal pathways from inputs and activities to outcomes.

Example 5. Japan (Western Pacific Region)

The following information is summarized from a translation of the 2017 Japanese Cabinet Decision called "The general principles of suicide prevention policy: realizing a society in which no one is driven to take their own life". For further details and references please refer to the original source.
Source: http://www.mindbank.info/item/6766

Context for suicide prevention

Suicide began to be viewed as a social problem in Japan around 2005 and this triggered concrete actions. In the symposium on suicide countermeasures held in May 2005, NGOs and some members of the Diet submitted urgent proposals for comprehensive suicide prevention and the Minister of Health, Labour and Welfare vowed to tackle the issue of suicide. Subsequently, Japan's Basic Act for Suicide Prevention was signed into law in June 2006. Following this, the driving force for suicide prevention shifted from the Ministry of Health, Labour and Welfare to the Cabinet Office, and suicide prevention became a multi-ministerial government policy. In 2007, the *General principles of suicide prevention policy* were enacted, aiming to prevent suicide and provide support to survivors. In 2012 these general principles were revised[1,2] to emphasize support for young people and for those who had previously attempted suicide.

Key components of the strategy

Vision	Achieving a society in which no one is driven to take their own life.
Mission	Promoting suicide countermeasures as comprehensive support for people's lives; strengthening coordination, with related measures to deal with suicide comprehensively; interconnecting policies and measures at each level tailored to the stage of response; promoting awareness-raising and practical initiatives in parallel to each other; identifying the roles of the national government, local public entities, related organizations, private-sector entities, businesses and the people in Japan and promoting cooperation and coordination among them
Time frame	2016–2020
Annual budget	US$ 27.58 million (JPY 3.1 billion)

Goal	Reducing the suicide rate by 2026 to more than 30% below the 2015 level.

Objectives

1. Strengthening support for practical initiatives at the community level: promoting preventive measures based on the contextual conditions of suicide by encouraging research and studies in order to understand the circumstances such as social factors.

Specific objectives:

- Preparing profiles of actual local suicide conditions.
- Preparing policy packages of local suicide countermeasures.
- Supporting the formulation, etc., of local plans for suicide countermeasures.
- Drawing up guidelines for formulating local plans for suicide countermeasures.
- Assisting local support centres for suicide countermeasures.
- Promoting the establishment of full-time departments for suicide countermeasures and the assignment of full-time staff to them.

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[1] Cabinet Decision. Japanese Government. The General Principles of Suicide Prevention Policy: realizing a society in which no one is driven to take their own life. Suicide Policy Research. 2017; 1:15-44 (https://jssc.ncnp.go.jp/file/pdf/SPR2017_1_4.pdf, accessed 8 November 2018).

[2] Ministry of Health, Labour and Welfare. Guidelines for Municipal Suicide Countermeasure Planning. Suicide Policy Research. 2018; 2(1):37-65 (https://jssc.ncnp.go.jp/file/pdf/SPR2018_1_4.pdf, accessed 8 November 2018).

2. Encouraging every citizen to be aware of and to monitor potential suicide victims: promoting public awareness.

Specific objectives:

- Enacting Suicide Prevention Week and Suicide Countermeasures Strengthening Month.
- Implementing education that will contribute to suicide countermeasures among primary and secondary schools.
- Disseminating accurate information about suicide and suicide-related phenomena.
- Promoting public awareness campaigns about depression.

3. Promoting research and studies that will contribute to the promotion of comprehensive suicide countermeasures.

Specific objectives:

- Research, studies and verification related to the actual suicide conditions and the state of implementation of suicide countermeasures, etc.
- Making use of the results of research, studies and verification.
- Collecting, organizing and providing information on progressive local approaches.
- Studying suicide among children and young people.
- Shedding light on actual suicide conditions in conjunction with the system to investigate cause of death.
- Conducting interdisciplinary research to clarify the pathology of depression and other forms of mental illness, to develop methods of treatment and to make ongoing improvements to community-based care systems;
- Expediting the use and application of existing data.

4. Recruiting, training and improving the quality of personnel engaged in suicide countermeasures.

Specific objectives:

- Providing early detection of and early response to those at high risk for suicide.
- Promoting education about suicide countermeasures in coordination with universities and special vocational schools.
- Training personnel in charge of coordinating suicide countermeasures.
- Improving the skills of family doctors and other primary care providers to evaluate and respond to suicide risks.
- Awareness-raising for school staff.
- Improving the quality of care provided by community health staff and occupational health staff.
- Providing training for long-term care support specialists and others.
- Providing training for district welfare commissioners, commissioned child welfare volunteers and others.
- Improving the quality of counsellors with reference to social factors.
- Improving the quality of personnel at public agencies who deal with bereaved family members and others.
- Training gatekeepers in various fields.
- Promoting mental health care for persons engaged in suicide countermeasures.
- Assisting those who provide support, including family and friends.
- Developing training materials.

5. Advancing the promotion of mental health and providing a supportive environment for it.

Specific objectives:

- Promoting mental health measures in the workplace.
- Improving the system for furthering mental health promotion in the community.
- Improving the system for furthering mental health promotion in the schools.
- Promoting mental care for, and rebuilding the lives of, victims of large-scale disasters.

6. Ensuring that the appropriate mental health, medical care and welfare services are received.

Specific objectives:

- Improving the interconnectedness of each programme, psychiatric care, health care, welfare, etc.
- Enhancing the psychiatric care system by training personnel responsible for mental health, medical care and welfare services.

- Assigning specialists to increase the interconnectedness of mental health, medical care and welfare services.
- Improving the skills of family doctors and other primary care providers to evaluate and respond to suicide risk.
- Improving the system to provide mental health, medical care and welfare services to children.
- Implementing screening for depression and other mental illnesses.
- Promoting measures for those at high risk for psychiatric illnesses other than depression.
- Supporting cancer patients and the chronically ill.

7. Lowering the risk of suicide in society as a whole.

   Specific objectives:
   - Extending a helping hand of social support.
   - Improving counselling systems in the community and transmitting easily understandable information on support policies, counselling services, etc.
   - Improving counselling services related to multiple debts and increasing safety-net loans.
   - Improving counselling services for the unemployed.
   - Implementing counselling programmes for business owners.
   - Improving the provision of information to resolve legal problems.
   - Regulating dangerous places, drugs, etc.
   - Strengthening suicide countermeasures that make use of information and communications technology (ICT).
   - Promoting measures to deal with suicide-related information on the Internet.
   - Dealing with suicide notices on the Internet.
   - Improving support for caregivers.
   - Improving support for hikikomori (social recluses).
   - Improving support for victims of child abuse, sex crimes and sexual violence.
   - Improving support for the poor and needy.
   - Improving counselling services for single-parent families.
   - Improving support for expectant and nursing mothers.
   - Improving support for sexual minorities.
   - Strengthening outreach and ensuring a diversity of counselling methods.
   - Making well-known information-sharing mechanisms necessary for coordination between related organizations.
   - Promoting the creation of places to go to that contribute to suicide countermeasures.
   - Making the WHO guidelines known to the news media.

8. Preventing repeated suicide attempts.

   Specific objectives:
   - Strengthening measures to prevent repeat suicide attempts.
   - Equipping medical facilities that are responsible for the core functions of supporting individuals in the community who have survived a suicide attempt.
   - Upgrading the medical care system provided by psychiatrists at emergency medical facilities.
   - Strengthening comprehensive support for those who have attempted suicide by promoting coordination between medical care and the community.
   - Providing support through interconnectedness with measures to create places to go to.
   - Providing assistance to family members and other close supporters.
   - Encouraging a post-crisis response in schools and workplaces.

9. Improving support for the bereaved.

   Specific objectives:
   - Providing care for the bereaved immediately after a suicide or attempted suicide in the family.
   - Supporting the operations of self-help groups for the bereaved.
   - Encouraging a post-crisis response in schools and workplaces.

- Promoting the provision of information to the bereaved.
- Improving the quality of personnel at public agencies who deal with bereaved family members and others.
- Supporting bereaved children.

10. Strengthening coordination with private-sector entities.

Specific objectives

- Promoting suicide prevention measures.
- Supporting human resource development at private-sector entities.
- Establishing a community coordination system.
- Supporting counselling programmes by private-sector entities.
- Supporting pioneering and experimental approaches by private-sector entities as well as their efforts in places where multiple suicides have occurred.

11. Promoting suicide countermeasures among children and young people even further.

Specific objectives

- Preventing suicide in children who are victims of bullying.
- Improving support for elementary school children and junior and senior high school students.
- Promoting instruction on how to raise an SOS.
- Improving support for children.
- Improving support for young people.
- Improving support for young people tailored to their special traits.
- Supporting their friends and acquaintances.

12. Promoting suicide countermeasures for work-related problems even further.

Specific objectives

- Rectifying the practice of long working hours.
- Promoting mental health measures in the workplace.
- Measures to prevent harassment.

Goals

- Promote systems at the national level: encourage and support measures carried out by the relevant ministries and agencies to implement comprehensive suicide prevention measures, and establish a mechanism under which the national government, local authorities, related organizations, NGOs and others coordinate and cooperate so that suicide prevention measures can be promoted by the nation as a whole.
- Ensure coordination and cooperation at community level: work actively to promote the setting up of a forum to study measures formulated by committees, composed of relevant groups and agencies in various fields in the prefectures and designated cities, and the planning of such community measures by the said committees, offering appropriate support by providing information, etc.
- Policy evaluation and management: the Council on Suicide Prevention Policy shall review and improve policies on the basis of its evaluation, including verification of the implementation status of policies based on the General Principles and the establishment of new mechanisms to assess the policies' effectiveness.
- Review of the *General principles of suicide prevention policy* every five years, based on socioeconomic changes, in the circumstances surrounding suicide, the progress made in implementing policies, the status of achieving the policies' goals, etc.

Implementation

Identifying the roles of the national government, local public entities, related organizations, private-sector entities, businesses and the people of Japan, and promoting cooperation and coordination between them.

Monitoring and evaluation

The Japan Support Center for Suicide Countermeasures put suicide countermeasures into practice through encouragement of research into the policy-making process at each step of the planning cycle.

Example 6. Namibia (African Region)

The following information is summarized from the 2011 strategic plan of the Namibian Ministry of Health and Social Services, called “National Strategic Plan on the Prevention of Suicide in Namibia 2012–2016”. For further details and references please refer to the original source.
Source: https://www.mindbank.info/item/6272

Context for suicide prevention
Before the strategy was implemented, a national SWOT analysis revealed that Namibia was struggling with a lack of qualifications and infrastructure, as well as high levels of stigmatization and governmental fragmentation. This analysis was the core information that guided Namibia to address the problem of suicide and its prevention. Namibia was the first country in the African region to introduce a national suicide prevention strategy. With the introduction of the National Strategic Plan on the Prevention of Suicide in Namibia, multi-professional teams received an opportunity to address the challenges through suicide prevention programmes, workshops, training sessions, counselling and other awareness-raising campaigns. The National Strategic Plan was developed in collaboration with all stakeholders in the field of suicide prevention.

Key components of the strategy

Vision	To be a nation free of suicide
Mission	Providing comprehensive, affordable and accessible services by relevant stakeholders pertaining to suicide
Time frame	2012–2016
Annual budget	[not available]

Goal	[not available]

Objectives

1. Objectives regarding constituency/stakeholders

   Specific objectives
   - Ensuring a responsive legislative/ policy framework.
   - Fostering an improved relationship with stakeholders.
   - Ensuring an accountable coordinating body.
   - Ensuring accessibility to support services.
   - Ensuring reduced incidences of suicide.
   - Strengthening the stewardship role of the steering committee.
   - Ensuring strengthened suicide services.
   - Fostering an adequate understanding of the suicide phenomenon.

2. Objectives for internal processes

   Specific objectives
   - Ensuring strengthened suicide services.
   - Ensuring implementation of the national strategic suicide prevention plan.
   - Ensuring decentralized services.
   - Ensuring a functional coordination body.
   - Ensuring efficient coordination of suicide services.
   - Ensuring public awareness of suicide.
   - Ensuring establishment of an accurate database.

3. Objectives on learning and growth

Specific objectives

- Ensuring skilled service providers.
- Building capacity of relevant stakeholders on expertise, knowledge and skills.
- Ensuring a motivated workforce.
- Ensuring positive staff morale.

4. Objectives for budget and finance

Specific objectives

- Ensuring availability of funds.
- Ensuring equitable and efficient allocation of resources among ministries, directorates and stakeholders.
- Ensuring effective financial management.

Implementation

[Not available].

Monitoring/evaluation

[Not available]; see indicators (Annex 2.5)

Example 7. Republic of Korea (Western Pacific Region)

The following information was summarized from the government plan, “Life Love Plan: Third Basic Plan for Suicide Prevention”. For further details and references please refer to the original source.
Source: Strategy document shared by the Korea Suicide Prevention Center.

Context for suicide prevention

The Life Love plan for suicide prevention developed by the Republic of Korea was the country’s third national plan for the prevention of suicide, following two earlier national strategies that succeeded in reducing suicide and reversing the trend of an increase in the rates of suicide in the country. After the Act for Prevention of Suicide and the Creation of Culture of Respect for Life was enacted and promulgated in 2011, the Republic of Korea saw a drop in suicide rates from 31.7 per 100 000 people to 27.3 in just three years, despite anticipated and sometimes still existent challenges such as the lack of government-wide cooperation, and the lack of tailored strategies, depression treatment and infrastructure. This reduction of 13.8% in just three years was a huge achievement and illustrated the effectiveness of the national strategy as a whole. It represented the government’s and all the stakeholders’ commitments to reduce suicide in the Republic of Korea.

Key components of the strategy

Vision	Create safe and healthy communities free from suicide, reduce the risk of suicide and strengthen suicide prevention capabilities of people
Mission	[not available]
Time frame	2016–2020
Annual budget	KRW 148.14 billion total for 2016–2020

Goal	Lowering the rates of suicide from 27.3 per 100 000 in 2014 to 20.0 per 100 000 (a reduction of 26.7%)

Objectives

1. Enabling society-wide suicide prevention.

   Specific objectives
   - Improve social awareness of suicide: creating a culture of respect for life and enhancing suicide prevention (with campaigns, supporting groups, improving press releases related to suicide, organizing campaigns during months when suicide rates are high, media coordination).
   - Create a social support system to prevent suicide: enhancement of a social safety net; system of pan-governmental suicide prevention and cooperation with local governments.
   - Improve the environment to reduce the risk of suicide: blocking access to means of suicide (hazardous materials management, improving risk environment); blocking harmful information online.

2. Providing suicide prevention services.

   Specific objectives
   - Pursue suicide prevention measures by life stage: creating specific child and adolescent suicide prevention programmes; adolescent and middle-aged adult suicide prevention (e.g. in the workplace, in colleges); suicide prevention among older people (e.g. integration services, early detection systems).
   - Enhance a high-risk group support system: suicide prevention measures to target specific high-risk groups (e.g. bereaved families, those with physical illness, the unemployed and poor); specific suicide prevention guidelines regarding severely ill patients; integration across the welfare system.
   - Prepare an emergency response and follow-up management system: 24-hour suicide crisis response system; preparing a follow-up care system for suicide attempters.

3. Enhancing suicide prevention pursuing base.

Specific objectives

- Enhance regional response to suicide: improving suicide prevention competency of primary medical institutions (e.g. introduction and improvement of identification and treatment, distribution of guidelines).
- Strengthen mental health infrastructure: improving regional and national mental health services delivery system (e.g. through gatekeepers); training experts.
- Secure suicide prevention human resources: expanding cultivation of gatekeepers, enhancing training of experts (e.g. medical and mental health professionals).
- Prepare an evidence-based suicide prevention research system: pursuing a suicide observatory; conducting evidence-based research (e.g. psychological autopsy).

Implementation

The Republic of Korea's Life Love plan drew upon evidence-based interventions from comprehensive strategies of other nations and tailored these interventions to fit the Korean culture and context. The plan was therefore tailored to the country's specific needs, establishing best practices and evidence-based interventions in a comprehensive approach. It also clearly identified the challenges that the strategy would face. Furthermore, the objectives outlined by the Republic of Korea's national strategy envisaged the accomplishment of both short-to-medium and long-term objectives, which were to be evaluated using indicators which would then feed into future planning. Each of the sub-responsibilities within the three broader strategies were allocated to specific ministries.

Monitoring and evaluation

Suicide services assessment is an integral part of the plan. The plan identified a number of indicators to establish this aim (Annex 2.6).

Example 8. Switzerland (European Region)

The following information was summarized from the government plan called “Suicide prevention in Switzerland. Initial situation, need for action and action plan”. For further details and references please refer to the original source.
Source: http://www.mindbank.info/item/6764

Context for suicide prevention
In 2005, the Government of Switzerland published a report called *Suicide and suicide prevention in Switzerland* [“Suizid und Suizidprävention in der Schweiz”], which described the possibilities of suicide prevention, suicide prevention programmes in other countries and projects. In 2014, the Federal Council received the task of strengthening suicide prevention throughout Switzerland by accepting a motion [“Motion Ingold 11.3973”]. As a result, the Swiss Federal Office of Public Health, the Cantonal Health Directors and the Swiss Foundation for the Promotion of Health have jointly developed a suicide prevention action plan.[1]

Key components of the strategy

Vision	Lower the rate of suicide and suicide attempts further and sustainably
Mission	Reduce the number of suicides
Time frame	2016 - [not available]
Annual budget	CHF 100 000 CHF (for knowledge base, coordination, networking and measures)

Goal	Reduce suicide mortality by 25% by the year 2030 (as compared to 2013), achieving a suicide rate of 10 per 100 000 population (men: 15 per 100 000 and women: 5 per 100 000 population); reduce the number of suicides by 300 per year.

Objectives

1. Strengthen personal and social resources in dealing with emotional burdens, as personal and social resources can strengthen psychological resistance.

   Specific objective: Strengthening personal and social resources in the different stages of life through learning life skills (to solve problems, to communicate and to lead relationships, to be empathetic, to exercise critical thinking, etc.).

   Key measure/activity: Implementing interventions that strengthen personal and social resources in children, adolescents, adults and older people.

2. Sensitize and inform: sensitization measures contribute to de-stigmatization of suicidal behaviour and provide information on prevention.

   Specific objective: Informing and raising awareness about suicide.

   Key measures/activities: 1) Designing suicide prevention campaigns which provide information about the phenomenon of suicide and preventive actions, and 2) implementing awareness-raising campaigns which provide contact information and prevention options.

[1] Bundesamt für Gesundheit (Federal Office of Public Health). Aktionsplan Suizidprävention Schweiz Action plan on suicide prevention in Switzerland) https://www.bag.admin.ch/bag/en/home/strategie-und-politik/politische-auftraege-und-aktionsplaene/aktionsplan-suizidpraevention.html, accessed 8 November 2018.

3. Provide easy access to help: people affected by suicidal behaviours and their environment know and use counselling and emergency services.

   Specific objective: Providing assistance and promoting its use.

   Key measure/activity: Offering consultancy and emergency services for everyone (24-hour services, youth/adult care, etc.).

4. Early detection and intervention: the early detection of suicidal behaviours and interventions can avoid or reduce fatal and non-fatal consequences.

   Specific objective: Recognizing suicidal behaviours in their early stages and providing appropriate assistance.

   Key measures/activities: 1) Promoting education on suicide prevention for professionals, specifically for addressing target groups in medical and nonmedical settings, and 2) facilitating early detection and early intervention through processes and protocols by health organizations and institutions.

5. Effective management and treatment: people who made a suicide attempt and those suffering after a suicide need to receive prompt follow-up.

   Specific objective: Treating and following up the people at risk for suicide quickly and effectively.

   Key measures/activities: Applying measures from the report The future of psychiatry in Switzerland, taking into account the specific needs of vulnerable groups and those who attempt suicide.

6. Suicide means and methods: restricting access to means of suicide is effective because people with suicidal behaviours usually prefer a particular method or even a particular place.

   Specific objective: Reducing the availability of means and methods through collaboration of different sectors: rail transport sector, sale of firearms, products of the chemical industry, etc.

   Key measures/activities: 1) Developing guidelines and norms for the construction of buildings to prevent suicide, as well as sensitizing and informing building construction specialists, 2) reviewing and establishing regulations for selling medical products, 3) controlling the prescribing and dispensing of medications, and 4) restricting the private storage of firearms on a voluntary basis.

7. Survivors and professionals involved: suicide causes great suffering to survivors and to those who are involved in a professional capacity.

   Specific objective: Providing support to survivors, families and professionals in accordance with their needs.

   Key measure/activity: Establishing services such as self-help groups, individual care, programmes for vulnerable groups, etc.

8. Media reporting for suicide prevention and digital communication: the media reporting after suicides can lead to imitation of suicides.

   Specific objective: Promote suicide-preventive media reporting as well as suicide-preventive use of digital communication.

   Key measure/activity: 1) Supporting journalists and media speakers to report responsibly about suicides, and 2) raising awareness about the proper use of the Internet and other communication channels among young people.

9. Monitoring and research: suicide data allow for evaluating and controlling the actions implemented.

   Specific objective: Collecting information and data on suicide and using these to assess the effectiveness of interventions and programmes.

   Key measures/activities: 1) Collecting data and evaluating suicide prevention interventions, and 2) research to fill knowledge gaps about primary, secondary and tertiary suicide prevention.

10. Examples of good practice: the dissemination of good practice examples enables the actors to make use of synergies and to implement effective suicide prevention.

    Specific objective: Providing good practice examples for suicide prevention to stakeholders.

    Key measures/activities: Reviewing and proposing evidence-based and best practice examples of suicide prevention and making them available to stakeholders.

Implementation
The federal government, specifically the Federal Office of Public Health, coordinates and supports all stakeholders in the implementation of the action plan, establishing networking groups. The main stakeholders who work closely with the federal government are the network of mental health, the cantons and Swiss health promotion institutions.

The action plan provides a common framework for action, with a number of key measures and actions. These are based on national and international examples of evidence and good practice. In particular, the federal government focuses its efforts on objectives 9) Monitoring and research and 10) Examples of good practice, and supports the implementation of the action plan as a whole through processing of data and providing evidence-based practice. The regional governments (cantons) are also responsible for various important areas of suicide prevention, such as the cantonal health care and welfare systems, the educational institutions, the police and judicial institutions.

Monitoring and evaluation
Evaluation is focused on quantifying the efficiency and effectiveness of past actions for the entire population; people with suicidal behaviours (including those with previous attempts) as a consequence of being exposed to risk factors; the environment; and professionals and other people involved in suicide prevention.

Example 9. USA (Region of the Americas)

The following information was summarized from the government plan, called "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action". For further details and references please refer to the original source.
Source: https://www.mindbank.info/item/2094

Context for suicide prevention
Suicide became a central issue in the USA in the mid-1990s, when survivors of suicide who were bereaved saw the need to bring the issue to federal attention in politics. Based on this, the first document *The Surgeon General's call to action to prevent suicide* was developed, introducing a blueprint for addressing suicide prevention and making 15 broad recommendations consistent with public health policy.[1] This then led to the development of the first National Strategy for Suicide Prevention in 2001.[2] Also in 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA), with the support of many national organizations, established a national network of crisis centres answering a national toll-free suicide hotline number, which has become the national suicide prevention lifeline. The lifeline answered more than two million calls in 2017.

The Suicide Prevention Resource Center was created in 2002 to promote the implementation of the national strategy. In 2005, the Congress passed, and the President signed into law, the Garrett Lee Smith Memorial Act launching a national youth suicide prevention effort based on the national strategy. Evaluations of this effort have shown reduced youth suicides and suicide attempts in counties implementing the grants compared to matched counties that were not. The national suicide prevention strategy also called for the development of comprehensive state suicide prevention plans and a national reporting system for violent deaths. Further milestones include the formation of the National Action Alliance for Suicide Prevention in 2010, and the revision of the national strategy in 2012.[3] The Alliance, a public-private partnership, is fulfilling the role of the coordinating/lead agency.

Key components of the strategy

Vision	A nation free from the tragedy of suicide: preventing suicide and promoting health, resilience, recovery and wellness for all
Mission	Reduce suicide through comprehensive implementation of the National Strategy for Suicide Prevention
Time framework	2012–2022 (the revised National Strategy for Suicide Prevention was designed as the nation's blueprint for the next decade and was published in 2012)
Annual budget	US$ 69 million (Congressional appropriation to SAMHSA to implement national suicide prevention efforts, but not the entire federal investment in suicide prevention in the USA)

Goal	Increasing the number of Americans who are healthy at every stage of life, by shifting from a focus on sickness and disease to a focus on wellness and prevention; reducing rates of suicide by 20% by 2025.

[1] The Surgeon General's call to action to prevent suicide. Washington (DC): U.S. Public Health Service; 1999 (https://profiles.nlm.nih.gov/ps/access/nnbbbh.pdf, accessed 8 November 2018).

[2] National strategy for suicide prevention: goals and objectives for action. Rockville (MD): U.S. Department of Health and Human Services; 2001 (https://www.ncbi.nlm.nih.gov/books/NBK44281/pdf/Bookshelf_NBK44281.pdf, accessed 8 November 2018).

[3] National strategy for suicide prevention: goals and objectives for action. A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington (DC): U.S. Department of Health and Human Services; 2012 (https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf, accessed 8 November 2018).

Objectives

1. Healthy and empowered individuals, families and communities: creating supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviours and related problems.

   Specific objectives:

   - Integrating and coordinating suicide prevention activities across multiple sectors and settings.
   - Implementing research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviours.
   - Increasing knowledge of the factors that offer protection from suicidal behaviours and that promote wellness and recovery.
   - Promoting responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and safe online content related to suicide.

2. Clinical and community preventive services: developing support systems, services and resources be in place to promote wellness and help individuals successfully navigate challenges.

   Specific objectives:

   - Developing, implementing, and monitoring effective programmes that promote wellness and prevent suicide and related behaviours.
   - Promoting efforts to reduce access to lethal means of suicide among individuals with an identified suicide risk.
   - Providing training to community and clinical service providers on the prevention of suicide and related behaviours.

3. Treatment and support services: guaranteeing evidence-based approaches for caring for high-risk patients, including safety planning and specific forms of psychotherapy that can be used to support treatment for underlying mental health conditions.

   Specific objectives:

   - Promoting suicide prevention as a core component of health care services. Promoting the adoption of "zero suicides" as an aspirational goal by health care and community support systems that provide services and support to individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
   - Promoting and implementing effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviours.
   - Providing care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

4. Surveillance, research, and evaluation: promoting public health surveillance through the systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality.

   Specific objectives:

   - Improving the timeliness and usefulness of national surveillance systems relevant to suicide prevention as well as the ability to collect, analyse, and use this information for action.
   - Promoting and supporting research on suicide prevention.
   - Evaluating the impact and effectiveness of suicide prevention interventions and systems and synthesizing and disseminating findings.

Priority areas

- Integrate suicide prevention into health care reform and encourage the adoption of similar measures in the private sector.
- Transform health-care systems to significantly reduce suicide.
- Change the public discourse about suicide and suicide prevention.
- Improve the quality, timeliness, and usefulness of surveillance data regarding suicidal behaviours.

Implementation

SAMHSA, in coordination with the National Action Alliance for Suicide Prevention and the Office of the Surgeon General, published an implementation assessment report in 2017.[4]

Monitoring and evaluation

Implementation of the National Strategy for Suicide Prevention is monitored by the National Action Alliance for Suicide Prevention and the Federal Working Group on Suicide Prevention. Evaluation of national suicide prevention efforts focused on youth were published in the peer-reviewed journals.

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[4] Substance Abuse and Mental Health Services Administration. National Strategy for Suicide Prevention Implementation Assessment Report. HHS Publication No. SMA17–5051. Rockville (MD): Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2017 (https://store.samhsa.gov/system/files/sma17-5051.pdf, accessed 8 November 2018).

Example 10. Uruguay (Region of the Americas)

The following information was summarized from the government plan, called "National Suicide Prevention Plan". For further details and references please refer to the original source.
Source: https://www.mindbank.info/item/3288

Context for suicide prevention

Relevant activities on suicide prevention had already been developed and implemented before the current plan. In 2006, the Technical Advisory Committee of the National Mental Health Programme (NMHP), and specifically its technical group on violence and violent deaths, prepared guidelines and recommendations regarding suicidal behaviour. In 2008, the *Prevention and detection guide of risk factors for suicidal behaviour* was published.[1] This document was widely distributed at various events, and in public, private and nonprofit health services in the country. Also, special training workshops based on the guide were carried out for the fire and police department. In 2010, the NMHP published *Strategic guidelines for suicide prevention*[2] and the following year the first national plan for suicide prevention was developed.

Key components of the strategy

Vision	Improving the quality of life and mental health of the general population, considering the distinctive geographical features
Mission	[not available]
Time frame	2011–2015
Annual budget	[not available]

Goal	Reduce suicide mortality by 10% from 2011 to 2020.

Objectives

1. Organizing comprehensive mental health care: Providing treatment and follow-up for mental disorders is an effective measure to prevent suicide.

   Specific objectives:

   - Designing a manual to define and organize a network of care for those who attempted suicide, and interdisciplinary teams to ensure comprehensive care to individuals and their families.
   - Increasing the coverage of mental health services for those who attempted suicide, as well as their families.
   - Developing a regulatory framework for those who attempted suicide and their families.

2. Developing an intersectoral network.

   Specific objective:

   - Strengthening the social, interinstitutional and intersectoral network, promoting a comprehensive approach for the problem of suicide.

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[1] Programa Nacional de Salud Mental. Guías de prevención y detección de factores de riesgo de conductas suicidas, Montevideo: Ministerio de Salud Pública del Uruguay; 2008 (http://www.msp.gub.uy/sites/default/files/archivos_adjuntos/Gu%C3%ADas%20de%20detecci%C3%B3n%20de%20factores%20de%20riesgo%20suicida.pdf, accessed 8 November 2018).

[2] Líneas estratégicas para la prevención del suicidio, Montevideo: Ministerio de Salud Pública, Programa Nacional de Salud Mental; 2010 (http://www.mec.gub.uy/innovaportal/file/19089/1/plan_nacional_de_prevencion_del_suicidio.pdf, accessed 8 November 2018).

3. Raising awareness and educating the community about mental health and suicide.

   Specific objectives:

   - Promoting mental health awareness with timely and meaningful community engagement and working towards the de-stigmatization of mental disorders.
   - Promoting the training of trainers for mental health promotion and suicide prevention.
   - Incorporating mental health programmes on promotion and prevention in the education sector, police force, etc.

4. Educating, training and reorienting human resources for addressing suicide prevention and care for suicide attempters and survivors.

   Specific objective:

   - Improving human resources training in health promotion, prevention, diagnosis, treatment and the follow-up of people at risk of suicide.

5. Developing and implementing a national surveillance system for fatal and non-fatal suicides.

   Specific objectives:

   - Improving the national data on suicide attempts and suicides, implementing a national surveillance system with mandatory registration and follow-up of cases.
   - Generating evidence on the effectiveness of strategies for suicide prevention and their implementation.

Implementation

A National Commission was assigned to articulate, supervise, evaluate and monitor the national suicide prevention plan. The National Commission is composed of representatives of the Ministry of Public Health, the Ministry of Education and Culture, and the Ministry of Interior. The National Commission coordinates the actions of the plan through different subcommissions and working groups. These groups are responsible for developing the strategies and activities of the plan. The groups are composed of, for instance, members of scientific societies, universities, civil servants, and representatives of NGOs and community health services.

Monitoring and evaluation

Indicators were developed based on the goal and objectives (Annex 2.7).

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WHO (2016). Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. Geneva: World Health Organization.

WHO (2018a). Global health estimates. Geneva: World Health Organization (http://www.who.int/healthinfo/global_burden_disease/en, accessed 8 November 2018).

WHO (2018b). Preventing suicide: a community engagement toolkit. Geneva: World Health Organization.

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Zalsman G, Hawton K, Wasserman D, van Heeringen K, Arensman E, Sarchiapone M et al. (2016). Suicide prevention strategies revisited: 10-year systematic review. Lancet. http://dx.doi.org/10.1016/S2215-0366(16)30030-X.

Annex 1. Countries known to have a national suicide prevention strategy

Countries which are known to have a stand-alone national suicide prevention strategy adopted by the government are listed below.

In addition, several countries have integrated suicide prevention into their mental health or other health plan, e.g. Chad, Cook Islands, Croatia, Ecuador, El Salvador, India, Marshall Islands, Monaco, Mozambique, Philippines, Romania, Russian Federation, Slovakia, Spain, Timor-Leste, Turkey, Uganda, Vanuatu. Other examples are Canada with a national framework but not a national strategy, Belgium, where suicide prevention is organized at regional level, Germany with a national initiative but not a government-adopted strategy, and Croatia and Italy with specific programmes for subpopulations (WHO, 2018c).

Country	WHO Region	National strategy document link / comment
Namibia	AFR	https://www.mindbank.info/item/6272
Argentina	AMR	Strategy document not available
Chile	AMR	https://www.mindbank.info/item/5651
Costa Rica	AMR	Strategy document not available
Cuba	AMR	Strategy document not available
Dominican Republic	AMR	https://www.mindbank.info/item/6094
Guyana	AMR	https://www.mindbank.info/item/6321
Nicaragua	AMR	https://www.mindbank.info/item/2849
Panama	AMR	https://www.mindbank.info/item/6093
Suriname	AMR	https://www.mindbank.info/item/6765
USA	AMR	https://www.mindbank.info/item/2094
Uruguay	AMR	https://www.mindbank.info/item/3288
Afghanistan	EMR	Strategy document not available
Iran, Islamic Republic of	EMR	Strategy document shared by WHO Collaborating Centre, Tehran
Austria	EUR	https://www.mindbank.info/item/4036
Belarus	EUR	https://www.mindbank.info/item/6756
Bulgaria	EUR	https://www.mindbank.info/item/6089
France	EUR	https://www.mindbank.info/item/857
Ireland	EUR	https://www.mindbank.info/item/5640
Israel	EUR	Strategy document not available
Lithuania	EUR	https://www.mindbank.info/item/6755
Luxembourg	EUR	https://www.mindbank.info/item/6095
Netherlands	EUR	https://www.mindbank.info/item/4288
Norway	EUR	https://www.mindbank.info/item/5371
Portugal	EUR	https://www.mindbank.info/item/2343
Sweden	EUR	https://www.mindbank.info/item/5200
Switzerland	EUR	https://www.mindbank.info/item/6764

Country	WHO Region	National strategy document link / comment
United Kingdom	EUR	https://www.mindbank.info/item/4911
Uzbekistan	EUR	http://www.mindbank.info/item/6763
Bhutan	SEAR	https://www.mindbank.info/item/6176
Sri Lanka	SEAR	https://www.mindbank.info/item/6096
Thailand	SEAR	Strategy document not available
Australia	WPR	https://www.mindbank.info/item/6781
Fiji	WPR	https://www.mindbank.info/item/5909
Japan	WPR	http://www.mindbank.info/item/6766
Malaysia	WPR	Strategy document not available
New Zealand	WPR	https://www.mindbank.info/item/3839
Republic of Korea	WPR	Strategy document shared by Korea Suicide Prevention Center

Source: MiNDbank (https://www.mindbank.info/, accessed 8 November 2018). MiNDbank is an online platform for resources and national/regional level policies, strategies, laws and service standards for mental health and related areas.
Notes: AFR = African Region, AMR = Region of the Americas, EMR = Eastern Mediterranean Region, EUR = European Region, SEAR = South-East Asia Region, WPR = Western Pacific Region.

Annex 2. Monitoring and evaluation indicators

The indicators used by the example countries (section 4) that have indicators specified in their national suicide prevention strategy documents are listed below, by country (i.e. Bhutan, Guyana, Iran (Islamic Republic of), Ireland, Namibia, Republic of Korea, Uruguay). No indicators were specified in the documents from Japan, Switzerland and the USA, and are therefore not presented here.

The sole purpose for listing the indicators here is to provide examples. Neither the strategy documents nor the indicators within them have been peer-reviewed. In general, it is important, and a particular effort should be made, to identify intermediate outcomes that are clearly and directly related to the primary outcomes of reducing suicide and suicide attempts.

2.1 Bhutan (South-East Asia Region)
Source: http://www.mindbank.info/item/6176

Indicators		Targets 2015–2018
1. Objective: Improving leadership, multisectoral engagement and partnerships for suicide prevention in the communities		
1.1	Secondary schools covered with at least one choshed leyrim visit by lam neten/khenpo per year that included suicide prevention	100 schools per year with one choshed leyrim for 90% of the students
1.2	Stakeholder yearly activity plan outlined in the action plan supported with funding from government or other sources	85%
1.3	Dzongkhags that included a suicide prevention agenda in the dzongkhag tshogdue at least once in a year	20
1.4	Dzongkhags reporting suicide prevention implementation indicators within the Government Performance Monitoring System (GPMS)	20
2. Objective: Strengthen governance and institutional arrangements to effectively implement comprehensive suicide prevention plans		
2.1	Meetings conducted by national SPSC at least twice a year with the required quorum	2 meetings with the required quorum per year from 2016 through 2018
2.2	National Suicide Prevention Programme with full-time staff	One full-time staff by June 2015 and second full-time staff by June 2017
2.3	Incidents attended by Dzongdag's Suicide Prevention Response Team to rescue suicide attempters	200
3. Objective: Improving access to suicide prevention services and support for individuals in psychosocial crisis and those most at risk for suicide		
3.1	One operational 24-hour national crisis helpline for suicide prevention	One centre functional by December 2015

Indicators		Targets 2015–2018
3.2	Number of crisis callers counselled through the helpline crisis centre	600
3.3	Number of people with suicide attempts including intentional self-harm provided with counselling in the health facilities	200
3.4	Patients presenting with suicidal ideation/intentional self-harm, followed up after discharge through one of the following modes: 1) telephone call, 2) SMS and 3) email, as per the protocol	70%
4. Objective: Improve the capacity of health services and gatekeepers to provide suicide prevention services		
4.1	Number of peer counsellors certified by the Bhutan Board of Certified Counsellors (BBCC), including school counsellors	100
4.2	Number of health workers, police personnel and other staff certified in crime, forensic and medico-legal investigations (1–2 months course duration)	30
4.3	Develop forensic court procedures for criminal and suicide investigations	2 procedures
4.4	Completed and attempted suicide investigations conducted by health workers and police personnel trained in medico-legal investigations	75%
4.5	Number of health facilities with at least one health worker trained in mental health and suicide risk assessment	150
4.6	Patients screened for mental health and suicide risk factors using the assessment tools at the 1) outpatient department, 2) indoor and 3) antenatal care settings for postnatal depressions	60%
4.7	Number of drop-in centres (DICs), rehabilitation centres and health information and service centres (HISCs) using the revised form that includes mental health and suicide risk assessment	16
4.8	Number of detoxification units in hospitals providing timely follow-up in at least 60% of detoxified clients per protocol	15
4.9	Number of health facilities that adopted mental health assessment and suicide risk assessment tools for general patient examination as a checklist	80
4.10	Number of clients with suicidal thoughts, ideation and severe self-harm cross referred to services from gatekeepers including: school, community-based support system (CBSS) volunteers, DICs, HISCs, rehabilitation centres, after establishing the memorandum of understanding for referrals using the client referral protocol	200
4.11	Number of clients attending detoxification services in the four Detoxification Excellence Health Centres	150
4.12	Number of health facilities with at least one health worker trained in detoxification and de-addiction services	120

Indicators		Targets 2015–2018
5. Objective: Improving community resilience and societal support for suicide prevention in communities, including schools and institutions		
5.1	Number of schools (all levels) undertaking yearly in-school mandatory two-hour orientation session for teachers on mental health, identification of behavioural disorders and suicidal behaviours among students and teachers	400
5.2	Districts reporting school guidance and counselling services within the Government Performance Monitoring System (GPMS) of the dzongkhag	20
5.3	Number of school children in distress and life triggering events counselled by school guidance counsellors	1000 per year
5.4	Number of lower, middle and higher secondary schools with at least 25 students trained and engaged in peer helpers programme in schools	75%
5.5	Middle and higher secondary schools including private schools with full-time school guidance counsellors reporting monthly counselling service reports to the Career Education and Counselling Division (CECD)	90
5.6	Schools receiving at least one supportive supervision visit per year for School Guidance and Counselling (SGC) by trained SGC supervisors	1 visit per school per year by trained supervisors
5.7	Parents attending at least one session per year on School Parenting Education Awareness (SPEA) Programme in lower, middle and higher secondary schools	Coverage of 50% of the parents in 60% of the schools per year
5.8	Number of clients in psychosocial distress (including victims of domestic violence) requiring psychosocial support identified and given on-site support by the CBSS volunteers disaggregated by rural and urban areas	2500
5.9	Number of male clients in psychosocial distress requiring psychosocial support identified and given on-site support by the CBSS volunteers disaggregated by rural and urban areas	500
5.10	Number of alcohol and drug users reached through self-help and peer network groups in the communities	300
5.11	Number of community confidantes identified in gewogs and providing informal community services for solving relationship problems and other social disputes	600
5.12	Number of community events conducted by youth groups and community-based groups to advocate self-help seeking behaviours or suicidal thoughts and promoting mental health	3 per year
6. Objective: Improving data, evidence and information for suicide prevention planning and programming		
6.1	National Registry of Deliberate Self-Harm and Violent Deaths established and in use for data collection	1
6.2	Key focal person of the Royal Bhutan Police, health workers, and counsellors trained in the national registry	200

Indicators		Targets 2015–2018
6.3	Yearly assessment report of the National Suicide Action Plan printed and distributed	400
6.4	School Guidance and Counselling database which includes deliberate self-harm and suicidal intent and ideation developed and in use for monthly report collection	1
6.5	Number of national surveys and studies conducted that included questions on suicidal thoughts, ideation and other suicidal behaviours included in surveys such the Bhutan Living Standards Survey, primary health care surveys, and the Children Study	2-3
6.6	Health management and information system (HMIS) reporting suicidal behaviours and intent with the revised ICD coding	By December 2016

2.2 Guyana (Region of the Americas)
Source: https://www.mindbank.info/item/6321

Indicators	Targets 2015–2020
1. Objective: To develop a comprehensive plan of activities for the promotion of healthy lifestyles and effective prevention of suicidal behaviour	
% of health units implemented the National Suicide Prevention Plan across the country	100%
Number of promotional activities to change lifestyles in communities, monthly	3
% of doctors, nurses, health workers trained in communication techniques to educate population	80%
Number of functional counselling facilities in at-risk areas identified. (Regions 2, 3, 4, 5, 6)	5 (one per region)
Numbers of supportive information materials distributed to the population	500
Services to prevent suicide through suicide prevention helpline	3
Reduction to 0 of negative reporting about suicidal behaviour by media propaganda	0
2. Objective: To strengthen the health and social system response to suicidal behaviour	
Number of health facilities to provide mental health services to people at risk or who attempted suicide	12
Reduction in number of suicide cases	≤ 150/year
Reduction in number of suicide attempt cases	10-12 x 1 suicide attempt reduction reported
% of cases with suicidal behaviour receiving a control and follow-up by psychiatrist	30%
% of cases with suicidal behaviour receiving a control and follow-up by doctor in community	50%
Number of cases with suicidal behaviour in special group (children, adolescents and older people)	Cases reported by group
Number of training activities done by region, monthly	1/month/region
Number of regions implementing regulated sale, use, and storage of toxic chemicals	10
3. Objective: To strengthen human resources in the health system for suicidal behaviour management	
% of doctors, nurses, health workers trained in management of suicidal behaviour	50%

Indicators	Targets 2015–2020
% of personnel trained to provide crisis care, in remote areas and vulnerable populations	According to identified areas (5)
Number of NGO networks to promote shared learning	5
% of communities with community members who have monitored access to pesticides	30%
% of specific social and non-health professionals trained in the risk, consequences and management of suicidal behaviour (teachers and other school staff; police, fire fighters and other first line responders; counsellors; and media professionals; workers in prisons)	50%
4. Objective: To improve data collection and research for effective evaluation and interventions for suicidal behaviour	
Data, collected through a routine system	30
% of cases for whom the questionnaire for the control and classification of suicidal behaviour was completed	80%
% of cases reported as suicide as the cause of death according to registration of death	80%
% of statistical reported cases with completed declaration card of suicidal behaviour	90%
Number of research conducted in the country about suicidal behaviour	10

2.3 Iran, Islamic Republic of (Eastern Mediterranean Region)
Source: Strategy document shared by WHO Collaborating Centre, Tehran, Islamic Republic of Iran

Targets	Indicators
1. Objective: To improve the accuracy of statistics of suicide and suicide attempts (non-fatal self-harm)	
Increasing knowledge of health staff concerning suicide registration in different levels	Knowledge of health-care workers concerning suicide registration (comparing before and after training)
Improving consistency between MoH and forensic medicine data	Proportion of universities that have corrected their annual data on suicide with the data of the Legal Medicine Organization
Establishing a monitoring system for controlling quality of data based on national protocol	Established monitoring system
Increase coverage of data collection	Proportion of universities that are controlling the data according to the national protocol
2. Objective: To reduce stigma relating to suicidal behaviour and mental health, and to increase awareness of suicide, attempted suicide, and improve mental health promotion	
Increasing knowledge and awareness and also correcting attitude of the general population (mental health literacy) in the field of mental health and suicide	Proportion of the population that has been educated in mental health and suicide prevention
Increasing knowledge and help-seeking behaviour in at least 70% of at-risk and high-risk groups for suicide	Proportion of high-risk population that has been educated in mental health and suicide prevention
3. Objective: To improve accessibility and consistency in care pathways for the assessment and management of people vulnerable to suicidal behaviour	
Keeping 80% of the suicide attempters in referral systems	Proportion of suicide attempters that can be traced in the referral system
Educating 100% of the health system staff in early detection of people that are at risk or high risk of suicidal behaviours	Proportion of health-care workers trained in each district
Educating gatekeepers in early identification of the people that are at risk or high risk of suicidal behaviours	Proportion of gatekeepers trained in each district
Collaboration with welfare organizations in 100% of universities through a memorandum of understanding (for active mutual collaboration between social emergency line and health centres)	Proportion of universities which have held meetings and signed a memorandum of understanding with a welfare organization

Indicators	Targets 2015–2020
4. Objective: To enhance engagement and collaboration with the media in relation to media guidelines, training and adherence to improve the reporting of suicidal behaviour, to disseminate information on mental health promotion	
Intersectoral collaboration with provincial media (virtual and in print) by 100% of universities	- Proportion of universities whose local media are using the instructions from the health system for suicide reporting - Number of memorandum of understanding and plans of action - Number of educational meetings and educational programmes in the media per year.
5. Objective: To reduce access to frequently used and highly lethal methods of suicide and attempted suicide (non-fatal self-harm), including pesticides, frequently used drugs, and to address other highly lethal methods, such as hanging and self-immolation	
Signing a memorandum of understanding and providing a plan of action with stakeholders	Number of memorandums of understanding and plans of action
Increasing the knowledge and awareness of the general population and correcting their attitudes about how they should use and maintain pesticides	Number of educational meetings and programmes in the media per year
Correcting policies and legislations concerning the access to pesticides and medications	Number of policies and legislations that have been corrected
6. Objective: To improve and maintain the response to suicidal behaviour within health and community-based services and ensure continuity of care	
Increasing the knowledge and improving the skills of health system staff for early detection and early intervention	Number of missing cases in the health system
Providing continued care and active follow-up for at least 70% of cases that are referred to emergency departments due to suicide attempt	Percentage of suicide attempters (referred to emergency department) who receive continued care or active follow-up
7. Objective: To improve and maintain the capacity of suicide bereavement support services and specialist interventions for people with prolonged and complicated grief	
Identification of special populations that might be affected by suicide for psychological support and counselling for 100% of the population, friends and co-workers	- Proportion of families who received postvention services - Proportion of gatekeepers who were trained; - Number of universities that have monitoring and periodic reports according to national monitoring plan
8. Objective: To reduce stigma of mental disorders and promote help-seeking behaviour in students	
Educating gatekeepers in schools, including teachers, counsellors and managers	Proportion of gatekeepers who were trained

Indicators	Targets 2015–2020
9. Objective: To develop a national monitoring and evaluation system and promotion of applicable research that supports national innovation and promotion in suicide prevention programmes and addresses knowledge gaps	
Providing monitoring for National Suicide Prevention Programme	Established monitoring system
At least 3 health system research (HSR) projects by local research centres on suicide prevention programmes and their effectiveness and challenges	Number of HSR projects by local research centres

2.4 Ireland (European Region)

Source: http://www.mindbank.info/item/5640

Primary outcomes		Indicators
1. Objective: Reduced suicide rate		
01.1	In whole population	- Standardized annual incidence of intentional self-harm deaths (definite suicide), overall and by each of the following comparison groups: gender, age group, socioeconomic status (individual/area level) - Male self-harm rate as proxy for male suicide rate [see note 1 below]
01.2	In priority groups (where data are available)	
2. Objective: Reduced rate of A&E presentations for self-harm		
02.1	In whole population	- Standardized annual A&E self-harm rates, overall and by each of the following comparison groups: gender, age group, socioeconomic status (individual/area level) - Episodes (events) and persons - Self-harm rates using highly lethal methods - Proportion of persons readmitted to A&E following self-harm in subsequent 12 months, overall; by sex; by sex and age group (annual cohorts) - Proportion of persons admitted to A&E following self-harm who have had previous such admissions, overall and by each of the following comparison groups: gender, age group, socioeconomic status (individual/area level - annual cohorts)
02.2	In priority groups (where data are available)	

Note 1. Given the delay in the release of suicide mortality data by the Central Statistics Office (CSO), consideration will be given to the use of a valid proxy measure for one of the strategy's principal outcomes, which is available in a timelier manner. There is evidence of a temporal association between the rate of hospital presentations for self-harm among males and the rate of completed suicide (intentional self-harm) among males in Ireland. National data on self-harm from the National Self-Harm Registry Ireland are available considerably in advance of data on suicide. In the context of this strategy, changes in male self-harm rates may therefore be considered a valid and useful proxy measure for changes in male suicide rates.

Note 2. Current data sources will be utilized and/or further developed in finalizing these indicators.

Intermediate outcome (IO)		Indicators
1. Strategic goal: To improve the nation's understanding of, and attitudes to, suicide, mental health and well-being		
IO1.1	Improved population-wide understanding of suicidal behaviour, mental health and well-being, and associated protective and risk factors	- Knowledge and awareness about support services - Understanding of protective and risk factors for suicide and self-harm - Understanding of mental health and well-being - Stigmatizing attitudes towards mental ill-health, self-harm and suicide - Self-stigma (priority groups)
IO1.2	Increased awareness of available suicide prevention and mental health services	
IO1.3	Reduced stigmatizing attitudes to mental health and suicidal behaviour at population level and within selected priority groups	
IO1.4	Engagement with the media in relation to media guidelines, tools and training programmes and improvement in the reporting of suicidal behaviour within broadcast, print and online media	- Poor reporting (does not adhere to guidelines) - Positive reporting (adheres to guidelines)
2. Strategic goal: To support local communities' capacity to prevent and respond to suicide		
IO2.1	Continued improvement of community-level responses to suicide through multi-agency approaches	Local action plan available to enhance community response to suicidal behaviour
IO2.2	Accurate information and guidance on effective suicide prevention interventions provided for community-based organizations	Community organizations' access to, and substantive knowledge of, guidelines, protocol and training on effective suicide prevention interventions
IO2.3	Training and education programmes on suicide prevention provided and delivered to community-based organizations	- Availability of relevant training and education programmes to community organizations - Delivery of relevant training and education programmes to community organizations
3. Strategic goal: To target approaches to reduce suicidal behaviour and improve mental health among priority groups		
IO3.1	Improved implementation of effective approaches to reducing suicidal behaviour among priority groups	- Best practice interventions (based on systematic review of evidence). - Interventions that are not evidence-informed and not evaluated
IO3.2	Support provided to the Substance Misuse Strategy, to address the high rate of alcohol and drug misuse	(Continued) roll-out of programmes aimed at early intervention and prevention of alcohol and drug misuse
IO3.3	Enhanced supports for young people with mental health problems or vulnerable to suicide	- Enhanced availability in primary care to early intervention psychological supports, including counselling - Schools and centres of education adopting a whole-school approach to health and well-being in line with the Health Promoting School, Healthy Ireland and School Self-evaluation frameworks

Intermediate outcome (IO)		Indicators
4. Strategic goal: To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour		
IO4.1	Improved psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour	- Availability of crisis nurses in primary and secondary care settings - GPs trained to manage suicidal ideation/ behaviour in primary care setting
IO4.2	Improved access to effective therapeutic interventions (e.g. dialectical behaviour therapy, cognitive behavioural therapy) for people vulnerable to suicide	- Availability of effective therapeutic interventions for persons who have self-harmed or attempted suicide - Systematic approach to offer therapeutic interventions to eligible persons
IO4.3	Improved uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide	- Systematic approach to offer timely and effective support services to families bereaved by suicide - Timely and effective support offered to families bereaved by suicide
5. Strategic goal: To ensure safe and high-quality services for people vulnerable to suicide		
IO5.1	Development and implementation of national standards and guidelines for statutory and non-statutory organizations contributing to suicide prevention	- Quality standards for suicide prevention programmes provided by statutory and non-statutory services - Implementation of quality standards
IO5.2	Improved response to suicidal behaviour with health and social care services, with an initial focus on incidents within mental health services	- Development and effective implementation of uniform procedure to respond to suicidal behaviour in mental health services - Development and effective implementation of uniform procedure to respond to suicidal behaviour in other health and care services
IO5.3	Reduction in and prevention of suicidal behaviour in the criminal justice system	Self-harm and suicide incidence in prisons (adults) and children detention schools (minors)
IO5.4	Best practice among health and social care practitioners ensured through 1) the implementation of clinical guidelines on self-harm and 2) the delivery of accredited education programmes on suicide prevention	- Implementation of clinical guidelines on self-harm - Delivery of accredited education programmes on suicide prevention
6. Strategic goal: To reduce and restrict access to means of suicide		
IO6.1	Reduced access to frequently used drugs in intentional drug overdose	Potentially risky prescribing practices (including number of tablets provided in a single prescription; repeat prescriptions without review; failure to switch to lower-lethality medication where available)
IO6.2	Reduce access to highly lethal methods used in suicidal behaviour	- Suicide-proofing of locations of concern - Reduced number (proportion) of suicide deaths by highly lethal methods

Intermediate outcome (IO)		Indicators
7. Strategic goal: To improve surveillance, evaluation and high-quality research related to suicidal behaviour		
IO7.1	Improved access to timely and high-quality data on suicidal behaviour	- Availability and timeliness of key data on suicide and self-harm - Effectiveness and timeliness of dissemination of key data on suicide and self-harm
IO7.2	Current recording procedures for suicide deaths in Ireland reviewed (and, if necessary, revised)	Review of current recording procedures
IO7.3	Development of a national plan that supports research innovation aimed at early identification of suicide risk, assessment, intervention and prevention	National plan supporting research and innovation
IO7.4	Evaluation of the effectiveness and cost-effectiveness of Connecting *for Life*	- Development and publication of comprehensive evaluation plan - Commissioning of evaluation studies - Successful implementation of evaluation studies - Publicly available report(s) on findings of evaluation studies

2.5 Namibia (African Region)
Source: https://www.mindbank.info/item/6272

Indicators		Target 2012–2016	
Constituency/ stakeholders	**1. Objective: Ensure a responsive legislative/policy framework**		
	1.1	Number of policies approved and developed	1
	2. Objective: Create improved stakeholder relation		
	2.1	Number of consultative meetings held out of those planned	5
	2.2	Satisfaction rating	100%
	3, Objective: Ensure an accountable coordinating body		
	3.1	Existence of steering committee	5
	4. Objective: Ensure accessibility to support services		
	4.1	% of outreach conducted according from the plan	100%
	5. Objective: Ensure reduced cases of suicide		
	5.1	% of suicide cases	-
	5.2	Suicide prevalence rate	-
	6. Objective: Strengthen the stewardship role of the steering committee		
	6.1	% of managers trained in leadership	100%
	6.2	% of partner plans aligned to the national strategic plan Number of quarterly reports	100%
	7. Objective: Ensure strengthened suicide services		
	7.1	Number of people seeking help	90%
	7.2	% reduction of cases of suicide	50%
	7.3	Satisfaction rating	10 Aug
	8. Objective: Foster adequate understanding of suicide phenomenon		
	8.1	Number of potential suicide cases reported	X
	8.2	Survey rating (1–5)	-
	8.3	% of suicide reduction	-
Internal Processes	**1. Objective: Ensure strengthened suicide services**		
	1.1	Number of people seeking help	-
	1.2	% of cases of suicide reported	-
	2. Objective: Ensure implementation of the National Strategic Suicide Prevention Plan (NSSP)		
	2.1	% of objectives achieved/implemented	-
	3. Objective: Ensure decentralized services		
	3.1	% (#) of districts with decentralized services	100%
	3.2	% of funds available	100%

Indicators			Target 2012–2016
Internal Processes	**4. Objective: Ensure a functional coordinating body**		
	4.1	Functional coordinating body in place	-
	5. Objective: Ensure provision of efficient services		
	5.1	Rating of services provided	100
	6. Objective: Ensure efficient coordination of suicide services		
	6.1	Number of coordinated activities	5
	6.2	Number of awareness campaigns conducted	50
	6.3	Develop and distribute IEC materials	14
	6.4	Number of people attended to, versus number targeted	-
	7. Objective: Ensure public awareness on suicide		
	7.1	Number of awareness campaigns conducted	-
	7.2	Develop and distribute IEC materials	-
	7.3	Number of people attended to, versus number targeted	-
	8. Objective: Ensure establishment of an accurate database		
	8.1	Existence of a functional database	-
Learning and growth	**1. Objective: Ensure skilled service providers**		
	1.1	Percentage of people trained	100%
	2. Objective: Build capacity of relevant stakeholders on expertise knowledge and skills		
	2.1	% of stakeholders trained	100%
	3. Objective: Ensure a motivated workforce		
	3.1	% staff turnover	5%
	4. Objective: Ensure positive staff morale		
	4.1	% staff turnover	5%
	4.2	Ratio of staff receiving rewards/total number of staff	100%
Budget/ finance	**1. Objective: Ensure availability of funds**		
	1.1	% of funds allocated versus requested	100%
	2. Objective: Ensure equitable and efficient allocation of resources among ministries, directorates and stakeholders for suicide activities		
	2.1	Existence of allocation criteria	-
	3. Objective: Ensure effective financial management		
	3.1	Number of economizing meetings held	Quarterly

2.6 Republic of Korea (Western Pacific Region)

Source: strategy document shared by the Republic of Korea Suicide Prevention Center

Indicators			Targets 2016–2020
Common	1	Suicide rate	20.0 per 100 000 population
Building society-wide suicide prevention environment	2	Percentage of people who are aware that suicide is a problem that can be prevented	87.4%
	3	Compliance rate with recommendations of standards for the press	30%
	4	Suicide deaths due to gas (e.g. charcoal)	1 700 people
Providing suicide prevention services	5	Suicide rate of adolescents 10–19 years of age	4.0 per 100 000 population
	6	Suicide rate of young adults and middle-aged people 20–64 years of age	22.5 per 100 000 population
	7	Suicide rate of older persons 65 years of age and over	30.0 per 100 000 population
	8	Follow-up rate of emergency room presentations of suicide attempters or case management	62.1%
Enhancing suicide prevention pursuing base	9	Primary medical institutions' depression screening implementation rate	50% of primary medical institutions
	10	Number of suicide prevention gatekeepers	2.5 million people
	11	Building a database of suicide attempts	-

2.7 Uruguay (Region of the Americas)
Source: https://www.mindbank.info/item/3288

Primary outcomes	
1. Component: Organizing the comprehensive care in mental health	
1.1	Number of services from the National Information System on suicide attempts that meet all the provisions of a service established by the Mental Health Services Plan for suicide attempters and their families divided by the total number of services from the National Information System on suicide attempts multiplied by 100
1.2	Number of health services from the National Information System on suicide attempts with a flowchart of users with suicide attempts and their families for the reference and counter-reference divided by the total number of health services from the National Information System on suicide attempts multiplied by 100
1.3	Number of services using guides and protocols of caregiving for people with suicide attempts divided by the total number of health services from the National Information System on suicide attempts multiplied by 100
1.4	Hotline (24-hour) installed and functioning
2. Component: Developing an intersectoral network	
2.1	National network of suicide prevention created and functioning
2.2	Number of services having and using guides for community resources to prevent suicide divided by the total number of health services from the National Information System on suicide attempts multiplied by 100
3. Components: Raising awareness and educating the community about mental health promotion and suicide prevention	
3.1	Number of brochures and other printed material for sensitization of the problem, timely consultation and mental health promotion
3.2	Number of advertisements having been placed in mass communication media about suicide prevention
3.3	Number of advisories having been placed in training programmes to target population/ total number of target population
3.4	Health promotion and prevention programme implemented in a school context.
4. Component: Educating, training and reorienting human resources for addressing suicide prevention and care for suicide attempters and survivors	
4.1	Number of training programmes on the topic developed for the health area of the Uruguay Republic University (UDELAR)
4.2	Number of primary care professionals that completed a training course in suicide prevention divided by the number of primary care professionals from the National Information System on suicide attempts multiplied by 100
4.3	Number of health professionals of the emergency departments that completed a training course in suicide prevention divided by the total number of health professionals from the emergency departments multiplied by 100
4.4	Specific training module on suicide prevention
4.5	Number of meetings organized with universities for the inclusion of suicide as a subject in graduate and postgraduate curricula

Primary outcomes	
5. Component: Developing and implementing a national surveillance system for fatal and non-fatal suicides	
5.1	National information system for suicide attempts, installed and functioning
5.2	Number of mandatory registration forms for suicide attempts used by services by age, origin and type of health service divided by the number of services from the National Information System on suicide attempts multiplied by 100
5.3	Number of people having taken a training course in health divided by the total number of health workers multiplied by 100
5.4	Number of annual investigations about suicide

For more information, please contact:
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http://www.who.int/mental_health/suicide-prevention

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