

EXECUTIVE SUMMARY

LIVE LIFE

AN IMPLEMENTATION GUIDE FOR
SUICIDE PREVENTION IN COUNTRIES



World Health
Organization

Live life: an implementation guide for suicide prevention in countries. Executive summary

ISBN 978-92-4-002773-2 (electronic version)

ISBN 978-92-4-002774-9 (print version)

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INTRODUCTION

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

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

PART A. LIVE LIFE CORE PILLARS

The core pillars of LIVE LIFE are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

The interventions described in the guide are:

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

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

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

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

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

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

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

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

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

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

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