Partnerships for Life — Aliados por la vida
IASP Suicide Prevention Network Program for The Americas

International Association for Suicide Prevention

Summary Report

Introduction

In April 2023 Partnerships for Life - Aliados por la vida launched its first series of workshops on National Suicide Prevention Strategies in the Americas organized by IASP Americas Region Lead, Dr. Mark Sinyor, and Research Assistant, Mr. Daniel Sanchez Morales. Four workshops were delivered, two in English and two in Spanish. They took place on April 28th, May 3rd, and May 5th. In total, nine countries presented: Argentina, Brazil, Canada, Colombia, Costa Rica, Dominican Republic, Ecuador, Mexico, and USA; approximately 50 partners attended across the Americas region and one partner joined from the Africa region.

The discussions were engaging and productive. Partners had the opportunity to share thoughts regarding strengths, challenges/limitations, and observations on their respective national prevention strategies and/or activities. Partners identified the following as important factors and considerations in the creation and implementation of national strategies:

- Stigma surrounding suicide is one of the biggest challenges, particularly in the Caribbean, Central and South American regions. Partners explain that barriers to speaking about suicide and its prevention are major hurdles to starting the conversation about preventive strategies. The lack of discussion poses a challenge to create and promote mental health laws and policies, which consequently limits the possibility of governments broadening their view of suicide as a public health issue rather than just a stigmatized health problem.
- A major agreement among partners is how difficult it has been to translate existing laws into practice due to a variety of implementation barriers.
- Funding remains a major issue in many countries with stigma and lack of public awareness, creating challenges. Partners commented that their governments often reduce or limit overall health expenditures for mental health programs and services, making it difficult to maintain the necessary infrastructure to provide initial attention and support to individuals at higher risk of suicide. Furthermore, most resources are centralized in urban areas, limiting access to support and adequate information to people living outside major cities.
- In cases where funding is available, shifts in the political climate may be a threat to prevention strategies. Partners explained that changes in the political party forming government and in political agendas may hinder or end prevention initiatives such as crisis lines, community support programs, and low-cost mental health services, among others.
- Another substantial challenge highlighted was data quality problems and, specifically, the underreporting of suicide cases. Partners identified two main sources of this problem: stigma and lack of training. Stigma surrounding deaths by suicide may result in no reporting

or misreporting and classification as due to a different cause. Partners explained that professionals in charge of reporting deaths may also not be optimally equipped with knowledge and resources to identify deaths as suicide events.

- Media reporting is also a concern across the Americas. Coverage that stigmatizes or propagates harmful myths remains common in many countries.
- There was general consensus among partners about the importance of moving away from a narrow, biomedical concept of suicide and its prevention toward a more holistic approach that accounts for the psychosocial determinants that impact suicide. They highlighted the importance of interdisciplinary knowledge and intersectoral participation in designing effective strategies.

Partners reflected on immediate action items for the initiative going forward. First, they agreed on the importance of finalizing our situational analysis of suicide and prevention across the Americas, delineating what has been done, what has been effectively implemented, and, in particular, which efforts in specific countries might be portable and adaptable to others in the region. Second, there was agreement that it is important to use our partnership to help exert international pressure on governments and stakeholders to create change. Finally, there was consensus on the importance of "low-hanging fruit", small practical efforts and advances that we can begin implementing without major funding or government assistance (e.g., individual and small group training sessions, webinars, media guidelines, etc.).

Argentina

Presentations were led by Occupational Therapist, Iris Lorena Resentera and, founder of non-profit organization Hablemos del Suicidio, Alberto Fernandez (Both Spanish Format). In Argentina, suicide is the second leading cause of traumatic death after car accidents, and teenagers are at higher risk of dying by suicide. It is estimated that, among people whose deaths were reported as suicide, 80-90% had communicated suicidal ideation but only 30% had sought professional help. Of those who do seek professional mental health support, 4 out of 10 people speak about their suicidal thoughts or ideation. This could be attributed to a taboo related to speaking about suicide in the region.

Argentina's national prevention strategy is comprised of both political and social measures and targets different population groups based in three areas: primary intervention, this involves first responders; other prevention, this involves NGOs and mental health professionals; and postvention, this involves survivors and support to families from mental health professionals. To highlight the Argentinian legal framework, Ms. Resentera emphasized the Mental Health Law (#26.657), which considers hospitalization as the last legal resort when a suicide attempt occurs and Law #27.130 (approved in 2021), which outlines the obligation to provide medical assistance and to enhance capacity regarding detection and attention to people at suicide risk and their families (however, each providence in Argentina is independent and not required to apply this law). This legal framework contributed to the construction of a protocol that outlines

the different steps to respond to a potential suicide case, including institutions in charge of each procedure.

Nevertheless, presenters emphasized how the stigma surrounding the topic poses a significant limitation to implementing strategies. For instance, presenters explained how failing to communicate suicidal intentions or thoughts may hinder help seeking and the provision of assistance: "A person might try to jump in front of a bus. This person is injured and therefore a family member takes the person to the Hospital. However, while waiting to receive medical help and file police reports, this person might ask the family member to keep what happened a secret. This causes the suicide attempt not to be reported as an attempt and rather as a car accident, preventing future intervention and inaccurate statistics."

Presenters finally reflected on key factors that they believe are most important for improved suicide prevention in Argentina. The most significant barrier to overcome is stigma. In addition, it is important to look at factors such as emotional education, capacity to ask for help, earlier attention, and detection, understanding the multifaceted social problems that contribute to suicide, eliminating bureaucracy inside hospitals and mental health services (i.e., it is hard to get appointments; there is insufficient continuity of care), maintaining suicide on the political agenda independent from political changes, among others.

Brazil

The presentation was led by Consultor and CEO of the Institute of Prevention and Postvention of Suicide Vita Alere, Dr. Karen Scavacini (English Format). Brazil has a population of approximately 200 million and both the size and geographic distribution of the population are significant factors in challenges ensuring access to mental health resources. The most up to date data indicate approximately 14,295 suicide deaths in 2022, with deaths more common in men and the age group 15 to 19 at higher risk. The region of Rio Grande du Sol has the highest number of suicides in Brazil; in southern of Brazil suicide is a particular issue in those aged 60+.

In 2006, the country officially created and presented a National Suicide Prevention plan; however, there have been major challenges implementing its elements. By 2011, the RAPS (community mental health system) started a movement to decrease hospitalization and instead prevent and promote support in the community to people with mental health illnesses. ABEPS (Brazilian association for suicide prevention) was created in 2015. To bring awareness, in 2015 the "Setembro Amarelo" or Yellow September was created, a month designed to open conversations surrounding suicide and provide information about resources for help-seeking. Dr. Scavacini noted that the format of information dissemination can make this month a bit overwhelming and reduce the effectiveness of its impact.

In 2019, an official law to promote suicide prevention was established but, again, in practice, its goals are often not achieved. Also in 2019, Brazil changed a law to make criminal offense to

induce others to take their lives. In 2022, the first association for suicide survivors was created. Finally, in 2023, a police law was passed for suicide prevention.

Dr. Scavacini shared different limitations in the implementation of initiatives and improving service access. First, stigma and access to mental care remains a substantial problem in Brazil. Contributing to this there are problematic reporting of suicide cases in the media. Dr. Scavacini explained that Brazil lacks adequate guidance regarding reporting on suicide and there are still misconceptions about how to speak about suicide. Further, access to lethal methods it is a problem that has not been addressed adequately. Dr. Scavacini described how the recent increase in firearms in Brazil as well as easy access to over-the-counter medication pose challenges. Finally, she emphasizes the importance of transitioning from a model focused on medical care to community service intervention, as the mental care system tends to be oversaturated with patients diminishing the possibility of proper intervention for suicide prevention.

Canada

The presentation was led by Executive Director of the Centre for Suicide Prevention, Mara Grunau who presented on behalf of herself and Chief Medical Officer of Talk Suicide Canada (National Crisis Line), Dr. Allison Crawford (English Format). Canada is moving from a deficit approach of suicide to a more integrated perspective. This includes empowerment of language aimed at reducing stigma and an emphasis on high-risk populations such as Indigenous communities. With respect to the latter, understanding intergenerational trauma as a key risk factor is a necessity. Ms. Grunau opened the presentation by stating how: "Spoiler alert, Canada does not have a National Strategy for Suicide Prevention." In fact, Canada currently has a framework and is building an Action Plan, but not a formal, resourced strategy. The province of Quebec and the Inuit community have each achieved major advancements in the creation of a regional strategy and a population-level strategy respectively; however, these efforts are, by definition, local and independent of any pan-Canadian plan. In 2012, the Federal Framework for Suicide Prevention was enacted as the result of a private member's bill and tireless advocacy from Canadian Association for Suicide Prevention. The Public Health Agency of Canada is responsible for the Framework's implementation.

The Framework has three main objectives:

- Objective 1: Reduce stigma and raise public awareness.
- Objective 2: Connect Canadians — information and resources.
- Objective 3: Accelerate the use of research and innovation in suicide prevention.

The first official progress report was released in 2016, with the most recent report released in 2022. Based on the three main objectives, the most recent report highlights the major action items developed during the last two years:

- Objective 1: Included workshops and campaigns to target specific populations as well as updating media guidelines. This also included the creation of Operation LifeSaver, an initiative with the transportation sector.
- Objective 2: Increased emphasis on crisis support and development of protocols. Implementation of 988 (crisis support line) and filling data gaps.
- Objective 3: Highlighted current research and evidence-based practices for suicide prevention and the work being done by Indigenous communities.

Ms. Grunau finally explained that a National Suicide Prevention Action Plan has been voted on unanimously and we are awaiting next steps by government. There is as of yet no plan to create a national suicide prevention strategy.

Colombia

The presentation was led by member of the Ministry of Public Health, Laura Múnera-Restrepo (Spanish Format). From an epistemological perspective, the Ministry of Health in Colombia has a vision for mental health and suicide that has been translated into both laws and strategies. To start, the law for Mental Health and Social protection (Law 1616 of 2013) defines mental health as a dynamic state that is expressed in daily life activities and that allows individuals to express their cognitive, emotional, and mental resources, and consists of two main elements: the capacity to face challenges and the capacity to understand feelings and be able to manage them. This is the vision underpinning the framework for Colombia's national suicide prevention strategy. In addition, the theory of crisis also informs the strategy, with the understanding that the population are repeatedly exposed to factors that may generated a crisis and that suicide is the most serious negative result of not being able to manage a crisis.

The ministry reports recent suicide rates of 58 per 100.000 individuals. There was a significant increase in reporting of cases in 2016 due to implementation of an improvement in their registry. However, during the pandemic there were some reductions in numbers, either due to physical isolation and the accompanied reduced access to lethal means or reduction of reports due to oversaturation of hospitals with COVID-19 cases. Colombia also follows similar global trends, where men die more frequently by suicide and women attempt suicide more. The most common methods are self-poisoning and hanging.

The Ministry of Health and Social Protection introduced the national strategy for suicide prevention in 2021. The strategy accounted for the heterogeneity in population within the country and integral prevention. Ms. Múnera-Restrepo explained that the strategy has six main aspects: comprehension of the meaning surrounding suicide, providing support to individuals at higher risk, minimizing exposition to risk factors, strengthening health care responses aimed at reducing risk factors, modifying social determinants that either increase or decrease risk, and community-oriented responses. The Ministry encourages a community and cross-institutional oriented response.

Nevertheless, the implementation of the system is decentralized, meaning that the Ministry of Health provides some guidelines, but implementation depends on the territories and institutions who decide whether and how the strategy will be applied. Participants in the workshop agreed that decentralization of the strategy can make implementation difficult.

Moving forward, Ms. Múnera-Restrepo emphasized that the first step is to help the territories modify, according to their needs and implementing the strategy suggested by the ministry. The territories define what needs to be addressed and done. In addition, reduction in stigma surrounding the understanding help-seeking behavior, especially among men, is fundamental. Finally, Ms. Múnera-Restrepo recognized the importance of reducing facilitators and means of suicide such as alcohol consumption or access to over-the-counter medication.

Costa Rica

Presentations were led by Clinical Psychologist, Elizabeth Seaward (English Format), and Clinical Psychologist, Leany Villafuerte (Spanish Format). Costa Rica is a small country that holds 5% of the total biodiversity of the world and Catholicism is a significant part of its culture. Since 1948, Costa Rica has had no army and has reallocated most of the budget previously used for defense to strength their healthcare system (as well as the educational system), which has helped it have among the most advanced systems in the Americas.

According to official reports, in 2021, Costa Rica had 388 suicides with 325 cases identified with males accounting for 84% of these deaths. Women have higher rates than men of attempted (46 vs. 29 per 100.000 individuals, respectively). In general, youth ages 15 to 19 were identified as at highest risk of dying by suicide. Hanging and pesticides are the most common methods.

Costa Rica already takes a multidisciplinary and intersectoral approach to suicide where, for example, teachers and mental health professionals have substantial influence in the dissemination, planning and execution of strategies. To start, mental health is understood according to the World Health Organization (WHO) definition, defined as a "Living in an environment that permits me to grow" and suicide is understood as a conscious decision that is the result of a complex process. Presenters explained how is important to speak the same language when it comes to suicide: "It was important for us, as professionals, to speak the same language across our region and thus have a common definition. Without this, we might not have the same goals towards prevention and thus potentially misunderstand each other."

Presenters emphasized how 20 years ago in Costa Rica there was no substantial work focused on suicide; instead, there was reluctance to talk about the topic. They noted that their country has strong laws and public policies that aim to prevent suicide in different ways, including standardized protocols for responses to suicidal crises, branches of the Ministry of Health known as "Secretaria Técnica" that focuses only on funding for and mental health affairs.

political policy that includes specific laws related to suicide, and emergency contact services, among other strategies. Many of those involved in suicide prevention in Costa Rica volunteer their time. Presenters note that work in this area has helped bring social awareness to the topic and has assisted in ensuring that existing resources remain available: "Everyone over 18 should understand what suicide is, risk factors, and where to go if they need to ask for help."

Finally, as with several other regions, presenters reflected on the importance of shifting our understanding of suicide from a medical model to a more holistic approach. There was some concern that changes in government over time could jeopardize efforts promoted by the community: "When a new government comes in, sometimes the priorities change, but you need to fight a little bit, so that the advances made are not completely lost."

Dominican Republic

Presentations were led by Clinical Psychologist, Miguelina Justo (English Format), and Clinical Psychologist and Director of the Mental Health and Telepsychology Institute, Angelina Sosa (Spanish Format). Presenters started by providing context about the country, sharing that the Dominican Republic (DR) has the largest population in the Caribbean, with a predominant African heritage, and most holding spiritual beliefs rooted in Christianity and the Roman Catholic church.

Based on data from 2021, DR registered 670 deaths by suicide, representing a suicide rate of 7.1 per 100.000 individuals. The median rate in recent years has been 6.7 per 100.000 individuals with a narrow range/consistent rates. In terms of genders, 87% of suicides occur in men, whereas women attempt more than men. The most common methods are hanging, self-poisoning, and firearms (the latter particularly in men).

From a cultural context, suicide is often viewed as a response to a desperate situation; however, the traditional Christian view that suicide is a sin predominates. Although suicide is not criminalized in DR, media reporting and press releases often portrait suicide in this light. Presenters explain that, in the end, "Suicide here may be considered the result of a desperate situation, where all hope is lost". Presenters emphasized how the pandemic for COVID-19 increased awareness on how suicide can be also the result of a long battle with mental health illnesses such as depression.

DR has both a law and national plan for managing its citizens mental health in general. In 2022, a bill highlighting the importance of suicide prevention was passed in the Chamber of Deputies and is currently being reviewed by the Senate before final ratification. Since 2016, there have been efforts to create a network of hospitals with a mental health focus, institutions that include crisis intervention and mental health response units; however, the COVID-19 pandemic disrupted this process. To date, there are no protocols in DR outlining the process of responding to potential suicide deaths and attempts.

Presenters highlighted the necessity of a multisectoral approach and recognized the efforts of non-government organizations in DR who provide services including crisis helplines, psychological support, events, survivors of suicide, among others: "Suicide prevention has traditionally been in charge of groups and associations that promote community interventions."

Presenters highlighted many limitations of efforts in DR such as the lack of local research, intersectoral collaboration, and legislation to develop frameworks and strategies. They also noted key risk factors and their impact on different groups. For instance, people with problematic alcohol and/or substances use, chronic diseases, access to lethal means, with relationship dissatisfaction. "There is still a fight to make suicide understood as a public health problem, not just a mental health issue."

Ecuador

The presentation was led by member of the Ministry of Public Health, Pablo Analuisa (Spanish Format). Ecuador has a suicide rate of 6.97 per 100.000 individuals and this number has been steady regardless of the pandemic and other social changes. Since 2021, suicide cases have remained below 1200 and suicide rates under 7.0 per 100.00 people. As Mr. Analuisa explained, the country is divided into three regions: West, Sierra and East. In the east, where Indigenous peoples from the Amazon region are located, they report a rate of 52 cases per 100.000 representing the highest number in Ecuador.

Ecuador follows a similar trend of sex differences in suicide with a 3:1 ratio (men vs. women). People ages 20 to 34 are at highest risk, whereas people over 60+ years of age have demonstrated a decreasing trend. In terms of most common used methods, deaths by men are often by hanging while women died by self-poisoning (either by over-the-counter medication or pesticides). Mr. Analuisa highlighted stressors such as emotional pain, relationship issues, and family problems as important contributors to suicide in Ecuador.

Currently, the country is working to finalize their national suicide prevention strategy. Mr. Analuisa commented on 3 main advances in their draft strategy: first, strengthening prevention efforts in general; second, attention and rehabilitation for people with suicidal crises, focusing on cross-sectorial collaboration; third, vigilance, assessment, and evaluation of the strategy's components. These points come from an extensive situational analysis. On May 2nd, the country approved the first ever mental health law in Congress, opening the door to more initiatives to promote mental health awareness. Mr. Analuisa explained that this will also facilitate improved mental health funding.

Finally, Mr. Analuisa highlighted some additional recent advances. For instance, the ministry of health was able to provide training to over 9000 health professionals in identifying signs of suicide, preventing suicide, and providing resources through online and in person spaces. In addition, the "Manual de prevención del suicidio para cuidadores" (Suicide Prevention Manual for community workers) introduced and implemented.

The idea is to provide key individuals with fundamental tools needed to respond to potential cases. With respect to challenges, Mr. Analuisa commented on the difficulty securing funds to implement action plans, as well as the need to improve Ecuador's registry system for reporting, monitor and evaluate suicide cases. Having a better registry system would facilitate the planning, implementation, and monitoring of preventive strategies, for example, to reduce access to lethal methods such as over-the-counter medications or pesticides.

Mexico

Presentations were led by Dr. Angela Beatriz (English Format), and Dr. Luis Miguel Sanchez (Spanish Format). To start, presenters recognized the cultural diversity of their country and how in specific zones the presence of indigenous communities influence the popular cultural believes. For example, zones such as the Mayan region, which includes the states of Yucatán, Quintana Roo, Chiapas y part of Tabasco, perceive suicide and death as a symbol. From there we find representative figures such as the goddess Ix Tab who has been presented as the goddess of death. However, this same areas from southeast Mexico have registered the highest suicide rate in the last decade, opening the door to strong social responses such as a stigmatization and rejection to families and survivors, censorship, social rejection, among others.

In 2021, Mexico reported a suicide rate of 6.6 per 100.000 individuals, where men had a rate of 11.0 and women 2.4 respectively, and suicide rates have been increasing every year recently. Over the past decade, Mexico has observed an increase in suicide among youth and young adults ages 15 to 34 years old as well as younger youth ages 9 to 14 years old. As presenters explained, the country does not recognize suicide as a cause of death in individuals under 9 years of age. Overall, suicide is the third leading cause of death in the 10-14 and 15-24 group ages after homicide and accidental death.

Up to date, there is not a single law approved for the prevention of suicide that covers all the country. From 2003 to 2020, there have been 20 initiatives for prevention of suicide in various places in Mexico, but nothing has been implemented country wide. Out of the 31 states in Mexico, only 12 have a strategy for prevention implemented regionally. However, those initiatives are applied periodically due to the lack of continuity, this because of the lack of political continuity or other factors. Since 2021, there has been an emerging national program focused on suicide prevention spurred by a mental health crisis during the COVID-19 pandemic. In 2022, Mexico's health law was updated to include a specific section regarding mental health, where six states have been identified for having an established Mental Health Law, but as yet does not include a specific section on suicide prevention.

Presenters explained that in terms of public policy, there is a clear distinction between the public and private sectors that make up their healthcare system, and this fragmentation makes it difficult to create a network for prevention. Healthcare is covered for those with a job; but for those who are unemployed, the government has a limited budget to provide coverage.

In addition, there is no financing of suicide research o laws that recognize suicide as a public health problem which delays the creation of response protocols. Presenters emphasized that the lack of a designated budget for mental health services and suicide limits the creation of resources for prevention. Up to date, Mexico is one of the countries with the lowest investments for health services, 6.2% of the GDP. Like other regions, most resources are concentrated in urban areas, and it becomes difficult to access resources in the rural zones. Furthermore, it is necessary to shift the perception of suicide as just the result of psychobiological processes (e.g., depression), and rather take a more wholistic approach (i.e., recognizing socioeconomic factors) to invest in integrated prevention strategies. Finally, Mexico needs to address problems in their continuity of their strategies and promote the coordination among different institutions to achieve effective suicide prevention strategies. This means encouraging an active participation of all involved actors, including government institutions, universities, research institutes, civil organizations, and citizens.

United States of America

The presentation was led by Chief of the Suicide Branch for the Substance Abuse & Mental Health Services Administration (SAHMSA), Dr. Richard McKeon (English Format). Dr. McKeon proceeded to explain the process involved in the development and implementation of the US's National Suicide Prevention Strategy. In the late 1990s, advocates from different backgrounds and expertise came together to call attention to the need for a national approach to suicide prevention in the US. Prominent politicians including a key senator, began sharing stories about their lived experience of suicide and/or struggles with mental health illnesses, especially depression. This slowly helped start a conversation that resulted in a resolution being passed recognizing suicide as a public health emergency and the necessity of a national strategy for suicide prevention.

By 2001, the first US national strategy was released. It outlined the need to develop a national alliance for suicide prevention and called for a public and private partnership to oversee progress. The first attempts to apply these recommendations encountered challenged. However, in 2010, during former President Barack Obama's administration, the initiative gained sufficient support to create a national alliance.

The first task of the national alliance was to revise the existing national strategy and provide feedback. A modified version was released in 2012 and remains in use at present. The strategy has four main initiatives: healthy empowered individuals and communities, community prevention, treatment and support, and surveillance. Recently, an implementation assessment report shed light on some of the challenges in the process of application: "There was not a single community that was doing absolutely everything from the strategy. However, there were communities implementing various goals from the strategy." Dr. McKeon highlighted the major role that the US national Lifeline has played in advancing the national strategy.The US government increased funding for the Lifeline from $3 million USD (2012) to $502 million this

year. This major investment has facilitated massive improvements in previously existing services and the creation of new resources. Dr. McKeon emphasized that suicide prevention has largely been a non-partisan issue in the US in recent years which has contributed to the successes observed in funding and implementation.

In 2021, there was a call by the White House to revise and enhance the current strategy. With support of the National Suicide Prevention alliance, the revision is working on an accelerated timeline with efforts underway to have the proposed updated strategy submitted by January 2024.

Summary report produced by Daniel Sanchez-Morales & Dr. Mark Sinyor

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