Chapter 1

Suicide Is a Global Problem

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This book is informed by some key propositions: that suicide is a major public health issue, that effective suicide prevention requires both clinical and public health measures, that culture and the ways in which societies are organised have a direct and measurable impact on suicide, that suicide has a significant human rights dimension. These concepts are not controversial to most of us involved in suicide and self-harm research, but they can be difficult for policymakers to take on board. They have implications and consequences. Understanding suicide as a global and interconnected phenomenon introduces an important perspective that is equally as important for high-income countries (HICs) as it is for low- and middle-income countries (LMICs).

1.1 Suicide Can Be Prevented

Taking one's own life is an act that evokes powerful emotional reactions, and it has an extraordinary social impact. Each instance has ramifications that ripple out through social networks, often extending far beyond those who had a direct relationship with the deceased [1]. For the bereaved, reactions to and the consequences of suicide can continue to resonate for decades and over several generations [2].

Suicide is not inevitable, and each case is a potentially avoidable death. For the bereaved, these life-changing events have multiple meanings, commonly including regret, grief, stigma, shame and loss of social/economic security. Suicide stands as one of the most difficult forms of loss in all cultures across the world. Loss of life in this way is untimely by definition. It is not surprising that suicide has raised special concern throughout modern history. Durkheim's choice of suicide as one of the first subjects for systematic study at the birth of sociology in the late nineteenth century was neither coincidental nor arbitrary [3].

We can only take action to reduce the number of people who take their own life when it is accepted that preventing suicide is possible and desirable. Despite high levels of professional and public concern across the world, there is a surprising degree of resistance to the idea that prevention can be effective in mental health in general and particularly with regard to suicide. This skepticism falls broadly into two categories, which are not mutually exclusive.

One is a fatalistic belief that can be summarised as 'if they're going to do it, no one can stop them'. This attitude is not uncommon amongst mental health professionals, where it may have roots in a difficulty in coping with the heavy emotional burden of their work and a particular difficulty in instilling hope in people who find life unbearable. The fear of failure is sometimes rationalised through a belief that human intervention cannot alter a suicidal trajectory. Fatalism is a form of denial, in this case denial of the human capacity to help other people or to improve their world. It is hard to think of another cause of avoidable

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death that regularly evokes a reaction of 'what will be will be'. There is ample evidence that this is simply not true.

As a matter of public policy, it is universally accepted that mental health services should make strenuous efforts to avoid loss of life amongst patients, although there are genuine controversies over how best to achieve this; the use of incarceration is particularly contentious. Professional and public fatalism are not harmless opinions. They have a negative impact on the effort taken to prevent death by suicide.

There is often a conflation of assessment of suicide risk (in other words, *prediction* at the individual level) and prevention of suicide. Assessment of suicide risk has been repeatedly shown to be very difficult or impossible to operationalise [4,5]. No risk assessment instrument has been shown to have the optimal combination of sufficient sensitivity and specificity to be useful in clinical practice, other than as an adjunct to clinical assessment. Fortunately, successful suicide prevention does not necessarily depend on identifying those individuals at particularly high risk. Measures that affect groups of people known epidemiologically to be at elevated risk are important and effective (e.g., eliminating ligature points in psychiatric inpatient facilities) [6], as are some measures that affect the population at large (such as restriction of access to particular lethal poisons and drugs) [7]. For mental health services, the most important suicide prevention measure is to ensure that care is accessible in a timely way for everyone who needs it, irrespective of the degree to which the individual is ostensibly at risk of suicide. It is particularly important that this includes those with the least resources. Within services, consistent adherence to standards of good practice is critical, including for patients who are consistently hard to help or challenging to professionals (such as people with substance misuse problems or who have been diagnosed as having a personality disorder).

Prevention is demonstrably possible and has been achieved in many parts of the world at different times. It may not be possible to be certain exactly whose lives have been saved, but the fact that lives have been saved can be established by examination of rigorously collected surveillance data. Evaluation of intervention is one of the reasons that surveillance is a key element in any suicide prevention strategy [8].

Therapeutic intervention by health services at the individual level has limitations in all forms of prevention and health promotion. For example, typhoid is a disease that can be treated with antibiotics, but prevention depends on good sanitation and vaccinations. Individual lives can be saved through the treatment of typhoid infection, but this is insufficient to have a major impact on death rates in the population at large. The same principles apply equally to suicide. It would be unconscionable to make no effort to prevent suicide of individuals in crisis, but major reductions in suicide rates involve measures that affect whole populations.

It has been known since the nineteenth century that suicide rates are affected by social conditions and by fluctuations in the economy [3]. The second category of skepticism is a response to the suggestion that suicide might be prevented through macro-socio-economic action, for example by avoiding high rates of unemployment, which are known to be associated with increased rates of suicide in the general population. The skeptic will generally acknowledge the abstract possibility that this might work, but the real-life task is construed as too big, over-ambitious or so disruptive to the economy as to be wildly unrealistic. Consequently, the proposition that public health and social measures can have sufficient impact to reduce suicide rates is often met with an eye-rolling cynicism and the implication that these are the utopian dreams of the hopelessly over-optimistic naïf. Similar

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reactions are seen in response to efforts to address the social determinants of health. The latter are closely related to, or the same as, the factors that affect suicide and self-harm, namely 'the social and environmental conditions in which people are born, grow, live, work, and age' [9].

This negativity is not congruent with the evidence, particularly when the problem is examined from a global perspective. There is no need to create a perfect world to achieve reductions in avoidable deaths, including by suicide. Each individual measure often has a relatively small effect, but when combined with other measures as a coherent strategy, it is possible to achieve significant change over time. Sometimes, surprisingly large reductions can occur relatively quickly, although not always as a consequence of a planned suicide prevention strategy. A key example is the reduction in suicide rates in China in recent years [10]. Between 1999 and 2017, the per capita suicide rate in China dropped by 63% overall and by considerably more for some sections of the population. This appears to have been due to exceptionally rapid socio-economic change, with an intense urbanisation of the population combined with large increases in per capita income for the new city dwellers. Most countries cannot expect socio-economic change on this scale, but it does clearly show that change can occur, accompanied by improvements in public mental health.

In the face of systemic resistances to suicide prevention measures, it is important to demonstrate that the potential to save lives and improve population well-being are not items of faith. Empirical evidence clearly indicates that suicide can be prevented within the world as it exists, with all of its imperfections and in the absence of utopian socio-political transformations. Measures affecting the whole population can result in reductions in suicide mortality rates. As suicide is a problem that affects a large number of people, suicide prevention is firmly in the arena of public health.

1.2 The Scale of the Problem

According to the World Health Organization (WHO), approximately 700,000 people across the world die by suicide each year. There are marked differences in rates per 100,000 population between nations, with equally marked differences in the distribution of deaths across age groups and according to gender. Seventy-seven per cent of those who take their own lives each year reside in low- and middle-income countries (LMICs). In 2016 suicide was the second-commonest global cause of death in 15- to 19-year-olds. In some LMICs, such as India, population rates of suicide are far higher than in most high-income countries (HICs) [11].

Rates of death alone do not reflect the full extent of the health burden related to suicide. The number of people who harm themselves but survive is believed to far exceed the number who die. A significant proportion of survivors suffer enduring physical, social and psychological sequelae. There is a similarly large number of people who are bereaved by suicide [12]. The impacts on survivors and on the bereaved are major and constitute significant public health problems in their own right. The WHO has made suicide a public health priority, which is reflected in the title of its 2014 document 'Preventing Suicide: A Global Imperative' [13]. The extent of avoidable loss of life is such that prevention merits a major commitment of effort and resources, because even partially successful measures can prevent a large number of deaths and much suffering. In any local, regional or national health strategy, prevention of a major public health problem has to be considered one of the highest priorities. It is achievable.

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There are major differences between nations in the ways in which deaths are registered and recorded, in the definitions used to classify cause of death and in methods of collation to generate national statistics. Some countries do not collate data or claim very low rates of suicide. As a result, the WHO figures are based on best estimates for some countries. It is arguable that the failure to attempt to accurately report these deaths represents a collusion with human rights infringements (as discussed later in this chapter). Nonetheless, many international comparisons are based on reliable figures with a known level of accuracy. Descriptions of trends across the world are not based on speculation. As a general pattern, the highest rates of suicide arise in societies with large agrarian populations, with poorly developed health infrastructure and high levels of inequality. Many of these LMICs have experienced disruption to social infrastructure as a result of socio-economic change, conflict or natural disaster. In fact, whether by coincidence or not, they are societies with similar problems to those prevalent in Europe when Durkheim did his early research on suicide.

In 1971 a Welsh family doctor, Julian Tudor Hart, set out his Inverse Care Law [14]. This states that the availability of good medical care varies inversely to the need for it in the population served. Tudor Hart attributed this to the effects of health care being distributed wholly or partly as a market commodity. The Inverse Care Law has proven to capture a profound truth. The inverse relationship between the availability of health care and the need for it inexorably follows as a result of the effects of the social determinants of health, whereby the healthiest part of the population is also the wealthiest. It applies within nations and between nations. The same pattern is seen with regard to suicide; within and between nations, the lowest per capita health resource is expended on those populations that suffer the highest rates of suicide.

1.3 Low- and Middle-Income Countries / High-Income Countries

Although the majority of people who take their own lives reside in LMICs, what we know about suicide, self-harm and their prevention is dominated by evidence from HICs. Research in (and therefore evidence from) LMICs is gradually increasing and this tells us that whilst there are some similarities with HICs, there are also major differences. Neither LMICs nor HICs are homogenous, and there are differences between nations in each category. Age and gender distributions differ markedly, as does the proportion of people with diagnosable mental disorders amongst those who harm themselves and those who take their own lives. These differences are not surprising, as many cultural, social and economic factors influence patterns of suicide.

A recent systematic review, based mainly on HIC findings, suggests that people with a diagnosable mental disorder have an eightfold increase in the risk of suicide compared with the general population [15]. There is a correspondingly high rate of psychiatric disorders amongst patients presenting to hospital with self-harm [16]. Taken from a narrow secondary health care perspective, the implication would seem to be that suicide is commonly a consequence of mental illness and that prevention should focus on its treatment. The ability to access care and treatment for mental illness is certainly important for a range of humanitarian and human rights reasons. However, mental illness and social stress are intimately connected. For example, high levels of structural income inequality make a significant proportion of the population vulnerable to financial stress. Financial stress is associated with both depression and suicide. Provision of secondary mental health

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care is not necessarily highly effective as a suicide prevention measure for the population at large. This is not to suggest that mental health services are useless or that they could be safely eliminated. Where mental health services exist, closing them would almost certainly lead to a noticeable increase in rates of suicide, together with other untoward consequences. It does mean that establishing such services, or improving those that already exist, is only likely to be effective in achieving major reductions in suicide where services are one part of a broader suicide prevention strategy.

The limited data from LMICs appears to show a key difference in that a lower proportion of people who harm themselves have diagnosable mental illness in some (though not all) LMICs [17]. HIC findings are not completely irrelevant to suicide prevention in LMICs, but there is a need for caution to avoid supposing that findings from well-conducted research in HICs are not culture-bound. Data from HICs must be placed in a global context where there appears to be considerable variation in the extent to which suicide, self-harm and mental disorders have an intimate association. The evidence as it stands shows that the stressors leading to suicide play out differently in different parts of the world. A key exemplar is the much higher proportion of death by suicide in women in some parts of South Asia. Women are disadvantaged compared to men everywhere, but there is clearly something different about life as a woman in countries where female suicide is as common as male.

In HICs, the evidence suggests that the most obvious linear causal chain (whereby social stress leads to mental illness, which then causes hopelessness and eventually suicide) is only one of a range of complex relationships between social factors, mental illness and suicide. Although studies using psychological autopsy suggest that the majority of people in HICs who take their own life are mentally ill at the time, there is a substantial minority who are not.

Amongst those people who are mentally ill, the relationship between their mental health problem and their social environment is complex. Social factors can be divided into structural background factors (affecting segments of the population collectively) and social stressors (which tend to be current and individual). Social determinants of mental health in childhood (predominantly poverty and marginalisation) are also associated with suicide later in life, but it should be noted that psychosis is associated with urbanicity, whilst suicide is associated with rurality. There is an element of common causation, as well as causal bidirectionality. Episodes of acute mental illness are associated with current social stress but also worsen it – or at least make it more difficult to resolve. Under some common circumstances, the relationship is still more complicated; there are consistent findings showing that the period immediate after discharge from psychiatric inpatient facilities is a high-risk period, at a time when it might be supposed that symptoms of mental illness are likely to be improving, if not resolved [18]. In suicide prevention, treatment of mental illness, structural change to reduce vulnerability and enhanced support in the face of immediate social stressors are all of importance.

Similar complex relationships between social factors, mental illness and suicide are likely to exist in LMICs. An example is the role of financial stress in LMICs. Financial stress is believed to be a significant factor in suicide everywhere, but it can differ in nature and quality between LMICs and HICs. The pace at which financial ruination develops is probably faster in LMICs because the gap between an adequate income and destitution is smaller. A seasonal drought can completely destabilise whole families where they have no financial reserves, lack social capital or cannot access affordable credit. Despair may rapidly appear with or without the development of a full range of depressive symptoms. Help is

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needed for symptoms and finances. Identifying and treating mental illness is relevant in LMICs, but suicide prevention in HICs and LMICs involves both social and clinical domains.

Comparison of trends in suicide underlines the need to develop good quality longitudinal surveillance data in every country, across all types of society, in order to develop effective strategies that are socially, economically and culturally appropriate to local conditions. There are lessons from LMICs for HICs; the dramatic reduction in suicide rates in China cited above being a case in point. Evidence of this sort casts a light upon international data, pointing to those factors that might be most usefully addressed in HICs as well as LMICs. It underlines that clinical intervention for mental illness cannot be the sole strategy to bring down suicide rates.

1.4 Targeting the Cause of the Causes

Professor Sir Michael Marmot is the world authority on the social determinants of health. He draws an important distinction between health inequalities, which are the differences in morbidity and mortality between various populations, and health inequity, which is a lack of fairness in the ill-health burden experienced by different demographic groups [9]. Generally speaking, the most powerless, marginalised and economically vulnerable people suffer the worst health outcomes everywhere. Their socio-economic disadvantage is principally determined by factors beyond their control, such as where they were born, their ethnicity, their gender and their family circumstances.

Although ill health is often mediated by modifiable behaviours such as smoking, alcohol consumption, obesity and lack of exercise, the degree to which people are free to make healthy choices is severely constrained by marginalisation and disadvantage. For example, the wealthy can exercise safely in a gym, but it is hard to exercise in crowded inner-city areas where unaccompanied women are not safe. It is a public health truism that the single most important choice anyone could make to avoid ill health would be to choose not to be born poor. A steep gradient of diminishing agency and control over one's own life across the socio-economic spectrum accounts for the concentration of poor lifestyle 'choices' in the least wealthy part of the population.

These effects are obvious as they apply to the poorest of the poor, but the gradient of health disadvantage affects people all the way up the social hierarchy, except for those at the very top [19]. Each group has less control and worse health than the groups above them. Health inequity affects the vast majority of the population, and health inequalities are most marked in the most unequal societies, a category that includes the United States as well as many LMICs. Fairness and social justice have a direct and measurable impact on public health. Health improvement and suicide prevention involve targeting a range of social inequities, particularly income inequality. After 40 years of neoliberal domination of economic policy, the doctrine that the unconstrained pursuit of wealth at the top of society 'trickles down' to those lower in the hierarchy has no credibility. The most enthusiastically neoliberal HIC countries, such as the US and the UK, have seen marked increases in inequality. It is not the case that good public health can only be achieved if everyone has the same income, but it is incontrovertible that countries with the largest difference between the income of the top 10% and the bottom 10% experience the worst health inequalities [19]. Whilst suicide is also modified by specific factors that vary between countries and subpopulations, in general it follows the same patterns as every other public health problem.

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The relationship between inequality and the risk of ill health is only one type of health inequity. As mentioned earlier, the Inverse Care Law dictates that access to treatment is worst for those with the greatest health needs. Tudor Hart's Inverse Care Law is not a natural law like thermodynamics and entropy, immutably woven into the fabric of the universe. It is a reflection of the ways in which societies choose to distribute health care. The part of Tudor Hart's paper that states that the Inverse Care Law applies where health care was distributed as a market commodity, wholly or in part, is important. The market model is not inevitable or the only way of paying for health care. It is certainly not the most cost-efficient way of distributing health care, as public sector health care systems have lower overheads than for-profit ones. There are equitable models, including the UK's National Health Service (NHS; despite slowly progressive privatisation) and Cuba's high-quality health care system, which was developed in a poor country subject to economic sanctions by the US [20]. Neither country could be regarded as a utopia, although each of them has aspired to be a socio-political exemplar, of the free market in the case of the UK and of socialism in the case of Cuba. What they illustrate is that inequitable distribution of health resources can be addressed (albeit without being fully resolved) within imperfect societies. Failure to distribute health care by need rather than by wealth is a choice, not an inevitability.

Suicide prevention must also address what Marmot has labelled 'the cause of the causes' [9], those structural obstructions to well-being that lie behind the circumstances that lead people to become ill or take their own lives.

1.5 Suicide and Human Rights

Suicide is most often thought of as a personal choice, albeit a misguided one with awful consequences. It is understood as a decision that is made by the individual. In the European intellectual frame of reference established during the Enlightenment, a person weighs up the advantages and disadvantages of the proposed course of action, including considerations of legalities and other consequences; makes a free choice; and acts. This is how the relationship between circumstances and actions are understood in the law, in theology, in fiction and in clinical psychiatry. It is captured in Hamlet's soliloquy, as he poetically ponders the pros and cons of continuing to live. The English coronial system, which is a strong influence in many jurisdictions across the world, expends as much effort in deciding the precise intentions of a person who appears to have taken their own life as it does in finding out what actually happened. Unfortunately, this abstracted decision-making process does not correspond to the psychological, psychiatric or social evidence on how behaviour is motivated or how self-harm incidents unfold, still less the factors that are known to influence them.

Standing back from individual circumstances to survey global patterns, variations in suicide rates between different parts of the population and between different nations clearly have some relationship with the extent to which human rights are respected. It seems highly likely that the relationship is causal, at least in part. There are plausible ways in which systematic and individual human rights violations can lead to suicide. For example, a lack of choice in who to marry and where to live, together with a lack of redress regarding domestic violence, can easily be seen to have implications for female suicide rates. The Universal Charter of Human Rights was proclaimed at the United Nations General Assembly in Paris on 10 December 1948 [21]. It is a remarkable document. Few of any political persuasion have felt able to contradict or reject it, either as a whole or in part. Seventy-five years after it

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was drafted, even a cursory reading shows that very few countries in the world (if any at all) are fully compliant with its articles. Most of the structural societal factors that are known to have a direct impact on suicide rates occur in contradiction of one or more its provisions.

We have no hesitation in unequivocally stating that structural health inequities are human rights violations. These violations and inequities create the context against which individuals decide to take their own life or, rather, come to feel that they have no other choice open to them. Supporting human rights does not entail acceptance of any particular political doctrine, but it does rest upon acceptance of values to the effect that everyone is of equal worth, irrespective of any personal characteristic that they have no control over. There is a profound relationship between public mental and physical health and human rights.

1.6 Interconnectedness

In mental health practice, understanding context is essential. Karl Jaspers' approach to phenomenological psychopathology [22] was based on the recognition that individual subjective experience could only be understood in relation to a general emotional and psychological state of mind. Difficult behaviours and relationship disruptions occur in the context of reciprocal relationships and social environment, including culture. These have a causal as well as a pathoplastic role when people develop mental ill health.

In public mental health, 'the cause of the causes' has a global dimension. International trade has existed for thousands of years, and it creates an interconnectedness in human affairs that has a tangible impact on health. For example, trade and travel are vectors that create the potential for global pandemics from the Black Death to COVID-19 [23]. In matters of economic policy, local decisions in Paris, Beijing or Washington have an impact on people in rural South Asia and Sub-Saharan Africa. When a container ship blocks the Suez Canal, as occurred in 2021, the effects are felt around the world.

Throughout history, powerful HICs have exported inequities and social injustice, most recently through globalisation. The ability of private companies to source cheap labour in LMICs has allowed them to bypass health and safety and other regulation in HICs. Products are made to a standard by third-party businesses, creating a distance between HIC company ownership and a LMIC labour force. European countries, including the UK, tolerate employment practices in Asia involving a form of modern slavery in order to manufacture cheap clothes for sale in markets where these employment practices are illegal [24]. These Asian workforces, predominately female, have high rates of suicide [25]. There is reluctance amongst HIC governments to create adequate penalties for companies benefiting from modern slavery abroad. The strength of these international networks of causation is tangible when the causes of the causes are examined closely.

The impact of interconnectedness flows back to HICs. Many LMICs correctly see themselves as having been treated unfairly from the days of slavery through the age of empire and, more recently, as a consequence of the modern form of economic imperialism that is generally described as 'globalisation'. There have also been adverse consequences of international social injustice for HICs at home. Prior to Brexit and the COVID-19 pandemic, the UK had the sixth-largest economy in the world, but the outsourcing of inequity to LMICs resulted in many towns and cities in the north of England sinking into a state of post-industrial decay. It would be difficult to persuade residents in British former mill towns that outsourcing fabric and garment manufacture to South Asia greatly benefitted their communities. Similar processes have created the so-called Rust Belt in the US. Attended

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high unemployment has an impact on domestic suicide rates, as can be seen starkly in Northern Ireland [26]. Neither HIC nor LMIC general populations benefit as a result of inequality and injustice.

The world's population has become highly mobile during the twenty-first century. A large proportion of people in HIC urban areas are either migrants or live amongst migrants. In the UK 2011 census, 37% of Londoners stated that they were born outside of the UK [27]. As a general rule, when people migrate, they slowly take on the characteristics of the population and culture that they join. Sometimes these changes take several generations, and patterns of ill health from their heritage culture disappear only slowly. These patterns include self-harm and suicide. Understanding what happens in migrant countries of origin, and those factors that relate to migration itself, are highly relevant to the development of comprehensive suicide prevention strategies in host HICs.

If social justice is a solution to 'the cause of the causes', we are bound to recognise that social justice cannot be achieved in one part of the world alone. The pursuit of social justice has to be a public health objective shared by a substantial proportion of the international health community. In the context of the COVID-19 pandemic, the WHO has repeatedly stated that 'no-one is protected unless everyone is protected' [28]. HIC governments acknowledge this but find it hard to act upon. At the simplest level, allowing COVID-19 to rage in LMICs whilst vaccinating whole populations in HICs simply creates a crucible for viral mutation and vaccine escape, which has the potential to prolong or repeat the pandemic. At a more complex level, the overall world economy cannot recover if some countries experience continued waves of infection and economic recession.

The need to address suicide globally is just as pressing. Worldwide, people engaged in agriculture are at particularly high risk of suicide, and this is the sector of the economy most affected by climate change. Agricultural infrastructure takes time to develop. Because farming is part of the rural ecosystem, changes to crops to accommodate changes in seasonal weather patterns are not easy and can have unforeseen consequences. Environmental degradation disproportionally affects the poorest people in the poorest nations. Drought and flooding cause crop failures, which in turn lead to high suicide rates amongst small farmers in LMICs. The solution involves action in both HICs and LMICs, which in turn must involve reductions in inequality within them and between them. The very richest do not have to be impoverished, but they will have to survive on a smaller multiple of average income than at present. We need a global scientific consensus to support a universal human rights approach to public health.

1.7 Evidence Saves Lives

If the previously noted points were simply matters of conviction or dogma, they would be political opinions. Instead, they rest on a well-established evidence base. They are facts that politicians and other policymakers need to accommodate. There is overwhelming evidence against contrary views to the effect that public health improves as wealth trickles down and that health inequalities are due to genetics and freely made personal choices. As applied scientists we can tell policymakers that whilst it is for them to form whatever strategies they consider appropriate, if they choose not to take action on 'the cause of the causes', then they will limit their own effectiveness. This is not the same as having no effect, but we can do much better than partial effects.

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In emphasising the importance of issues of socio-economic structure, there is a danger of seeming to imply that all other efforts are futile. This is far from the case. The evidence shows that a good deal can be done, including building a locally relevant evidence base. Suicide and self-harm surveillance are essential components to an effective suicide prevention strategy. It is impossible to track what is happening with respect to suicide and self-harm in a population without reliable national and local data collection and analysis. Tracking changes and trends gives invaluable information as to where effort should be targeted and whether suicide prevention measures are having any discernible effect. Surveillance gives information about commonly used suicide methods.

One of the most robust findings in the suicide literature is that restriction of access to common means of suicide can produce a significant reduction in rates of suicide. For example, campaigns to reduce access to ligature points in UK psychiatric inpatient facilities have resulted in a significant and persistent decrease in suicide amongst inpatients [29]. Globally the most common means of suicide are hanging, firearms and ingestion of pesticides. Suicide rates are substantially higher where access to firearms and/or pesticides is unrestricted. Neither are easily obtained in the United Kingdom, which has relatively low rates of suicide by international standards, whereas India (where pesticides are freely available) has a much higher rate, as does the United States, where 50% of the population live in a household where there is a gun.

1.8 Conclusion: 'No One Is Protected Unless We Are All Protected'

It is a truism to say that the COVID-19 pandemic and the climate emergency have profoundly increased the urgency of global cooperation on health to tackle the challenges that lie ahead. Suicide is one of these. Suicide prevention is achievable. It requires a multifaceted approach that goes beyond the provision of mental health services. Local, national and global factors are important. A key strategy to tackle suicide worldwide is the coordinated development of local solutions to this global problem. This involves building on existing international networks of cooperation among researchers, clinicians and policymakers to facilitate the reduction of suicide rates everywhere.

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