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Active suicide prevention

A comprehensive look at suicidal behaviour in Spain

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Production method

Reports C are brief documents on subjects chosen by the Bureau of the Congress of Deputies that contextualise and summarise the available scientific evidence on the analysed subject. They provide insights into areas of agreement, disagreement, uncertainties, and ongoing discussions. The preparation process for these reports is based on an exhaustive bibliographical review, complemented by interviews with experts in the field who subsequently conduct two review rounds of the text. Oficina C conducts this process in collabouration with the management team of the Spanish Parliament's Lower House Documentation, Library and Archive service.

To produce this report, Oficina C referenced 551 documents and consulted 23 experts in the field. Of this multidisciplinary group, 56% were from the social sciences (psychology, sociology, communication sciences, social work, and education), 35% from the life sciences (medicine—psychiatry and epidemiology—and neurobiology), and 9% from other sectors (police and fire departments). 78% work in Spanish institutions or centres, whereas 22% have affiliations abroad.

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Summary C

The report in 5 minutes

Relevance

Suicidal behaviour is one of the most challenging public health problems for human understanding and scientific explanation. In 2022 (the last year with definitive official figures published), Spain recorded a record 4,227 deaths from this cause, making it the leading cause of external death. Estimated figures for suicide attempts are up to 20 times this number.

The drama and impact it entails is undeniable. It generates profound individual suffering that extends to family and friends, and is exacerbated by the stigma that suicidal behaviour still carries today. In fact, experts point out that in most cases, people do not seek to end their life, but rather their suffering. Furthermore, the phenomenon has repercussions and implications at multiple levels, including health, economic, employment and educational aspects, among many others.

Contrary to popular belief, the expert community stresses that this is a prevenBox phenomenon. In Spain, the prevention of suicidal behaviour still requires significant progress and can be strengthened by applying existing knowledge and evaluating the actions developed.

This report offers a comprehensive overview of suicidal behaviour in order to improve knowledge about the phenomenon, the main barriers to its prevention in the Spanish context and the available scientific evidence that can help to overcome them.

Understanding suicidal behaviour

Managing and preventing suicidal behaviour first requires a deeper understanding of it.

Suicidal behaviour goes beyond death by suicide and includes a broad set of thoughts and behaviours related to intentionally taking one's own life. The former include death wishes or suicidal thoughts, among others. The latter include communication about intentions or plans to take one's own life, and suicidal acts. The latter, in addition to death by suicide, differentiate between attempted suicide and self-harm, which may or may not include suicidal intent. The thoughts and behaviours noted do not necessarily occur in a linear fashion and an attempt may occur without any thought or communication. In Spain, currently, there is only official data on deaths by suicide. Furthermore, there are no precise estimates on other related aspects, such as the socioeconomic impact of the phenomenon.

There are theoretical differences and it is not yet fully understood how they emerge and what are the processes and factors that imply the transition from one manifestation to another. Suicidal behaviour is multifactorial, heterogeneous and dynamic: individual, family and social factors converge, so it is assumed that suicide does not occur for a single reason. Furthermore, these reasons are different for each person and vary over time. For example, suicidal thoughts can vary from hour to hour, be triggered by specific situations, etc. Data in Spain show that mortality varies with age and many other factors (sex, geographic area, economic level, etc.). Any simplistic or unicausal explanation of suicide is necessarily reductionist and must therefore be rejected.

Evidence indicates that this is a phenomenon in which psychological, biological and social factors interact, including cultural, educational, political, economic and work-related aspects, among many others. Although there are many factors related in the specialised literature, it is important to emphasise that these are not causal mechanisms of suicidal behaviour and their predictive capacity is very limited: they do not accurately explain why some people die by suicide and others, who may present the same factors, do not.

For all these reasons, addressing suicidal behaviour requires a holistic and multi-sectoral approach that also allows the focus to be placed on the person, their context and their life situation. Thus, preventing it can be understood as preventing and reducing suffering and improving the quality of life in all areas. It is about providing the individual and social resources necessary for people in crisis to be able to face the problems and dilemmas that their lives present to them. Therefore, preventing suicidal behaviour requires a community-wide approach that is not limited to the health field. It includes, among others, sectors such as education, economy, social rights, equality or housing, and other sectors or agents with an active role in prevention such as the media or civil society.

Focal point: barriers and evidence-based interventions

The expert community points out that the prevention of suicidal behaviour faces multiple challenges in the Spanish context. It highlights the need to combat stigma and myths, as they make the problem invisible, increase suffering and make it difficult to seek help. Awareness, empathy, social and institutional support and training are key to saving lives. Expanding and improving data collection beyond mortality is another important aspect. It can, together with the provision of adequate resources, allow for a more precise definition of objectives and a medium- and long-term evaluation. Progress is also conditioned by the need for specialised personnel, trained in suicidal behaviour, in all related areas. Greater allocation of economic resources and national administrative tools is also required to facilitate the implementation, coordination and execution of strategies.

FREEPIK image

The complexity of suicidal behaviour is another important barrier. It makes prevention difficult, as there is no single clear objective for treatment and prevention. It is related to the lack of effective clinical tools to predict who and when. For all these reasons, prevention must combine universal measures, aimed at the entire population, as well as selective measures, for vulnerable population groups, and indicated measures, aimed at people who display suicidal behaviour in any of its forms. It also requires incorporating the care of family members and friends of people who have died by suicide so that they can have the necessary support and resources, which is known as postvention.

Universal measures considered most effective include restriction of lethal means and school prevention programes. Although more evidence is still needed to assess its effectiveness, training and responsible communication in the media, public awareness and the implementation of telephone and internet helplines are also recommended.

Selective interventions are aimed at vulnerable groups, such as the elderly, professionals such as healthcare workers, the military or the police, groups at risk of social exclusion (homeless people, LGBTIQ+ community, prisoners, etc.), victims of violence, people with chronic illnesses or mental disorders, and those suffering from addictions. The training of so-called guardians or gatekeepers, to identify people at risk in specific contexts and connect them with help services, is considered one of the most effective strategies in selective prevention, although it still requires further studies.

In the case of people who already show suicidal behaviour, the indicated actions that have been recognised as being most effective are the use of psychological and pharmacological treatments with scientifically proven efficacy and continuity in the care chain. They are followed up by monitoring people at risk, for example, through so-called brief interventions. The therapeutic approach to improving assessment processes and training in suicidal behaviour is also recommended, although the level of evidence surrounding them is somewhat lower. The latter is indicated for all healthcare personnel, including mental health personnel, and all those involved in crisis situations (health workers, fire departments, police, etc.). New technologies, such as the Internet, artificial intelligence and mobile devices, can also help to assess suicidal behaviour and prevent it in the medium to long term.

On the horizon

The expert community stresses that, given the complexity of the phenomenon, management tools are needed to enable multi-sectoral and coordinated action. For this reason, they particularly highlight the need for a national-level standard or strategy that incorporates a multidimensional vision (at universal, selective, and indicated levels), an integrated approach (covering the various forms of suicidal behaviour), a multifactorial perspective (involving all relevant sectors and acting at a governmental or cross-sector level), independence (with its own autonomy and resources), and a foundation based on scientific evidence. There are models in countries around us and studies on the type of strategies and their effectiveness. Its development also requires the participation and collabouration of all the agents involved: public authorities, experts and researchers, companies, the media, educators, any other related sector and social participation. Each person can reflect on how, in their personal or professional sphere, they can reduce suffering, strengthen ties and offer hope to those affected. Suicide prevention is an issue that involves society as a whole.

Active suicide prevention

Introduction

Suicidal behaviour is a prevenBox public health problem that has a significant impact at multiple levels.

Suicidal behaviour constitutes an important public health challenge globally[1–5] and also in Spain[6–9]. Although it can be considered one of the most challenging problems for human understanding and scientific explanation, it is also a preventable phenomenon[3,4,7,8,10–13].

Suicide can be defined as the act by which an individual intentionally ends their own life[14,15]. It remains one of the leading external causes of mortality worldwide[10,15,16]. In Spain, although the figures are considered underestimated[17], the record data for 2022 place it as the main external cause of death, well above others such as traffic accidents[7,18]. In any case, beyond the figures, it is recognised that the majority of people who attempt or die by suicide do not seek to stop living, but to put an end to the severe suffering they endure[15,19,20]. This suffering extends beyond the individual, since the drama that suicide represents has a strong impact on families and loved ones and has important repercussions at a social level[21–26].

It includes a broad set of thoughts and behaviours related to intentionally taking one's own life, which go beyond death by suicide.

The term commonly used is suicidal behaviour, a concept much more diverse and complex than death by suicide. It refers to a broader set of thoughts and behaviours related to intentionally taking one's own life[14,15,27]. Thoughts include suicidal ideation and planning. Behaviours integrate communication and suicidal acts. The latter, in addition to death by suicide, differentiates betwen suicide attempt and self-harm, which may or may not include suicidal intent[28–32]. However, there are different definitions, nomenclatures and classification systems, without a general consensus on this matter[15,27,33–36].

The prevention of suicidal behaviour faces significant barriers inherent to its complexity, multicausality, dynamism and heterogeneity[5,15]. Furthermore, the strong stigma and the many myths surrounding it amplify the suffering and lack of understanding, and make it difficult to ask for help and to understand the aspects involved[37] (**Key point 1**). It therefore requires empathy and a comprehensive, multi-level approach that can reach the entire population and move away from simplistic or single-cause approaches and explanations[38–42], as indicated by scientific evidence and national and international experience regarding its prevention[7,43–52]. The expert community highlights that in Spain prevention still requires significant advances and greater transfer of developed knowledge[44,53–55]. It highlights, among other aspects, the lack of a specific strategy at national level[1,3,4,7,8,42,44,47,52,56–58].

- Suicide: There are multiple definitions. The WHO establishes that it is an act with a lethal outcome, deliberately initiated and carried out by the subject, knowing or expecting the lethal outcome and through which the subject intends to obtain the desired changes. Other definitions place more emphasis on aspects such as intentionality, the positive nature (doing) or negative nature (not doing) of the action. Suicide is usually considered to be death by injury, poisoning or suffocation if there is evidence of such intent.
- External causes of death: These are those resulting from factors other than diseases or internal medical conditions of the body. The National Institute of Statistics includes multiple causes of death under this heading, including suicide.
- Suicidal ideation: Manifestation of thoughts, desires or plans related to the act of intentionally ending one's own life. It can vary in intensity and frequency. It is called passive when it includes desires of not existing, of disappearing or not waking up, of a fleeting nature and without a plan to take one's life. It is active when it includes specific considerations and planning regarding methods and timing.
- Suicide plan: It refers to the formulation of a method for taking one's own life.
- Suicidal communication: It includes verbal and non-verbal expression of suicidal intent with or without threatening intent.
- Suicidal acts: Behaviours for which there is explicit or implicit evidence that the person intends to die.
- Suicide attempt: Engagement in potentially self-destructive behaviour in which there is at least some intent to die as a result of said behaviour, but in which a fatal outcome does not occur.
- Self-harm: Defined by the *National Institute for Health and Care Excellence* (NICE) in the United Kingdom as acts of self-poisoning or intentional self-harm, regardless of the motive. They therefore include those that are carried out without suicidal intention (an aspect that is not always clear in practice). These are behaviours that cause immediate injuries to the body surface, have low lethality and tend to repeat themselves over time. Its high prevalence among young people has raised some social alarm. Although they may not have suicidal intent, they reflect suffering that the person self-directs in the form of physical pain and that should be addressed. There is no general scientific consensus regarding its relevance as a possible risk factor for death by suicide.

Box 1. Common preconceptions about suicidal behaviour adapted from the Handbook of the Psychology of Suicidal Behaviour[15], some guidelines[59–61], and other documents[11,62,63]. General guidelines outlined by expert staff in relation to such ideas are presented with the aim of improving understanding of the phenomenon. There is great variability surrounding suicidal behaviour, so this Box presents general aspects that are expanded upon later in the document.

Preconceived idea	Orientation
Asking if someone is thinking about suicide may prompt them to do so	Asking and listening without judging, without minimising or arguing about the suffering, showing respect and a desire to help, can ease their tension.
Talking publicly about suicide has negative effects	Doing it right is a powerful tool for prevention. The opposite may increase the probability of iatrogenic effects or contagion effects. The media can be a valuable tool for prevention, as in the case of traffic accidents.
People who express the desire to end their lives will not do so	The data indicate that most people who die by suicide have given prior notice, although this aspect cannot be generalised. Any warning or threat poses a real risk. Listening and facilitating the request for help is essential.
People who want to die by suicide don't say it	It may mean ignoring warning signs that some people (not all) display in these circumstances. If you suspect something, investigate and take the signs seriously.
It is an impulsive act and if someone is determined there is nothing to do	In many cases it can be prevented and there are warnings. Even the most severely depressed people display ambivalence, which enables them to act. If the active suicidal crisis is overcome, it is likely that the person will not die by suicide. Although it may not seem like it, many times hopelessness, pain and emptiness are temporary states, not permanent ones.
Only people with serious problems die by suicide	It is advisable to avoid underestimating the pain that another person is experiencing. Very diverse situations can lead a person to consider suicide. The apparent lack of problems should not make us think that there is no risk.
Some attempts are to get attention	Suicide attempt is the factor most closely related to death by suicide. Any attempt should be taken seriously and the person should be encouraged to seek help from their environment or a mental health professional.
It occurs in people with serious psychiatric problems	Many people have considered suicide at some point in their lives in situations of great suffering that they do not know how to deal with. It is not an issue exclusively linked to mental health. A significant percentage of people do not have psychological conditions.
It is an isolated problem and does not affect childhood or adolescence	The data refutes this. We should not minimise the seriousness with which adolescents view their problems or the pain they cause. If there are suspicions, it is advisable to investigate.
Approaching without preparation, only with common sense, is harmful	Anyone can be of great help in prevention: by showing interest, closeness and understanding, and by helping the person to ask for help from their environment or a professional.

Situation and preventive approach in Spain

National data and trends

The suicide rate in Spain is lower than the European average. Even so, and despite the fact that the data are considered to be underestimated, it was the main cause of external death in 2022.

In 2022, 4,227 people died by suicide in Spain, an all-time high as a result of an upward trend over the last decade[64,65]. Provisional data for 2023 indicate a total of 3,952 deaths from this cause[18]. Although these figures may still be adjusted, they are very similar to those reported in 2020 (3,941)[18].

Several studies indicate that the upward trend recorded could have been reinforced by an increase in deaths in recent years due to the influence of the pandemic, especially in the most vulnerable groups[65–69]. However, their influence on these figures is not yet fully understood, as trends vary by period (lockdown, subsequent years), age, sex or country[70–72]. More years of study are needed to confirm their relationship.

The suicide rate in 2022 in Spain was 8.85 deaths per 100,000 inhabitants (8.17 according to provisional data for 2023), slightly below the European average (10.2; range 3.5-21.8). However, it is recognised that the figures are underestimated, mainly due to difficulties (legal, administrative and forensic) in determining the cause of death and registering suicides and aspects related to social rejection[73–76]. Furthermore, these aspects vary between countries, making comparisons difficult[77].

· Iatrogenic damage: Any unintentional adverse or harmful effect experienced by a person as a direct result of a medical treatment, procedure or intervention performed by a health care professional.

Nationally, men (especially between 40 and 60 years old) and the elderly die more by suicide than women (ratio 3:1) and the young population[16], respectively. However, women and young people are the groups that try and think about it the most[8]. However, there are no official data or estimates on suicide attempts or other aspects such as ideation at the national level[6], and the expert community recognises the difficulty in establishing precise calculations with the available information[6,78,79]. Although there are various estimates in this regard, the World Health Organisation (WHO) indicates that, on average, there are about twenty attempts for each death (which would raise the figure to 85,000 attempts in Spain)[3]. At the regional level, based on 2022 data, Asturias and Galicia have the highest suicide rates (12.54 and 12.19), followed by the Canary Islands, Castilla y León and Cantabria (10.70-10.08). At the other extreme are Melilla and Ceuta (1.17 and 2.41), followed by the Community of Madrid (5.93). The causes of these variations are not yet understood.

There are few studies regarding the socioeconomic impact at the national level[26,80]. The available data refer only to the cost of lost productivity, which is 2.167 billion euros for the year 2016[80]. In countries around us, the total calculated cost, including other relevant parameters such as healthcare costs[81,82], reaches figures as high as 24 billion euros in the case of France[82]. Estimates at European level indicate that its direct and indirect costs could represent an annual loss of 150 billion euros[47].

Current preventive approach and European framework

In Spain, suicidal behaviour is addressed through a mental health strategy. However, contrary to general recommendations, there is no independent national strategy.

The European Pact on Mental Health includes suicide as one of its five priority areas[83]. European guidelines on suicide prevention are aligned with those of the World Health Organisation (WHO)[56]. Some specific actions in this regard include recommendations based on interventions developed in member countries and the development and financing of projects and initiatives for research and prevention[56]. In this respect, the multi-level prevention strategy model from Austria[42,84] and Belgium stand out, the implementation of which in other regions of Europe is promoted through the "ImpleMental" plan. Spanish participation in it is local and through some autonomous communities[85].

The Spanish Constitution recognises the right to health protection and dictates that it is the responsibility of the public authorities to organise and protect public health through preventive measures and the necessary benefits and services[86]. In Spain, suicide prevention is included in the Mental Health Strategy (2022-2026)[9] and is implemented through action plans, currently 2022-2024[45]. These plans include prevention, early detection and care for suicidal behaviour as a strategic line with its own financing. The main execution falls on the[45] autonomous communities, which currently all have some plan, action, intervention or strategy for suicide prevention[44]. At the national level, a Clinical Practice Guide for the prevention and treatment of suicidal behaviour (updated in 2020)[87,88] and a protocol for the management of self-harm in adolescence[89]have been developed within the Guideline Programme in the National Health System. These documents aim to guide strategic actions and professionals, although the degree of their implementation at present is unknown. Recently, the Ministry of Health has announced the intention to develop a new multidisciplinary Action Plan for Suicide Prevention 2025-2027[90]. On the other hand, the Senate has launched a study committee on mental health and suicide prevention, formed within the Health Commission[91].

The expert community and civil society welcome progress in this area, but point out shortcomings. They highlight the need for more resources, the lack of data and homogeneity at the national level, an aspect that is reflected in the strong atomisation of existing strategies and plans at the national level, the lack of coordination between them and the need for updating in various cases[6,44,52,55,92]. Differences between regions are also highlighted in the degree of application of interventions whose effectiveness is proven, the importance of greater alignment with the standards indicated by the WHO and, in many cases, a lack of knowledge of the degree of

· Action and intervention: In this document, both terms are used interchangeably, although "action" is often used in the context of prevention measures and "intervention" in the context of measures against manifested suicidal behaviour.

implementation in each territory and of evaluation of the results achieved[44,52–56,75]. Research staff, health professionals, crisis responders, survivors of bereavement by suicide groups, survivors and affected people underline the need for a comprehensive national strategy, a tool considered largely absent, which would facilitate a common framework and objectives, coordination and the provision of the necessary resources[4,6,7,49,52,53,55,56,75,87,88,92–98].

A complex challenge: understanding suicidal behaviour

Suicidal behaviour is a particularly complex phenomenon. This raises important challenges that need to be addressed, as they can act as barriers that hinder understanding and prevention[33,34,58,73].

Stigma and the social gaze

Stigma and invisibility surrounding suicidal behaviour amplify suffering, make it difficult to ask for help, and are an obstacle to prevention.

Thinking about one's own death is a deeply human phenomenon linked to the meaning and purpose of life. In fact, suicide is an individual act with social meaning[6]. Some experts point out that considering suicide as something merely intimate and voluntary has implications for social disinterest in prevention. It is "*their decision*" so "*we neither know, nor do we want to know*"[99].

The social perspective has been historically and culturally shaped by the many disciplines that have dealt with it, such as religion, philosophy, sociology or, more recently, medicine and psychology[15,100,101]. It is thus associated with concepts such as honour, sacrilege, romanticism, heroism and patriotism or illness, depending on the historical moment and the social context reviewed[102]. In addition, there are situations in which the decision to take one's own life, such as euthanasia, or assisted death, arises from very specific and qualitatively different conditions and processes (at a legal, personal, family level, etc.) from those addressed in this document. These are ways of ending one's own life that are not considered a public health problem nor do they enter into the prevention framework proposed in this report[6,101,103]. In fact, in Spain, available data indicate that they have social support[104].

On the other hand, although some progress has been made, suicidal behaviour is stigmatised and silenced, leading to rejection and social criticism[37,105–108]. Thus, it is excluded as a subject of attention, care or learning[109]. Death by suicide is therefore assumed to be the worst of deaths[7,15], which is reflected in aspects such as the difficulty in knowing the real number of suicides due to concealment or in a grief that can be especially complex[22]. Stigma acts as a barrier that can generate shame, fear of being singled out, judged or exposed to insensitive and morbid questions, which together limit the request for help and increase the risk[37,110], both for those affected and for those grieving[22,37,111–115]. It is therefore part of prevention to minimise stigma. Various studies indicate that this extends even to healthcare and specialised personnel[116,117]. Furthermore, some international studies highlight the existence of defensive clinical practices around the phenomenon in different developed countries[118–120].

- Survivors of bereavement by suicide: People who have lost a loved one (family, partner, friends, etc.) to suicide.
- Suicide attempt survivors: People who have survived a suicide attempt.
- Euthanasia: Deliberate intervention to end the life of a patient with no prospect of improvement, usually in the context of terminal illness or chronic pain. This act may be carried out by a medical professional at the request of the patient.
- Assisted death: The act of providing a person with the means to end his or her own life, usually due to intolerable suffering or terminal illness. Unlike euthanasia, in assisted dying the patient themself performs the final act that leads to death.

A multifaceted phenomenon: conceptual difficulties and insufficient data

There are disagreements and gaps in knowledge about suicidal behaviour that, combined in many cases with a lack of data, make it difficult to understand the phenomenon.

The study and prevention of suicidal behaviour faces limitations[73,121] derived from the multiple manifestations it encompasses (see introduction) and from some disagreements among the expert community regarding its terminology and conceptualisation[15,27,33–36]. Currently, the theories that explain the passage of the ideation to action have meant an evolution in the framework of work and knowledge about the phenomenon[19,55,122–126]. However, on the one hand, the different manifestations do not necessarily occur in a linear fashion. Thus, an attempt can occur without any thought or communication, especially in impulsive people[55,121,127] On the other hand, the factors that determine the transition from one to the other are not yet well understood[19,121].

In Spain, as in other countries in the area[128,129], there are no official data on ideation or attempts. Experts highlight the importance of having mortality data that is close to "real time" and some consider the accompanying variables to be scarce[6,55,92,130]. All of this limits the understanding of the situation and its determinants.

The study of suicidal behaviour has focused mainly on deaths and attempts due to their great impact. However, suicide is, from a statistical perspective, rare (global average prevalence 0.014%[131], 0.008% in Spain[16]), which, together with other aspects[73,132–134], imposes certain methodological difficulties[131,135]. In contrast, the frequency of attempts is higher (average prevalence of 0.79%[131]) and ideation is even more common. However, the expert community generally estimates that only one third of people with suicidal ideation also die by suicide[136].

Some studies estimate that 9% of the population has suicidal thoughts at some point in their lives[12,137]. There are national studies[13,138] and international studies[139] that raise the figure to 20-30% for the young and adolescent population. Currently, the expert community highlights the importance of studying ideation to broaden the understanding of the phenomenon as a whole, as well as its management and prevention. This may have a role in regulating individual distress and socio-emotional life skills, and faces fewer statistical limitations than other man ifestations[136,137,140,141].

Multifactorial, open, dynamic and heterogeneous nature

The expert community highlights the importance of understanding the processes and factors that lead to situations of suffering, hopelessness or lack of purpose that commonly characterise suicidal behaviour[3,15,19,20,142–144].

Related but not causal factors

Suicidal behaviour is a heterogeneous, multicausal and markedly dynamic phenomenon, so any simplistic or unicausal explanation is necessarily reductionist and must be rejected.

It is generally accepted that suicidal behaviour arises from the dynamic and complex interaction between multiple factors at the individual, family and social levels[15,21,38,43,88,144,145]. Given its extraordinary dynamism over time (suicidal thoughts can vary throughout the day or hour), the phenomenon is subject to sudden and discontinuous changes. Furthermore, it is markedly heterogeneous. The factors involved, which are not equivalent to causal mechanisms, show low specificity and vary between individuals, by sex, age, region, cultural aspects or depending on the manifestation of the behaviour studied, among many other aspects[8,14,40,51,74,122,123]. Their existence or absence correlates with the presence of suicidal behaviour, but they do not precisely explain why some people die by suicide and others, who may present the same factors, do not.

- Theories from ideation to action: These aim to explain the determinants, factors, or processes that promote the transition from thinking about suicide to attempting it, as ideation or desires for death alone are not considered sufficient for this. It includes various theories and models, which are presented in the section High Complexity: Multifactorial, open, dynamic, and heterogeneous nature.
- Prevalence: Percentage of people showing the indicated manifestation.
- Hopelessness: Subjective state in which the person perceives few or no alternatives or personal choices and is unable to mobilize energy for his or her own benefit.

For all these reasons, it can be said with certainty that no one dies by suicide for a single reason, and, furthermore, the reasons are different for each person and are subject to temporal variations[11]. Given this marked multifactoriality and heterogeneity, any simplistic or unicausal explanation of suicide is necessarily reductionist and therefore must be rejected[38,144]. Common examples include considering it the product of a mental health condition or assuming that the cause is a specific adverse life event. In any case, there is no clear consensus regarding the different paradigms that attempt to explain its origin and motivation[14,38,74]. All these aspects make it difficult to define and understand the determinants of suicidal behaviour[14,74]. However, recent works from psychiatry[96,146,147] and psychology[15,142,148], among others[3,55,147,149], recognise the importance of implementing a vision of suicidal behaviour and its prevention that incorporates all its dimensions (**Key point 2 and 3**).

Multifactoriality: An evolving approach

The determinants and factors related to suicidal behaviour include psychological, social and biological aspects. The expert community highlights the importance of incorporating all its dimensions in its study and prevention.

There is extensive scientific research regarding the determinants of suicidal behaviour and many related factors have been examined[88,145]. Psychological factors[19] (**Key point 2**), biological factors [150,151] (**Key point 3**) and social factors are included, which encompass contextual, cultural or political aspects[55,152–154] (**Key point 2**). However, beyond the accepted multifactoriality, part of the expert community highlights the existence of various theories and approaches that have evolved and modified until today[12,15,39,155,156]. Among the existing paradigms, differences can be detected that are reflected at the social and care level[12,15,146]. These are divergences regarding the conceptualisation of the phenomenon or variations regarding the importance and type of association established with related factors and regarding their usefulness for prevention. Thus, theoretical frameworks of an etiopathological nature[43,143,144,157] coexist with other more recent paradigms such as the so-called contextual-phenomenological-existential[12,15].

Key point 2. Psychological, social and contextual aspects and factors related to suicidal behaviour

Psychological theories that explain the transition from ideation to action have broadened the understanding of suicidal behaviour.

Psychological models that attempt to understand suicidal behaviour focus on understanding the aspects that explain the transition from ideation to action. Regarding the processes that lead to the desire and thoughts of dying, the following stand out: the presence of intense psychological pain[20], perceived as unbearable, unavoidable and endless[7,20,142,158]; hopelessness and lack of purpose (three-step theory[159]); the perception of being a burden and feelings of frustrated belonging (interpersonal theory[160]); the feelings of entrapment and defeat are added, and the alteration of cognitive processes and coping and problem-solving skills that influence the ability to carry out a suicide attempt (integrated motivational-volitional mode[1161])[19,121]. Other prominent traits and aspects are cognitive rigidity, anxiety and depression, isolation[162] or perfectionism[88,145]. The transition to action is determined by aspects such as the development of the acquired capacity. To do so, access to lethal means and planning, marked impulsiveness or imitation, among others[19,121].

Part of the expert community relates suicidal behaviour to multiple contextual determinants: the degree of social integration and regulation, family, cultural, demographic, and political aspects, adverse events at a life, work, or educational level, such as inequality or harassment, among many others.

Part of the expert community highlights the relevance of multiple social and contextual factors that lead to some of the states described. They are associated with the degree of integration (or exclusion) and social regulation[163], social defeat[164], sociocultural aspects[165,166] and political aspects[147], as well as with the capacity and opportunities to acquire skills to cope with life's adversities in circumstances that may be favorable or very adverse. Some of the factors with the most evidence of a relationship with suicidal behaviour, in general (since these vary depending on the population group, age, sex, among other factors)[167], are: the level of socio-family support, family history of suicide or exposure to the phenomenon[168], stressful life events (personal, financial losses, etc.), aspects linked to socioeconomic level169, inequality[170], employment situation[171], educational level, sexual or ethnic discrimination, harassment (bullying and cyberbullying, especially in young people), loneliness[162] (especially in the elderly[172]) or isolation.

- Etiopathological: In medicine, it refers to the combined study of the cause (etiology) and development (pathogenesis) of a disease or condition. In the case of suicidal behaviour, it focuses on identifying what triggers it and how it develops on a biological, psychological, or social level.
- Psychological pain: It consists of intense emotional and mental suffering. Its definition is complex and there is no consensus on it. It is an unpleasant and unsustainable feeling that persists over time, characterised by a perception of incapacity or deficiency of the self, as well as frustrated psychological needs and social disconnection.
- Acquired capacity for suicide: Concept describing the decreased fear of death and increased tolerance to physical pain, developed through repeated experiences of suffering, self-harm, or exposure to risky situations, facilitating the transition from suicidal ideation to the act of suicide.

Other notable contextual aspects are the presence of chronic pain[173], the diagnosis of serious illnesses and access to the means to die by suicide. Demographic variables such as age (especially between 40 and 60 years), sex (being female for attempts, being male for deaths) or geographical variations between regions, countries, etc. must also be considered. Other environmental factors are associated with crisis situations arising from war conflicts or natural disasters.[145,174,175] and, more recently, with changes associated with global warming[176–178,178–180].

In youth and childhood, development can be altered by contextual factors that could have repercussions at the psychological and also biological level (**Key point 3**). Exposure during these periods to physical and psychological adversities (history of violence, sexual abuse, bullying, trauma, serious emotional or material deficiencies, among others) and other environmental aspects[181] They are associated, on the one hand, with multiple factors considered to be risk factors. These include a significant increase in the presence of severe and early mental health conditions or difficulties in emotional regulation and low self-esteem, which make it difficult to establish healthy and protective interpersonal relationships. On the other hand, it is related to an increase in the presence of suicidal behaviour in late adolescence and adulthood.[182–185].

The first ones are aligned with a biomedical vision and focus especially on endogenous aspects of the individual, of a clinical or diagnostic nature (physiopathological, genetic, psychopathological or others)[12,15,43,144,148,157,186,187]. Biopsychosocial models, such as the classic diathesis-stress model[43], and epidemiological models also recognise and try to integrate social and contextual aspects[96,143,143,144,146,188]. Although multiple models exist, these approaches generally align with the epidemiological view of risk[12,43,144,146]. Thus, the factors related to suicidal behaviour (**Key point 2 and 3**) have been commonly referred to as risk factors, which may or may not be precipitating, and protective factors [88,145], although there are multiple ways of classifying them and not all of them are modifiable. The recent development of psychological models of suicidal behaviour (Theories from ideation to action, **Key point 2**) complements the epidemiological view of risk[15,19,142]. Furthermore, part of the expert community highlights recent advances in biopsychosocial models that allow a better explanation of human behaviour[43,188].

Current paradigms highlight the importance of providing people with the individual and social resources necessary to manage the suffering and circumstances arising from the problems and dilemmas that their life presents.

On the other hand, the phenomenological approach to suicidal behaviour focuses on the person's life circumstances and their biographical context, and therefore also their social and cultural context, as a basis for understanding their suffering and giving it meaning[24,96,148]. They conceive the phenomenon more as an existential drama, resulting mainly from the problems faced in life and the suffering derived from it, as opposed to the concept of symptom, pathology or something that must be "cured." This type of paradigm is aligned with the evidence that points to the inability to accurately predict risk and the lack of effectiveness of prevention based on it[40,131,145,156,205,206], which is why it focuses on a therapeutic evaluation of suicidal behaviour[12,24,131,148,152,207]. This consists of supporting and helping people in crisis to face the problems and dilemmas that their lives present to them, providing them with the necessary individual and social resources. Along these lines, part of the expert community emphasizes the need for qualitative studies that try to explain the whys and wherefores[55] and complete the quantitative vision of the risk models and the traditional clinical approach[156,208–210]. Likewise, it highlights the importance of the so-called humanisation[211] of services and care[12,152,212]. Therefore, it is a community and general approach that is not limited to the health field[12,24,96,148].

- Diathesis-stress: This theory postulates that suicide is the result of the interaction between a vulnerability or predisposing factors (diathesis, biological, psychological, developmental or other) and environmental stressors (which would include social aspects).
- Risk factor: Characteristic, condition, or circumstance that increases the likelihood that a person will consider, attempt, or complete a suicidal act
- Precipitating factors: Characteristic, condition, or circumstance that triggers an acute crisis, significantly increasing the likelihood that a person will consider or attempt suicide. These would be factors that act as catalysts, exacerbating existing vulnerability due to underlying risk factors.
- Protection factors: A characteristic, condition, or circumstance that reduces the likelihood that a person will consider, attempt, or complete a suicidal act.
- Modifiable factors: Not all factors associated with the risk of suicidal behaviour are modifiable, such as genetic aspects or age. Most of them are, and it is on them that prevention is currently focused.
- Humanisation: It means doing something more humane, less cruel, less harsh for people. It includes the relationship with others, sharing a community and empathic contact, attention focused on the individual. Although there is no agreed definition, in the world of health and care it refers to a complex process that encompasses all dimensions of the person. It ranges from politics to culture, healthcare organisation, the training of professionals or the development of care plans in everything that is done to promote and protect health.

Key point 3. Biological aspects related to suicidal behaviour

At the biological level, the abundant scientific literature suggests that suicidal behaviour may be related to pathophysiological aspects such as **alterations in the nervous system**[43,189] linked to the individual **genetic profile**[190] and **alterations during early development associated with adverse environmental factors**[181].

Multiple studies attempt to improve knowledge of the biological factors that could be related to suicidal behaviour. Many of them focus on some morphological and physiological alterations of the brain or on other neuropsychological aspects, although their specificity is considered low[43]. The most recognised include alterations in the stress response system, with some dysfunctions in the system that regulates the presence of serotonin (an aspect linked to multiple functions in addition to the stress response) being the best described[43,87,88,191]. Furthermore, suicidal behaviour has been associated with multiple complex and dynamic changes at the cognitive level and with other systemic aspects outside the neuropsychological field, such as immune or inflammatory responses, among others[150,182,192–198]. The expert community indicates that neuropsychological alterations can lead to a perception, interpretation and response or decision-making in response to environmental information characterised by distortion, impulsiveness, lack of flexibility or premeditation, among other aspects, which can increase the possibility of suicidal behaviour[199]. They are also associated with behavioural alterations, such as anxious and impulsive-aggressive traits and cognitive deficits[193,194,199,200].

The search for genetic causes of these alterations is based on the observational evidence that exists on the prevalence of suicidal behaviour in family groups[201]. Although the identification of gene sets associated with suicide prevalence (and differentiated from mental health conditions)[190] and the neuropsychological alterations described constitutes an important line of work, consistent genetic results for improving prevention have not yet been produced[43].

Part of the expert community also relates adversities suffered in childhood (**Key point 2**) with possible alterations in the morphology and functioning of the nervous system and stress regulation that may act as risk factors[202,203]. Specifically, some works indicate that these alterations could be due to epigenetic changes caused by these experiences[203,204].

Part of the expert community points out that Suicidal behaviour may be related to alterations in the nervous system associated with genetic aspects and early development in adverse circumstances.

The challenge of prediction and the opportunity of prevention: some key factors and advances

The heterogeneity and dynamism surrounding suicidal behaviour prevent effective prediction of the phenomenon, but not its prevention.

Despite advances from fields such as sociology, psychology and psychiatry, there is currently a lack of tests, psychological tests or biomarkers that have consensual clinical value for predicting suicidal acts[87,96,145,207,213,214]. Furthermore, although some predictive models based on risk factors show appropriate sensitivity in their study contexts, their predictive power is limited, so they lack clinical application[8,40,55,131,144,205,206,215]. Nevertheless, knowledge of the factors related to suicidal behaviour is recommended, since they allow for the characterisation of especially vulnerable population groups (Selective Prevention Section) and, from a preventive perspective, it is important to minimise suffering and risk factors and amplify protective factors[138].

Addiction and mental health conditions entail difficulties that increase vulnerability and risk of suicidal behaviour in these population groups. Its specialised management and treatment is essential to reinforce the prevention.

Various studies indicate that the existence of previous attempts is one of the factors that best correlates with death by suicide[145,216]. Following these, others stand out, such as substance abuse conditions, especially alcohol[141], the presence of some mental health conditions[141] and hopelessness[217]. It is worth remembering that the diagnosis is not the cause. That is, these conditions do not explain suicidal behaviour and the vast majority of people who suffer from them do not die by suicide[12,141]. In fact, part of the expert community points out that the relationship of these aspects with suicidal behaviour is based on the added difficulties derived from the stigma and dehumanisation experienced by people who suffer from them, and not so much on the condition or diagnosis *per se*[12,55,156,212,218]. In any case, proper management and treatment is essential to reduce vulnerability and strengthen prevention.

Currently, there are significant discrepancies regarding the percentage of people with mental health conditions among those who die by suicide[96,141,219]. Some studies indicate that the mental health condition most commonly associated with death by suicide are affective conditions, specifically severe depression, alcohol and other substance abuse conditions, bipolar condition and schizophrenia[43].

Social protection and integration, belonging or the development of social and emotional skills to cope with adversity are protective factors large cross sections importance.

Research on protective factors is less extensive[73], but experts highlight among them the importance of integration, family and community support and stability, well-being, and a sense of belonging - an adult, partner, or friend who cares about you. Cultural adaptation, development of social and emotional skills (such as cognitive flexibility and conflict resolution), access to medical care and comprehensive mental health care are also key protective aspects[73,87,88]. Others include: having children, family obligations or dependents, personal religious and spiritual beliefs, and positive values.

Overall, the multifactorial nature of suicidal behaviour poses difficulties in prevention associated with the absence of a single, clear objective for treatment and prevention[135,220]. The lack of effective predictive, but not preventive, tools[207]at the individual level to identify *who* and *when*[135,145,221,222] constitutes a major challenge. In fact, some expert staff highlight the importance of moving towards personalised or precision management and prevention that is not stratified by risk. New technologies such as artificial intelligence or the use of mobile devices may allow advances in the assessment and understanding of suicidal behaviour that allow us to address its fluctuating nature and variability at the individual level[135,223,224], in order to facilitate intervention when necessary[73,122].

Key point 4. Artificial intelligence and momentary assessment: towards personalised prevention and treatment

In the medium and long term, AI and the use of mobile devices may enable an assessment of suicidal behaviour that responds to the dynamism and individual heterogeneity of the phenomenon.

Personalising prevention and treatment at the individual level in a dynamic manner can serve to reinforce prevention[223].

Multiple studies highlight the potential that new tools based on artificial intelligence (AI) could have in preventing suicidal behaviour through the analysis of individuals' data or electronic records. This analysis focuses in many cases on medical records[225–230], but a vision that integrates social and contextual factors from other sectors of interest (employment, social security, education, and a long etcetera) is also required[230–233]. Its potential is also explored for detecting vulnerable people or groups on social networks and the Internet[136,225,231,234], an environment that can reflect multiple contextual aspects that are not otherwise recorded. Currently, the general application and scaling up of these tools in the Spanish context is still considered unfeasible due to multiple aspects: lack of interoperability of data, either within the healthcare field or between different sectors[235,236], lack of homogeneity with which suicidal behaviour is recorded in clinical contexts[96,187], multiple limitations in data access and collection[235], as well as ethical and privacy obstacles that would have to be addressed in any of the aforementioned contexts[224,234–236].

Another particularly promising strategy is ambulatory assessment or momentary ecological assessment, which uses mobile applications for near-real-time analysis and detection of suicidal behaviour[237,238]. These apps assess suicidal ideation and other factors in people already identified by the health system by answering brief questions (active) or by analysing routinely expressed activity and messages (passive). In case of risk, they provide an immediate therapeutic response through personalised messages or care recommendations if necessary. This is the most advanced technology, with recent follow-up studies and pilot clinical trials carried out, including in the Spanish context, which bring it closer to clinical practice and support its potential[239–243]. They are part of self-guided digital interventions (without the direct participation of a professional)[244], which in addition to via mobile phone, can be available through from the web. These are tools whose use may be convenient in contexts of isolation and lack of access to basic health services.[244,245]. Despite its potential, the Spanish Network of Health Technology Assessment Agencies, in its 2023 assessment of applications developed for mobile phones and computers internationally, as well as some recent studies[244], point out that the evidence regarding the preventive efficacy of these tools is still insufficient[245].

Components for a comprehensive multi-level response

Prevention must involve the implementation of specific strategies at a national level, with a multidimensional vision (at universal, selective, and indicated levels), comprehensive (covering the various forms of suicidal behaviour), multifactorial (involving all relevant sectors), and based on scientific evidence.

Given the multifactorial nature and the challenges posed by suicidal behaviour, part of the expert community highlights the need for comprehensive strategies that approach prevention from a multi-level and intersectoral perspective[21], as shown in Figure 1: The levels categorise interventions based on the target population, classifying them as universal, selective, and indicated[43,52,57,58,246,247]; selective, and indicated. Intersectionality aims to capture the heterogeneity of the factors involved in suicidal behaviour through the cooperation of all relevant sectors.

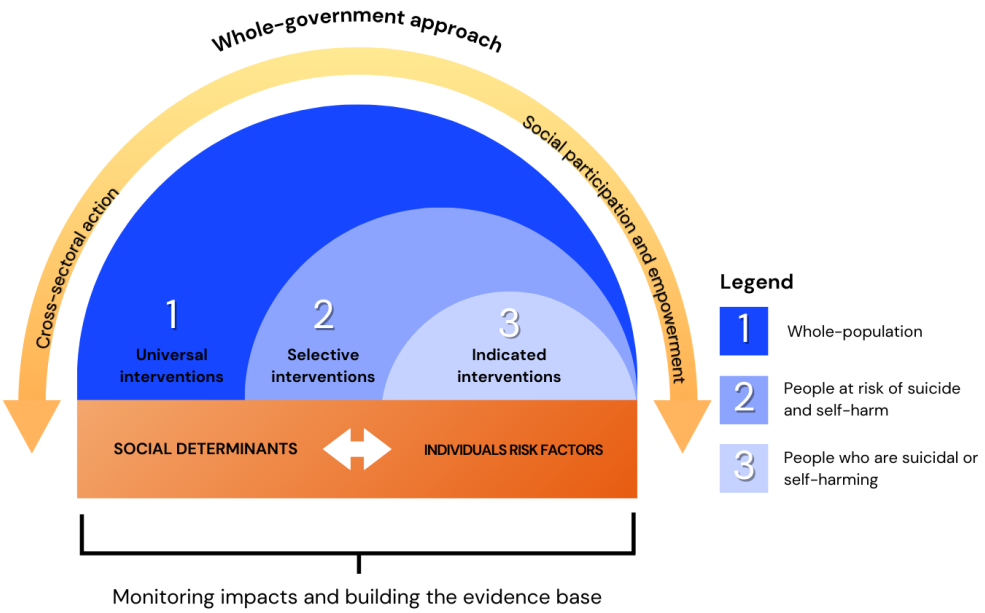

Figure 1. Comprehensive model for the prevention of suicidal behaviour. Adapted from Pirkis et al. 2023[151].

The evidence indicates that the more levels and factors are integrated, the greater their effectiveness[248] and their synergistic action on the different manifestations of suicidal behaviour[3,8,249,250]. Some studies estimate, although this has not yet been empirically confirmed, that if all evidence-based interventions were included in a comprehensive approach, between 20% and 25% of all suicides could be prevented[215].

Organisations such as the WHO[3,4,250,251] or the European Alliance Against Depression[252], much of the expert community[41,47,50,53,56,58,95,246,247,249,253,254] and experience in multiple countries[42,57,248,250,254–260], support multi-level, national-level models for suicide prevention. However, the importance of improving the level of evidence regarding the general effectiveness of the approaches and some specific aspects of them is recognised[4,40,42,47,74,246,261]. There are multiple documents[4,42,84,254] and some consensus works[47,213,262] to guide the development of this type of actions.

To know what type of measures should be implemented, it is necessary to know the situation of the population to which they are intended, define objectives based on this analysis and consider different scales of work[76]. In terms of time, some measures act immediately, but many of them promote structural changes whose consolidation and results require long periods of time. At the geographical level, the general approach can be complemented by the development of regional strategies, more adapted to local needs[73,135,263].

Improving background knowledge: situation, data and surveillance

Expanding and improving the data collected can support the development and implementation of prevention strategies through monitoring and evaluation of the previous situation and subsequent assessment of the objectives achieved.

Early intervention and the design and evaluation of the interventions themselves requires a robust information system to be able to identify territorial particularities, relevant changes and trends[52,128,129]. Various studies underline the need for strategies coordinated by institutions and observatories for the management and analysis of information[128,264]. There are works and guidelines with directives for their development and for improving data collection[77,264,265]. Spain lacks public bodies designed for this purpose and currently only collects data on deaths by suicide[6]. Since 2006, the official reference is the National Institute of Statistics, which is fed by information provided by the Institutes of Legal Medicine of the different autonomous communities[76].

Improving data quality involves intervening at several levels: from expanding the type of suicidal behaviour recorded and the number of variables collected[4,254] to improving the legal aspects related to the confirmation of death by suicide[49,102]. Expert staff point out the possibility of including specific questions in the national health survey[49] to collect information on suicidal attempts and ideation or establish mechanisms to collect in a coordinated manner the information recorded by health centres and hospitals in this regard. So far, the available data comes mainly from independent studies. In addition, being able to integrate data from multiple sources and sectors (see next section) may allow for improvements in the identification of vulnerable individuals or groups[232,233]. As regards the confirmation of the type of death, the psychological autopsy is a qualitative tool that can be of great relevance to better understand the determinants or the reasons for suicide. Although it has recognised limitations, its application is of great relevance since it can allow improving the design and development of preventive strategies[49,102,266]. Some experts point out that its application in Spain is very limited at present.

Intersectoral approach: policies for a protective environment

Intervention is required across all sectors, including the economy, housing, employment, education, social rights and equality, among others, in addition to healthcare, to improve living conditions and well-being and to foster a social environment that protects against suicide.

Intersectoral public actions and policies can contribute significantly to prevention. They are necessary to act on the diverse and variable nature of the factors linked to suicidal beha viour[3,4,6,12,47,57,75,254,259]. They are promoted from all possible levels of areas other than health, which, precisely, impact the general health of the population[152]. This approach thus seeks to improve living conditions to promote well-being and a social environment that protects against suicide[42,57,147,152,254,267,268], focusing on reducing aspects of broad vulnerability. Some of the most notable are substance and alcohol consumption, loneliness[162,172,269–271], unfavorable working conditions, educational level, discrimination and harassment, access to lethal means, inequality and lack of equity or lack of economic support in times of crisis, among many others.[8,43,47,48,58,138,152,254,272,273].

For all these reasons, the objectives and actions for prevention must cover health policies[4,48,58], but also be integrated into macroeconomic, educational, labour, equality and social rights, justice, transportation or development policies, among others[54,57,147,152,172,254,274,275]. It involves providing the individual and social resources necessary to face the problems and dilemmas that life presents and that may be related to suicidal behaviour[12]. Universal access to health care and mental health services and plans are considered effective measures to reduce suicidal behaviour[4,48,58,276]. However, it is estimated that most people who are going to die by suicide are not part of the clinical population and therefore are not identified in the national health system[8,58]. Therefore, shared leadership between health and the rest of the areas involved in the development and implementation of strategies can expand intervention on multiple modifiable social factors. For example, the approval of divorce without spousal consent in a country such as the USA has been linked in some studies to a reduction in the female suicide rate of between 8% and 16%[147].

· Psychological autopsy: Indirect and retrospective investigation technique consisting of determining whether the death of a person, which has occurred under dubious circumstances, is due to natural causes, accident, suicide or homicide. It is about understanding the psychological, emotional and social factors that may have contributed to the death, knowledge of great relevance for the prevention of suicidal behaviour.

Ideally, the expert community suggests that national suicide prevention strategies should promote a "*prevention of suicidal behaviour in all policies and by design*" approach. They should also be led at the government level or by specially designated ministries with an intersectoral mandate, and be provided with their own resources, so that responsibilities and actions are shared simultaneously among all sectors[152]. Countries such as the United Kingdom and Japan have specific ministers for this purpose[277,278]. The British[254], Austrian[42], Irish[57,259] or Australian[279] strategies are considered good intersectoral examples based on a national or also called government approach. In Spain, regional strategies offer important examples and experiences that can be extrapolated at the national level or to other territories[44].

Universal interventions

Universal prevention aims to modify aspects of the social environment (access to media, stigma, etc.) and strengthen individual resilience (knowledge) since it focuses on risk factors for the entire population, regardless of the individual possibility of manifesting the problem that is trying to be prevented. Some recent studies identify them as the least developed type of tools in Spain[54].

Restricting access to lethal means

Restricting access to lethal means is one of the most effective interventions to reduce suicide deaths.

Restricting access to and availability of lethal means is a measure with proven short-term effectiveness in reducing rates of suicidal behaviour[4,47,48,52,71,74].

Many suicide attempts are unplanned, involve impulsiveness and there is ambivalence in the intention, so restricting access to the means allows reducing the probability of carrying it out, since they can function as a discriminative stimulus for behaviour. This may serve to "buy time", during which suicidal thoughts are reduced and the crisis is overcome[40]. Empirical evidence indicates that reducing access to weapons, highly lethal drugs (especially in older people[280]) and pesticides (mainly in rural areas), as well as monitoring, identifying and neutralising black spots allow for effective prevention[4,47,48,51,281]. The latter consist, for the most part, of elevated places, means of transport such as the metro, train (as indicated by the European RESTRAIL project[282,282,283]) or others. The establishment of physical barriers, screens or preventive messages that include means and contacts for requesting help act as a deterrent[246,284]. Data on suicide deaths in Spain record the lethal means, which can guide actions[18].

Prevention in educational contexts

Educational institutions are the "natural" place to develop and implement programmes for suicide prevention. Promoting health and psychological well-being, as well as developing socio-emotional skills, are key aspects of this approach.

Educational centers are considered to be the "natural" and ideal place for the prevention of suicidal behaviour[4,285] (**Key point 5**). The expert community highlights the need to improve the empirical validation of strategies and avoid specific, unrelated actions or actions outside the framework of evidence, since they could be negative.[286]. The concern and need for action extends to all educational spheres, including the university.[287–289].

To address the psychological aspects required for suicide prevention among young people and adolescents, it is essential to combine several strategies in an integrated manner[13,290–292]. First, a general one of health promotion (at a curricular level, through sport, arts, etc.) and psychological well-being. The aim is to encourage the development of socio-emotional skills and abilities to deal with life's difficulties as well as other protective aspects, with activities and spaces that allow the development of a "sense of belonging" to the group. Second, specific interventions that have empirical support (**Key point 5**).

This vision of comprehensive promotion and prevention requires involving the entire school (whole-school approach)[285], which includes teachers, students and families, together with actors outside the educational context such as health, social services, administrations or the media. Some studies estimate that addressing absenteeism, bullying or mood-related conditions in the school environment through actions that were 100% effective could prevent 28%, 22% and 26% of deaths by suicide, respectively, but also other problems[138]. Coordination and networking are of great importance in this area. for an effective multidisciplinary and multisectoral approach, which is why it is important to have a psychology professional who can act as a point of reference[13,285,293]. This may also pay special attention to false positives or iatrogenic damage that may be caused by excessive attention to discomfort[12,286].

Some of the specific suicide prevention programes most recognised for their effectiveness and cost-effectiveness[294] are the commonly called YAM, acronym for *Youth Aware of Mental Health*, from the European research project *Saving and Empowering Young Lives in Europe* (SEYLE)[295–298], and *Signs of Suicide* (SOS)[138]. The most effective tools that compose them are collected in **Key point 5**. Recent studies point to specific active interventions that significantly reduce the likelihood of suicidal ideation and attempts in students[299]. Its estimated effect is equivalent to the prevention of at least one suicide attempt for every two standard-sized classrooms[299].

In Spain, there are very few empirically validated school programmes[13], with the exception of the YAM program that was validated in Asturias (without subsequent transfer)[138] and, already in advanced stages but still in the evaluation process, PostivaMente 2.0[300], a universal school prevention plan led by the University of La Rioja in collabouration with researchers from the University of Oviedo and the Complutense University of Madrid. Currently, the YAM program is applied in some regions such as Galicia. At the university level, there are few programes in Spain[301–304] and their effectiveness has not been proven, which reflects the importance of accelerating actions in these contexts[289,305].

The increase in suicidal behaviour among young people is worrying in Spain. There is evidence of the effectiveness of universal interventions for prevention in school contexts, but more studies are still required.

Key point 5. Suicidal behaviour among the younger population and specific tools for prevention in educational contexts

Adolescents generally show more impulsive and less lethal behaviour than adults, characterised by a higher frequency of less serious attempts[306]. In line with this, young people (under 29 years of age) in Spain have lower mortality and suicide rates than the rest, but a greater tendency towards suicidal ideation. The prevalence of attempted intercourse ranges from 3.7% to 9.3%, depending on the study[13,138].

Some independent studies by non-profit organisations in Spain have pointed out a marked increase in suicidal behaviour in recent years (2012-2022) among adolescents and young people, aged 15 to 19, or under 15 years[307]. The official data available on suicide deaths in minors in these age groups do not clearly reflect this trend[18,65]. However, multiple studies in different Spanish regions recognise an increase in hospital care for suicide attempts and self-harm associated with the pandemic and confinement among young people, especially among women and after confinement[64,308–310]. Another sociocultural aspect commonly associated with the increase noted is the influence of the Internet and social networks, although evidence in this regard is insufficient[311–316] (see next section).

Currently, the factors best related to suicidal behaviour among young people and adolescents[38,317,318], all of which are modifiable, are clinical and subclinical anxiety and depression[319], alcohol consumption[320] or other substances[321], school absenteeism, family problems[322] and a history of suicide[323], abuse and being a victim of bullying[324,325], which now extends outside of educational centres every day of the year in a digital way (cyberbullying). There are also others, such as maladaptive or pathological use of the Internet[321,326,327], stressful and frustrating events (breakups with friends or partners, health status of relatives, death of a loved one and many others)[322], the feeling of being a burden and not belonging[328], or unhealthy lifestyles (sleep and physical activity patterns, consumption of energy drinks, etc.)[329–331].

Specific prevention tools in the school context include evaluation and detection systems[138] that allow early intervention when necessary[332], as well as specific actions. Among the latter, those included in programmes for school contexts due to the greatest evidence available on their effectiveness are: awareness and education via curriculum, peer leadership training, training of student socio-emotional skills, and training of school staff[13,299]. Creating a safe space for adolescents to express their opinions without being judged and providing them with strategies to ask for help when faced with emotional distress of oneself or a peer are specific aspects of utility[295,298,333]. For detection, a broader assessment of students' social and emotional skills can be used, as is done for other skills (as in the case of the PISA report). These could include specific measurement tests validated in Spain such as SENTIA, the Paykel scale and the Columbia[13,38,334,335].

It is necessary to evaluate the effectiveness and the possibility of unintended effects of the interventions that are developed.

It should be noted that some studies question the usefulness of screening methods intended to detect particularly vulnerable people in school settings[336] (listed in **Key point 5**). Recently, it has also been pointed out that some school interventions for mental health may cause iatrogenic damages[12,286]. According to these authors, this is especially relevant for universal approaches, in which all students are exposed to the same content, which may be useful, irrelevant or even harmful, depending on the person. The mechanisms by which this occurs are not yet fully understood, but it highlights the importance of always evaluating tools accurately and reporting any adverse effects detected (as in clinical trials). It is an ethical and necessary starting point to be able to advance and improve prevention among the youngest[12].

Responsible communication and awareness: media, internet and social networks

Information and awareness about suicidal behaviour is a necessary tool for prevention.

You cannot prevent something you cannot talk about.[55] The media play an important role in the construction of reality and have an important responsibility in preventing suicide[337]. On the one hand, they can facilitate visibility and awareness[61] by reducing the stigma and myths about suicide[4], improving the identification of warning signs[63] and the widespread understanding of the phenomenon and risk factors[55]. On the other hand, the way in which they communicate about the phenomenon, the help resources they offer, and the related events they expose determine whether they act as a risk or protective factor. There is abundant evidence that highlights the existence of the so-called Werther effect[4,147,338,339]. It consists of an increase in the risk of imitation, that is, the probability of suicide attempts and deaths, in the days following inadequate information. It especially affects vulnerable populations, such as adolescents, and the contagion effect is amplified when it involves the death of famous people[340]. In contrast, the Papageno effect, based on adequate communication about suicidal behaviour, acts in the opposite direction in a preventive manner[4,147,338,339]. The dilemma also applies in other contexts such as institutional communication, social networks or the Internet.

The media can help by reporting accurately, avoiding stigma, and offering hopeful testimonies and resources for help. On the contrary, they may increase the risk of imitation in vulnerable people if they publish risky and sensational information.

For years, WHO and multiple organisations have been urging the media and journalists to act as agents of prevention, relying on the publication of guidelines that promote the Papageno effect at the international[341–343] and national[344,345]levels. These highlight the importance of avoiding glamourised and sensationalised coverage of deaths and detailed references to suicide methods and thus focusing news on the loss and not the fact of suicide in order to avoid sensationalism and promote rigour, respect and responsibility[40,345]. It is beneficial to ultimately shift the focus from events to health[55] and to do so, promote stories of hope and recovery that normalise suffering, prevent stigma, and always provide details on how to get help. In Spain, there is no external body that oversees these practices and existing studies indicate low adherence to recommendations[56,346–352]. The specialist staff also highlights the lack of internal controls, such as a trained reference editor or writer. Furthermore, some studies indicate that few awareness-raising campaigns have been carried out at institutional or large-scale level compared to other European countries[353].

The expert community therefore stresses the importance of implementing a coherent and ethical communication policy within and outside the media. It is also important to address all these aspects in the academic training of journalists and communicators, as well as through the dissemination of updated style guides to increase awareness within the sector[4]. Both raising awareness among the general population and the use of guidelines to promote responsible media are considered advisable measures to reduce the incidence of suicidal behaviour, but more studies are still required to reinforce the evidence on their degree of effectiveness[48,354].

· Werther effect: Phenomenon whereby media coverage of suicide, especially when sensational or detailed, can trigger an increase in suicides and copycat behaviour in vulnerable people. This effect was named after Johann Wolfgang von Goethe's novel *The Sorrows of Young Werther*, in which the protagonist dies by suicide, which is believed to have inspired a series of copycat suicides in the 18th century.
· Papageno effect: Phenomenon in which responsible and positive media coverage of crisis management and overcoming suicidal thoughts can have a preventive effect, helping to reduce the incidence of suicides. It is named after the character Papageno in Wolfgang Amadeus Mozart's opera *The Magic Flute*, who reconsiders suicide after being consoled and supported by other characters.

The relationship between the Internet and suicidal behaviour is not yet fully understood and poses a challenge: the Internet offers new opportunities for prevention, but also multiple risks.

In the case of the Internet, major search engines and social networks, there are some important differences. Today, they are among the main means used by the population to obtain information, but monitoring the risks is much more complex in this context.[337]. The evidence to establish a relationship with the increase or decrease in suicidal behaviour is less than in the case of traditional media[355–360]. On the Internet, anti- and pro- suicide pages and spaces coexist, so it can function as a support network (something that projects in the European context point out, such as SUPREME[361,362]), as an agent of change and protection, but also as an instigating agent[313].

The debate surrounding the risks[313] and opportunities for suicide prevention that the Internet provides remains open[40,363,364], including guidelines that attempt to guide how to present and discuss suicidal behaviour on social networks to minimise risk[365–367]. The risks include access to inappropriate content that encourages harmful behaviour, addictive use of networks, cyberbullying and extortion, among many others. Conversely, the ecosystem may also provide new opportunities for targeted and indicated surveillance, identification, and prevention[313] (**Key point 4**). The use of algorithms and other techniques that can automatically recognise risky behaviours and content[368–371] or pro-suicide in order to act and the responsibility of digital platforms in this regard are still subject to various legal, technical and ethical debates[372,373]. At the other extreme, search and recommendation engine algorithms could favour the visibility of content or news developed from a preventive perspective. Specialised personnel also emphasise that training on suicidal behaviour for security forces and bodies operating on the Internet can also improve the detection and assessment of potential people at risk.

Free 24-hour helplines

Spain has multiple lines for assistance and information regarding suicidal behaviour, such as the national, 24-hour, free number 024.

Their objective is to contain or reduce the intensity of suffering at a given time, the risk of suicidal behaviour and refer to specialised services when necessary. This is a measure recommended by the expert community[3,4,58,374], but the available evidence on its effectiveness is heterogeneous and is considered insufficient to determine this aspect with precision[58,375,376].

Spain has a telephone, chat and sign language line, 024, promoted by the Ministry of Health since 2022[377]. To date, they report that they have handled some 260,000 calls, of which 12,800 were referred to emergency services and 5,668 corresponded to attempts[378]. There are also several older helplines operated by associations and non-profit organisations, such as the Telephone of Hope[379] (717003717), the ANAR foundation[380] for the younger population (900202010) or regional or local services (autonomous communities or town councils)[381], among others[63,382–384]. Professional organisations such as Papageno[385] and the AIPIS-FAeDS Network[386] are part of the broad range of national or regional organisations that offer their help[63,382].

Selective interventions

They act on the vulnerability derived from factors that increase the incidence of suicidal behaviour compared to the population average, in a given group of people. These are macro and micro factors and variables that define inequity, inequality, social exclusion and various social determinants (demographic, environmental, lifestyle and access to resources, etc.)[387].

Demographic groups

Among others, elderly people, certain professions such as healthcare workers and law enforcement, or individuals with socioeconomic difficulties make up some well-defined vulnerable population groups.

According to age, young people and adolescents stand out as vulnerable[388] (**Key point 5**) and older people[270,389]. The latest show rates that double the national average from the age of 70 (quadruple in the case of men)[16], which is why the expert community highlights at national and international level the need to strengthen prevention in these groups[270,280,389,390] . Actions focus on mitigating loneliness, isolation and other characteristic risk factors[49,270,271,390,391]. Furthermore, the implementation of specific strategies at the national level and programes for nursing homes, as has been carried out in some countries[262,270,389,392], is an aspect that part of the expert community points out as necessary in the Spanish context[389].

The so-called gender paradox (common in the West) is also relevant and defines different approaches for men and women[393,394]. It includes subgroups with suicide rates as the primary cause of death, such as women in the perinatal period in some Western countries[395–400].

Socioeconomic difficulties[253,401–404], literacy and cultural level[388,388,405], or marital status[406–408] also configure groups vulnerable to suicidal behaviour. There are also geographical variations marked by the tendency for the phenomenon to concentrate in specific areas. These are typically characterised by their rural nature, an aging population, isolation and limited access to healthcare resources[16,387]. In Spain, some specific areas of Asturias, Galicia and Andalusia require special attention, although the determinants of the high rates are not really known[409].

Regarding occupation[405,410], high-risk professional areas such as law enforcement (both national and regional)[411–416], military personnel[417,418] and healthcare workers require[419,420,420], specific prevention strategies[418,421], due to their access to lethal means, their knowledge of these means[422] nd the high levels of stress they experience[423–425]. For example, according to data presented in Parliament, in 2023, six police officers and ten civil guards died in Spain by suicide[426] and there are multiple studies that emphasise the need for prevention among health professionals. People in manual and less-skilled jobs also show particular vulnerability[405]. The debate surrounding suicide as an occupational accident, associated with stress, harassment or other reasons is open[427] as indicated by several legal actions in Spain[428,428].

People at risk of social exclusion and isolation

Vulnerable groups such as the homeless or LGTBIQ+ community among many others, show higher suicide rates than the general population due to the discrimination they suffer.

Social exclusion and rejection form groups of populations that show a greater presence of risk factors for suicidal behaviour[387]. It is also important to take into account the presence of suicidal behaviour, especially attempts (see section Indicated Prevention)[217,387], can motivate these social processes.

People living in poverty, especially the homeless, have high suicide rates. The few data available estimate that around 25% of homeless people in Spain attempt suicide.[429], although there are reasons to think that it is higher[429–433].

Various studies indicate that the LGTBIQ+ community, due to discrimination[434,] show a probability of attempting suicide between two and three times higher than that of the general population[435,436]. Although there are strong variations between studies, countries, etc., some studies estimate that between 11% and 20% of the population belonging to sexual minorities attempts suicide[437]. The figure may rise to 30–50% in transgender people[438–441]. The percentages of people showing ideation are even higher in these population groups. They also need specific care programes due to their greater vulnerability and high suicide rates[387] the prison population[442,443], in deprivation of liberty or upon recovery, and although there is little data on this subject in the Spanish context, some international works also point to some racial minorities and migrants[444–446].

Victims of violence

Victims and often also perpetrators of violence are groups vulnerable to suicidal behaviour.

It includes those who have suffered traumatic and violent situations, both victims and perpetrators, in contexts such as family, school or work. Violence can be psychological, emotional, physical or sexual and can occur within the family, in child abuse, abuse of the elderly or women, workplace, school or sexual harassment[387,447,448]. For example, recent studies in Spain indicate that psychological and controlling violence, as well as fear of one's partner, influence suicidal thoughts and attempts in women[449].

· Gender paradox: It refers to the presence of higher suicide rates among men and higher rates of attempts among women in most countries and cultures. Multiple theories try to respond to the phenomenon based on differences associated with sex (biology) and gender (social and cultural), such as the theory of lethality (type of media used), the theory of recall bias (communicating more or less), prevalence of depression and alcohol consumption (antidepressants as a protective factor in women, alcohol as a risk factor in men) and socialisation (acceptance of behaviour as masculine).

Chronic illness and pain, addictions and mental health conditions

Addiction, especially with regards to alcohol, has been widely have been widely linked to increased vulnerability and risk for suicidal behaviour.

Multiple vulnerable groups are configured around the state of health[43]. On the one hand, the presence of diseases and chronic pain and disability stands out[387,450,451]. On the other hand, the population with mental health conditions (see sections The challenge of prediction and the opportunity for prevention and specialised treatments) and addictions are also especially vulnerable.

In Spain, the highest number of emergency visits for attempted suicide occur during weekends and under the influence of alcohol and/or recreational drugs, whose consumption among the younger population is of increasing concern[79]. Data in Spain indicate that[452] may act as precipitating factors. It is estimated that prior alcohol consumption generally accounts for a large proportion of suicide deaths and attempts, although there are strong variations between studies in the specific figures[453]. The relationship between both factors is widely recognised[454,455], although there are cultural variations between countries associated with the form of consumption[456,457]. Prevention of alcohol abuse and other behavioural addictions is considered an effective measure to reduce suicidal behaviour[453,456,458–460].

Reducing vulnerability: community intervention and gatekeepers

The training of gatekeepers is a preventive action recommended by expert staff, but further studies are still required on its effectiveness.

Prevention in these contexts requires minimizing the factors that generate vulnerability and amplifying the protective ones[387]. Social support and cooperation are essential for this[440,461–463]. The objectives include improving the visibility of the groups and the complexity of their realities in order to raise awareness among the general population, reduce stigma, and promote social integration processes. Its approach allows for psychological and social interventions, especially at the community level, which also facilitate access to specialised services[50,252,438,440,463–469]. Therefore, the work of social services personnel (education and social work, normally, and psychology), who provide psychological support to hundreds of thousands of people in Spain, is of great importance[55]. Furthermore, the training of gatekeepers, specialised help lines and services for vulnerable groups, and instruments such as associations[152] and mutual aid groups make up the response at this level of prevention[387].

The presence of gatekeepers in community intervention involves training key personnel from social services, law enforcement (both national and regional), firefighters, and pharmacists to support the general population. It also includes the training of figures in contact with specific population groups, such as personnel dedicated to care, education or health[8,52] and even family members and friends of people at risk[470]. In the USA. In the US, some initiatives in the most disadvantaged groups are resorting to peer training, inspired by the "friendship bench " model and other community-based public health experiences[471,472]. In these, people who belong to the disadvantaged community itself and know how to live in that context are trained and interact with their neighbours in community spaces (public or others such as barbershops, laundries, etc.) to provide help and understanding, and direct them towards the services they may require.

The presence of gatekeepers has been tested in military, religious, and school populations, as well as among healthcare workers and the general public, with positive results. However, more evidence is needed regarding their individual effectiveness[47,48,88,473–475]. In addition, the training of healthcare personnel is especially relevant (see next section).

· Gatekeepers: People with a prominent role in the community (they are in contact with certain population groups). They have the ability to identify people at risk of suicide and connect them with the appropriate resources to get help. To this end, they are offered specific training to recognize suicide risk factors and initiate basic assistance and referral actions. These individuals may be health professionals, educators, peers or community leaders, pharmacists, educators and social workers, friends, family members, etc.

Indicated interventions: crisis care and the health system

The most effective measures to improve suicide prevention in the clinical context are related to: training, evaluation, monitoring and the application of specific treatments.

The indicated interventions focus on people who already display suicidal behaviour. Among them, a previous suicide attempt is the known factor most correlated with a possible death from this cause. In addition to this, the indicated interventions are directed at other factors such as mental health conditions and addictions, suicidal ideation, chronic physical illnesses, disabilities or family history of suicide[52]. There are various consensus documents on the type of priority interventions to respond to these needs[87,213] and their effectiveness[43,48,74,98].

The most effective interventions indicated to prevent suicide are related to an adequate evaluation, monitoring and application of specific psychological treatments to each case[4,43,48,74,98]. To carry them out, organisational and financial development is important to implement health teams that can fulfill the multiple functions required by these interventions, in different services, such as emergencies or primary care[213]. Furthermore, the specialised staff indicates that they can be significantly improved and strengthened by the creation of a network that can guide the application and evaluate the effectiveness of care strategies in a homogeneous manner throughout the territory.

At the national level, the expert community points out some deficiencies in the health system that should be perceived as challenges in terms of suicide prevention.

Currently, there are models for the integration of prevention and management of suicidal behaviour in the health system[255,476–478]. However, the expert community points out deficiencies in the Spanish system that must be perceived as challenges in the field[478]. Across the board, the availability of mental health resources and specialists in the public system (whose scarce available data suggest that Spain is below the European average) and the lack of coordination between services or with other related sectors are key aspects that can hinder the necessary progress[55,56,479–483]. More specifically, among other factors, some of the expert staff highlights some deficiencies derived from the fragmentation and lack of continuity of care in the health and care system that prevent effective preventive strategies[55,478].

Training of all healthcare personnl

A significant proportion of people who die by suicide access primary care or emergency services without reaching specialist services, which reflects the importance of all health personnel being trained in suicide prevention.

Some international[484] and national[392,485] data suggest that a significant proportion of people who die by suicide seek primary care medical consultations and other non-psychiatric settings in the 30 days prior to their death, the majority if the previous twelve months are considered. Although these data cannot be generalised, since they fluctuate between studies, regions and factors such as age or time, they reflect the importance of acting at different levels of care and of considering the prevention of suicidal behaviour as an objective shared by the entire health sector[219].

Numerous studies indicate that training of health personnel at all levels reduces suicidal ideation, attempts and mortality[51,88,486,487], although more evidence is needed to confirm this[8,48,87]. At the national level, expert staff rate this type of action as necessary[6,55,478]. It also points out that addressing suicidal behaviour should be included in the training of mental health specialists and other disciplines involved in Spain[6,55]. Although part of the expert community points out that specific postgraduate training in Spain has recently increased (an aspect that is often unknown), another highlights that generic degrees such as Psychology mostly lack specific training on this subject in their programes[6].

Crisis intervention and responders

Healthcare personnel, firefighters, and law enforcement officers, among others, require adequate training for crisis suicide intervention to promote prevention and ensure their own safety and well-being.

It constitutes the first link in the emergency assistance relationship. Typically, this is directed at people at maximum risk in the here and now, someone who is trying to materialise their decision to take their own life, which may require immediate rescue actions.[488,489]. It involves a context where healthcare resources are not available, which can sometimes pose direct risks to those intervening,[488,489] such as firefighters or law enforcement officers[102,488–492]. Its ultimate goal is to hand over the affected person to the intervening health personnel and, often, to communicate and mediate with family members[488,493,494]. As a whole, it involves semi-structured intervention mechanisms that include the reception, accompaniment and support of the affected person and their loved ones[488] and specialised psychological[488,493] and/or medical care[494].

Expert staff points out the importance of establishing action protocols (there are various local examples[495]) throughout the territory that are adapted to the characteristics of the situation and its risks[492]. On the one hand, since it does not correspond to a problem of public disorder, it requires defining the competencies and improving coordination between those involved. On the other hand, it is considered a potentially critical situation for this staff, since they may be affected. Individual actions to cope with stress and specific training regarding suicidal behaviour are therefore necessary to reinforce the resilience of all the personnel involved, as well as to improve the capacity for intervention and communication with family members and friends[49,55,491], a demand that is widely extended among these sectors.

Assessing suicidal behaviour: from risk to therapeutic assessment

The clinical interview is the primary recommended method for assessment. It also involves intervention, since beyond determining the risk, it is important to focus on finding the most appropriate way to prevent suicide in each case.

It consists of evaluating the suicidal behaviour of a person who accesses the health system and, based on this, establishing the treatment and guidelines to follow. Although there are several levels, in general, it is people with previous attempts[216,217,387] (with variations due to environmental lethality, impulsiveness, active suicidal crisis, etc.) who are of most concern. This is a question of great importance, given the high probability of repetition in the weeks following an attempt[455,496–500]. Although there is significant variability between studies, some indicate that 16% reattempt and between 0.5% and 2% die by suicide within six months[498,499], although the considerable risk extends up to three years after the attempt[498]. In Spain, some studies indicate that evaluation is not a routine or systematised aspect in emergencies or in primary care[38,478]. They also highlight the need to implement specific protocols and systematise and improve the evaluation process within the Spanish system.[55,478]. There are somewhat different visions regarding the how, when, where and why of evaluation, which align with different conceptualisations of the phenomenon (Section A Complex Challenge).

Regarding how, the expert community points out the clinical interview as the best method for evaluation[477,501]. Adapted to the objectives and needs of the clinical context, it should include a behavioural, risk, and contextual-phenomenological assessment. Standard scales and different types of validated questionnaires[40] can be used as a guide in primary care or emergency services, together with brief strategies[502], such as "quick kits" based on simple question schemes[503]. New technologies may also open up new opportunities for assessment[504,504–506] (**Key point 4**).

Regarding when and where, some expert staff highlight the importance of systematic evaluation in all people who arrive at the emergency room and show warning signs[74,262,507–511]. It is advisable that people with a history of suicide in the last year receive a comprehensive evaluation (clinical and toxicological, personal factors, information from family members when possible) and be referred to a specialist[213]. However, some studies point out the limited evidence on the effectiveness of expanding the evaluation, given its limited predictive capacity[51,75,487]. This, coupled with limitations in available resources, questions clinical decisions based on high-risk predictions[156,205,207].

From this perspective, the task in the assessment would not be so much to predict the risk of suicide, but to carry out a therapeutic assessment. This involves finding the most effective way to prevent it and generating care that promotes continuity of care, avoiding the abandonment of the person and their family members[131,205,207,213]. In fact, for some expert staff, evaluation and intervention are inseparable processes[501]. This is a key moment to ensure that the person feels that they are in a safe environment, which can be fostered with a therapeutic relationship based on acceptance, trust, accompaniment and support[15,207,213,512]. In the same

· Clinical interview: A structured process in which a mental health professional assesses a person's suicide risk using a series of questions and assessment techniques.
· Contextual-phenomenological: Focused on understanding the suicidal process/behaviour. In order to do so, it is important to assess, in addition to suicidal behaviour, psychological pain, personal style and coping strategies, in order to analyse them from the perspective of the person's vital-biographical context.

A continuous chain of care and follow-up after discharge have been shown to be two of the most effective aspects of preventing death by suicide.

vein, collaborative decision-making with patients and family members is advisable, including the formulation of advance decisions regarding treatment and hospitalisation[213,477]. All of these are aspects that can also promote adherence to treatments and indications, something that is usually complex[213,477].

Chain of care and follow-up

The follow-up, which establishes a helping relationship and the supervision of individuals with suicidal behaviours who are in contact with clinical or healthcare professionals, is considered a central part of prevention. The lack of coordination and fragmentation of care between services (time for appointments with specialists, between appointments, etc.) or between levels of care, the absence of a reference within the staff responsible for care and the time of discharge, with or without hospital admission, define moments of high risk of suicide reattempt. Consequently, the existence of specific protocols and a continuous and coordinated care itinerary or chain, which includes the accompaniment of a specialist[3,4,478,513,514], is an effective and efficient measure in reducing reattempts and death by suicide[48,255,477,478,509,513,515,516]. After discharge, effective measures include the adoption of a follow-up and safety plan (proactive, with multiple appointments scheduled in the short term and with a long-term vision, including informal contacts such as emails, calls, etc.)[255,516], such as the so-called Suicide Risk Code[517]. This should incorporate a long-term multimodal approach to the most effective treatments (see next section), as well as relying on continued care at community level[213].

Specialised treatment of suicidal behaviour

There are medium- to long-term psychological treatments with proven efficacy in reducing suicidal behaviour and multiple brief interventions that have increasing scientific evidence on their results.

Some studies indicate that specialised assistance in mental health services is one of the most effective measures in preventing suicide attempts and deaths among people who come into contact with health services[50]. The expert community highlights the importance of treating suicidal behaviour as an independent problem and focusing therapeutic efforts on it, regardless of underlying conditions, if they exist[55,73,187] (**Key point 4**). Access to proper treatment for conditions or other health problems is of great importance to reduce vulnerability and prevent them from acting as a risk factor[4,48,58,276].

The main psychological treatments that are effective as a medium-long term strategy in mitigating suicidal ideation and behaviour are widely described[11,40,74,87,508,518]. In Spain, part of the expert community highlights the importance of guaranteeing urgent and continued access to specific psychological treatments in the health system[478]. On the other hand, brief interventions, such as contacts with people, by telephone or mail, reinforce follow-up and psychoeducational intervention after a suicidal crisis[74] and are easy to implement at a low cost[518]. They include strategies for immediate and long-term responses. Among them, the so-called "safety plan"[519,520] stands out for the greatest evidence of its effectiveness[74,213,255].

Psychoeducational interventions, aimed at improving understanding and skills for managing and preventing the phenomenon, can be directed at both patients and their environment[213]. They may improve adherence to plans and treatments, although they still require further research[521]. In Spain, there is currently a clinical trial dedicated to assessing the effectiveness of safety plans[522] and some works on telephone follow-up and psychoeducational interventions have obtained disparate levels of effectiveness, which may be associated with the heterogeneity with which these strategies are implemented, so more studies are necessary[87,496,521,523–525].

- Psychological treatments: Those with the most evidence of their effectiveness in reducing suicidal behaviour are cognitive-behavioural therapy, transdiagnostic, and dialectical-behavioural therapy in the case of young people managing emotional dysregulation.
- Security plan: A safety plan is a personalised strategy developed jointly by a mental health professional and a person at risk of suicide. This plan provides a set of steps and resources that a person can use to stay safe during times of crisis. It includes identifying warning signs, coping strategies, activating the support network (family, friends, professionals, support groups), or adopting a safe environment (elimination of lethal means, safe places), among other aspects.

There are medium-long term pharmacological treatments indicated. Furthermore, there are promising advances in this field for reducing ideation in the face of a crisis almost immediately.

The use of pharmacology in suicide is complex[73,87,88,148]. There are few alternatives and data available and there is no general consensus regarding some existing treatments[213,477]. However, its use is recommended in people who have received diagnoses such as depression, especially major depression, bipolar condition and schizophrenia[40]. Its use is linked to the treatment of the underlying diagnosis. However, recently, some studies propose the use of drugs that can act directly on suicidal behaviour in the short term to reduce ideation in crisis and emergency situations, such as ketamine[87,213,512,526,527]. Its long-term effect is not proven. Various guides and studies contain specific recommendations on the drugs indicated[40,43,87,88] and the need to consider recent advances in this regard to provide specialists with the best tools available[95,213].

Postvention: caring for survivors of bereavement by suicide

Postvention is part of comprehensive suicide prevention programmes, although in Spain it seems to be largely disconnected from the public health system.

If prevention fails, support should be offered to those closest to the person who has died by suicide, commonly called survivors of bereavement by suicide and sometimes survivors, as part of a comprehensive suicidal behaviour prevention strategy[21,22,528–530]. This is a traumatic experience that can have serious repercussions on those close to the victim[22]. Many of these people suffer the consequences of stigma and feel their suffering silenced and their loss made invisible[115,531,532].

Although grief due to suicide can be understood as a normal process of reconstruction and readaptation to loss, evidence indicates that the reactions it generates can be qualitatively different from other types of grief[22,529,533,534]. It can generate the so-called "complicated or prolonged grief", of a pathological nature[535–537], which is accompanied by psychological problems and, in the most serious cases, risk of suicide[538–540]. Stigma, taboo, secrecy, misunderstanding and sometimes guilt or trauma resulting from the discovery of the body can be associated with this type of process[531,534,539].

Postvention encompasses a wide range of interventions with preventive and therapeutic purposes[22,49,529,541,542]. It can be said that it begins during crisis intervention, which is probably one of the hardest and most impactful moments in the lives of family members and loved ones. This aspect once again highlights the need for training of all personnel involved[488,530]. Survivors of bereavement by suicide call for immediate specialised intervention, which provides information on available resources and facilitates mourners' requests for help and their early access to specialised care and therapies (when necessary) through monitoring, advice and support[22,87,532,541]. The expert community stresses the importance of family members or loved ones receiving this information in writing and from the specialist staff involved. Community strategies, such as grief support groups, and other professional approaches, such as grief therapy groups, are also highlighted[22,87,541,542]. In any case, various works point out the need to continue strengthening the evidence regarding the effectiveness of post-treatment therapies and programes[22,529,542,543], which is still considered scarce, especially in some vulnerable groups such as minors[543]

The expert community emphasizes that, in Spain, the support, care, monitoring and attention strategies required by postvention are carried out in their vast majority by survivor associations and other organisations of specialised professionals[21,22,55]. It highlights the urgency of incorporating postvention into suicide prevention strategies, the importance of strengthening the resources allocated to organisations that currently develop postvention and the need to incorporate interventions dedicated to it into the portfolio of health services, social services and other sectors involved[22,528], as occurs in Australia or the United Kingdom, among other countries[529,544].

· Complicated or prolonged grief: A condition in which a person experiences intensely painful and persistent grief that significantly interferes with daily functioning and does not diminish over time (as is typical in the normal grieving process) or even increases.
· Postvention: In general, this term refers to supportive activities that take place after a stressful or hazardous situation. In the case of individuals grieving the suicide of a loved one, the primary needs focus on processing what has happened, providing support throughout the bereavement process, and addressing feelings and beliefs that may hinder a healthy adjustment to grief (see Postvention section).

Actions do not necessarily have to be limited to the clinical setting and survivors; they can also be extended to other people who are affected, such as friends, classmates, work relationships, or healthcare and intervention personnel[488–490,493,494,545]. In this regard, there are guidelines for postvention interventions in specific contexts, such as educational settings, [287,546,547] workplaces[548], and others.

A shared responsibility

Suicide prevention involves society as a whole and requires a collabourative and intersectoral approach that includes public authorities, expert personnel and civil society, in order to approach the phenomenon in a comprehensive manner.

Making progress in suicide prevention and the development of public policy requires the participation and collabouration of all those involved: public authorities, expert and research staff, the media, any other related sector and social participation[56,259].

Although there is a significant body of knowledge on the prevention of suicidal behaviour[4,57,250], the expert community points out that prevention still requires scientific advances, resources and management tools that allow it to be improved and amplified its potential[4,6,21,55,56,95,246,247]. Thus, a key element is the need to expand knowledge regarding the effectiveness of interventions, in order to improve and guide strategies[50,51,55,246]. Therefore, it is necessary to empirically evaluate the degree to which they are implemented, the difficulties that exist for this and the results they produce[4,55,56,76,250,549]. This evaluation should be enriched based on socioeconomic criteria (cost of inaction, cost-effectiveness, etc.) and incentives should be established to improve strategies[550,551]. These are aspects that have been questioned or pointed out as lacking in the national framework in recent studies[44,52,53,56] and are demanded by the expert community and civil society for more effective prevention[6,13,43,55,92,95,135].

On the other hand, dialogue for the development of public policies dedicated to the prevention of suicidal behaviour requires a plural perspective that incorporates multiple interrelated sectors (health, education, economy, etc.), media, expert personnel (interveners, health professionals, researchers, etc.) and civil society (survivors' associations, survivors of bereavement by suicide, professional Organisations, etc.)[3,4,6,21,47,55,56]. Therefore, encouraging their participation and recognising their valuable experience in committees, expert groups and other processes for the development of public policies can reinforce a comprehensive vision of prevention and facilitate social support[6,76,87,152]. Furthermore, at a social level, raising awareness to reduce stigma and taboo can facilitate prevention and act as an incentive to motivate public action regarding suicidal behaviour. It is important to encourage individual reflection on how, from one's personal or professional perspective, one can contribute to reducing pain, strengthening bonds and offering hope.

Suicide prevention is, more than anything else, an issue that challenges society as a whole with the aim of generating hope through action[138].

Key concepts

- Scientific evidence indicates that suicidal behaviour is a significant social and public health problem in Spain that is prevenBox.
- This is one of the most challenging problems for human understanding and scientific explanation with interrelations at personal, family, school, economic, work, social or health levels, among others. Any simplistic or unicausal explanation is necessarily reductionist.
- Preventing suicide means alleviating suffering and improving quality of life in all areas. Evidence indicates that this is a phenomenon in which psychological, biological, social and cultural factors converge, so its approach requires a holistic and multi-sectoral approach, in order to focus on the person, their context and life situation.
- Suicidal behaviour is complex. It is a polyhedral, dynamic, heterogeneous and multi-causal phenomenon, which makes it difficult to identify its determinants and predict it accurately, adding the need for multi-level strategies for its prevention.
- Social stigma and existing myths about suicidal behaviour are a barrier to its prevention and amplify the suffering of individuals and those close to them, as well as grief in the event of loss.
- Social and institutional awareness and empathy are essential. Talking openly about pain, without fear or judgment, accompanying, seeking and accessing specialised help and, especially, training in all related areas, can save lives.
- The expert community identifies urgent needs at the national level in the prevention of suicidal behaviour. These include the implementation of specific national plans or strategies that coordinate and promote actions through the provision of their own resources and a comprehensive, multi-sectoral approach based on scientific evidence.
- The effectiveness of prevention depends on a good initial and subsequent evaluation, which allows for the establishment of specific objectives and verification of the degree of compliance. To achieve this, it is key to improve the availability and collection systems of data and to empirically evaluate the implementation and results of the interventions.
- The expert staff reflects the importance of acting in a comprehensive manner, including universal actions aimed at the entire population; selective actions for vulnerable groups; and indicated actions for people who display suicidal behaviour in any of its forms.
- More evidence is still needed around multiple interventions to improve prevention. The most widely supported are: restricting access to lethal means, universal prevention in school settings, access to psychological and pharmacological treatment, and the ongoing care and monitoring of affected individuals.
- Suicide prevention requires the collaboration of public authorities, experts, and civil society, involving all relevant agents and sectors beyond healthcare, such as education, economy, media, housing, law enforcement, and equality, among others. It is important for each person to reflect on how, from their personal or professional sphere, they can help reduce pain, strengthen connections, and offer hope.

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