Belize National Suicide

PREVENTION PLAN

2024 - 2030

FOREWORD

As Minister of Health & Wellness, it is with profound urgency and dedication that I present the National Suicide Prevention Plan. Suicide is a complex and deeply concerning public health issue that affects individuals, families, and communities worldwide, including here in our beloved nation. It is a tragic loss of life that reverberates through society, leaving behind immeasurable pain and grief.

Yet, amidst the darkness of despair, there exists a beacon of hope: prevention. This comprehensive plan represents our unwavering commitment to saving lives, fostering resilience, and promoting mental well-being for all citizens. It is a testament to our collective resolve to confront this crisis head-on, with empathy, compassion, and evidence-based strategies.

This plan is not just a document; it is a roadmap to action. It outlines a multifaceted approach that addresses the underlying risk factors contributing to suicide, including mental illness, social isolation, economic hardship, and stigma. It emphasizes the importance of early intervention, access to quality mental health care, community support networks, and destigmatizing conversations about mental health.

I extend my deepest gratitude to the dedicated professionals, advocates, and experts with lived experience who have contributed their expertise and passion to the development of this plan. Your tireless efforts embody the spirit of collaboration and solidarity necessary to tackle such a complex and multifaceted issue.

To every citizen of our nation, I urge you to join us in this vital endeavor. Whether you are a healthcare provider, educator, policymaker, or concerned citizen, your involvement is crucial to the success of our collective mission. Together, let us build a society where every individual feels valued, supported, and empowered to seek help in times of crisis.

With determination and compassion, let us embark on this journey toward a future where suicide is not just prevented, but unimaginable. Together, we can save lives and build a healthier, more resilient nation for generations to come.

Sincerely,

Minister of Health & Wellness Belize

ABBREVIATIONS

BHIS	Belize Health Information System
CBT	Cognitive Behavioral Therapy
COMISCA	Council of Ministers of Health of Central America and the Dominican Republic
HFLE	Health and Family Life Education
IASP	The International Association for Suicide Prevention
MHA	Mental Health Association
mhGAP	mental health Gap Action Program
MoHW	Ministry of Health and Wellness
NCA	National Council on Aging
NDACC	National Drug Abuse Control Council
PAHO	Pan American Health Organization
PNP	Psychiatric Nurse Practitioners
SDG	Sustainable Development Goal
WHO	World Health Organization
WSPD	World Suicide Prevention Day

ACKNOWLEDGEMENTS

We acknowledge all people in Belize who have direct experience of suicide, including those who have attempted suicide and people bereaved by suicide.

Thank you to the many organizations, service providers and community members in Belize who shared their views, their knowledge and expertise, and their stories to help shape this Plan. We would also like to acknowledge the work of these key organizations that assisted the Ministry of Health and Wellness's Mental Health Unit in the development of this plan. These include representatives from these organizations/departments:

The Pesticide Control Board
School Management – Ministry of Education
School Counselors Association.
Community Policing
RESTORE Belize
Primary Care physicians
Community Representatives
Consumer groups
The Mental Health Association
Belize Defense Force
The Council of Churches
Psychiatric Nurse Practitioners, Counselors, Social Worker and Psychiatrists from the Ministry of Health and Wellness.
The Epidemiology, Policy and Planning and Belize Health Information System Units of the Ministry of Health and Wellness
The National Drug Abuse Control Council
Pan American Health Organization/ World Health Organization (PAHO/WHO)

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INTRODUCTION

Suicide affects people of all ages and all statuses. According to the World Health Organization (WHO), 75% of suicides occur in low and middle-income countries and is the second leading cause of death among 15-29-year-olds[1]. Although suicides are preventable and there are many effective interventions to reduce suicide and suicide attempts, approximately 800,000 people still die by suicide annually. Poverty, limited access to mental health services and widespread stigma attached to mental ill-health contribute to this occurrence.

Suicide prevention has received renewed attention due to the COVID 19 pandemic. Pandemic-related restrictions acted to increase the number of people unable to access mental health care. Additionally, suicide risk factors such as economic and job loss, trauma and abuse are being amplified by the pandemic (PAHO 2021)[2].

The development on plan relied on the core interventions and cross-cutting pillars of the WHO LIVELIFE Implementation Guide for Suicide Prevention in Countries. This guide provides a series of evidence-based interventions to reduce suicide rates in communities. LIVE stands for **L**eadership, **I**nterventions, **V**ision and **E**valuation and builds the pillars of LIFE – i.e. the core interventions, which are:

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- **L**imit access to the means of suicide
- **I**nteract with the media for responsible reporting of suicide
- **F**oster socio-emotional life skills in adolescents
- **E**arly identify, assess, manage and follow up anyone who is affected by suicidal behaviours.

The cross-cutting foundational pillars identified as key to the successful implementation of suicide prevention plans are

[1] Suicide prevention from a global perspective Dr. Alexandra Fleischmann, Department of Mental Health and Substance Abuse World Health Organization

[2] Suicide prevention must be prioritized after 18 months of COVID-19 pandemic. PAHO September 2021. https://www.paho.org/en/news/9-9-2021-suicide-prevention-must-be-prioritized-after-18-months-covid-19-pandemic-says-paho.

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

Additionally, the plan applied the socio-ecological model to understanding the risk and protective factors which converge to produce suicide behaviours. This model considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk for suicide or protect them from attempting suicide in the future. The overlapping rings in the model illustrate how factors at one level influence factors at another level.

As stated by the WHO, a prior suicide attempt is the most critical risk factor for suicide in the general population. Underlying mental health disorders such as depression and substance abuse are important risk factors as well. Protective factors against suicide include:

- Helping at-risk individuals to become resilient in coping with adverse life events.
- Instilling in them a sense of personal worth and confidence.
- Equipping them with effective coping and problem-solving skills and adaptive help-seeking behaviors.

JUSTIFICATION

The drafting of the National Suicide Prevention Plan for Belize was based on the following facts about suicide and suicide attempts published by the World Health Organization[3]:

- Each suicide is one too many!
- Over 700 000 people die by suicide every year – this is more than the number of persons that die from diseases such as malaria, breast cancer and dementia among others.

[3] Preventing suicide: A global imperative – World Health Organization.

- For each suicide, there are likely to be more than twenty persons trying to take their lives.
- For each suicide, there are likely to be hundreds of bereaved persons who suffer.
- Suicide is the second leading cause of death among 15–29-year-olds and the first leading cause of death among 15–19-year-old girls globally.
- 75% of suicides occur in Low- and Middle-Income countries.
- The COVID-19 crisis may increase suicide rates during and after the pandemic and suicidal behavior are likely to be present for a long time and peak later than the actual pandemic.[4]

The suicide rate for Belize fluctuated over the past decade but has gradually increased. As is the case of many middle-income countries, Belize shows some common trends in suicide behavior over the past few years. Almost half (46%) of the people who died by suicide were between 15- 34 years. The ratio of male: female suicide deaths was approximately 3:1 (106 males and 35 females) and the ratio of female: male suicide attempts was 2 to 1. The suicide rate for 2020 was calculated to be 7.6/100,000 population.

In light of those statistics, the Mental Health Unit of the Belize Ministry of Health and Wellness (MOHW) initiated the process of developing a suicide prevention and response action plan with technical support from the Pan American Health Organization (PAHO) in 2017. The plan was developed in consultation with stakeholders from health units, government sectors and civil society and targets priorities in suicide prevention. These consultations generated the following overarching elements to help reduce the country's suicide rate.

1. Surveillance: Strengthen suicide surveillance, increase the quality and timeliness of national data on suicide and suicide attempts.
2. Means restriction: Reduce access to means of suicide with particular attention to pesticides.
3. Media Implement guidelines relating to the reporting of suicide in the media.
4. Training and education: Train gatekeepers, including general practitioners, police, teachers and prison staff, to identify and support people at risk of suicide.

[4] The impact of the COVID-19 pandemic on suicide rates. Sher L; From the James J. Peters Veterans' Administration Medical Center, 130 West Kingsbridge Road, Bronx, NY 10468, USA.

5. Treatment: Facilitate and increase early access to treatment and referral pathways for people at risk of suicide.
6. Crisis intervention: Access to evidence-based therapies to people at risk of suicide or experiencing a crisis situation.
7. Postvention: Provide postvention support to individuals and educational institutions affected by suicide. Implement follow-up procedures for anyone affected by suicide
8. Awareness: Establish public education campaigns to support the understanding that suicides are preventable and increase early intervention at first points of access. Foster socio-emotional life skills in adolescents
9. Stigma reduction: Promote the use of mental health services. Establish programs to reduce discrimination against people using these services.
10. Coordination and Research: Strengthen the health and social system response to suicidal behaviours and Support suicide research to inform future planning.

SITUATIONAL ANALYSIS

Suicide and Suicide Behavior

Suicide prevention is an issue for the entire country of Belize and a priority for the Ministry of Health and Wellness– it is everybody's business. The WHO estimates that for each suicide, there is likely to have been more than twenty (20) suicide attempts and that the single most important predictor of death by suicide is one or more previous suicide attempts or self-harm. Many of those persons who attempt suicide do not seek nor receive medical attention. The data on suicide behavior in Belize was obtained from the Belize Health Information System (BHIS), the health information system of the MOHW. The BHIS collects health information on users of government health facilities countrywide. However, the data presented in this section does not include attempt suicide data from private facilities as this information is not collected. An analysis of suicide and suicide attempt data for 2022, the most recent complete data year as well as data on trends over time from 2008 – 2022 are presented in this section.

Suicide Deaths - 2022

Data from the Belize Health Information System (BHIS) for 2022, the most recent complete data year, indicate that 37 persons died by suicide in Belize, representing a death rate of 8.38/100,000. Twenty-nine (29) males and eight (8) females died by suicide that year which indicates a male-to-female ratio of 3.6 to 1. (Fig 1)

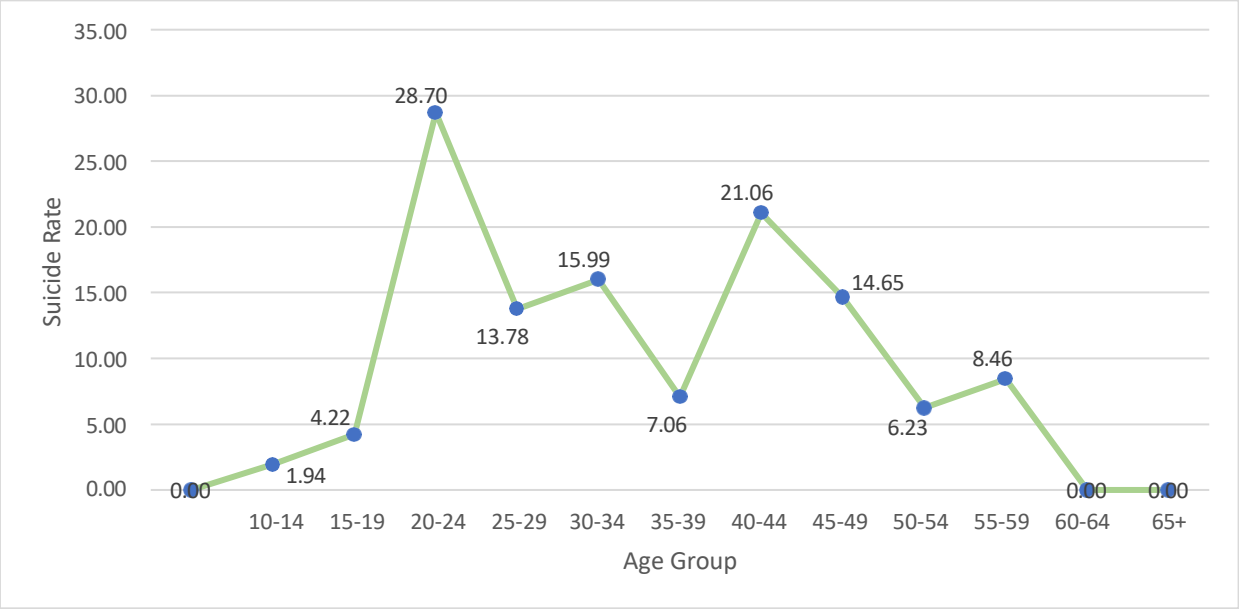
Figure 1: *Suicide Deaths – 2022*

Suicide Deaths - 2022			
	# of suicide deaths	Percentage	Suicide Rate
Females	8	22	3.62
Males	29	78	13.14
Total	37	100	**8.38**

Source: The Belize Health Information System

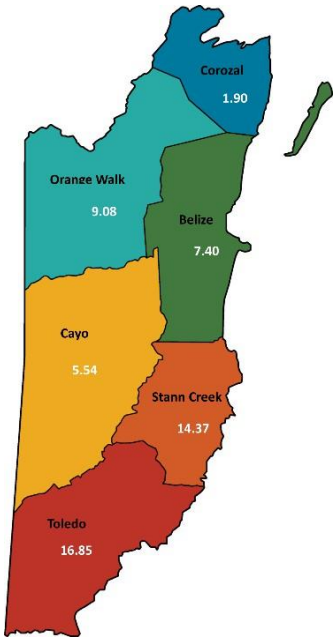
In figure 2, the rates of suicide by age group for 2022 shows that the highest rate of suicides in 2022 was among persons in the 20 – 24 age group.

Figure 2: *Suicide rates by age group - 2022*



Source: The Belize Health Information System

Figure 3: *Geographical distribution of suicide rate - 2022*



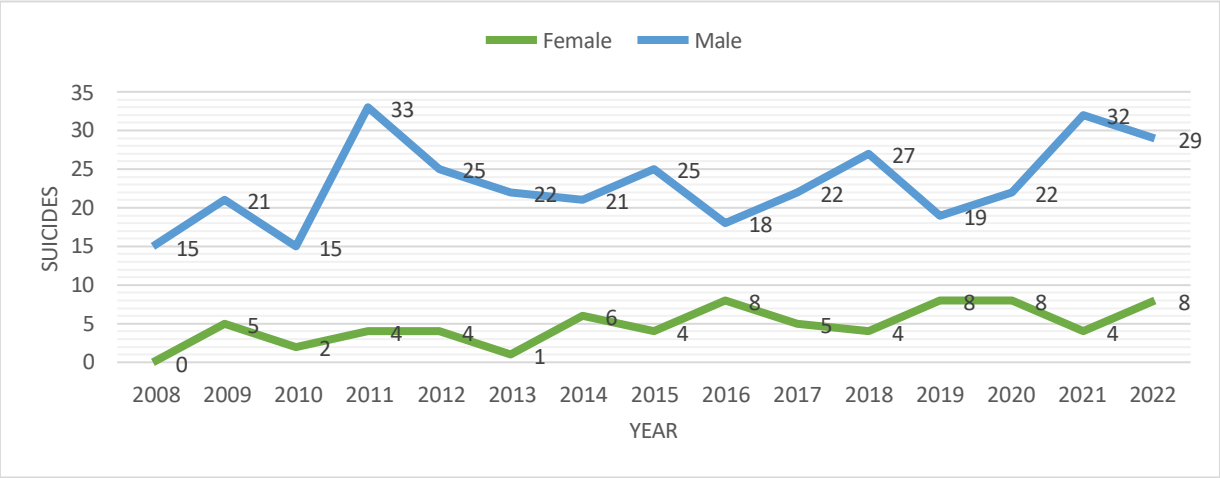
Source: The Belize Health Information System

Suicide rates vary in different parts of Belize. In 2022, the Belize District recorded the highest rate of suicide in Belize, while the districts of Stann Creek and Toledo had the second highest rates. The Corozal District had the lowest suicide rate recorded in 2022. Although Belize, Toledo and Stann Creek districts reported the highest number of suicide losses of ten (10), seven (7) and seven (7) per district respectively, the Belize District's larger population accounted for this rate. Corozal, with a small population recorded one suicide in 2022 and a comparatively low suicide rate of 1.90/100,00 pop. This data was collected at the district level and did not specify if the deaths occurred in urban vs. rural areas in the districts.

Suicide Trends over Time

During 2008 – 2022, four hundred seventeen (417) persons died by suicide, the number of males being 346 and females 71. The male: female ratio consistently reflects the well-established fact that more males than females die by suicide. The figure below shows that even though the number of deaths fluctuated over time, the male to female comparison was constant with 2011 showing the most significant widening of the numbers.

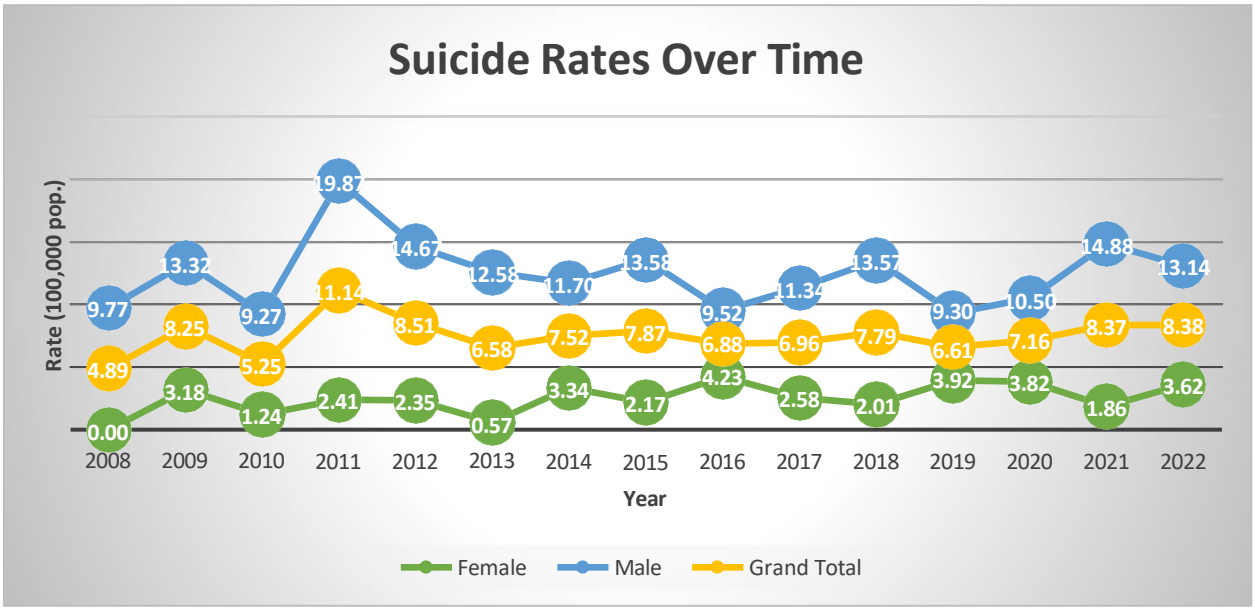
Figure 4: *Suicide Deaths by Year and Sex 2008 - 2022*



Source: The Belize Health Information System

The figure below shows that suicide rate for Belize was the lowest in 2008 at a rate of 4.89/100,000 population and highest in 2011 at 10.54/100,000 population. These numbers reflect a consistently lower than average rate when compared to global statistics.

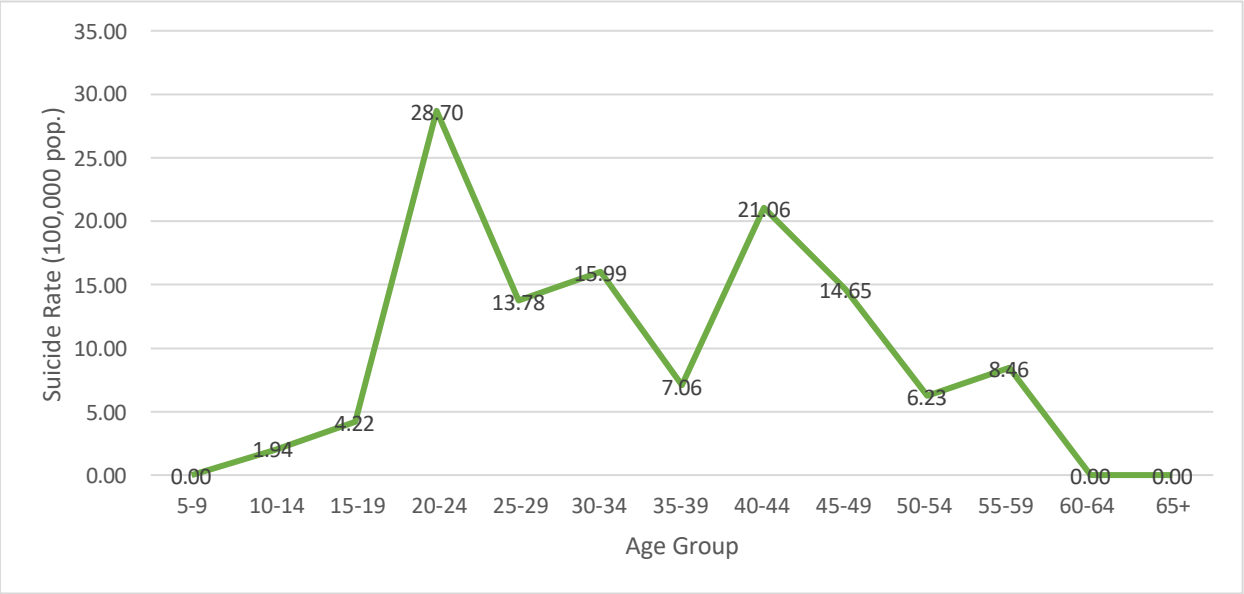
Figure 5: *Suicide Rates 2008 - 2022*



Source: The Belize Health Information System

Figure 6 shows the rate of suicide by age group from 2008 -2022. It shows that the rate was lowest in those 14 or less and highest among those 20 – 24. Persons in the 30 – 34 and 40 – 44 age groups, especially males, remain of significant public health concern.

Figure 6: *Rate of Suicide by Age Group 2008 - 2022*



Source: The Belize Health Information System

Figure 7: *Means of Suicide 2008 - 2022*

Method	2008 - 2022
Gunshot	40
Hanging	276
Poisoning	26
Poisoning: Pesticides	54
Other	23
Grand Total	**419**

Source: The Belize Health Information System

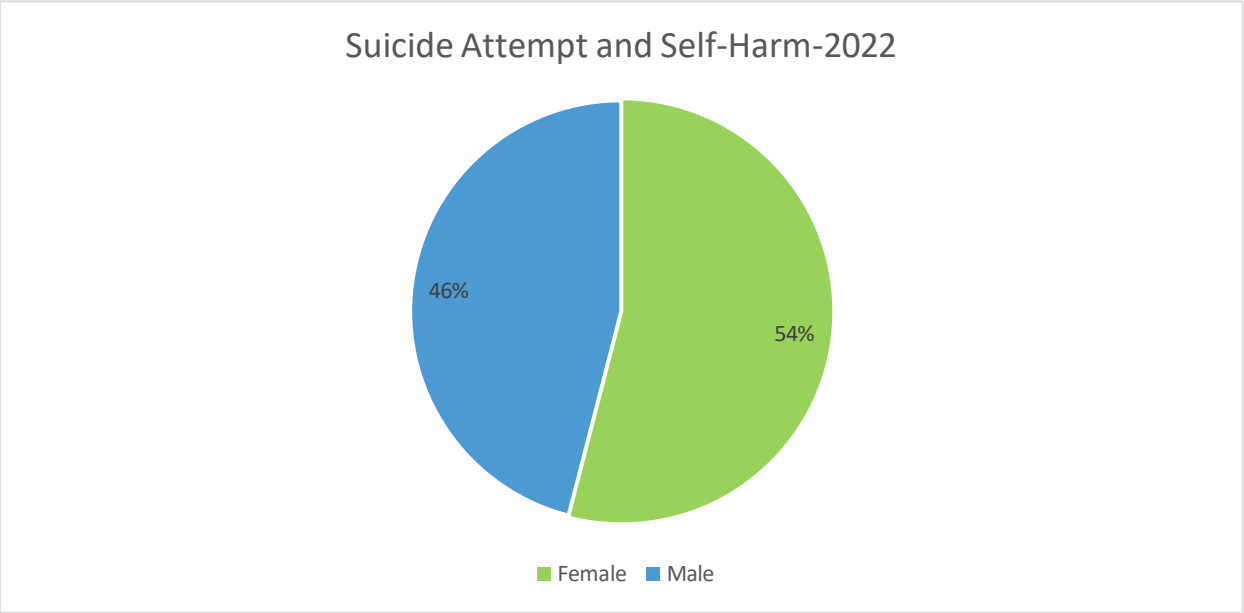
For the reporting period of 2008 – 2022, 276 persons died intentional hanging, followed by 54 by ingesting pesticides. Poisoning by other means such as household chemicals, prescription and over-the-counter medications and alcohol was the cause of 23 deaths. Less common were death by gunshot, jumping and sharp objects classified together as "other" in figure 8. The intentional ingestion of highly toxic herbicides as a means of suicide and self-harm continues to be a significant challenge.

Suicide attempts and self-harm – 2022

Health-facility reported suicide attempts and self-harm for the most recent completed year of statistics showed that the total number of suicide attempts and self-harm reported via the BHIS system was 87 - 47 being females and 40males (Figure 8). This translates to 46% males and 54%

females. Since facilities in the private sector are not connected to the BHIS system, this data is incomplete as the numbers of persons treated in that environment are not reflected here.

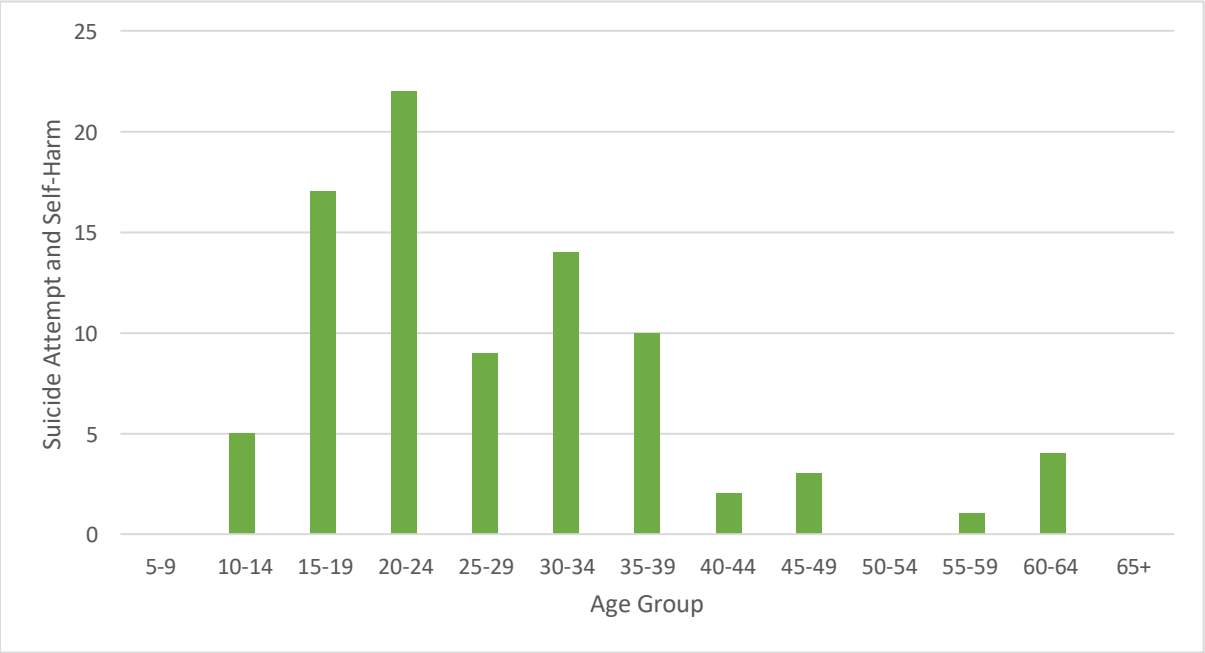
Figure 8: *Suicide Attempts and Self-harm 2022*



Source: The Belize Health Information System

Figure 19 shows the distribution of suicide attempts across age groups in 2022. The age group with the most recorded attempts was 20 – 24 followed by the 15 – 19 age group. There were no recorded numbers for the 5-9, 50-54 and 65+ groups and there was a general decline in numbers with advancing age.

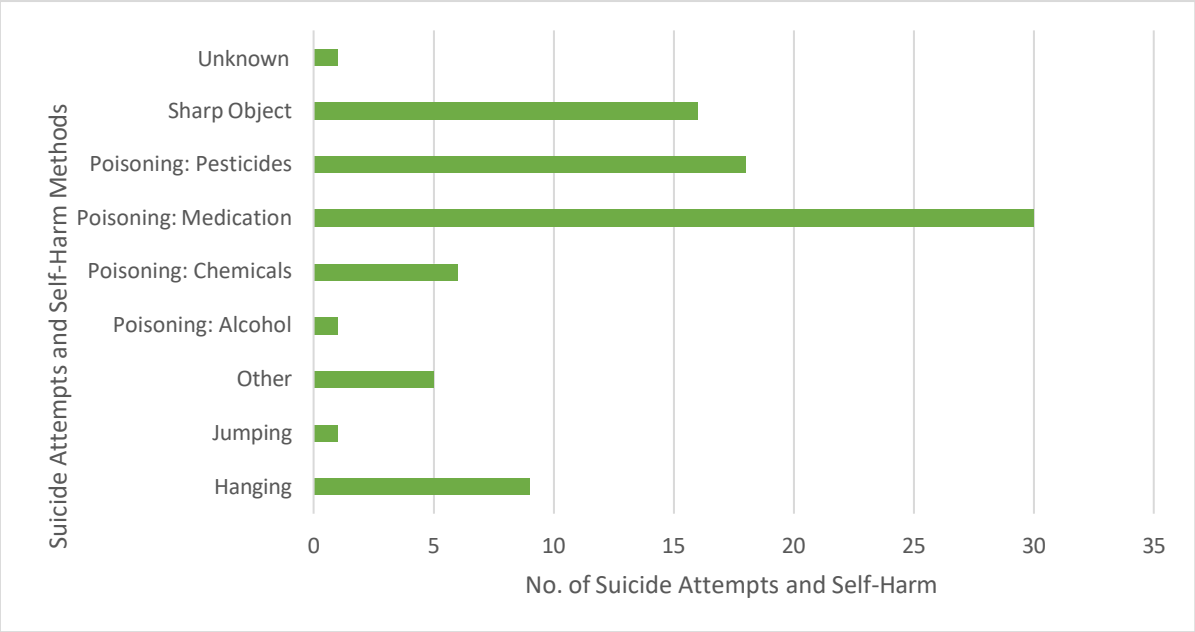
Figure 9: *Suicide Attempts and Self-harm by age group - 2022*



Source: The Belize Health Information System

The method most often used in suicide attempts in 2022 was overdose with medications. The data did not specify if they were prescribed or over the counter. Ingestion of pesticides and use of a sharp object were the second and third most often used methods over in 2022.

Figure 10: Suicide attempt and self-harm methods - 2022

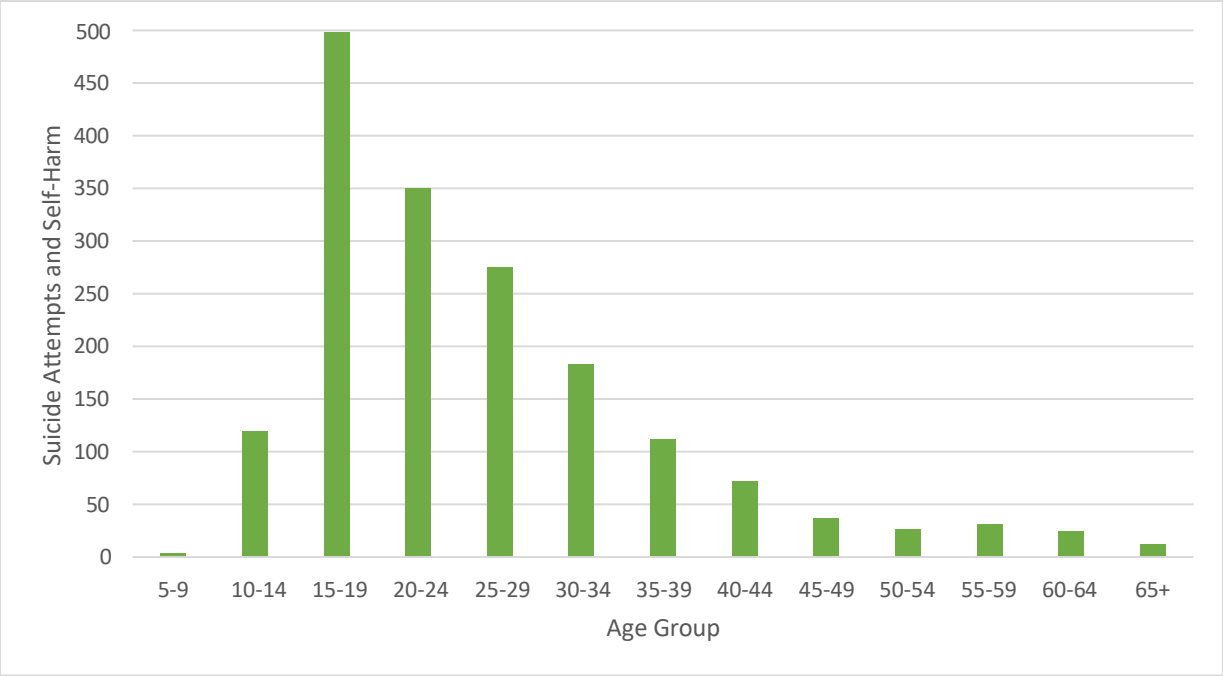


Source: The Belize Health Information System

Suicide Attempt and Self Harm over time

Data from the BHIS showed 1742 reports of suicide attempts and self-harm throughout 2008 – 2022. Most of the reports were by people between the ages of 15 – 29. The number of reports drastically decreased in people over 35 years of age.

Figure 11: Suicide attempt and self-harm 2008-2022



Source: The Belize Health Information System

Figure 12: Methods of suicide attempts 2008-2022

Suicide Attempts by Method 2008 - 2022	
Poisoning: chemicals	109
Suffocation (Hanging)	178
Sharp Object	208
Poisoning: Pesticides	293
Poisoning: Medication	756

Source: The Belize Health Information System

In 2008 - 2022, most hospitalizations for self-inflicted injury in Belize involved poisoning (drug or medication overdose) and swallowing pesticides and other chemicals. Injury from cutting oneself was second and suffocation (typically hanging) was third. Attempted drowning, gunshots and jumping had low numbers and were not included in the figure. (Figure 12)

Suicide Risk and Protective Factors

In a paper entitled, *A National Suicide Prevention Program for Belize (2010)*[5] the author identified the following risk and protective factors for suicide at the time of the research.

Risk Factors

- Pesticides were easily accessed as there were no regulations governing the storage and distribution of pesticides after purchasing by a licensed buyer.
- Treatment of depression and alcohol and substance abuse was not available in primary health care as doctors do not provide integrated care by assessing for depression or initiating treatment for the disorder.
- Doctors in primary health care were not sufficiently trained to assess suicide risk even though research indicates that a large percentage of people who die by suicide visit a physician within weeks of dying.
- A significant percentage of males were heavy drinkers, and most males in Belize consume three to four times more alcohol than women. The 2005 Belize Gender, Alcohol and Culture: An International Study (GENACIS)[6] confirmed this reality. Excessive alcohol consumption especially among men presents a significant risk especially for men who are dying by suicide at a significantly higher rate than women.
- Post-discharge care for those who had attempted suicide was inadequate, compounded by a lack of follow-up, shortage of human resources, and fragmented communication between general health services and mental health services. Also, the lack of a clearly defined suicide alert system failed to provide a rapid response to those in acute need.
- There were no established guidelines for the Belize media for the reporting on suicide. Many reports were sensationalized and detailed despite the decriminalization of suicide attempts in 2001.

[5] Bennett, E. National Suicide Prevention Program – Belize – Course work for the Masters in Mental Health Policy and Services Course (2010)

[6] Belize Gender, Alcohol and Culture: An International Study (GENACIS) 2005. PAHO

Protective Factors

- Trained Psychiatric Nurse Practitioners (PNP) were available in the primary health care setting to assess and treat patients referred by the general practitioner for symptoms of depression. This increased access to mental health services at this basic level of care.
- Some school-based programs include school counselling programs, Life Skills classes that taught decision-making and skills for coping with emotional stressors and the Health and Family Life (HFLE) curriculum taught in primary schools taught students how self-esteem building, communicating effectively and interpersonal skills.
- Strong faith, a prayerful attitude and fellowship in the church setting were seen as protective factors. A large percentage of the population belonged to the Roman Catholic and other denominations such as Methodist and Baptist are very active in Belize. Churchgoing was a significant activity in Belize especially on Sundays.
- Belizeans in general, maintain strong family and community relationships. It was not unusual to find two to three generations of relatives residing together in the same household. The strong family support and involvement offers protection against suicidal behavior.

HEALTH SYSTEM IN BELIZE

The Ministry of Health plays a central role in advising and coordinating the organization of the public healthcare system which is divided into four health regions – namely the Northern, Central, Western and Southern Health Regions. Each health region comprises of a Regional Hospital, a Community Hospital, clinics and health posts. The Central Health Region has the only tertiary level hospital that serves as the National Referral Hospital, providing specialized care such as Gastroenterology, Orthopedics, Cardiology and specialized units such as the Intensive Care Unit and the Neonatal Intensive Care Unit.

CURRENT MENTAL HEALTH SERVICES

The national mental health program is the key provider of public mental health services. The Mental Health Unit, located at the headquarters of the MOHW is headed by a coordinator who provides leadership for mental health planning and programmatic activities. The staff complement includes psychiatrists, psychiatric nurse practitioners (PNP), a counselor, a social worker and a few psychiatric aides and support staff. The services are largely community-based and are delivered via various avenues such as outpatient mental health clinics, an acute psychiatric unit, inpatient beds on general wards of general hospitals, a residential facility, a Day hospital which also provides drop-in services to the homeless with mental health disorders is in Belize City. The Mental Health Association operates the Welcome Resource Center, a facility in Belize City that provides meals and hygienic facilities to persons with mental health disorders who are socially disadvantaged.

Organization of Mental Health Services

The Belize mental health services went through a significant reorganization over the recent past years. Through this reorganization, primary health care mental health clinics were established throughout the country, the psychiatric institution (Rockview) was closed down (2008) and acute services were integrated into general health services. Mental health services are essentially delivered at three levels:

1. Primary Health Care: At this level, PNPs, psychiatrists and some trained medical officers provide mental health care including assessment, diagnosis of mental health problems, medication prescription, referral to counseling to other levels of services.
2. Secondary Health Care: The secondary health care services provided in general hospitals, include diagnosis and assessment of severe mental illness and provision of specialist services on general wards and the acute mental unit.
3. Community Mental Health Services: Outreach mental health services are provided to persons living in rural and remote areas through regular mobile visits. Treatment teams also provide care for the homeless, incarcerated patients and clients living in residential

institutions and facilities for children and the elderly. Community nurses also provide maintenance management for persons living in small communities.

Legislation and Policy

Suicide attempts were decriminalized in the year 2001 through the efforts of the Mental Health Advisory Board which later became the Belize Mental Health Association (MHA). The MHA convinced lawmakers that persons who attempt suicide would benefit from mental health treatment rather than incarceration. As a result of decriminalization, the policy of most health facilities is for personnel who encounter someone who attempted suicide, to refer these individuals to the mental health professionals before release from the facility or provide a referral for mental health care in the community. The International Association for Suicide Prevention (IASP) in its policy position on the decriminalization of attempted suicide states that it will "reduce social stigma, help remove barriers to obtaining adequate mental health care, increase access to emergency medical services, foster suicide prevention activities, improve the well-being of people who are vulnerable to engaging in suicidal behaviours, and contribute to more accurate monitoring of suicidal behaviours"[7].

Gaps in Mental Health Services

- Community mental health and rehabilitative services are limited. Many community programs are available in Belize City and are not available at the district level.
- Programs addressing children's mental health are not available in the public sector nor are there specialists in this area employed by the government.
- Substance abuse treatment is limited. The National Drug Abuse Control Council (NDACC) whose, mandate is drug demand reduction, employs outreach caseworkers who refer clients for treatment to the public mental health clinics and the privately-owned residential facilities. The quality and effectiveness of treatment in these facilities have not been studied.

[7] International Association for Suicide Prevention the Decriminalization of Attempted Suicide Policy Position Statement (May 2020)

- There is a lack of public-private relationships aimed at creating and implementing a sustainable plan to support and promote suicide prevention programs at district and community levels.

Current Suicide Prevention Interventions

The Mental Health Unit currently carries out interventions to prevent suicide on which this plan capitalizes to strengthen suicide prevention efforts in the country. Existing suicide prevention programs include raising awareness on mental health and suicide prevention in the general population, training of primary health care providers in suicide assessment and intervention and making available school counseling services in most high schools. Below are two examples of effective interventions that have had a positive impact on suicide prevention.

I. *Suicide Attempts Surveillance and Early Intervention*

The Mental Health Unit has implemented a suicide surveillance mechanism in which an automated notification is generated when an ICD - 10 X code is entered in the BHIS at a public health facility. The Intentional self-harm Alert functions as an early notification that a client is at a medical facility and mental health assessment if required. A mental health professional is notified and implement established protocols before the patient leaves the facility.

II. Central American and the Dominican Republic Suicide observatory

Suicide data is uploaded to the Central American and the Dominican Republic Observatory of suicidal behaviour and mental health monthly. Data from all the participating countries including Belize can be accessed via this platform. The data repository is hosted by the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA).

SUICIDE PREVENTION STRATEGIES

The overarching purpose of the national suicide prevention plan is to promote, coordinate and support appropriate inter-sectoral actions for the prevention of suicidal behaviors. The key effective suicide prevention strategies, guided by the WHO LIVE LIFE are

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

Mission

A Belize where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and well-being

Goal

To reduce the incidence of suicide and attempted suicide (by 30%), across the lifespan by 2030 among the Belize population.

One-third reduction in premature mortality from suicide, is in line with the UN's Sustainable Development Goal (SDG) 3.4.2. which established the suicide mortality rate of countries as the indicator to measure this target.

Objectives

The objective of this plan is in line with the strategic areas and has the following general objectives:

1. To build capacity in early identification and delivering evidence-based interventions
2. To reduce the risk of suicide in key high-risk groups
3. To reduce or restrict access to the lethal means individuals use to attempt suicide.
4. To support the media in responsible reporting of suicide

5. To promote youth resilience through the provision of psychosocial interventions
6. To provide support to those bereaved or affected by suicide
7. To promote research on suicidal behavioural and support the establishment of an integrated data collection system.

Budget

Successful implementation will depend on several factors including the financial commitment of government and leadership by the Ministry of Health in directing and monitoring the activities of the plan. It is important to ensure availability of funds, equitable and efficient allocation among ministries, and ensuring effective financial management. Therefore, this plan will be costed.

Timeframe, Baseline and Target

Time frame: 2024- 2030
The plan's activities will commence in 2024 and will be completed by the end of the year 2030 which is also the year the UN's SDG No. 3.4.2 expires.

Baseline

The baseline suicide rate is 8.38/100,000 for the year 2022.

Target:

If the target of reducing by 1/3 the suicide rate is reached, the suicide rate will be reduced to approximately 2.79/100,000 population.

Priority Action Areas and Objectives:

In order to achieve the goal of reducing the suicide rate by one-third by the end of 2030, the Suicide Prevention Action Plan 2023-2030, prioritized seven strategic lines of action and objectives. The action areas and rationale are outlined below.

Action Area I: Capacity Building

Objective: Build human resource capacity in early identification and delivering evidence-based interventions.

- Using cost-effective and evidence-based approaches that focus on intervening as early as possible is critical to the success of any suicide prevention strategy. This means having effective pathways between all parts of the health service system and other community supports.
- Capacity-building enhances the competence of health care providers by updating the skills and knowledge to do their jobs competently, and it is to include training on the suicide module in the mhGAP.
- Build the capacity of local gatekeepers, whose knowledge of and access to the community enables them to identify at-risk individuals and mobilize support.

Action Area II: Prevention and Early Intervention

Objective: Reduce the risk of suicide in key high-risk groups (young and middle-aged men; people with a history of suicide attempts, people with a history of substance and alcohol misuse and, the elderly).

- A prior suicide attempt is the most critical risk factor for suicide in the general population and evidence suggests that the risk of suicide can be reduced if people get timely access to services, are followed up after being discharged from health services and have seamless transitions between health and community services.
- Technology must integrate into services across mental health and suicide prevention programs and services.
- Include the importance of mental health literacy in schools.

Action Area III: Reduce access to the means of suicide.

Objective: Reducing or restricting access to the lethal means individuals use to attempt suicide.

- Reducing or restricting access to means of suicide has been highlighted as one of the most effective suicide prevention interventions globally.

- Access to a large quantity of medications (over the counter and prescribed) can be reduced by the quantity of individual sales for medications and other poisonous substances. This limits the stockpiling of medications for future suicide attempts.
- Implementing policies to monitor the sale, storage and use of acutely toxic, highly hazardous pesticides has had some success in reducing access for their use as a means to attempt suicide.

Action Area IV: Media guidelines for reporting suicide

Objective: Support the media in delivering sensitive approaches to suicide and suicidal behaviors.

- Evidence suggests that specific ways of reporting suicide can increase suicidal behaviour in vulnerable community members. However, the media and other digital communication platforms have a role in improving literacy around suicide prevention and mobilizing community and individual action to support those at risk of suicide and/or affected by suicide.
- Positive relationships with media outlets in Belize and key online personalities are vital in developing and promoting messages that are likely to assist with suicide prevention.

Action Area V: Psychosocial Interventions

Objective: Promote youth resilience through the provision of universally delivered psychosocial interventions.

- Cost-effective interventions for mental health have been developed to teach socio-emotional life skills in schools.
- Life skills training is more effective if the programs employ a positive mental health approach.

Action Area VI: Suicide Postvention

Objective: Provide support to those bereaved or affected by suicide.

- Every suicide affects families, friends, colleagues, and others exposed to or affected by the death.

- Postvention approaches that support affected individuals and communities are showing promising outcomes.

Action Area VII: Suicide surveillance and research

Objectives: Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention.

- Consistent suicide-related data can help public health practitioners better understand the scope of the problem, identify high-risk groups, and monitor the effects of suicide prevention programs.
- Suicide-related surveillance is needed to inform and guide suicide prevention and early intervention efforts nationwide.
- Regular collection and rapid dissemination of suicide-related data are needed to guide appropriate public health action.
- Strengthen the suicide alert system in the BHIS.
- Research is essential to assess the effectiveness of suicide prevention interventions, thereby adding to the knowledge base in suicide prevention.

SUICIDE PREVENTION ACTION PLAN

Action Area I: Capacity Building

Objective: To build human resource capacity in early identification and delivering evidence-based interventions.

ACTIONS	ACTIVITIES	INDICATOR	TIMEFRAME
Build capacity in the health sector and the community for suicide prevention.	• Train non-specialized and specialist mental health workers in early identification, assessment, management, and follow-up of self-harm/suicide.	% or number of non-specialized and specialized mental health workers trained in early detection, assessment, management and follow-up of self-harm/suicide annually.	2024 - 2030
	• Assess the competency of non-specialized health workers and specialist mental health workers, in early identification, assessment, management and follow-up of self-harm/suicide.	The number of non-specialized health workers and specialist mental health workers assessed for competency in early identification, assessment, management and follow-up of self-harm/suicide annually.	2024 - 2030
	• Train community healthcare workers in early identification of the risk of suicide, referral	Number of community gatekeepers trained in early identification of the risk of suicide, referral and follow-up	2024 - 2030

	and follow-up in the community		
	• Train community helpers in delivering evidence-based suicide prevention interventions.	Number of community helpers who received training in interventions such as Problem Management Plus (PM Plus)	2024, 2026, 2028, 2030
	• Enhance training of mental health professionals in evidence-based therapies such as Cognitive Behavioural Therapy (CBT).	Number of mental health professionals trained in the delivery of evidence-based treatment and therapeutic interventions e.g., CBT	2024, 2026, 2030
	• Develop workplace health programs to advocate good practice for workplace mental health and wellbeing.	Number of workplace health programs and awareness campaigns conducted at workplaces.	2024-2030

Action Area II: Prevention and Early Intervention

Objective: To reduce the risk of suicide in key high-risk groups (young and middle-aged men; people with a history of suicide attempts, people with a history of substance and alcohol misuse and, the elderly).

ACTIONS	ACTIVITIES	INDICATOR	TIMEFRAME

Embed suicide prevention in the annual plans of groups and organizations providing services to identified at-risk groups.	• Map the different services, organizations, and groups that each of the at-risk groups are likely to have frequent contact with high-risk groups to identify gaps and where pathways can be improved.	List of organizations providing services to at-risk groups identified.	2024
	• Use the above to identify suicide prevention opportunities, risk identification, raise awareness and referral to support.	% or number of the population and at-risk groups targeted by awareness-raising.	2024 - 2030
	• Develop appropriate multi-media public awareness materials to improve knowledge and attitudes (and reduce stigma) about suicide, self-harm and mental health in the population in at-risk groups.	Number of brochures and other printed material for sensitization of the problem, timely consultation and mental health promotion.	2024 - 2030

	• Engage persons with lived experiences to promote wellness and prevent suicide and related behaviors	Number of promotional sessions conducted.	2024- 2030

Action Area III: Reduce access to the means of suicide.

Objective: To reduce or restrict access to the lethal means individuals use to attempt suicide.

ACTIONS	ACTIVITIES	INDICATOR	TIMEFRAME
Promote safe handling of pesticides	• Implement monitoring mechanism for sellers and purchasers of agricultural pesticides	% reduction in suicide attempts and deaths by pesticide poisoning.	2025
Promote safe prescribing and dispensing of prescription and nonprescription drugs	• Conduct a needs assessment and make recommendations for safe prescribing and dispensing of medications.	Number of measures implemented to promote safe prescribing and dispensing. % reduction in suicide attempts and deaths by overdose of medication.	2025

Explore possibilities for safe surrendering of firearms	• Identify a list of options for persons with suicidal ideation to voluntarily surrender firearms.	List of options for safe surrendering of firearm available	2028
Integrate mental health assessment to access firearms	• Draft legislation or policies for firearm sellers and the police department to obtain a psychological assessment from a licensed mental health specialist for buyers/ gun holders • Train gun retailers to assess and/or identify potential at-risk buyers and provide suicide prevention information in stores.	Number of measures implemented to promote safe firearm distribution	2026

Action Area IV: Media guidelines for reporting suicide

Objective: To support the media in delivering sensitive approaches to suicide and suicidal behaviors.

ACTIONS	ACTIVITIES	INDICATOR	TIMEFRAME

Encourage the responsible reporting of suicide by the media.	• Develop and Implement guidelines and training programs for the reporting on stories related to suicide and suicide behaviors on print, broadcast, and social media	Number or % of media organizations whose reporting does not meet country guidelines.	2024
	• Encourage local media to include information on where mental health services can be accessed after articles or reports that may trigger distress in other people.	Number or % reporting which includes resources for where to seek help.	2024
	• Build a proactive suicide prevention media campaign, which includes airing stories of coping with life stressors or suicidal thoughts and supporting World Suicide Prevention Day.	Number or % reporting which includes stories of coping with life stressors or suicidal thoughts, and how to get help.	2024- 2030

Action Area V : Psychosocial Interventions

Objective: To promote youth resilience through the provision of universally delivered

ACTIONS	ACTIVITIES	INDICATOR	TIMEFRAME
Integrate suicide prevention training in curriculum of educational institutions	• Collaborate with the Ministry of Education and the University of Belize to include suicide prevention in the teacher training curriculum.	Updated curriculum which includes suicide prevention education information available.	2026
	• Incorporate Mental Health Literacy in the HFLE and life skills curriculum for all educational institutions.	Updated curriculum which includes mental health literacy materials available. Number of schools or educational settings which are delivering universally evidence-based psychosocial interventions in adolescents.	2026
Improved early intervention for youths	• Develop policies for responding to students identified to be at risk for	Number of schools or educational settings that have response protocols available and circulated.	2024

	suicide or who have attempted suicide.	% change in suicide deaths in adolescents aged 15-19 years or young people.	
	• Create and strengthen links to external support services and provide this information to students.	Written protocols for student referral to external mental health services available.	2024

Action Area VI : Suicide Postvention

Objective: To provide support to those bereaved or affected by suicide.

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ACTIONS	ACTIVITIES	INDICATOR	TIMEFRAME
Standardize approach to supporting those bereaved by suicide.	• Implement discharge planning to include a schedule for follow up for people who receive care for suicide attempts at public facilities.	% of follow up plans documented in BHIS.	2024 - 2030

	• Develop postvention procedures for school counselors to respond if necessary.	Number of schools or educational settings with written postvention procedures available.	2024
Strengthened pathways and referral to bereavement support services.	• Strengthen effective referral to bereavement support/services by emergency services that attend the death and those in contact with the families soon after bereavement from suicide occurs so that referrals are appropriate and timely.	Number of referrals for bereaved family members documented in BHIS. % of bereaved persons provided with timely postvention support.	2024
Develop postvention toolkit for bereaved families and community	• Create a toolkit that will provide a framework for on how to support families and the community at large	Written document providing information and examples on how to cope with loss by suicide	2025

Action Area VII: Suicide surveillance and research.

Objective: To build on the existing research evidence and other relevant sources of data on suicide and suicide prevention.

ACTIONS	ACTIVITIES	Indicator	Timeframe
Standardize data collection management tools implemented public and private health sectors. Surveillance systems for suicide/self-harm are established or strengthened.	• Develop data collection protocols for suicide-related information.	Data set identified % or number of hospital or regions participating in self-harm surveillance system. Data on suicide deaths and self-harm are disaggregated by at least age, sex and means.	2024
Build capacity of medical personnel to improve accuracy in coding and data quality.	• Train medical officers across all levels of health care in the public and private sector in applying the relevant ICD 10 codes	% of medical officers trained in ICD 10 coding.	2024
Establish links with local and external universities to explore research	• Contact research departments of tertiary institutions to conduct	Number of annual investigations about suicide.	2024 - 2030

opportunities on suicide behaviors.	suicide autopsies or other suicide research-related priorities.		

IMPLEMENTATION AND MONITORING AND EVALUATION PLAN

Methodology for Monitoring and Evaluation

The Mental Health Unit of the Ministry of Health has responsibility for delivering on and monitoring progress towards the National Suicide Prevention Plan. The monitoring framework for the plan outlines the specific indicators that are aligned to each strategic objective. The timeline outlined in the plan will be used to track the different goals and milestones for the execution of the plan.

1. Components of the suicide prevention plan will be integrated into the mental health program's annual operational plans.
2. A monitoring and evaluation committee will be established to conduct semiannual audits and reviews of the progress of the implementation of the plan.
3. The mental program coordinator will be responsible for tracking the plan.
4. A midterm review and an end of term evaluation of the plan will be conducted.

ANNEX

Annex 1 – Plan Development Methodology

A seven-member working group guided the plan's development with the mental health unit as the lead agency. The methodology applied consisted of key persons from the National Mental Health Program and technical consultants from PAHO. The working group reviewed relevant statistics and resource documents to draft a framework and identify a list of priority actions which were:

1. Suicide Surveillance and Research
2. Crisis and Health Sector response
3. Reduce Access to Means
4. Intersectoral Collaboration

The working group identified the key stakeholders in suicide prevention in Belize. Mental health professionals, representatives from other health sectors including Planning Unit and the Epidemiology Unit were engaged from the beginning of the drafting process. Other stakeholders included representatives from the education sector, social services, the Pesticide Control Board, consumer groups and other civil society organizations. Thus, the plan acknowledges the complex interplay between the various stakeholders in society that are involved with and, indeed, required for successful suicide prevention efforts.

Annex 2 – Table of Figures

TABLE OF FIGURES