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Letter to Editor

Psycho-education as the School Suicide Prevention Strategy in Low and Middle-Income Countries: Half Bread is Better than None

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Dear Editor

Suicide is a growing public health concern due to the disturbingly high mortality, morbidity and burden associated with it. It is among the leading causes of death in people aged 15–19 years (1). According to the World Health Organisation, the global suicide prevalence per 100,000 is 13.68 in the lower-middle-income countries, 22.68 in the upper-middle-income countries, and 12.72 in high-income countries. Following the COVID-19 pandemic, the rate of suicide in all age groups and races has continued to rise steadily (2). This underscores the need for renewed efforts to address this public health issue.

The school provides a suitable ground for suicide prevention on a public scale given that it reaches a large proportion of the population for many years. The school plays a crucial role in the early recognition and identification of children with mental illness. This is salient because mental illness is central to the development of suicide. Further, the school environment provides a unique opportunity to access students for mental health promotion, prevention, and intervention which are core to suicide management. By promoting school mental health, it is possible to reduce incidents of suicide among children significantly.

High-income countries have not only designed suicide awareness programs in schools but also developed school policies and strategies for suicide prevention. This has led to a downward trend in the cases of suicide reported in such communities (3). The existing programs are so robustly organised that they promote a framework for a multi-tiered system of support (4). For instance, in the first level of intervention (universal), parents, teachers and other school staff are trained in detecting those at suicide risk; school climate and connectedness are improved; social/emotional competency and resilience are built; and mental health literacy is raised including suicide prevention education. The second layer of targeted interventions is directed at screening and identifying groups of children at higher risk including those undergoing stressful life situations and providing them with social support. The third layer is an individualised intervention where the level of suicide risk is determined, assessment and triage are done, brief interventions are given, parents are notified, and cases are referred to community mental health professionals for treatment. Some schools also provide postvention programs where there is a loss of students or staff from suicide. All these policies and programs are in written protocols, pre-planned, with well-defined roles, and properly coordinated by trained personnel for effective delivery.

Paradoxically, most low and middle-income countries (LMICs), the residence of nearly 90% of the world's adolescents and 88% of adolescents who died by suicide (5), do not have definite school suicide prevention policies or are not well-coordinated where they exist. This is unlike what is obtained in high-income countries. This disparity is due to multiple factors such as poor recognition of the magnitude of the suicide problem and the importance of a school suicide prevention policy, and lack of adequate research and vital statistics in LMICs. Other factors include a deplorable physical (classroom) structure and learning environment, the absence of school health services and insufficient

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resources such as human personnel and funding. Further, LMICs are fraught with corruption, including the lack of political will to implement policy, which stalls programs where they exist. Lack of monitoring, defective coordination and negligible supervision have also led to poorly implemented strategies in existing cases.

How then can LMICs leverage the rich ground that the school provides in suicide prevention when they are constrained by resources in providing comprehensive programs, though the effectiveness of these programs has been sometimes questioned (6). Suicide education is the suggested low-hanging strategy considering that it is affordable, within reach and requires little personnel training to be delivered. Empirical data exist for the effectiveness of psycho-educational programs in suicide prevention (7) as the most commonly applied suicide prevention approach for young people (8). Education works in suicide prevention by improving suicide literacy (9), which in turn will improve help-seeking behaviour, reduce stigma, and promote better health outcomes (10).

Though suicide education is limited in altering overall suicide behaviour (8), the degree of applying this intervention as a strategy may matter in determining its effectiveness. Thus, it is imperative to continually involve students in suicide education in order to enhance its effectiveness in preventing suicide. Including suicide psycho-education in the school educational curriculum, such that it is regularly and amply taught in the Health Education (HE) subject by the teachers, is recommended. This would not incur any additional financial cost, human training or program coordination since teaching the HE subject is routinely done in the school. Stakeholders, such as the parents or local authorities, should be carried along to successfully initiate and implement this model in schools. Further, collaboration with local mental health organizations or professionals on designing the content of the curriculum will enhance the credibility of the strategy and the buy-in of the stakeholders.

Nevertheless, suicide education does not stand alone; it is meant to be incorporated as an essential component of a comprehensive and multi-prong approach to support students' well-being. Suicide education, as a sole strategy, is therefore not the panacea to suicide prevention in schools in LMIC. However, since far-reaching strategic frameworks are non-existence or within reach in most LMIC schools, suicide education is the best available option for suicide prevention. The adoption of this strategy becomes a case of *half-bread is better than none*. Further, initiatives like this may appear small when started, but the ripple effects and potential long-term benefits on suicide prevention may be massive.

Authors' Contribution

All authors have contributed equally to the conceptualization of the work and writing and reviewing of the manuscript. All authors have read and approved the final manuscript and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflict of Interest

The authors of this manuscript declares no relationships with any company whose products or services may be related to the subject matter of the article. Oluyemi O. AKANNI is a member of the editorial board.

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