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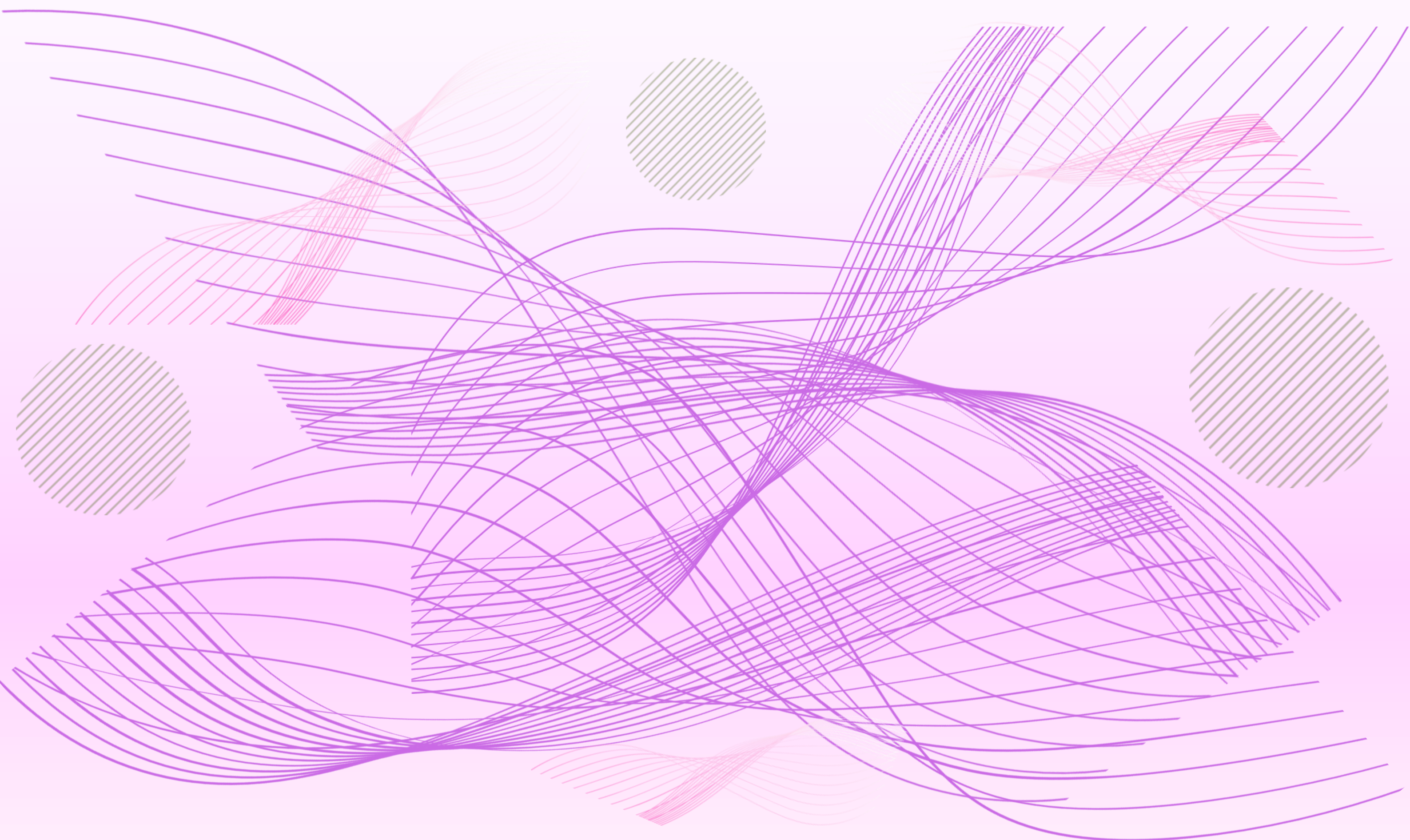

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About this journal

This is an open-access, pee-reviewed journal for advancing research on the reality of suicide and suicide prevention and promoting suicide countermeasures through such research activities. By requesting and publicly soliciting manuscripts, the Japan Suicide Countermeasures Promotion Center (JSCP) collects and publishes a wide range of articles on comprehensive suicide countermeasures. These include interdisciplinary, high-quality research papers and practical reports that contribute to on-site responses and policy development.

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Contents

Editorial

Suicide Policy Research is Being Reconstituted as a Journal Dedicated to Advancing Suicide Prevention Measures……………………………………………….01

Hiroe Tsubaki

Commentary

Integrating Social and Cultural Research into the LIVE LIFE Framework for Implementation and Localisation of a National Strategy…………………………..03

Sandersan Onie, Byron J. Good

Perspective

Essential Skills for Suicide Prevention Data Analysts……………………………….13

Takahiro Arai, Keita Yamauchi

Overview

Suicide Rates and Countermeasures in South Korea:
Emphasis on Recent Legislative Reforms Focused on Young Adults…………….17

Hyunjung Park

Editorial

Suicide Policy Research is Being Reconstituted as a Journal Dedicated to Advancing Suicide Prevention Measures

Hiroe Tsubaki[1)]

On behalf of the editorial board, I am pleased to announce that *Suicide Policy Research* is being relaunched after a pause of four years.

Global peer-reviewed journals on suicidology include the "Archives of Suicide Research," edited by the International Academy of Suicide Research (IASR) and published by Taylor & Francis, and "Suicide and Life-Threatening Behavior," published by Wiley. These journals are highly regarded for the publishing studies on suicide research. They receive submissions from diverse academic disciplines related to suicide and have editorial boards composed of university researchers.

In contrast, *Suicide Policy Research* is an academic journal edited and published by the Japan Suicide Countermeasures Promotion Center (JSCP). The JSCP does its own research and verification work to promote suicide countermeasures in Japan. I participate in the editorial board as a statistician and have supported data analysis that contributes to Evidence-Based Policy Making (EBPM) for suicide countermeasures.

This journal aims to deepen suicidology and improve suicide countermeasures. Suicide policies and measures have been promoted within each country's social system as practical knowledge in the field of suicide preventive activities by governments, medical institutions, welfare institutions, educational institutions, and corporations engaged in community-based mutual aid activities. The medical health sciences and sociology, public administration, law, and religious studies related to suicidology may have supported these activities.

I believe the ideal form of suicide policy management organically combines the solid PDCA cycle regarding field practice and the academic knowledge necessary for each phase of the PDCA cycle. Effective suicide policy management works toward improving the quality of a society that does not drive its people to suicide.

Edited by the JSCP editorial board and accessible to all, the mission of *Suicide Policy Research* is to support suicide prevention activities by focusing on evaluating the usefulness of reported activities and how national policies contribute to suicide management, rather than novelty of their academic contributions to suicidology.

Submitted papers should offer valuable insights into suicide prevention activities, highlighting the successes and failures of suicide prevention measures employed by different countries, with clear articulations of the causes of the failures and appropriate remedial measures. This would demonstrate the PDCA cycle's effectiveness in suicide prevention management.

The journal was temporarily suspended during the restructuring of the editorial board and the reorganization of its editorial policies as an academic journal. As a member of the new editorial

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board, I am very pleased to see its reissuance as a new journal.

While we expect many submissions on Japanese cases in initial stages, the editorial board welcomes contributions from around the world, sharing valuable information on effective suicide management, the challenges they face, and the issues and their solutions in current practice.

Commentary

Integrating Social and Cultural Research into the LIVE LIFE Framework for Implementation and Localisation of a National Strategy

Sandersan Onie[1)], Byron J. Good[2)]

Abstract

Suicide prevention strategies traditionally focus on quantitative data-driven approaches, often overlooking the critical role of cultural contexts. While the World Health Organization's LIVE LIFE framework offers a robust structure for the development of a national strategy, explicit integration of social, cultural, and ethnographic factors could further strengthen the implementation and localization of national policies. This paper argues that national suicide prevention strategies would benefit from the inclusion of culturally-focused qualitative and anthropological approaches and provides a framework for qualitative inquiry using the LIVE LIFE framework as a foundation. By incorporating social and cultural analyses and understanding the diverse ways communities perceive and respond to suicide, these national and local suicide prevention strategies can be more effective and inclusive. Drawing on anthropological and ethnographic approaches, the paper presents key questions concerning local social and cultural contexts for each LIVE LIFE component, as well as how the answers may guide the implementation and localisation of a culturally informed strategy.

Keywords: suicide prevention, national strategy, anthropology, culture, ethnography

Introduction

Suicide is a public health crisis, claiming over 700,000 lives each year worldwide, with 73% of these deaths occurring in low- to middle-income countries (World Health Organization [WHO], 2024). Despite numerous prevention initiatives, suicide continues to be a leading cause of death, particularly among young people aged 15–29 (WHO, 2024). The ramifications of suicide extend far beyond the immediate loss, deeply affecting families, communities, and entire societies by fostering psychological distress, social isolation, and incurring significant economic burdens (WHO, 2021).

WHO LIVE LIFE Suicide Prevention

In response, the World Health Organization introduced the LIVE LIFE framework, detailed in *LIVE LIFE: An Implementation Guide for Suicide Prevention in Countries* (WHO, 2021). This comprehensive framework aims to reduce suicide mortality through four primary interventions and six foundational pillars. The interventions are designed to address both immediate risk factors

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and promote long-term protective measures. First, limiting access to means of suicide involves restricting the availability of commonly used means such as lethal substances, a strategy proven to significantly decrease suicide rates (Yip et al., 2012). Second, responsible media-reporting seeks to minimize imitation effects by guiding news outlets to avoid detailed descriptions of suicide methods and locations (Niederkrotenthaler & Sonneck, 2007). Third, fostering socio-emotional life skills in adolescents equips young individuals with resilience, stress management, and relational skills to better handle future challenges (Barry et al., 2013). Finally, early identification, assessment, management, and follow-up focuses on community-level support, training in suicide risk detection, and providing ongoing care for those at risk (Mann et al., 2005).

To implement these interventions effectively, the LIVE LIFE framework outlines six cross-cutting pillars: situation analysis, multisectoral collaboration, awareness-raising and advocacy, capacity-building, financing, and surveillance, monitoring, and evaluation. Situation analysis entails a comprehensive examination of suicide patterns, risk factors, and existing resources to identify action priorities. Multisectoral collaboration brings together various government agencies, community leaders, and service providers to ensure that policies and interventions address the multifaceted nature of suicide. Awareness-raising and advocacy aim to destigmatize mental health issues, while capacity-building focuses on enhancing the skills of professionals and community members involved in prevention efforts. Financing ensures the sustainability of these initiatives, and surveillance, monitoring, and evaluation suggest that outcomes should be tracked and strategies continually evaluated and refined for improvement (WHO, 2021).

The need for culturally sensitive qualitative and anthropological approaches

National suicide prevention strategy frameworks can be strengthened by considering local cultural contexts. In addition to considering each country's context, each national strategy should undergo a process of local adaptation and implementation. Anthropological research can provide a deep understanding of the local culturally and socially shaped experience, shedding light on the experiences of individuals in distress and suicidal crises, as well as the structural barriers individuals and families encounter when seeking help (Chandler & Lalonde, 2008). Such studies demonstrate that local social and cultural frameworks are pivotal in determining the effectiveness and sustainability of suicide prevention efforts. Cultural understandings and societal structures—families, schools, health care facilities—significantly influence how members of communities perceive mental health, communicate distress, and seek assistance (Kirmayer, 2012). While there has been substantial anthropological work on suicide (Colucci & Lester, 2013), it can be further integrated into existing national strategy frameworks.

Integrating anthropological and qualitative methods into suicide prevention strategies can provide a comprehensive and nuanced understanding of the cultural, social, and systemic factors that influence their success. These methods include interviews, focus group discussions and ethnographic observations, focused on identifying salient social and cultural subgroups in a community, investigating particular distinctive characteristics relevant to understandings of suicide, and exploring individual cases of suicide attempts within these groups. While suicide is often framed primarily as a mental health issue, it is deeply rooted in cultural norms and societal structures that shape individuals' perceptions and responses. For example, in communities guided by the First Nations Social Emotional Wellbeing (SEWB) Framework, suicide is perceived as a consequence of deteriorating relationships,

highlighting the importance of restoring familial and community connections to prevent suicidal behaviour (Gee et al., 2014). In contrast, in predominantly religious societies like Indonesia, suicide is often viewed as a sin, which significantly impacts how individuals and communities address and respond to suicidal ideation and behaviour (Onie et al., 2023a; 2023b). These differing cultural perspectives underscore the necessity for suicide prevention interventions to be tailored to align with local values and behaviours.

Qualitative research allows for an in-depth exploration of these cultural contexts, uncovering the lived realities and identifying structural barriers that may impede the effectiveness of prevention efforts. For instance, Tumilowicz et al. (2016) outlined the effectiveness of ethnographic methods in nutrition interventions by thoroughly understanding community practices and barriers. For example, one case study noted how nutritionist's recommendations directly conflicted with local beliefs among pregnant women in Puerto Rico in 1971 and how harmonising beliefs led to mutual understanding and greater uptake of evidence-based practices. This example illustrates how ethnographic insights can enhance the design and implementation of public health initiatives, ensuring they are culturally relevant and more likely to succeed.

By understanding how cultural norms, stigma, and traditional practices influence help-seeking behaviours and the acceptance of interventions, policymakers and practitioners can design strategies that are not only effective but also culturally respectful and relevant. This culturally informed approach ensures that suicide prevention initiatives can be more inclusive, sustainable, and capable of addressing the unique needs of diverse populations, ultimately leading to more meaningful and lasting outcomes in reducing suicide rates. Understanding the human experience behind the statistics is indispensable in this context as cultural backgrounds profoundly influence how suicide is perceived and how individuals seek support (Colucci & Lester, 2013). By integrating anthropological insights into the pillars and interventions of the LIVE LIFE framework, policymakers and practitioners can design and implement strategies that resonate with local communities. Such integration can lead to greater acceptance, sustainability, and effectiveness in suicide prevention efforts.

Article aims

In this article, we present key areas of inquiry for stakeholders—including policymakers, mental health professionals, community leaders, and researchers—to consider when a) developing a national suicide prevention strategy, and b) implementing the national strategy framework on a local level. This framework aims to ensure that interventions are culturally sensitive and contextually appropriate given the diversities that exist within a country. By addressing these critical questions, stakeholders can tailor their approaches to align with the unique social and cultural dynamics of their communities, thereby enhancing the overall impact and sustainability of suicide prevention initiatives.

Cultural Framework for LIVE LIFE

Here, we outline specific ways that ethnographic and culturally focused qualitative research can be integrated into national, regional, and local suicide prevention methods that can be embedded in a situation analysis, or conducted as the project is ongoing. Questions are provided, first focusing on general questions for the situation analysis which apply to a wide range of LIVE LIFE pillars and are central to the localisation of a national strategy, followed by additional questions specific to each relevant cross-cutting pillar or intervention. Recognizing that ethnological investigations may not be as relevant to certain sections of LIVE LIFE (e.g., the cross-cutting pillar of financing), we will emphasise sections relevant to culture and context.

1. Situation Analysis

Local social and cultural considerations are crucial in the initial situation analysis phase. This requires data on what social and cultural categories of individuals are at highest risk for suicide and how similar or different these groups are – beyond looking at the suicide rates of subgroups, as underreporting is common among marginalised groups. Age groups ('youth culture,' elders), gender, religious subgroups in a society, rural versus urban, and social categories such as caste, class, and status groups may have distinctive perspectives and require a deeper understanding of who is at risk. Understanding distinctive characteristics of local cultural and social settings can provide insights into how mental health and suicide are perceived, what most commonly leads to suicidal ideation and attempts, whom individuals who experience suicidal thoughts can confide in, and what factors influence their willingness to seek help and the types of interventions that will be accepted. These may vary by specific groups at high risk (students, rural and urban poor, educated urban workers). Traditional healing practices and support systems, including schools, religious groups, and social networks can be identified and potentially integrated into the formal health system to create a more holistic and culturally resonant approach. The situation analysis identifies key factors pertaining to suicide; here, the experience and perception of individuals and communities are emphasised.

Ignoring cultural context can lead to interventions that are ineffective or even harmful (Tumilowicz et al., 2016). For instance, in some cultures, mental health issues are stigmatized, and individuals may be more likely to seek help from traditional healers, religious specialists, or school teachers or counselors than mental health professionals. Conversely, destigmatisation efforts may not be effective in a community that does not stigmatize professional help-seeking but is hampered by the costs. By understanding these cultural nuances, interventions can be tailored to be more acceptable and effective.

Key questions:

1.0. What are the most important subgroups or subcultures within a society, which are at most risk for suicide, and in what ways do they differ?

1.1. How do individuals within these groups perceive suicide, suicide prevention, and help-seeking within the prevailing culture of their community?

1.1.1. What cultural and religious understandings and practices shape how individuals in the community view mental health and suicide?

1.1.2. What frameworks or concepts are commonly used by the population to talk about well-being, mental health, and suicide?

1.1.2.1. Where do these frameworks or concepts come from?

1.1.2.2. How do these vary in forms of expression – e.g. on social media, in religious preaching, in popular literature and news reports?

1.1.3. What words or phrases do people in the community use when discussing well-being in relation to suicide, and how are they related to help-seeking or, conversely, non-help-seeking?

1.1.4. How do people experiencing suicidal thoughts or who have attempted suicide feel they are perceived and treated by the community?

1.1.5. How are families or loved ones of individuals who have died by suicide viewed and treated within the community?

1.2. How do social, cultural, historical, and economic factors shape individuals' views on suicide, suicide prevention, and seeking help?

1.3. Where do people go and whom do they feel they can turn to when they are experiencing suicidal thoughts?

1.3.1. How do individuals feel they are received by those they approach for help?

1.3.2. What training and support do those providing help have, and how does this affect individuals' experiences?

1.3.3. What are some structural barriers to obtaining and providing help?

1.3.4. Are there recognized sources of support—such as particular individuals, organizations, or institutions—that people avoid approaching when experiencing suicidal thoughts, even though these sources are known to provide help? If so, what factors might explain why individuals avoid them?

How to use this information to implement or localize a national strategy:

The answers to these questions posed in the situation analysis provide a roadmap for developing culturally relevant and effective interventions. For instance, identifying key subgroups or subcultures who are at most risk of suicide provides a starting point for LIVE LIFE's universal interventions. Furthermore, if certain communities predominantly seek help from religious specialists or some categories of local healers, general physicians, or school counsellors rather than mental health specialists (as seen in Question 1.3), focusing capacity building on these individuals and integrating them into a network of care could improve early identification and referrals and help implement LIVE LIFE intervention 4. Conversely, a common source of support in one context may not be considered a source of support in another (as seen in Question 1.3.4). By understanding these challenges, a localized national strategy may seek to rectify modifiable risk factors or focus on alternative sources of support in implementing LIVE LIFE intervention 4.

Communities are often centralized around key organizations that shape their perception of suicide. Engaging these organizations is critical for the LIVE LIFE pillars of Awareness Raising, Capacity Building, and Multisectoral Collaboration, especially when these organizations are linked to government agencies.

Data on structural factors (Question 1.3.3) enable local and national authorities to consider policy changes, resource reallocation, or infrastructural improvements to enhance service access. Whether through subsidized transportation to mental health facilities, telehealth services in remote areas, or financial incentives for clinics to expand culturally appropriate care, policymakers can build systems that respond directly to the community's identified needs. For example, a lack of professional help-seeking may be due to stigma, a low number of professionals, cost, or a combination of these factors—each requiring different solutions.

The language and terminologies revealed through questions on how communities talk about suicide (Questions 1.1 and 1.1.1) can be integrated into all forms of public messaging. For example, awareness campaigns and educational materials can adopt the community's existing words and expressions for distress to resonate more deeply with local values. This approach can reduce stigma and prevent unintended alienation from imposing unfamiliar terminology or evoking unwanted emotions. Additionally, these linguistic insights can form the basis of competency training for healthcare providers and volunteers, enabling them to recognize and respect the community's "idioms of distress." Conversely, campaigns disregarding cultural nuances risk alienating their audience, reinforcing stigma, or being dismissed as irrelevant or invasive (Kral, 2019).

Insights into how families and individuals who have experienced suicide are treated (Questions 1.1.4 and 1.1.5) can guide the development of support systems that are sensitive to cultural stigma. This fosters a more inclusive and supportive environment, increasing the likelihood of disclosure of suicidal thoughts and behaviours and facilitating LIVE LIFE intervention 4. These questions can also inform

destigmatization programs and case registration practices, enhancing the likelihood of suicide disclosure and improving the monitoring, surveillance, and evaluation pillar of LIVE LIFE.

Finally, understanding how communities perceive and support those bereaved by suicide (Questions 1.1.4 and 1.1.5) is key to developing sensitive postvention strategies, aligning with LIVE LIFE intervention 4. Approaches can range from community-led bereavement groups to supportive dialogue sessions that help reduce isolation and shame. Embedding these strategies within broader monitoring and evaluation frameworks ensures that interventions remain responsive to community feedback and evolving cultural contexts.

2. Awareness-Raising and Advocacy

Culturally sensitive awareness-raising and advocacy efforts are central to reducing stigma and promoting help-seeking. Tailoring messages, delivery methods, and spokespersons to reflect local languages, symbols, and storytelling traditions can increase both acceptance and reach. As previously mentioned, campaigns that do not consider culture risk evoking unwanted emotions and having adverse effects on desired behaviour (Kral, 2019).

Additional questions:

2.0. Who are the community's leaders or influencers who shape the perception of suicide and help-seeking?

2.1. What communication formats (e.g., local radio, community theatre, social media) are most likely to be both culturally acceptable and accessible by people across the lifespan?

How to use this information to implement or localize a national strategy:

The questions in this domain lay the groundwork for constructing messages that resonate with local linguistic and cultural expressions. For instance, when certain communities are found to place great trust in religious leaders or local elders (as indicated by Question 2.1), national strategies can integrate these figures into awareness campaigns to enhance credibility and reach. In many cases, it may become apparent that community members rely more on radio broadcasts, street theatre, or social media (Question 2.2) than on other channels for their information. By tailoring campaigns to these preferred communication methods, messaging can extend to broader segments of the population and elicit more meaningful engagement. Furthermore, incorporating the everyday language communities use to talk about distress or help-seeking (Question 1.1.3) can reduce stigma and avoid the pitfalls of employing terminology that might be perceived as foreign or inappropriate.

3. Surveillance, Monitoring, and Evaluation

Surveillance, monitoring, and evaluation systems must consider local cultural contexts to promote accurate reporting and reduce stigma. Families, individuals, and professionals (such as the teachers, police, coroners, and healthcare staff) may be reluctant to disclose suicide-related information when social repercussions or cultural sanctions are perceived to be severe (Colucci & Lester, 2013; Onie et al., 2023a). Ethnographic insights can reveal the local factors that shape disclosure and reporting practices, helping policymakers and practitioners design effective data collection tools and protocols.

Additional questions:

3.0. How does a person in the process of case registration for suicide feel when having to report a suicide, and how does the community perceive them?

3.1. What is likely to encourage an individual to disclose or record a suicide?

3.2. What are some structural barriers or factors relating to the accurate reporting of suicide?

How to use this information to implement or localize a national strategy:

Effective surveillance systems depend on building trust with communities that may be hesitant to report suicide-related information, as revealed by Questions 3.0, 3.1 and 3.2. In some settings, families or individuals registering a suicide case may feel shame, fear legal repercussions, or worry about cultural sanctions, which leads to underreporting. Drawing on these insights, local and national authorities can design reporting protocols that mitigate such fears, for example, by offering anonymity or ensuring that data collection processes are culturally sensitive. These measures may not only create a safer atmosphere for disclosure but may also supply more accurate data for the monitoring, surveillance, and evaluation pillar of LIVE LIFE.

4. Limiting Access to Means of Suicide

Restricting access to lethal means is a core strategy in suicide prevention. However, the sociocultural significance of certain methods—such as pesticides in agricultural communities or firearms in rural areas—varies greatly. Ethnographic research can elucidate these local meanings and practical uses, helping policymakers design more acceptable, context-specific regulations (Kral, 2019).

Additional questions:

4.0. Which methods of suicide are most prevalent in different social and cultural subgroups within a society, and what sociocultural factors shape their usage?

4.0.1. Given that means are often selected based on familiarity, how does the group engage with the method in daily life?

4.1. How do local perceptions or practices influence acceptance of limiting access to lethal means (e.g., perceptions of firearms as a constitutional right, or lethal pesticides as essential for farming)?

4.1.1. Are there established non-suicidal uses for these means, and how might alternative solutions be introduced to maintain livelihoods?

How to use this information to implement or localize a national strategy:

Questions 4.1 and 4.2 illuminate the significance of lethal means in specific cultural and economic contexts. For example, pesticides may be integral to a farming community's livelihood, or firearms may hold historical or constitutional importance in rural regions. Recognizing these factors prompts policymakers to balance regulation with respect for local needs. In communities dependent on particular pesticides, requiring diluted or substitute agricultural chemicals or buy-back initiatives could diminish suicide risk without threatening farmers' economic stability.

5. Interacting with the Media for Responsible Reporting

Media coverage has a demonstrable impact on suicide-related behaviours and attitudes. Culturally tailored guidelines for reporting can prevent sensationalism, reduce imitative behaviours, and limit stigmatizing language (Kirmayer, 2012; WHO, 2021). However, norms about discussing death or mental distress vary widely, and anthropological research can illuminate cultural practices that influence the way media outlets portray suicide.

Additional questions:

5.0. From where are particular subcommunities likely to receive news about a suicide?

5.1. How do people in the community and particular subgroups feel after hearing about a suicide?

5.2. How can the media be leveraged to reduce stigma and encourage help-seeking behaviours in culturally resonant ways?

How to use this information to implement or localize a national strategy:

The questions in this section underscore the role of mass media and community-specific channels in shaping attitudes and behaviours related to

suicide. If a region relies predominantly on community radio or local newspapers for news about suicides (Question 5.1), tailored guidelines for responsible reporting can be disseminated to those specific outlets. If youth receive most information from social media, how can such media be guided? Equally important is identifying and training the media personalities and influencers who can effectively champion help-seeking messages (Question 5.3).

6. Fostering Socio-Emotional Life Skills in Adolescents

Developing socio-emotional competencies in adolescents is a key protective measure against suicidal behavior. Yet the ways in which adolescents learn and express these skills are shaped by cultural norms around family, education, and community life. Integrating ethnographic insights into program design ensures that socio-emotional learning (SEL) initiatives resonate with local contexts.

Additional questions:

6.0. In which community settings (e.g., schools, youth clubs, religious institutions) do adolescents naturally gather, and how can socio-emotional skills be taught in those spaces?

6.1. What cultural practices already promote emotional well-being among adolescents?

6.2. How do cultural norms around parenting, extended family, and educational roles shape adolescent development and mental health?

6.2.1. Who plays key roles in guiding adolescents' emotional and social development?

How to use this information to implement or localize a national strategy:

While LIVE LIFE focuses primarily on schools (WHO, 2021), adolescents may congregate in other settings in which SEL can be fostered (Question 6.1) – such as religious communities and arts community centres, which may have greater coverage or be better equipped than the education system (Onie et al., 2023a). Furthermore, answers to these questions will shape the design and delivery of SEL interventions in ways that respect local cultural traditions (Question 6.2). For example, in some cultures, grandparents or hired caretakers may have a larger role in a child's social development than parents, and thus must be considered in efforts. By recognizing the informal networks and influential figures that support adolescent well-being in local communities (Question 6.2.1), policymakers can enlist these community actors in program implementation, improving acceptance and efficacy.

7. Early Identification, Assessment, Management, and Follow-Up

Early identification, assessment, management, and follow-up are cornerstones of comprehensive suicide prevention. Cultural factors, however, may determine how individuals articulate distress, seek care, and adhere to follow-up recommendations (Colucci & Lester, 2013). Incorporating anthropological perspectives helps practitioners and programme designers recognize culturally specific manifestations of distress—such as physical complaints in contexts where emotional language is less common—and adapt interventions accordingly.

Additional questions:

7.0. How do various cultural groups express emotional distress or suicidal ideation, and what local idioms of distress might healthcare providers need to recognize?

7.1. To whom are troubled individuals from particular groups most likely to disclose suicidal thoughts and behaviours?

7.1.1 How can such persons be taught to respond most effectively?

7.2. How can forms of culturally grounded follow-up care—such as community-based support circles or spiritual practices—be integrated into formal suicide prevention protocols?

How to use this information to implement or localize a national strategy:

By identifying local idioms of distress (Question 7.1), professionals can refine screening tools and training programs to detect suicide risk more accurately. Addressing cultural barriers to care (Question 1.3.3) informs the creation of supportive systems that normalize help-seeking, for instance, by linking traditional healers with medical clinics or sponsoring community-led peer support groups. Finally, embedding culturally acceptable follow-up procedures (Question 7.2)—such as making space for spiritual or communal rituals—may enhance treatment adherence and reduce the recurrence of suicidal behaviour through provision of follow up support.

Conclusion

Integrating cultural competency into the WHO LIVE LIFE framework may be key for the successful implementation and localization of national suicide prevention strategies. This approach ensures that interventions are not only evidence-based but also resonate deeply with the unique cultural, social, and economic contexts of diverse communities – allowing a national framework to be translated into local action. By leveraging anthropological, qualitative, and ethnographic insights, policymakers and practitioners can design and execute programs that honour local traditions, address specific stigmas, and utilize trusted community leaders and communication channels. Such tailored strategies enhance the effectiveness and acceptance of suicide prevention efforts, fostering an environment where individuals feel understood, supported, and empowered to seek help. Moreover, culturally informed surveillance and follow-up mechanisms may improve the accuracy of suicide data, enabling more precise monitoring and evaluation of prevention initiatives. As suicide remains a complex and multifaceted public health issue, embracing cultural diversity within prevention frameworks stands as a critical step toward achieving meaningful and lasting outcomes.

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Perspective

Essential Skills for Suicide Prevention Data Analysts

Takahiro Arai [1) 2)], Keita Yamauchi [2)]

Abstract

Suicide prevention policies increasingly emphasize the integration of high-risk and population-based approaches. Despite the legal foundation provided by Japan's 2006 Basic Act on Suicide Countermeasures, the General Principles of Suicide Prevention Policy (2022) neglect the need for specialized training for data analysts. This study highlights three key areas for effective suicide prevention data analysis: data, analytical, and domain knowledge.

Keywords: suicide, mental health, exploratory data analysis

Introduction

The World Health Organization (WHO) promotes a tiered suicide prevention model comprising three components: (1) advocacy and policy frameworks, (2) strategies targeting high-risk groups, and (3) enhanced screening efforts [1]. These tiers form a comprehensive model integrating population-based and high-risk approaches. Furthermore, the implementation of population-based and data-driven approaches to suicide prevention is closely linked.

In Japan, the 2006 Basic Act on Suicide Countermeasures established a legal foundation for comprehensive suicide prevention efforts. The Act mandates that "Suicide countermeasures must be implemented on a comprehensive basis through the organic coordination of measures and policies related to health, medicine, welfare, education, labor, and other relevant issues (Article 2, Paragraph 5)" [2]. This approach highlights the necessity of incorporating high-risk and population-based perspectives into suicide prevention measures. As stated in the WHO report [1], increasing the effectiveness of these measures requires developing appropriate human resources, including establishing many suicide research units and graduate and postgraduate courses.

The General Principles of Suicide Countermeasures Policy (2007, revised 2022) [3] focuses on training human resources for mental health and medical welfare services and supporting human resource development in private entities; however, the policy is ambiguous about the role of suicide researchers and data analysts who have employed population-based methodology.

As shown in Figure 1, this article outlines the core competencies required for suicide prevention data analysts focusing on three essential elements.

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Data Knowledge

In Japan, representative suicide surveillance systems include vital and police statistics, which differ significantly, particularly in terms of accessibility. Although vital statistics are available for research and enhance the effectiveness of the analysis, access to police microdata is highly restricted. To overcome such limitations, analysts must incorporate supplementary data, such as information on suicide attempts, suicidal ideation, and mental health issues [4]. Public statistical microdata, termed "official microdata," encompass diverse suicide-related resources, including the Survey on Time Use and Leisure Activities [5] and surveys on loneliness and isolation [6]. Furthermore, official microdata addresses various issues related to mental health problems and socioeconomic factors preceding suicide. For example, in case regional economic disparities influence suicide rates, combining microdata related to economic issues with vital statistics clarifies the pathways leading to suicide. This integration supports effective local government monitoring and developing targeted suicide prevention strategies. Researchers can examine multifaceted underlying risk factors by leveraging these detailed datasets. Notable, initiatives such as the Innovative Research Program on Suicide Countermeasures under the Japan Suicide Countermeasures Promotion Center (JSCP) have utilized these data to produce impactful outcomes in suicide prevention [7]. Consistent efforts to analyze such microdata are essential for advancing population-based suicide prevention strategies.

Analytical Knowledge

Proficiency in statistics and computer science is fundamental for data analysis, and advances in generative artificial intelligence (AI) have further enhanced analytic efficiency. Generative AI offers support across multiple research stages, including hypothesis formulation, study design, data preprocessing, implementation, and discussion.

Hypothesis testing, which tests specific hypotheses, is highly compatible with generative AI capabilities. However, in the exploratory approach, which generates new hypotheses through careful data observation without any preconceived notions and links them to practical issues, the ideas produced by generative AI may appear unoriginal. While the hypothesis-testing approach represents "day science," emphasizing the application of rigorous statistical methods, the exploratory approach can be seen as the 'night science' of freely experimenting with data without constraints [8]. Suicide is a complex process, involving multiple intertwined factors, such as family, school, work, relationships, health, and finances. At first glance, the hypothesis-testing approach appears to be the most suitable to analyze suicide data. However, an exploratory approach may uncover significant issues that have not been clarified or remain overlooked, and therefore have not been integrated into suicide prevention strategies.

For this reason, analysts must balance the gravity of suicide with the playfulness of exploration, ensuring that innovative insights are not overlooked when addressing this multifaceted problem.

Recognizing that not all aspects of suicide prevention can be addressed solely by data-driven methods is also crucial. Although suicide monitoring can yield valuable insights, analytic systems must ultimately inform tangible prevention strategies. Otherwise, such efforts may become self-contained exercises that fail to achieve their end goal.

Domain Knowledge

Suicide is an inherently interdisciplinary issue spanning medical, psychological, and sociological domains. Therefore, a deep understanding of suicide prevention, combined with strict adherence to ethical standards—especially in handling sensitive personal information—is critical.

Public health systems promote suicide prevention through a population-based approach. However, as it is often framed within medical schools and graduate programs in medicine, this approach is biased toward education from medical perspectives and hypothesis-testing approaches. Evaluating educational programs in academic fields such as health services research and data science is essential, as curricula increasingly incorporate exploratory approaches and sociological and humanistic knowledge that go beyond traditional public health approaches.

Developing standardized educational materials on data surveillance, access, and management—combined with certification programs—is a crucial first step toward building capacity in this emerging field. However, developing such materials may be challenging owing to the field's interdisciplinary nature. Therefore, to fully develop human resources for suicide prevention data analysts, more resources should be allocated to fields that offer cross-disciplinary educational services, such as health services research and data science.

Analysts must integrate data from diverse sources, including surveillance systems, official microdata, healthcare records, hotline logs, and online platforms. This multidisciplinary approach generates novel insights and informs the development of effective policies. Suicide prevention strategies, as emphasized by the iceberg model, must account for both visible and invisible factors contributing to suicide. The model suggests that while visible indicators represent the tip of the iceberg, the underlying causes, which include social, psychological, and environmental factors, often remain hidden.

Mastering these competencies is complex and requires advanced training. However, most Japanese research institutions and universities lack structured development programs, largely leaving skill acquisition to individual initiative. In contrast, JSCP functions as a specialized organization that fosters interdisciplinary collaboration among media professionals, municipal officials, bereaved families, psychologists, legal scholars, and public administrators. This unique synergy enables JSCP to address suicide prevention from multiple perspectives. Notably, JSCP is one of the few institutions with access to police data, allowing it to develop more robust, data-driven suicide prevention strategies. Therefore, JSCP can serve as an incubator for these critical skills in Japan.

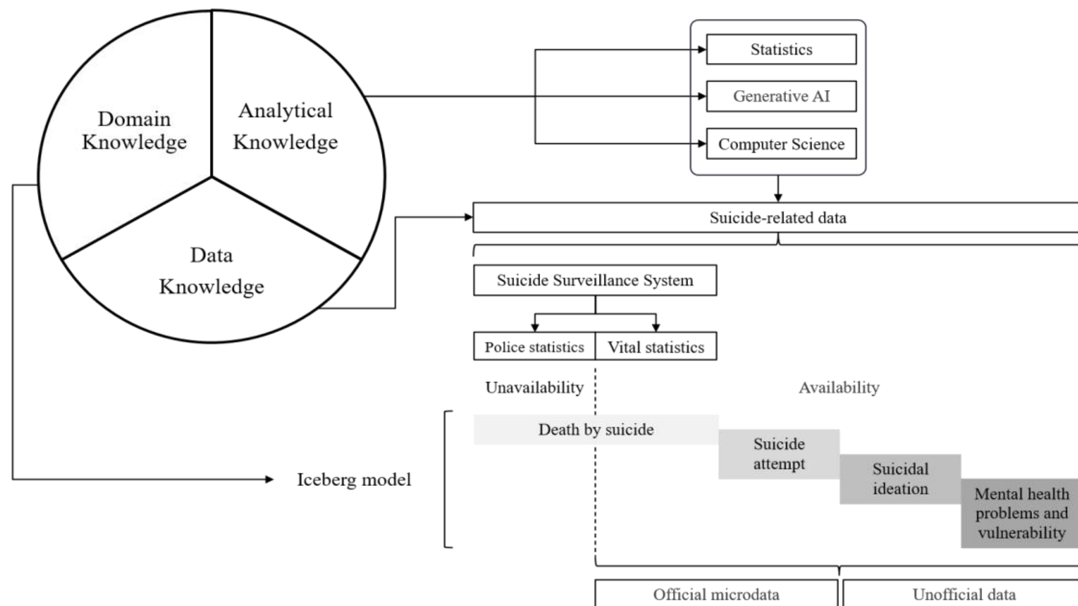

Fig. 1 The three types of knowledge and skills required of suicide prevention data analyst.

Conflicts of Interest

None declared.

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Overview

Suicide Rates and Countermeasures in South Korea: Emphasis on Recent Legislative Reforms Focused on Young Adults

Hyunjung Park[1)]

Abstract

This study examines the actual situation—and outlines the system—regarding the suicide rate and relevant countermeasures in South Korea, and considers the implications for Japan. The suicide rate in South Korea has spiked since the late 1990s, attaining the highest prevalence among the Organization for Economic Co-operation and Development (OECD) countries in recent years. Thus, the government of Korea launched a national suicide prevention program in 2004 by forming a government plan to address the issue. Owing to the prevailing political circumstances, a legislation could not be enacted until 2011. As of October 2024, the law has been amended nine times—most recently in July 2023, with the stated objective of explicitly defining the target demographic for suicide prevention initiatives as comprising individuals aged 20–34, with a lifespan perspective. This is because of the recent spurt in youth suicide rate. The revised law includes measures such as expanding mental health checkups for young people, integrating suicide prevention and mental health services with financial counseling to prevent financial issues leading to suicide, and promoting mental health support for young people in high-risk groups. However, there are challenges in promoting suicide prevention measures at the local community level. The underlying causes include differences in social development and governance systems between Japan and South Korea.

Keywords: Republic of Korea, Suicide Countermeasures Legislation, Young Adults, Implications for Japan

Introduction

In October 2004, the Mental Health Policy Division of the Ministry of Health and Welfare of the government of Korea launched the “Five-Year Suicide Prevention Plan,” marking the commencement of suicide prevention initiatives at the government level. In 1998, the suicide mortality rate in Korea had skyrocketed because of the impact of the Asian currency crisis (IMF bailout finance) toward the end of 1997. As the issue gained traction in social discourse, the government of Korea recognized the need to formulate national-level measures (Kim, 2020, p. 59), and the “Detailed Implementation Plan” was announced in September 2005. The Plan details the background and necessity of the suicide prevention project, promotion strategy, promotion system and division of roles, project content (12 items), information management and reporting, regional cooperation organizations, and situation and plans of the relevant government departments at the time (Ministry of Health and Welfare, 2005).

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However, such an administrative plan had its limitations: it lacked sufficient legal basis as well as human and financial resources (Kim, 2020, p. 65). Initially, a suicide prevention bill was proposed based on the opinions and suggestions of an expert panel led by the Korea Association for Suicide Prevention, which was organized in 2003. However, owing to the political situation amid which the then-president, Lee Myung-bak—he assumed office in March 2008—ordered a policy of "private initiative" in suicide prevention (Ministry of Culture, Sports, and Tourism 2013; Kim, 2020, p. 67),[1] it took some time to enact the law (Kim, 2020, pp. 59–72). Subsequently, in response to a further increase in suicide deaths in Korea because of the 2008–2009 financial crisis—as discussed below—and a spurt in copycat suicides due to celebrity suicides, the "Act on the Prevention of Suicide and the Creation of Culture of Respect for Life" (hereinafter, the Korean Suicide Prevention Act) was passed by a plenary session of the National Assembly in March 2011. It went into effect on March 31, 2012.

The Korean Suicide Prevention Act has been amended nine times. The most recent amendment was on July 11, 2023, and its contents came into effect on July 12, 2024. The keyword of this amendment is "young adults" (20–34 years old).[2]

The Ministry of Government Legislation of Korea has stated the following reasons and main contents for the ninth revision: "To improve and supplement the problems identified in the operation of the current system, such as establishing a basic plan for suicide prevention by specifying young adults in the measures for suicide prevention by life cycle and making suicide prevention education mandatory for state institutions, public institutions, schools and universities."[3]

Article 7, Paragraph 2, Item 3 of the Act stipulates the items to be included in the Basic Plan for Suicide Prevention established by the government of Korea every five years. Previously, it was titled, "Suicide Prevention Measures for Children, Young adults, Middle-Aged, and the Elderly by Lifetime Cycle." Now, it has been revised as "Suicide Prevention Measures for Children, Young adults, Young Adults, Middle-Aged, and the Elderly by Lifetime Cycle." Additionally, the amendment stipulates mandatory suicide prevention education in schools as stipulated in the "Elementary and Secondary Education Law" and the "Higher Education Law," as well as an obligation for heads of universities, etc., to endeavor to provide suicide prevention counseling and foster a culture of respect for life, as stipulated in the "Higher Education Law."

What conditions and perceptions induced this revision? What specific countermeasures exist to target the young adult segment? This study reviews these issues and considers their implications for Japan.

Trends and characteristics of suicide mortality in Korea

According to the government of Korea data as well as media reports, the suicide mortality rate in Korea is the highest among the Organization for Economic Co-operation and Development (OECD) countries—a large gap exists between Korea and the second country on the list. Furthermore, it is high compared to Japan—as of 2021, the World Health Organization (WHO) Mortality Database figures indicate 16.5 in Japan and 26.0 in Korea.

Initially, the suicide mortality rate in South Korea was lower than in Japan. It surged during the Asian currency crisis period in the late 1990s, overtaking Japan in 2004. However, the rate decreased after

[1] According to the "Lee Myung-bak Government White Paper on National Policy" published by the Ministry of Culture, Sports and Tourism of the government of Korea in 2013, the core of the government's "Accompanying Growth" measures comprises the keywords "private sector initiative," "market affinity," and "social consensus."
[2] The specific age range for young people is not stipulated in the Act. However, it is explicitly stated in the Fifth Basic Plan for Suicide Prevention.
[3]The source text was retrieved and quoted from the National Legislation Information Center (law.go.kr) of the government of Korea's Legislation Bureau, and subsequently, rearranged by the author.

attaining a peak in 2011 (31.7), before slightly increasing since 2017 (24.3). Policy documents and related studies indicate an increase in suicide mortality among young adults after the COVID-19 pandemic, and countermeasures were adopted for multifarious ascertainment of the actual situation.

The initial step will be to examine the comprehensive alterations in suicide mortality rates in South Korea over time, with emphasis on comparisons with Japan. Figure 1 illustrates the shifts in the suicide mortality rates in Japan and South Korea from 1985 to 2021.

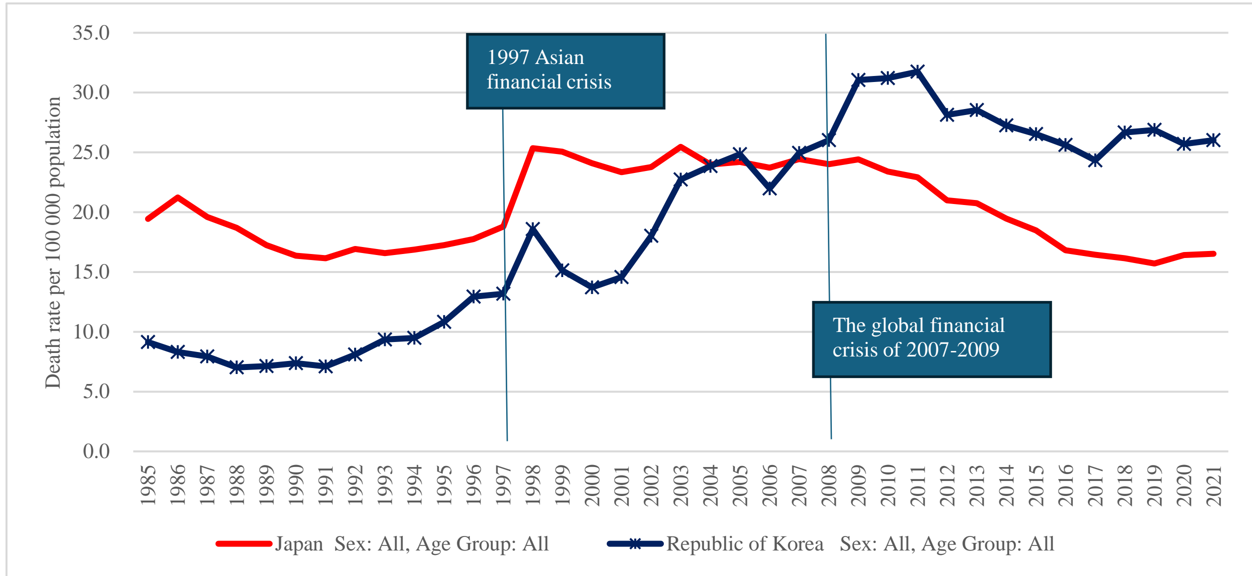

Figure 1: Suicide mortality rate over time in South Korea (compared to Japan)
(Source: WHO Mortality Database)

Figure 1 illustrates that the suicide mortality rate in South Korea increased immediately after the two global financial crises. Regarding the surge in suicide mortality during these two periods, a study published in 2018 in the Korea Social Policy Review—a local South Korean academic journal—analyzed the effects of unemployment, mainly among regular workers in large firms, during the first crisis. During the second crisis, the suicide mortality rate increased because of suicides of the working poor, who were mainly non-regular workers (Moon & Jeoung, 2018).

In conjunction with this, Moon and Jeoung (2018) discuss unemployment and the working poor in each period in the context of gender issues: the first crisis had a relatively significant impact on men working as regular workers in large firms; the second crisis had a relatively significant impact on women working as low-wage informal workers. Moon and Jeoung (2018) analyze that the first economic crisis led to significant male unemployment, mainly in large companies, inducing the collapse of the "one breadwinner model" in Korea. Additionally, employment flexibility during this period continued to accelerate afterward, and the ratio of dual-income households to non-regular workers significantly increased. Consequently, the number of women working as non-regular workers also considerably increased. However, social security policies did not encompass non-regular workers, which led to an increase in the number of women marginalized in the labor market, resulting in the feminization of poverty. The analysis indicates that, during the second crisis, the impact on women working in this peripheral area—that is, as irregular workers—was significant, leading to a spurt in the suicide rate among women. Lee (2023) states that the diffusion of gender equality awareness has increased the tendency among young women to perceive marriage as a choice rather than a necessity, and to

aspire for similar life plans as men. However, that women remain peripheral in the labor market is a potent background for suicidal ideation.

The analysis above is demonstrated in Figure 2, which displays the trajectory of suicide mortality rates among young adults over time. The figure elucidates the change in suicide mortality rates over time for young individuals in their 20s and 30s in Japan and South Korea, classified by sex. The vertical lines in the corresponding periods mark the two economic crises.

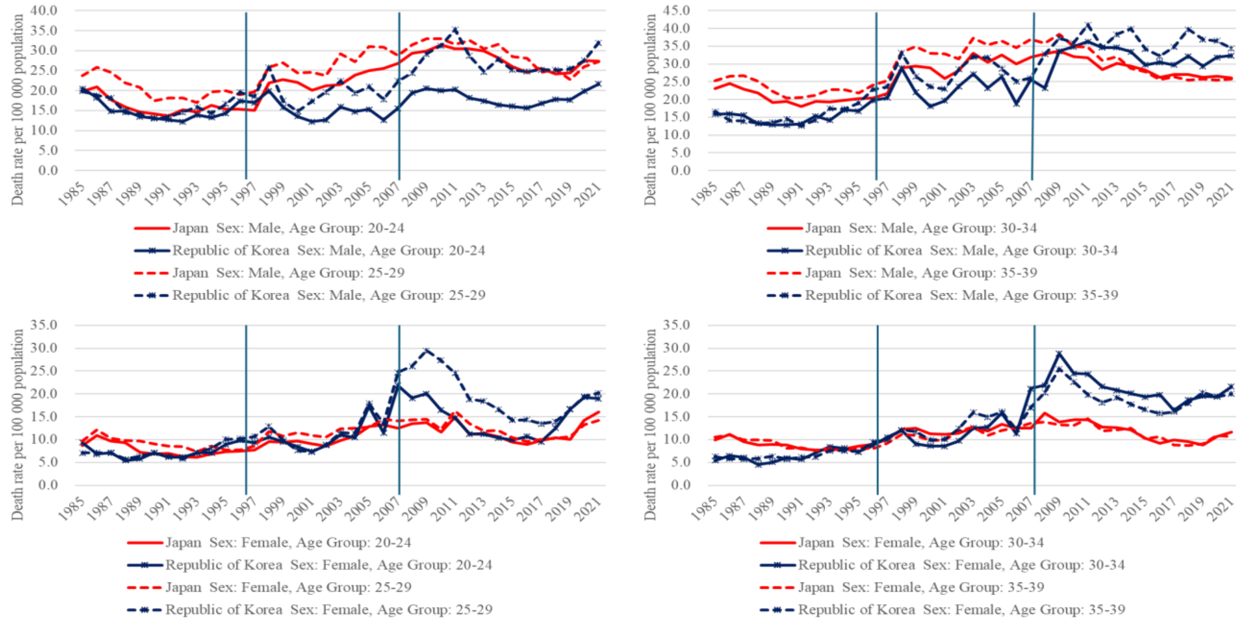

Figure 2: Change over time in suicide mortality rates by gender among young adults in Japan and Korea (Source: WHO Mortality Database)

The upper panel of Figure 2 depicts the suicide mortality rate for males (left side: 20s; right side: 30s). In Japan, the suicide mortality rate has sharply increased owing to the economic turmoil in Asia and the collapse of major financial institutions in Japan. However, this increase was not significant during the second financial crisis period. By contrast, South Korea experienced another significant increase during the second period. This feature becomes even more pronounced when examining the suicide mortality rate for women, as shown in the lower panel.

Furthermore, after the COVID-19 pandemic, suicide mortality rates increased among Japanese and Korean young adults, except for males in their 30s. Many Korean studies have analyzed the spurt in suicides among young adults during the COVID-19 pandemic.

As was the case in Japan, the suicide mortality rate among women also increased in South Korea. However, as illustrated in Figure 2—and, as previously indicated—the spurt in the suicide mortality rate among young female adults in South Korea has been remarkable since before the COVID-19 pandemic (i.e., the second financial crisis). Therefore, analyses and proposals regarding the high suicide mortality rate among female young adults have accumulated since the 2010s—mainly by a few researchers (Lee, 2010). Furthermore, international comparative studies have analyzed this issue from the perspective of gender discrimination. Lee (2010) identified that the sex ratio of suicide mortality (male suicide mortality rate/female suicide mortality rate) is generally between 2 and 4, but for Korean young adults, the ratio is smaller than 2, and for certain years, the female suicide mortality rate is higher

than the male suicide mortality rate for the same age group—a rare phenomenon worldwide. Findings regarding the size of the sex ratio are related to gender equality. The higher the sex ratio, the closer it is to gender equality; the lower the sex ratio, the more serious the inequality (Lee 2023).[4]

The "resident registration number" system, which corresponds to Japan's My Number, has been in place since 1968.[5] Various kinds of economic, health-related, medical, and educational data can be linked to this number. Additionally, an analysis of suicide mortality rates by income group has also been conducted.[6]

Studies that have analyzed the current situation regarding suicide among young adults indicate disparities in education and employment opportunities by class of origin (Lee et al., 2022).[7]

This section is dedicated to a nuanced exploration of the actual circumstances surrounding suicide in South Korea, with a specific focus on young adults' experiences. Table 1 summarizes the similarities and differences between Japan and South Korea.

Table 1 Trends and Characteristics of Suicide Mortality in Korea: Focusing on Comparison with Japan

The commonality in suicide mortality rates between Japan and Korea.	● Suicide mortality rates skyrocketed immediately after the Asian currency crisis in the late 1990s. Significantly, a spurt in suicide mortality among males, including young adults males. ● Surge in suicide mortality among young adult females during the COVID-19 pandemic. ● Low sex ratio of suicide mortality compared to developed Western countries.

Differences in Suicide Mortality Rates (Characteristics of Korea, below)	Background of Differences (Social Background in Korea)
● Suicide mortality rates also spiked immediately after the second financial crisis. Particularly, suicide death rates among young women skyrocketed.	● Restructuring of the labor market and employment since the currency crisis of the late 1990s. Feminization of poverty. ● The proliferation of gender equality awareness has diminished marriage as an option among young women's lifetime prospects, increasing the likelihood of similar lifetime prospects as men's.

[4] In fact, Japan and South Korea, which are considered to have low gender equality indexes, tend to have smaller sex ratios than the G7 countries. The sex ratio in the G7 countries excluding Japan is generally 3 or more, but in Japan it is around 2, and in South Korea it is below 2 (calculated by the author from the WHO Mortality Database).

[5] At the outset, the resident registration system was not a mandatory requirement. However, following an incident on January 12, 1968, when armed agents from North Korea infiltrated the area around the presidential residence, then-President Park Chung-hee and the government decided that it was necessary to distribute a single form of identification to all citizens. It was also deemed necessary to be able to confirm the identity of citizens when necessary, and, to this end, it was thought that accurate confirmation of identity would be facilitated by the introduction of a unique resident registration number and registration card. Thus, distinctive resident registration numbers and registration cards were provided to all citizens (Source: National Archives of Korea https://theme.archives.go.kr/next/koreaOfRecord/identityCard.do, last accessed October 30, 2024).

[6] In recent years, income disparity and polarization of income have become an issue in South Korea. As of 2018, the Gini coefficient was 0.345 based on disposable income, which is higher than Japan's Gini coefficient of 0.334 for the same year. It has since decreased slightly, and as of 2021, South Korea's Gini coefficient was 0.329 and Japan's was 0.338 (Source: OECD Income distribution database).

[7] While the rate of students pursuing higher education has risen to approximately 80%, the proportion of jobs requiring a university degree is not relatively high because of the industry's structure. Consequently, the employment rate for university graduates is low, and competition is fierce. Therefore, in addition to achieving greater academic success, it is necessary to have other "specifications" that require economic capital and time, such as internships, language skills, and studying abroad. However, because the socioeconomic status of parents has more of an impact than individual effort in acquiring these skills, many young people feel powerless, frustrated, angry, and a sense of unfairness. This induces a sense of "relative deprivation" among young people in Korea. This is linked to loneliness, isolation, and suicide, according to the analysis (quoted from Lee et al., 2022, p. 371).

The following section presents an overview of the suicide prevention system in South Korea, with a focus on the relevant legislation and regulatory framework.

The overarching framework of the Suicide Countermeasures System

1. Overview General

As stated above, in South Korea, suicide prevention measures were initiated by the government in 2004, with the establishment of an administrative plan by the Ministry of Health and Welfare. The enactment of the Korean Suicide Prevention Act, which constituted the basis for the aforementioned plan, was a subsequent addition because of the shifts in the political landscape, including changes in the government. Following the enactment of the legislation, the suicide prevention plan that had already been established was reinforced and promoted in accordance with the existing legal framework. The practice of reviewing the plan every five years has been maintained. Additionally, the law has been amended nine times—most recently in 2023—to respond to the actual situation regarding suicide. Table 2 summarizes the timing and critical points of these amendments.

Table 2 Reasons for the enactment and revision of the Korean Suicide Prevention Act,[8] versions of the Suicide Prevention Plan, and the ministries in charge (by year and president)

Fiscal Year Presidential Name	Reasons for enactment and revision of the law	Versions of the Suicide Prevention Plan
2004 Roh Moo-hyun	-	First National Basic Plan for Suicide Prevention (2004-2008)
2008 Lee Myung-bak	-	Second National Basic Plan for Suicide Prevention (2009-2013)
2011 Lee Myung-bak	The Korean Suicide Prevention Act was enacted on March 30, 2011, and came into effect on March 31, 2012. Reason for enactment: ✓ Because suicide is highly socially contagious and can lead to the destruction of an entire society if not intercepted at an early stage, the state, which has the primary responsibility to protect the lives of its citizens, should take the lead in establishing effective and systematic preventive measures. ✓ This will stipulate in the law proactive prevention measures at a multifaceted and pan-divisional level by gender, age, class, motivation, etc., and measures to foster a culture of respect for life to protect the lives of our precious citizens and prevent socioeconomic loss.	
2016 Park Geun-Hye	Reasons for Suicide Prevention Law Amendments (1st: May 29, 2016):[9] ✓ The Mental Health Act is entirely revised, and its name is changed to “Act on Mental Health Promotion and Support for Welfare Services for Persons with Mental Illness” and “Mental Health Center under Article 13-2 of the ‘Mental Health Act’ ” in the text of the Korean Suicide Prevention Act is changed to “Mental Health Welfare Center	Third National Basic Plan for Suicide Prevention (otherwise known as the “Love of Life Plan”) (2016-2020)

[8] The source text was retrieved and quoted from the National Legislation Information Center (law.go.kr) of the government of Korea’s Legislation Bureau, and subsequently, rearranged by the author.

[9] The National Legislation Information Center of the government of Korea’s Legislation Bureau has given this amendment a separate name, “amendment to other laws”; however, as the result is the same as an amendment to the Korean Suicide Prevention Act, this article includes this amendment to other laws in the number of amendments.

	under Article 3-3 of the 'Act on Mental Health Promotion and Support for Welfare Services for Persons with Mental Illness.' "	
2017 Moon Jae-in	Reason for Suicide Prevention Law Amendment (2nd: February 8, 2017): ✓ To include a clear legal basis for a psychological autopsy ✓ To make the statutory penalty for violation of the obligation not to disclose confidential information in the course of employment more severe	*Suicide prevention measures are included in the government's 100 major national policy issues
2018 Moon Jae-in	Reason for Suicide Prevention Law Amendment (3rd: December 11, 2018): ✓ To reflect the Suicide Reporting Recommendation Criteria and Methods of Ensuring Performance in the Basic Plan for Suicide Prevention ✓ To establish a basis for establishing criteria for suicide report recommendations ✓ To establish a new Suicide Prevention Policy Committee under the State Minister to deliberate on important matters related to the suicide prevention policy ✓ To establish an inter-agency information coordination system with the National Police Agency and Suicide Prevention Center, etc. ✓ To establish a basis on which the Secretary of Health and Welfare may request that first responders and others provide suicide prevention counseling and education ✓ To provide a basis for national and local support for self-help groups for bereaved families of suicide victims	The Fourth Basic Plan for Suicide Prevention (also known as the National Action Plan for Suicide Prevention) (2018-2022)[10]
2019 Moon Jae-in	Reason for Suicide Prevention Law Amendment (4th: January 15, 2019): ✓ To add suicide survivor support and management services to the operations of the Suicide Prevention Center ✓ To provide for the obligation of the Minister of Health and Welfare to distribute publicity videos on suicide prevention and for broadcasters to make efforts to distribute public service announcements or information on suicide prevention counseling phone numbers ✓ To prohibit the distribution of information on suicide inducement through the information and communication network and to strengthen the penal provisions for violations ✓ To allow emergency rescue agencies to request information and communication service providers to view and submit personal and location information of persons at risk of suicide to rescue persons at risk of suicide, and to provide that information and communication service providers shall cooperate with such requests without delay ✓ To provide for state and local self-governing bodies to be able to support the necessary expenses for gatekeeper activities Reason for Suicide Prevention Law Amendment (5th: December 3, 2019): ✓ The state and local self-governing bodies may request the heads of related agencies, corporations, and organizations to submit necessary materials or to state their opinions to investigate the actual state of suicide. To stipulate that those requested must cooperate with the request unless there are justifiable reasons for refusal.	
2020	Reason for Suicide Prevention Law Amendment (6th: April 7, 2020):	

[10] Regarding the fourth plan, the Korea Foundation for Suicide Prevention states, "While complementing the existing Basic Plan for Suicide Prevention, it presents a specific Action Plan that focuses on effective issues. To this end, it explains that a pan-governmental promotion system led by the Prime Minister's Office has been established, and that it includes the implementation of a full-scale survey of all suicide deaths in order to emphasize cooperation between departments and to take a strategic approach based on scientific evidence" (https://www.kfsp.or.kr/web/contents/contentView/?pMENU_NO=283, accessed on October 30, 2024).

Moon Jae-in	✓ To expand the distribution of public service announcements and requests for broadcasters to transmit public service announcements or suicide prevention counseling phone number information by the Minister of Health and Welfare to include these general programming channels in addition to existing terrestrial broadcasting in response to the increased viewership of "general programming channel broadcasting" other than terrestrial broadcasting, etc.[11]	
2022 Moon Jae-in	Reason for Suicide Prevention Law Amendment (7th: February 3, 2022): ✓ To ensure that information-holding organizations provide information on suicide attempt victims, etc., to suicide prevention organizations on a preferential basis without the consent of the parties concerned and to destroy such information if the parties concerned request it after the fact ✓ To enable the Minister of Health and Welfare to effectively carry out suicide prevention work by specifying the grounds on which the Minister can request the provision of criminal justice information from the Chief of Police and others when necessary for surveying the actual status of suicide or for collecting and analyzing suicide statistics	Fifth Basic Plan for Suicide Prevention (2023-2027)
2022 Yoon Suk-Yeol	Reason for Suicide Prevention Law Amendment (8th: June 10, 2022): ✓ To stipulate the basis for the establishment and operation of the Korea Foundation for Suicide Prevention in the law: to support the establishment of the basic Plan for suicide prevention, to conduct surveys on the actual status of suicide, psychological autopsies, and the work of the (former) Central Suicide Prevention Center, etc.	
2023 Yoon Suk-Yeol	Reason for Suicide Prevention Law Amendment (9th: July 11, 2023): ✓ To establish a basic plan for suicide prevention by specifying "young adults" as the target of support by life cycle ✓ To stipulate the obligation of each educational institution to make efforts in suicide prevention education and counseling	

The purpose of the revision, which appears in Table 2, is to develop a significant framework for the development of a national organizational structure, the development of a legal basis for providing information (e.g., exceptions to the Personal Information Protection Law), support for bereaved families, requests for broadcasters, consolidation and abolition of organizations, and review of governance systems. Concrete images of the development of the Korean-style psychological autopsy, the development of a gatekeeper education program tailored to the Korean context, a survey on the actual state of suicide, a survey of all suicide deaths through police investigation records, and the implementation of an emergency room-based post-suicide attempt management program (from FY2013) have been developed through the Basic Plan for Suicide Prevention.

Additionally, based on the issues recognized locally in Korea regarding the plans up to the 4th Plan,[12] a 5th Plan was developed. The issues up to the 4th Plan are based on the common recognition of the fact that the overall suicide mortality rate in Korea remains the highest among the OECD countries, and include: (1) improving systematic and sustainable local management and implementation and supporting systems, (2)

[11] Broadcasting by a business operator using a general programming broadcast channel. "General programming" refers to programming in a variety of broadcasting fields, such as news, education, and entertainment (Article 2, Item 18 of the Korean Broadcasting Act).

[12] A regular publication (Health and Welfare Forum) of the Korea Institute for Health and Social Affairs—a national research institute in South Korea—summarizes the opinions on the issues discussed during the one-day seminar, which was attended by representatives of the Ministry of Health and Welfare, representatives of the Korea Foundation for Suicide Prevention, researchers in various fields, local suicide prevention project workers, bereaved families, etc., and covers up to the fourth plan (Ko et al., 2023, p. 61).

focusing on fostering a culture of respect for life, (3) focusing on the fact that proactive prevention is not sufficient, (4) emphasizing the need for outreach to working adults, young adults, and middle-aged people, (5) focusing on the challenges regarding the governance of the promotion system (more systematization of policies, encouraging mutual communication and cooperation, and making it a priority for the President, the Ministry of Health and Welfare, and the Chief of Staff), (6) focusing on the enhancement of evidence-based promotion, (7) expanding budget and infrastructure, (8) addressing new media that induce suicide, (9) identifying the underlying issues of suicide (poverty, disease, relative deprivation, etc.), (10) focusing on the perception that suicide is an individual problem, (11) limiting suicide to a mental health issue, etc.[13]

The fifth plan, which was newly developed based on this study, includes the following items:

(I) Suicide Prevention in the Community, under the item title, “Community-Led Suicide Prevention,” addresses (1) building alarm services targeting areas with suicide surges, (2) providing consulting on preventive measures suited to local characteristics, and (3) creating “life respect safe villages” that reflect local characteristics.

(II) The mental health examination system has been significantly expanded and reorganized, introducing (1) enhanced treatment and management for mental health risk groups, (2) enhanced risk factor management for mental health risk groups, and (3) an enhanced post-disaster response system for mental health risk groups. In conjunction with these changes, (4) post-morbidity management of suicide attempters and (5) post-morbidity management of suicide survivors has also been expanded and reorganized. Particularly, for young adults, as specified in the most recent amendment to the law, the government has made it possible to provide support for physical injuries and psychiatric treatment costs due to suicide attempts, regardless of the income level of the parties involved, as long as the parties involved provide consent.[14]

(III) Support is strengthened for the economic crisis group, the mental health crisis group, and the place of living as a so-called “needs fit type” that considers the life cycle.

In addition to these newly established items, another distinctive feature of the overall project is strengthening the system for data utilization to develop an evidence-based suicide prevention policy. The report titled, “Establishment of Suicide Prevention Policy Evidence Base” includes the following items: “Ensuring Timeliness of Regional Suicide Death Statistics through Prompt Receipt of Police Agency Criminal Justice Information Data” (p. 28); “Publication of National Report on the Data Provision Base of Criminal Justice Information and City/County Region Reports by the National Police Agency and Marine Police Agency” (p. 35); “Criminal Justice Information and Health Insurance National report analyzing the characteristics of suicide deaths nationwide through data linkage: current status of suicide deaths by health insurance quintile, health insurance status, mental illness, chronic physical illness, and disability type” (p. 35), “Transferring the production of the Suicide Survey to a specialized research institute for the development of national statistics and improvement of statistical quality” (p. 36), etc.

The system and content surrounding information technology—these are intimately related to data utilization—are strengthened as follows. First, regarding the multi-agency collaboration system for the database, it specifies “providing integrated

[13] In the detailed implementation plan formulated in 2005 to conduct the First Basic Plan for Suicide Prevention, the item, “Theories of the Causes of Suicide” was established as a sub-item under “1. Background and Necessity of the Project.” It states that, “it is more efficient for suicide prevention to focus on depression, which can be treated through early detection, as the main project target, rather than biopsychological and socioeconomic factors, which are difficult to change due to modern medicine and economic conditions, it is more efficient for suicide prevention to focus on depression, which can be treated through early detection, as the main target of the project” (Ministry of Health and Welfare, 2005, p. 11).

[14] Until then, support was only provided if the “middle income” was 120% or less.

health and welfare services through collaboration among police, fire departments, emergency medical institutions, suicide prevention centers (mental health case management system), and social security information systems" (p. 25).

The contents include:

(I) Development and execution of research on mental health services targeting high-risk groups for suicide and individual-fit digital services for early intervention (applications, virtual and augmented reality (VR/AR) devices, software such as AI-based tools)

(II) Suicide prevention and management services using digital technology (jointly with the Ministry of Science, Technology and Information Technology): Development of services for prevention and management of emotional disorders and digital treatment devices (DTx), and demonstration for students, military personnel, etc. (e.g., mental health self-testing, counseling chatbot, wellness contents such as physical activity games, etc.)

(III) Suicide and self-harm risk, suicide-inducing information detection AI models, and the development and demonstration of suicide prevention digital services.

Generally, in Korea, the central government is poised to take the lead in adopting countermeasures suited to the population at risk of mental health issues, economic crisis, time frame of life, and place of living. These countermeasures will be based on data (that can be linked to resident registration numbers and transformed into big data). The following section examines the policies of the 5th Plan that are directed toward the young adult population.

2. Policies targeting young adults

The interventions targeting the young adult demographics outlined in the Fifth Plan are as follows:

(I) Expand and restructure the mental health screening system, prioritizing young adults (20–34 years old) to proactively address mental health concerns and broaden the age range [expand and reorganize the mental health screening system].

(II) Support services for economic crisis groups aimed to prevent economic problems from leading to suicide, and suicide prevention and mental health services aimed at financial and credit-related counseling [targeted needs-fit suicide prevention: needs-fit policy for economic crisis groups].

(III) Implementation of mental health support specifically for young adults, introduction of an online application system, and enhancement of collaboration with mental health welfare centers (Priority support for young adults experiencing psychological difficulties due to the COVID-19 pandemic, barriers to employment, and other factors, with particular emphasis on young adults requiring independence support (* young adults who have resided in child welfare facilities or foster homes)) [life cycle and residence-specific policy approach].

(IV) Survey to assess suicide risk and mental health among young adults who have experienced abuse and school violence (41.3% of suicide deaths were associated with traumatic incidents during childhood, and 44.1% were linked to childhood abuse) (2021 Psychological Autopsy Interview Results Report) [fitted by life cycle and place of living policy].

(V) Identification of high-risk populations and provision of mental health services to young adults preparing for independent living (implemented by 17 cities and provinces nationwide, monitoring of self-support status by individuals, and provision of case management tailored to their needs) through enhanced collaboration among agencies and mental health welfare centers dedicated to supporting self-sufficiency [policies aligned with life cycle and geographical location].

(VI) Expand-targeted psychological autopsies focusing on specific groups and incidents, such as economically disadvantaged young adults preparing for self-reliance and post-murder suicides (broadening the scope of survivors

participating in psychological autopsies and gathering comprehensive information) [strengthen the foundation for promoting efficient suicide prevention: build an evidence base for the suicide prevention policy].

(VII) Implement consultation services through social networking sites (SNS), which are familiar to young adults, and expand contact points to enhance accessibility [strengthening suicide prevention infrastructure].

Thus, the mental health screening system has been comprehensively enhanced. High-risk groups have been identified by targeting clusters with economic and social vulnerabilities (e.g., individuals from child welfare institutions and those who experienced childhood trauma). Support mechanisms have been reinforced in various domains, including mental health, financial assistance, credit facilities, and other economic aspects of the identified clusters. Furthermore, emphasis has been placed on improving accessibility via online platforms that are integral to young adults' daily lives and strengthening the implementation of psychological autopsies.[15]

Consideration

This study examined the trends and characteristics of suicide mortality rates in South Korea, the country's comprehensive system for suicide prevention, and specific interventions targeting youth demographics. The following observations were made based on the aforementioned analysis.

Considering the overall situation in Korea, although the enactment of the Basic Act was subsequent to the administrative plan because of political circumstances, subsequent revisions have been implemented periodically to improve the system and address the prevailing suicide situation. The primary basis for system enhancement appears to be data utilization. Specifically, the government has identified clusters in which the suicide mortality rate has increased—or remained elevated—in each period, determined their characteristics and etiological factors, and implemented corresponding countermeasures (Chang & Jin, 2012, p. 8). One of the foundations of these measures is the establishment of a centralized data management system that incorporates mental health data, considering the resident registration number and the protection of personal information. The current direction of strengthening measures that specifically address young adults can be considered as an extension of this approach.

Policies have been formulated to promote community-specific measures since the First Basic Plan for Suicide Prevention. However, they continue to face the challenge of establishing a foundation for these measures. This can be attributed to the more volatile political and social dynamics compared to Japan and the difficulties in cultivating the basis for voluntary grassroots initiatives in local communities within a robust centralized structure referred to as an imperial presidency."[16]

Therefore, compared to Korea, Japan has a long-term presence of stable local communities.[17] The civil sector has assumed a prominent role in suicide prevention initiatives with efforts rooted in

[15] The criticism in South Korea also extends to the perception that these measures are being implemented as a matter of mental health alone. Additionally, the discussions at the Korea Institute for Health and Social Affairs acknowledge the influence of social context on suicide rates. For instance, Chang and Jin (2012, p. 8) note that "suicide is occurring in our country under different circumstances from other countries due to rapid economic development and the process of the dissolution of the family." Consequently, suicide prevention strategies must account for these distinctive circumstances.

[16] The Constitution of the Republic of Korea has undergone nine amendments. This phenomenon is not solely attributable to political instability; rather, it is also a consequence of the macro-level characteristics of modern Korean politics and society. One such characteristic is the "simultaneity of non-simultaneity," which Lim Hyugbaeg (2014) has identified as a defining feature of Korean politics. Moreover, the macroscopic characteristics of modern Korean politics and society, which can be elucidated through the lens of social change, such as "compressed modernity" (Chang, 2022), can be considered to provide the contextual background for this constitutional evolution.

[17] The modernization of Japan is characterized as semi-compressed modernity (Ochiai, 2011).

individual communities. Based on specific local characteristics, policies formulated using a bottom-up approach have been developed into fundamental government legislation and comprehensive guidelines for suicide prevention in Japan. This approach fundamentally differs from the current situation in Korea in terms of governance. Conversely, Japan may acquire more empirical evidence if the My Number system is established, potentially enabling the integration of diverse data within legal frameworks in the future.

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