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Psycho-Spiritual Perspective on the Challenges of Suicide Prevention in Kenya

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Abstract*: In Kenya, death by suicide or suicide attempt is a criminal offence according to the penal code 226 of section 36 of the Kenyan constitution. In the spiritual dimension, it is considered to attract eternal damnation and special burial rites are performed for persons who die by suicide. Culture treats death by suicide as a taboo and punitive burial rites are taken with the survivor families taking the consequences of such actions. This may impact on holding open, rational and objective discussions on prevention and intervention on deaths by suicide. However, the rise in cases of suicide is a concern, while knowledge and understanding of causes, prevention and effective intervention strategies is limited especially to the significant persons in the community who could be instrumental in such programs. This paper therefore seeks to review the concept of death by suicide, the irony surrounding its definition and legal dimension. It also explores the dilemmas therein and specifically discusses the possible preventive strategies by adopting cultural, social, psychological and spiritually sensitive interventions. This was a desktop review that reviewed literature by utilizing general and specific search engines. Key words guided the search and helped to narrow the scope. Recommendations have also been made for the government, community and to individuals in preventing death by suicide.*

Keywords*: Psyco-spiritual, Perspective, Challenge, Suicide, Prevention and Kenya*

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1. Introduction

Suicide is a significant cause of death and disability globally (Klonsky, May & Saffer, 2016). According to the World Health Organization (WHO) about 800,000 people die from suicide each year (that is one person every 40 seconds), majority of them aged 15-29, in which age-group suicide is the second leading cause of death (Canady, 2021; WHO, 2021). Additionally, data between 1999 and 2013 by the Center for Disease Control and Prevention (CDC) places suicide as one of 15 leading causes of death for individuals between 10 and 64 years of age, especially among adolescents and young adults (Zielinska, 2018). According to Zielinska (2018) in 2013, suicide was the second leading cause of death among all races and genders for ages 10-24, and the fifth for ages 25 -44. Suicide is an act of taking one's own life voluntarily and intentionally (Awan, 2002).

Suicide is caused by a combination of genetic, psychological, social, and cultural risk factors, as well as trauma and loss experiences. Models of suicide, such as stress–diathesis, gene–environment, and gene–environment and timing interactions, can explain internal or external risk factors and their relationships. With certain exceptions, such as in China (Mann, Apter, Bertolote, Beautrais, Currier, Haas,...& Hendin, 2005), psychiatric disease is a key contributing factor, with more than 90% of suicides (Holm, Salemonsen, and Severinsson 2021) having a DSM-IV psychiatric condition. Unfortunately, governments and policymakers generally place a low premium on suicide prevention. Suicide prevention must be prioritized on global public health and public policy agendas, and public awareness of suicide as a public health concern must be elevated through a multifaceted approach that considers social, psychological, and cultural factors (Mann, Michel, & Auerbach, 2021; WHO, 2018).

One of the most difficult aspects of suicide prevention is identifying suicidal people who are hesitant to share their thoughts, feelings, or intentions (Hawgood, Woodward, Quinnett & De Leo, 2021 citing Cross et al., 2010; Isaac et al., 2009). Some research in the United Kingdom, Australia, the United States, and Northern Ireland found that primary care physician education programs improved depression detection and treatment, whereas other studies in the United States, Brazil, and the United Kingdom found the opposite. Nurse case management, collaborative care, or quality improvement programs can help with depression recognition and management when education alone isn't enough (Mann, Apter, Bertolote, Beautrais, Currier, Haas,...& Hendin, 2005).

Suicide prevention involves a variety of treatments aimed at community or organizational gatekeepers who come into touch with potentially vulnerable groups and can identify at-risk persons and refer them to appropriate assessment and treatment. Clergy, first responders, pharmacists, geriatric carers, personnel workers, and those working in institutions like schools, prisons, and the military are all gatekeepers. Because of the small sample sizes, psychosocial interventions have not been proved to be beneficial in reducing suicide mortality (Zalsman, Hawton, Wasserman, van Heeringen, Arensman, Sarchiapone, ... & Zohar, 2016 citing Crawford, Thomas, Khan & Kulinskaya, 2007).

Screening is another suicide prevention method that tries to identify people who are at risk of suicide and help them get help. A review of trials on depression screening in people in primary health care settings by the US Preventive Services Task Force (USPSTF) indicated a 10% to 47% increase in rates of detection and diagnosis of depression with the use of screening tools. Due to variances in study methods, the effect on treatment was mixed. A review of depression screening trials conducted in Canada found that routine screening in primary care did not enhance depression care (Mann, Apter, Bertolote, Beautrais, Currier, Haas,...& Hendin, 2005).

In Kenya, WHO data estimates that 1408 people commit suicide yearly, or simply put, four deaths daily, a number that is higher than what the Kenya National Bureau of Statistics reported for 2018 African Population and Health Research Centre (APHRC)(APHRC, 2019) in 2014, Kenya's mortality rate due to death by suicide, ranked 29th world wide with an estimate of 6.5 per 100,000 deaths; however, the reliability of this estimate is unknown because sources of data on deaths by suicide are limited by the fact that it is a criminal offence in Kenya (BMC psychiatry, 2018). Furthermore, the Kenya National Police Service annual crime reports seems to indicate that the figures for the crime of attempted suicide is higher, coming second to murder in the homicide category (Kenya National Commission on human Rights, 2020). Death by suicide appears therefore to be the single psycho-spiritual concern with the most increasing frequency across the population and lifespan. A greater percentage of the population is increasingly affected yet it has received little emphasis so far in mental health care policies, pastoral care, funding for research and lack of comprehensive strategies for prevention and intervention. In Kenya, death by suicide still remains a criminal offence which may be a factor in the lack of credible data and information on the state of death by suicide in Kenya. The aim of this study was to explore the conceptualization dilemma of suicide and possible preventive strategies around cultural, social, psychological and spiritually sensitive interventions.

2. Literature Review

Although several factors have been found, according to O'Connor and Nock (2014:73), the roots of suicidal behavior are not entirely understood. Despite its presence since time immemorial, solutions to issues of death by suicide can be emotive. Its concepts and trends also keep changing in complexity and dynamics and interventions require context -sensitive strategies. For example, the increase in suicide rates among the youth in both developed and developing nations is attributed to among others, the emerging phenomenon of the digital world that has created concepts such as "cyber bullying", causing "cyber suicide", Kabugi (2019) and environmentally triggered factors like superhighways, skyscrapers and digital platforms which are easily accessible may further complicate effective preventive strategies.

The evidence of the impact of accessibility to the digital platform is further evident by the fact that the age of persons attempting suicide in particular, with a significant number completing suicide is dropping. The Kenyan landscape is increasingly seeing younger people attempting and some completing suicide following poor academic performances, cyber bullying, failed relationships, loss of money in betting and other underlying mental illnesses. An in-depth study and

understanding of region -specific factors to death by suicide would enable the government of Kenya to review the existing policies especially those related to mental health so that mental health care workers and other personnel in human care can adopt institutional frameworks and develop effective and appropriate prevention and intervention strategies but more significantly, to access funding and financial allocation during budgets.

Suicide is generally defined as "The act of intentionally causing one's own death" Jobes and Schneidman (2006) define suicide as an intentional self-afflicted death where an individual makes a direct and conscious effort to end their own life. The interfaith Suicide Prevention dialogue (2008) states that "life is a sacred gift, and suicide is "a desperate act by one who views life as intolerable". The interfaith Suicide Dialogue continues to clarify that self-destruction is never condoned, but faith communities increasingly support, rather than condemn, the person who contemplates or engages in suicidal behavior.

Is there an irony or a paradox in these definition(s)?

The discussion intends to examine three perspectives that may likely point to some irony in the conceptualization of death by suicide, namely the legal paradox, the suicide reality, the preceding pointers and the cry help.

The legal paradox; Under Kenyan law, attempted suicide is a crime. Section 225 of the penal code defines attempted suicide as a misdemeanor. Categorized under the section Offenses Connected with Murder and Suicide, a misdemeanor is punishable by a jail term of up to two years, or a fine, or both, according to section 36 of the Penal Code. The following could help to illustrate the concept of legal paradox (Adinkrah, 2016).

> *"David who is currently working with an organization that offers support to those who have attempted suicide had himself tried to take his own life 3 times. He says that he has lived with depression for 12 years and in 2016, he tried to hang himself from a tree in his neighbourhood, but was rescued by members of his community before he could do so. This was after a month long of suicidal thinking. The paradox here is that although they prevented his death, instead of offering support, his friends advised his wife to leave him and contact the police" (Authors opinion, 2021).*

It has been established that persons who experience suicidal thoughts, attempt suicide or even complete death by suicide need medical help or psychological support and not punishment. Suicide prevention requires mental health therapy for persons who are at risk of suicide. At least one psychiatric condition is present in almost 90% of suicide victims. Antidepressant prescriptions are linked to a decreased risk of suicide. Suicidal conduct has been proven to be reduced by cognitive therapy and interpersonal psychotherapy, as well as other forms of therapy (McClellan, Ali & Mutter, 2021).

The other paradox is in the legal processes where once a person has been finger printed and captured in the legal justice system as having been involved in a criminal act, they are faced with the challenge to access certain privileges and opportunities for work or business and this can only exacerbate the mental condition that the person has and further complicate the possibility of recovery (Muthee, 2020 citing Wattanaporn, 2013; Grommon, 2013; Gunnison et. al. 2016). The Kenyan, law as it stands now, is therefore a hindrance to people living with suicidal thoughts because the knowledge that it is a criminal offence makes them suffer in silence instead of seeking help making the suicide attempt or completed suicide rate go higher. The mental health practitioners on the other hand are required under the obligation of their professional ethics to break confidentiality in the case of attempted suicide or suicidal thought that score high on a self -harm assessment scale and this report is made to the police in ideal circumstances. There has been attempts by human rights bodies and other stake holders to either amend or repeal that law since 2016.

The suicide reality; Death by suicide is considered a tragic reaction to an overwhelming, stressful or an unmanageable life event or a series of events; therefore there is a link between suicide and mental health as well as physical or socioeconomic well-being. A history of suicide attempts, mental health issues, social isolation, financial stress or professional difficulties, criminal or legal issues, having a serious physical illness, substance use disorder, adverse childhood experiences, a family history of suicide, having experienced sexual violence, barriers to health care, stigma associated with mental illness or help seeking are all factors linked to an increased number of suicides (Efstathiou, Stefanou, Siafakas, Makris, Tsivgoulis, Zoumpourlis & Rizos, 2021). Study attributes death by suicide to feelings of hopelessness and worthlessness, stressful life events or circumstances such as loss of a loved one or livelihood and underlying mental illnesses or medical conditions that are life threatening. According to WHO (2014) world report on suicide, approximately 75% of death by suicide occur in low- and middle-income countries which may have motivated the inclusion of suicide as an indicator for Sustainable Development Goals (SDG)(Quintana& Williams, 2018). There are also pointers of a genetic link to suicide where people who complete death by suicide or have suicidal thought or behavior are more likely to have a family history of suicide or what is referred to as "generational curses" in the spiritual domain (Edwards, Ohlsson,

Mościcki, Crump, Sundquist, Lichtenstein,... & Sundquist, 2021). This genetic or generational factor is commonly hidden to the impacted individual rendering them helpless to take precautionary measures. Sometimes when help is sought for in the two arenas, the mental health personnel or the spiritual leader may still miss to identify such issues of suicide due to lack of appropriate assessment tools or expertise. Finally, the side effects, withdrawal symptoms or adherence issues due prolonged use of life sustaining medications could be another major cause of helplessness and feelings of loss of control and freedom, making the individual vulnerable to suicide thoughts (Tubbs, Fernandez, Ghani, Karp, Patel, Parthasarathy, & Grandner, 2021). In view of the above factors, the use of the term "intentionally causing one's own death" would be an irrational statement.

The preceding pointers; every suicide attempt whether completed or failed is often preceded by some form of suicidal ideation or suicidal thoughts (Balt, Mérelle, Van Bergen, Gilissen, van der Post, Looijmans, ... & Popma, 2021), a sort of "tunnel vision" where there seems to be no help or support, making life worthless and the only solution to the affected person seems to be to end it. This is what often leads to a conscious or unconscious warning signs, referred to as symptoms of suicide which include; talking about suicide; getting the means for accomplishing the act; withdrawing from social life; being preoccupied with death, dying or violence; increasing use or abuse of substance such as alcohol and other drugs; changing normal routine , including eating or sleeping patterns; engaging in risky or self - destructive behavior, such as recklessness in driving or sporting; giving away belonging or getting affairs in order when there's no logical explanation for doing this; saying goodbye to people in very subtle words or behavior. These are actions that have been proven to be by and large, responses and reactions that appear to be beyond the individual's control but a "cry for help" which can only be effectively handled by significant persons interacting with them but more effectively, if they are knowledgeable in listening to such pointers.

The cry for help; evidence suggests as has been stated on the discussion on "the preceding pointers" that persons with suicidal thoughts often give some warning signs or red flags. However, the responsibility of reaching out for help, which we will refer to as the "burden of prevention and intervention "in this concept of "intentional cause of death" seems to be placed on the person with the suicidal behavior. The discussions on 'the reality of suicide', however clearly points to the fact that person(s) with suicidal behavior more often than not have lost the capacity or the locus of control to reach out for the needed help (Umphrey, Sherblom & Swiatkowski, 2021). The paradox is that, person going through suicidal thoughts (hopelessness and helplessness) is on the other hand expected to be reasonable, objective and rational enough to take some actions because suicidal thinking does not get better on its own but requires support. Such expectations may include; reaching out to a close friend or a loved one; to contact a spiritual leader or to making an appointment with a doctor or a mental health care professional and to call a hotline number (Entilli, Leo, Aiolli, Polato, Gaggi & Cipolletta, 2021).

A close examination of the common warning signs of suicidal thought therefore focuses on what any care giver or everyone interacting with the individual ought to look out for in as much as the specific individual is the one manifesting the symptoms. These symptoms are ironically agreed on by mental health experts as "a cry for help" yet the person crying for help appears to be expected "to initiate the help by themselves". It is a notable factor in interviews with families or friends of persons who have died by suicide that, "this cry for help" was missed, belittled or help sought from non-professionals. Where there was a suicide attempt or an alert of suicidal behavior, an inappropriate intervention was used by an inexperienced person and sometimes it involved being watched closely by family for a few days but such a close watch is often unsustainable.

3. Methodology

The current study's research methodology included a literature review in order to establish the Psycho-Socio-Spiritual Dilemmas in Suicide Prevention. This study adopted a desktop review utilizing general and specific search engines. Key words were used in the search of literature. We searched PubMed, Scopus, Google scholar and the Cochrane library for all relevant English language studies. The Medical Subject Headings identifiers for "suicide" (including the subheadings "attempted suicide," and "prevention and control") were used in the initial search. Suicide, attempted suicide, suicidal behaviour, and suicidal ideation were used as search identifiers in combination with each of the following identifiers: control, depression, and health are all words that come to mind when thinking about prevention and control.

4. Results and Discussion

This section presents the finding of the study according to the thematic areas around the various dilemmas presented in relation to strategies adopted in preventing and dealing with attempted suicide or completed suicide.

4.1 Psycho-spiritual Risk factors for suicide

Aspects, conditions, antecedents, stresses, or behaviors that can cause suicide conduct are known as risk factors. Based on the stage at which they arise and the length of time they last, these are classified as predisposing, vulnerability, and trigger variables. Physical and mental

diseases are among the most important risk factors for suicide conduct. Mood disorders include depression, bipolar disorder, anxiety and psychological distress, substance use disorders, borderline personality disorder, and psychotic disorders, to name a few. Similarly, personality traits like low frustration tolerance, impulsivity, and hopelessness have been linked to an increased likelihood of suicide behavior (Hemming, Shaw, Haddock, Carter & Pratt, 2021). Attempting suicide before is thought to be the most major risk factor for suicide deaths (Valdés-García, Sánchez-Loyo, Velasco & Márquez, 2021 citing Echeburúa, 2015; Villar-Cabeza, Esnaola-Letemendia, Blasco-Blasco, Prieto-Toribio, Vergé-Muñoz, Vila-Grifoll, et al, 2018; Moreno-Carmona, Andrade-Palos, BetancourtOcampo, 2018; López, 2017; López, 2019; Orri, Galera, Turecki, Boivin, Tremblay, Geoffroy, et al., 2019).

4.2 **Critical Factors and Signs for Vulnerability to Death by Suicide**

The critical factors and signs of vulnerability to suicide include but are not limited to: a previous history of attempted suicide which is the most accurate predictor of completed suicide (Bostwick, Pabbati, Geske & McKean, 2016), family history of suicide (Jones, Boyd, Calkins, Moore, Ahmed, Barzilay, ... & Gur, 2021), previous hospitalization for suicidal behavior (Kim, Lee, 2021), war veterans or security personnel due to PTSD. Substance misuse coupled with a mental condition (dual diagnosis). Other signs are: getting organized suddenly after a period of disorganization and making peace with significant others, major mood disorders-depression & Bipolar (Rihmer & Kiss, 2002), recent life stresses, job loss or bereavement, growing in violent or dysfunctional families, history of childhood abuse, bullying or significant adversities. Persons with more than one life threatening medical condition (Ahmedani, Peterson, Hu, Rossom, Lynch, Lu, ... & Simon, 2017), the emergence of legalizing euthanasia or assisted suicide, emergence of altruistic suicide (taking one's life for another person to live) and religiously motivated suicides to attain martyrdom are also signs of suicide (Henry, 2021).

4.3Criminalizing suicide or attempted suicide

Attempting suicide, also known as "nonfatal suicidal behavior," "failed suicide attempt," "nonfatal suicidal attempt," or "parasuicide," is a criminal offense in several countries, including Bangladesh, Ghana, India, Kuwait, Nigeria, Pakistan, Rwanda, and Singapore, according to a recent review of the penal codes of several countries and jurisdictions around the world (Crime, 2021). Many Islamic countries considered attempted suicide to be a crime (Adinkrah, 2013; Khan & Syed, 2011; Musoni, 2011a, 2011b; Sareen & Trivedi, 2009; Za'za, 2011). Recent studies show that suicide has been decriminalized in most Western countries or countries with the fewest Muslims, however in Muslim-majority countries, it is highly prohibited by Islamic law and is regarded an illegal/criminal offense punishable by fines or jail. The Islamic Shariah law is followed by the vast majority of Muslim countries, including Afghanistan, Pakistan, Kuwait, Algeria, Morocco, Oman, Brunei Darussalam, Indonesia, Djibouti, Somalia, Bahrain, Qatar, Sudan, Albania, Iraq, United Arab Emirates, Malaysia, Saudi Arabia, and Bangladesh. Because of the fear of legal procedures and conflicting jurisprudence, the legal sanction for suicidal behavior discourages people from seeking help (Arafat, Khan, Menon, Ali, Rezaeian & Shoib, 2021).

In fact, former British colonial countries make up a major portion of the jurisdictions where attempted suicide is prohibited. Existing anti-suicide statutes in each of these countries are part of a corpus of rules imposed on the society during colonial rule. Attempted suicide continues to be criminalized, prosecuted, and punished in former British territories, which raises a number of troubling considerations (Crime, 2021). What is the social, moral, or legal justification for anti-suicide legislation, for example? How strictly are these anti-suicide laws implemented? What are the most prevalent legal consequences for attempting suicide? What justifications are presented to explain the campaign to decriminalize anti-suicide laws? Is there a link between the legal ban of attempted suicide and fewer suicide deaths and attempts? Will decriminalizing attempted suicide lead to major increases in suicidal behavior in these societies? (Adinkrah, 2016). However, attempting suicide nolonger a crime in India (Pooja, 2021).

The legal dimension where death by suicide is a criminal offence in Kenya and punishable by law, may be the reason that vital statistics on death by suicide would not be declared in the official statistics hence a heavy reliance on media expose of such deaths. To further complicate this lack of data, families with strong religious background previously declared any death by suicide to their spiritual leaders and this meant that the burial rituals would be performed as per such death by suicide but that has since changed significantly for reasons that may include the dilemma the spiritual leaders are likely to face in regard to the criminality of the act (Adinkrah, 2016). Suicide as mental health problem should be given the required attention from a health perspective and not focusing more on criminalizing it (Ochieng & Kamau, 2021).

4.4 Psycho-spiritual perspective on challenges of preventing suicide

Most major world religions regard life as a holy gift from God and forbid suicide (Koenig, King, & Carson, 2012; VanderWeele, 2017). One of the earliest scientific studies on religion and suicide was conducted by Durkheim in the

19th century, who discovered that suicide rates were lower in Catholic countries than Protestant countries on a global scale (Durkheim, 1897). Since then, hundreds of studies have looked into the relationship between various aspects of religion (e.g., religious affiliation, religious importance, service attendance, spirituality) and suicide (suicide ideation, suicide attempts, and completed suicide), with the majority indicating that religion is a protective factor against suicidality (Koenig et al., 2012). Suicide survivors, according to the studies reviewed, express a strong need to be helped by members of their religious community in various ways (Vandecreek and Mottram 2009; Lynn Gall et al. 2015; Castelli Dransart 2018; Jahn and Spencer-Thomas 2018; Mastrocinque et al. 2018).

Suicide is one of the major mental health problems in the world (Kučukalić & Kučukalić, 2017). A study showed that 15-35% of respondents reported that they have tried to hide or not talk about their loss by suicide of a loved one citing shock, anger, shame, embarrassment, betrayal and guilt as the possible causes of silence when such deaths occur (Kučukalić & Kučukalić, 2017 citing Tzeng 2010). Many families therefore no longer declare death by suicide unless the method chosen to complete the suicide is obvious or the action is in public knowledge and these perhaps may be the cases that go into the police records. However, declared death by suicide creates a challenge to the spiritual leaders on the content of the burial rituals or even the liturgy to use in the burial ceremony. The evidence of this is the fact that the religious institutions who had "special burials for persons who die by suicide" have since reviewed the liturgical content for burials of persons by suicide and in the Anglican church of Kenya (ACK) where there exists a common book of prayer, the liturgy for the burial of a person who has died by suicide has since been reviewed to show more compassion and understanding towards the surviving family. The psycho-spiritual implication of the non-declared death by suicide can however remain a source of guilt and impact negatively to the ability of such survivors to fully participate in spiritual activities as a result of self-conviction. There is therefore a need for spiritual leaders to demonstrate the openness and empathic understanding on issues of suicide behavior to ease the burden of non-disclosure among their Christians. The need to review the criminality of attempted suicide is however more critical now than ever (Wanyoike, 2015),

In today's world, mass media coverage plays a key role in the social construction of reality, which may influence people's exposure to suicide behaviors, particularly among susceptible populations like children (10 years and above), adolescents (up to around age 24 years) and the elderly (Ortiz, & Khin Khin, 2018). Suicide reports in the media have been linked to an increase in the frequency of suicides in a number of studies (Niederkrotenthaler, Braun, Pirkis, Till, Stack, Sinyor, ... & Spittal, 2020). Certain depictions or prominent repetitive coverage with detailed description of the process used to attempt or complete suicide may trigger "copycat" suicide and the risk is greater in adolescents and persons with mental illnesses, who are often impulsive in nature (Lai, Li, Peng, Zhao & He, 2021 citing Sisask, & Värnik, 2012). There is already evidence that Prevalence of death by suicide among the 15 – 29-year-old are higher due to life demands including course work, at this developmental stage and this age group forms the greater percentage of most populations (Crispim, Santos, Frazão, Frazão, Albuquerque & Perrelli, 2021). The elderly on the other hand are at a risk due to susceptibility to multiple factors-ranging from health challenges, psycho-social issues and possibilities of loneliness but the risk of trigger could however be higher, for any person who is vulnerable or at the "tip over" state. The information available on the digital platforms, especially when intricate details of how any person died by suicide, for example, "1000 ways to die series" and emergence of pandemics such as the Covid- 19, is capable of pushing the button for those who are vulnerable or predisposed over the edge (Shefler, Joiner & Sachs – Erison, 2021)

However, if such information is preceded or superseded by information on professional social support systems in even greater details, complete with accessibility contacts, then preventive intervention is likely to occur even when exposed. The media therefore have an important role to play through adherence to guidelines for accurate, sensitive, responsible, and ethical reporting of death by suicide. In the context of suicide contagion, using social media to communicate about suicide has both advantages and disadvantages. Accessibility, acceptance of social media platforms, and the speed with which helpful information can be disseminated are all potential benefits (Hui, Wong, Fu, 2015). Social media posts, on the other hand, may contain distressing or sensationalized content, normalize suicide as a response to one's problems, and disseminate information about suicide locations and methods (Luxton, June, Fairall, 2012; Memon, Sharma, Mohite & Jain, 2018; Robinson, Cox, Bailey, Hetrick, Rodrigues, Fisher & Herrman, 2016), all of which may increase suicidal behaviors (Luxton, June, Fairall, 2012; Dunlop, More, Romer, 2011) and contribute to suicide contagion. Best practices for using social media to prevent suicide are still in their infancy. Evidence-based, publicly available chatsafe recommendations to help young people safely converse about suicide on social media were recently produced for a US audience, but they have yet to be broadly embraced (Swedo, Beauregard, de Fijter, Werhan, Norris, Montgomery, & Sumner, 2021 citing Robinson, Hill, Thorn, et al, 2018).

In underlying psychiatric illnesses which have not been diagnosed such as depression; there is a strong link between suicide and mental illnesses such as depression. In 2017, a WHO report ranked Kenya in the sixth position among the African countries with of at least 1.9 million diagnosed with depression (WHO, 2017). A study by Ndetei, Khasakhala, Mutiso and Mbwayo (2010)

established that depression contributed to 84% of death by suicide or suicide attempt cases. In fact, mental illness has been referred to as the African continent's "silent-epidemic". Kenya's Mental Health task force revealed that mental illnesses accounts for 13% of the entire disease burden in Kenya a deliberate effort to address this major causes of suicide is therefore critical. Suicide being closely associated with mental illness hence creates the need to fast track amendments of laws and other pieces of legislation that are likely to impact on promoting mental and well-being such as 'the mental health policy document' and 'the counsellors and psychologists act of 2014' (it is worth noting that this act has taken seven years before implementation yet psychologists are the single most important professionals in mental healthcare). This is because the authoritative Medical Practitioners & Dentist's board (KMPDB) lists 100 psychiatrists, 427 psychiatric nurses against an estimated population of 47 million Kenyans. The majority of these psychiatrists are established to be practicing within the capital city, Nairobi county (Kanyoro, 2018), while Kenya Counselling and Psychological Association (KCPA) 2020 data, records 5,559 psychologists spread over 43 out of the 47 counties in Kenya

A study by Kanyoro (2018) further declares a highly debatable mental health structure that tends to focus on treatment and management of mental health issues even with the current state of affairs by suggesting that, the psychiatrist who is a medical doctor with specialization in psychiatry comes first, followed by psychiatrist nurses who execute psychiatrist orders, then psychologists and counsellors who help in the management of patients before and after medication. In view of the numbers of the current mental health specialists against a population of forty seven million, with at least one in every four Kenyans suffering from a mental illness at one point in their lives and only 0.5% budgetary allocation for mental health, psychologists and counsellors are therefore the critical pillar in management of mental health (Mutiso, Musyimi, Rebello, Gitonga, Tele, Pike & Ndetei, 2020).

Lack of standardized assessment tools or protocols in handling suicide patients. A study by Osafo, Asante and Akotia (2020) on national responses to suicide prevention in Africa in which eighteen countries responded, established that none of the countries had a national suicide prevention strategy in place and only three countries namely Algeria, Congo and Madagascar were in the process of developing any kind of strategy at the time of the survey. Training programs on death by suicide assessments and interventions for general practitioners or mental health professionals were very limited, available in just four out of the eighteen countries. This lack could still be majorly related to stigma and perhaps lack of skilled mental health practitioners in assessing self-harm. Accurate diagnosis of behavior such as sudden change to excellence or perfection which could be masked under spirituality or "turning points" or "successful deliverance" before the suicide are extremely critical in preventive and intervention strategies for suicide. Access to such preventive care can be enhanced by training of non-specialized health workers in the assessment and management of suicide behavior Wekesa and Kigongo (2019) and even get further to adopt strategies of prevention such as psycho education and empowerment of community leaders, volunteers and opinion leaders on the basic knowledge of suicide behavior.

Data is critical in any effective planning for prevention strategies which can prioritize those who are extremely vulnerable such as persons with mental illness or a history of suicide. The surveillance system may also determine the methods used in suicide so that the current trend in prevention strategies which focus on restriction can be reviewed as well as context based and culturally sensitive preventive measures. A study by Mutiso et al. (2020) indicates that by that year of study, there were no operational governance, policy or administrative structures specific to mental health in Kenya despite recognition by the County governments of the importance of mental health. The study further identified the main major barriers to effective mental health care as human and financial resources and low prioritization of mental health. The role of community support therefore cannot be overemphasized where families, religious leaders, village elders and learning institutions have the basic awareness on the risk factors and are able to respond appropriately to the high-risk groups within the community. This could also help in destigmatization of suicide and increasing the rate of early detection and seeking psycho social interventions.

Suicide and suicidal behavior are multifaceted, dynamic issues determined by the interaction of biological, psychological, social, cultural, and environmental factors (Valdés-García, Sánchez-Loyo, Velasco & Márquez, 2021 citing Arroyo, Herrera, 2019 & Hjelmeland, Jaworski, Knizek, Marsh, 2018). There are risks related to the developmental dynamics of life which creates a sense of either "entitlement or powerlessness" thus increasing the vulnerabilities to suicide (Valdés-García, Sánchez-Loyo, Velasco & Márquez, 2021). A high recommendation for guidelines on employees lay off and retirement plans is critical and should be developed to include psychological and financial planning support. Networking for comprehensive care in suicide prevention; Spiritual leaders, faith communities may require an in depth understanding of this concept of suicide behavior especially in the current world where there is an increase in understanding of illnesses and health. The faith community can work towards enhancing activities that foster cultures and norms that are life preserving, practices that promote healthy living and provide pathways through human suffering, instill a sense of hope, meaning and purpose in life. Due to the influence the faith communities have and the regular interactions that they have with their congregation throughout the year, suicide prevention can take a quantum leap forward as members of the faith

communities are retrained or trained to gain understanding and the necessary culturally competent skills to minister to people and communities at the heightened risk for suicide and to support the healing of those who have either struggled with suicide themselves or survived the suicide of a significant person in their life (Suicide Prevention Resource Center, 2009). Adolescents have a greater risk of "copycat" suicide and attempted suicide due to their natural tendency as a developmental factor to take risky behavior.

5. Conclusion and recommendations

Death related to suicide can easily become a national crisis if strategies for prevention and management are not developed because basic knowledge and information on early identification and intervention of known risk factors can be availed to all persons who are interacting in such contexts. This study envisions a time when a national center specifically dedicated to research, prevention of mental illnesses in Kenya will be establish to include research on emerging trends on suicide. Also envisioned is that professional psycho spiritual support would be available for families affected by suicide death to minimize stigma and increase awareness and knowledge on death by suicide prevention at basic levels of the community.

We therefore recommend governments including the government of Kenya to invest seriously in suicide related interventions as an area within mental health. Following the findings by studies about the lack of national suicide prevention strategy, we recommend that countries should put in place National suicide prevention strategies.

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