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Suicide among Jamaicans Aged 0–18 Years: A Secondary-Data Study

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Article Publication Details

This article is published in the **International Journal of Multidisciplinary Research and Bulletin**, ISSN 3108-1428 (Online) Volume 4 Issue 5 (Sep-Oct) 2025.

ABSTRACT

Suicide among adolescents in Jamaica is a significant public health concern that extends beyond mortality statistics. Official death records suggest relatively low rates among individuals under 19 years; however, secondary data indicate that nearly one in four Jamaican adolescents report suicidal ideation, and approximately one in ten report suicide attempts. Gender differences are notable, with girls more likely to report ideation and boys more frequently using lethal methods such as hanging. Key risk factors include exposure to interpersonal violence, bullying, family instability, and poor sleep, while protective factors encompass parental support, school engagement, peer relationships, and community networks. Patterns of suicide methods reveal that ingestion of pharmaceuticals or pesticides predominates in non-fatal attempts, emphasising the role of access to means in shaping outcomes. Regional comparison demonstrates that Jamaica's adolescent suicide rate is moderate relative to Caribbean peers, yet rising trends, particularly among males, signal the need for urgent intervention. Schools emerge as critical sites for early detection and intervention, while community and faith-based networks provide protective support. Policy frameworks aligned with international guidelines, such as the WHO LIVE LIFE strategy, are essential to strengthen mental health services, promote evidence-based interventions, and implement culturally sensitive prevention strategies. Sustainable suicide prevention requires integrated approaches across clinical, educational, community, and policy domains. These findings underscore the hidden burden of adolescent suicidal behaviours in Jamaica and highlight opportunities for targeted, multi-level interventions to reduce morbidity and mortality.

Keywords: adolescent suicide, Jamaica, risk factors, protective factors, policy implications, regional comparison

Introduction

Suicide among young people represents one of the most pressing public health concerns globally, with adolescents being particularly vulnerable to psychosocial stressors. The World Health Organization (2017a, 2021) identifies suicide as a leading cause of death among individuals aged 15–29 years,

a trend that highlights the intersection between developmental transitions and heightened emotional distress. Ilic & Ilic (2022) wrote, "A total of 759028 (523883 male and 235145 female) suicide deaths were reported worldwide in 2019. The global ASR of mortality of suicide was 9.0/100000 population in both sexes (12.6 in males *vs* 5.4 in females)" (p. 1044). They continued, "Decreasing trends in suicide mortality were observed in most countries across the world. Unfortunately, the mortality of suicide showed an increasing trend in several populations" (p. 1044). For Jamaica, although the absolute number of suicides among minors appears comparatively low, secondary data suggest significant levels of suicidal ideation and attempts among those below 19 years (Abell et al., 2012). Abell and colleagues (2012) found that the prevalence rate of suicidal ideation among students aged 10-15 years old in Jamaica was 9.7%.

According to Holder-Nevins et al. (2012), "[In Jamaica] the incidence of suicide in adolescents was 1.1 per 100,000 [i.e., 14% of total suicide cases]. Rates for males were significantly higher than those for females. Most suicide cases were students, and the majority of cases were from rural areas (65%)" p. 516). They added, "The present study found that the peak periods for adolescent suicides were June to September and December to February. It is not known exactly why this is so" (p. 519). A cross-sectional descriptive study of 342 adolescents aged 10-19 years from 19 schools in Western Jamaica was conducted, and 24.6% of them have attempted suicide, with females constituting 64% (Kukoyi et al., 2010). Holder-Nevins et al. (2012) articulated that, "A history of psychiatric disorders, sexual abuse, previous history of attempted suicide, exposure to violence, family history of suicide and mood disorders have been documented as risk factors for adolescent suicide" (p.519). Kukoyi et al. (2010) articulated that, "…33% reported past sexual abuse to them or a family member. About 5% reported monthly or more frequent alcohol use, while 6% indicated monthly or more frequent other substance (ganga) use" (p. 5). Those behaviours, even if non-fatal, carry substantial morbidity, reflecting psychological pain, impaired functioning, and increased risk of subsequent attempts. A critical examination of the Jamaican context is therefore warranted.

The regional situation further contextualises Jamaica's youth suicide problem. In the Americas, suicide rates have been increasing since the year 2000, even as many other regions have experienced steady declines (Ilic & Ilic, 2022). This divergence suggests that unique social, cultural, and structural dynamics shape youth vulnerability within the Caribbean and Latin America. Within Jamaica, high levels of exposure to interpersonal violence, academic pressures, and family instability compound mental health challenges for young people (PAHO, 2017b). Recognising these risk patterns enables policymakers to situate Jamaica's adolescent suicide crisis within broader hemispheric trajectories. Understanding these regional differences can inform the development of tailored interventions.

Jamaican school-based surveys provide a critical lens into the prevalence of suicidal thoughts and behaviours among adolescents. According to the Global School-based Student Health Survey (GSHS) of 2017, nearly one in four Jamaican students reported seriously considering suicide, with girls disproportionately affected (PAHO, 2017a; WHO, 2017b, 2027c). Such findings demonstrate a striking discrepancy between mortality data and self-reported experiences of suicidal distress. While official registries may undercount youth suicides due to stigma or classification issues, the survey indicates a hidden epidemic of psychological suffering. Thus, Jamaican adolescents confront significant risks not always reflected in mortality statistics.

Risk factors for youth suicide in Jamaica emerge across multiple domains. Interpersonal violence, bullying, feelings of loneliness, and disrupted sleep are particularly associated with higher reports of suicidal ideation and attempts (PAHO, 2017b). Conversely, protective factors such as parental understanding, supportive friendships, and school engagement appear to buffer these risks. The Jamaican context also highlights the dual role of religion and community networks, which can either serve as protective factors or reinforce stigma that suppresses open discussion about mental health (Gallimore et al., 2023; Pederson et al., 2022; World Health Organization and the United Nations Children's Fund [UNICEF], 2024). By recognising the interplay of risk and protective factors, interventions can be designed that resonate with Jamaica's cultural and social realities.

Another important dimension is the methods employed in suicide attempts and deaths among Jamaican minors. Evidence indicates that hanging predominates as the method of death, while ingestion of agrochemicals and pharmaceuticals is more common in non-fatal attempts (Holder-Nevins et al., 2012). These patterns are critical because they reflect both accessibility

of means and lethality of methods. High-lethality methods like hanging increase the likelihood that an attempt will result in death, underscoring the importance of early detection and prevention rather than solely crisis response. Restricting access to pesticides and raising awareness about safe storage practices may significantly reduce the likelihood of fatal outcomes.

The Jamaican policy landscape has begun to acknowledge the burden of suicide among young people. The Ministry of Health and Wellness has expressed commitment to expanding suicide prevention initiatives, strengthening crisis response, and embedding mental health services into primary care and schools (MOHW, 2020a, 2020b; JIS, 2023). These align with the World Health Organization's LIVE LIFE strategies, which emphasise restricting access to means, fostering life skills, and providing timely support (WHO, 2021a). Nevertheless, translating policy commitments into measurable outcomes requires intersectoral coordination, sustainable funding, and accountability systems. Schools, communities, and health providers must work in tandem to address both the psychosocial and structural drivers of suicide. Hence, this study synthesises existing secondary evidence to assess the magnitude, determinants, and implications of suicide among Jamaicans under 19 years.

Methods

This study employed a secondary-data narrative review design, focusing on suicide and suicidal behaviours among Jamaicans aged 0–18 years. The researcher chose this approach due to the paucity of nationally disaggregated datasets and the value of synthesising insights from multiple surveillance and research sources. By integrating epidemiological reports, peer-reviewed publications, and government policy documents, this method enables a multi-perspective understanding of children-to-youth suicide. A narrative review is particularly appropriate when sources vary in design, scope, and quality, as is the case for Jamaica. It allows both descriptive and thematic presentation of findings.

The data collection process relied on a structured search strategy. Academic databases such as PubMed, Scopus, and Google Scholar were scanned using terms including “Jamaica adolescent suicide,” “youth suicide ideation Jamaica,” and “GSHS suicide Jamaica.” Grey literature from the Pan American Health Organization (PAHO), the World Health Organization (WHO), and Jamaica’s Ministry of Health and Wellness was also reviewed. Inclusion criteria prioritised publications or reports that provided age-specific or adolescent-disaggregated data relevant to suicide in Jamaica. Sources published before 2010 were

included only if they provided unique insights into methods, risk factors, or protective factors not addressed in more recent studies.

Data synthesis followed a thematic approach. Sources were categorised according to epidemiology, risk and protective factors, methods of suicide, and policy or programme interventions. Within each category, findings were extracted and summarised to highlight commonalities and divergences across studies. This thematic structure ensured coherence and avoided over-reliance on any single dataset, especially given that Jamaican suicide mortality data remain limited for under-19s. Interpretive synthesis was then employed to link findings back to global and regional patterns. This approach maintained fidelity to the original data while facilitating analytical depth.

Quality appraisal was conducted informally rather than via a formal risk-of-bias instrument. Peer-reviewed studies published in reputable journals such as the *West Indian Medical Journal* were given higher weight due to methodological transparency (Holder-Nevins et al., 2012; Abell et al., 2012) as well as the *International Journal of Environmental Research and Public Health (*Ilic & Ilic, 2022) and *Crisis (*Kukoyi et al., 2010). Surveillance reports from PAHO and WHO were considered authoritative because they employed standardised protocols and cross-national comparability (PAHO, 2017a, 2017b; WHO, 2021a). Government documents were assessed for relevance, recency, and policy utility, while acknowledging potential political bias. The triangulation of sources enhanced the robustness of the conclusions.

Ethical considerations were minimal given the exclusive reliance on secondary data. No primary data were collected from human participants, and therefore, issues of consent and confidentiality did not arise. Nonetheless, the study was attentive to the sensitive nature of suicide research, striving to interpret findings responsibly without sensationalism. Care was taken to avoid reinforcing stigma by framing suicide as a preventable public health challenge rather than a moral failing. Terminology was aligned with WHO recommendations to ensure clarity and non-stigmatising communication.

Results: Magnitude and Patterns

School-based surveillance indicates high levels of suicidal ideation and non-fatal attempts among Jamaican adolescents. Nearly one in four students reported serious consideration of suicide, and almost one in eleven reported an attempt in the previous year. Female students

consistently exhibited higher ideation, whereas male students showed slightly higher attempt prevalence. These sex-patterned differences mirror international findings that girls report more ideation, but boys may engage in more lethal or externalising behaviours. Although national vital statistics list relatively few youth suicides annually, the GSHS data reveal a much broader prevention mandate (PAHO, 2017a; Ilic & Ilic, 2022).

Table 1 provides a concise summary of the 2017 Global School-based Student Health Survey (GSHS) for Jamaica, based on the official WHO fact sheet (2017c). Methodologically, the survey used a two-stage cluster design to produce nationally representative estimates for students in grades 7–12 (typically ages 13–17). The school response rate was 84%, the student response rate was 71%, and the overall response rate was 60%, yielding a total of 1,667 participants. The instrument spans multiple domains, alcohol and other drugs, mental health, diet and weight status, physical activity, tobacco, sexual behaviours, protective factors, and violence/injury, allowing a broad snapshot of modifiable risks in adolescence.

Several behaviours stand out as high-prevalence and early-onset. Nearly half of students (48.9%) reported current alcohol use, and among those who had ever drunk, 71.1% first drank before age 14, underscoring early initiation. Cannabis exposure was also notable: 21.5% had ever used marijuana (28.2% of males vs 15.9% of females). Tobacco exposure appeared both active and passive: 19.4% currently used any tobacco product, 14.9% currently smoked cigarettes, and 67.4% reported second-hand smoke exposure in the prior week. Sexual initiation was common (46.7% ever had intercourse; 66.7% of males vs 28.6% of females), with condom use at last sex around two-thirds (64.3%; WHO, 2017C)

Mental health and violence indicators are concerning. One in four students (25.0%) seriously considered attempting suicide in the past year, and 18.0% reported at least one suicide attempt, figures that are high by international standards and with consistently higher prevalence among females for ideation/attempt. Social connection was mixed: 8.8% reported having no close friends, while parental understanding and monitoring were reported by roughly one-third (31–40%), suggesting scope to strengthen family protective factors. Violence and injury risks were widespread: 31.2% were in a physical fight, 39.3% were seriously injured, and 23.9% reported being bullied in the prior month, highlighting the need for school climate and anti-bullying interventions (WHO, 2017c)

Nutrition and activity patterns point to dual burdens. Overweight and obesity affected about one-third of students (overweight 23.3%, obese 9.2%), alongside high intake of sugary drinks

(69.1% consumed carbonated soft drinks ≥1/day). Only 23.2% met daily 60-minute physical activity on all 7 days, while 56.4% spent ≥3 hours/day sedentary outside school—behaviours that track into adult non-communicable diseases. Together, these findings make a clear case for integrated, school-centred prevention: delay substance-use initiation, expand mental-health supports (including suicide prevention and social connectedness), reduce violence and bullying, and improve diet/physical activity through policy and curriculum (WHO, 2017c).

Table1. Key issues from Jamaica GSHS 2017 (students aged 13–17 years)

Domain	Indicator (Total 13–17)	Prevalence	Brief implication
Alcohol	Currently drink alcohol	48.90%	Early initiation is common; tighten school/community alcohol controls. WHO, 2024
Alcohol (initiation)	First drank before age 14 (ever-drinkers)	71.10%	Prevention must start in early adolescence. WHO, 2024
Cannabis	Ever used marijuana	21.5% (M 28.2%, F 15.9%)	Gender gap: target male-focused prevention. WHO, 2024
Tobacco	Any current tobacco use	19.40%	Strengthen school tobacco policies/cessation. WHO, 2024
Second-hand smoke	Exposure ≥1 day in the past week	67.40%	Enforce smoke-free homes/public spaces. WHO, 2017c
Mental health	Seriously considered suicide (12 mo)	25.0% (F 32.3%)	Urgent need for school-based mental-health screening/support. WHO, 2017c
Mental health	Attempted suicide (12 mo)	18.00%	Scale evidence-based suicide-prevention programmes. WHO, 2017c
Peer support	No close friends	8.80%	Build peer-connection programmes. WHO, 2017c
Violence	In a physical fight (12 mo)	31.20%	Implement violence-prevention and conflict-resolution curricula. WHO, 2017c
Injury	Seriously injured (12 mo)	39.30%	Improve safety education and enforcement. WHO, 2017c
Bullying	Bullied (past 30 days)	23.90%	Anti-bullying policies and reporting mechanisms. WHO, 2017c
Weight status	Overweight / Obese	23.3% / 9.2%	Integrate nutrition education and active school environments. WHO, 2017c
Diet	Soft drinks ≥1/day	69.10%	Consider SSB policies; promote water/milk. WHO, 2017c
Physical activity	60 min/day on all 7 days	23.20%	Increase PE frequency and active transport. WHO, 2017c
Sedentary time	≥3 hours/day leisure sitting	56.40%	Screen-time guidance and alternatives needed. WHO, 2017c

Clinical and medico-legal records provide insight into methods and lethality. Jamaican adolescent cases historically feature hanging as the predominant method of death, reflecting high lethality and ready access to means within home and community environments. Poisoning and ingestion are also reported, particularly among non-fatal presentations, with agrochemicals and pharmaceuticals implicated in some events. These method profiles underscore the importance of means restriction strategies alongside psychosocial interventions, and emphasise the need for rapid crisis response and safe storage practices in households (Holder-Nevins et al., 2012).

Risk and protective factors cluster across individual, relational, and school domains. GSHS indicators highlight bullying victimisation, feelings of loneliness, and poor sleep as correlates of suicidal behaviours, while parental understanding and connectedness function as protective buffers. Broader literature in the Americas links adverse childhood experiences, depression, and substance use to elevated risk, suggesting the value of integrated screening in school and primary care. Community stressors, including exposure to violence, may compound vulnerability, while faith, school engagement, and supportive peer networks appear to mitigate risk and facilitate help-seeking (PAHO, 2017b; Ilic & Ilic, 2022b).

Table 2 summarises global, regional, and national estimates of adolescent suicidal ideation, attempts, and deaths, highlighting the discrepancy between high self-reported morbidity and relatively low official mortality counts. This matter underscores the hidden burden of adolescent suicide risk in Jamaica, situating it within global and regional contexts. Globally, suicide ranks as the second or third leading cause of death among young people aged 15–29, with the Region of the Americas also reporting a rising trend since 2000. Jamaica shows that while completed suicides among those under 19 are relatively rare, they do occur annually, with potential undercounting due to stigma and misclassification. This matter suggests that although Jamaica's absolute mortality numbers may appear low, the risk is real and may be underestimated. Thus, prevention strategies must take into account both data limitations and hidden burdens.

When examining suicidal ideation, Jamaica stands out with higher reported levels than both global and regional averages. Globally, 14–16% of adolescents report considering suicide, while in the Americas, it ranges from 18–22%. In Jamaica, however, nearly one in four adolescents (24.8%) reported suicidal ideation, with girls (31.5%) substantially more affected than boys (17.5%). This gender disparity aligns with international findings that girls report

higher psychological distress and internalising symptoms. The elevated rates in Jamaica underscore the urgent need for culturally grounded, gender-sensitive mental health interventions.

Suicide attempt patterns also reveal important nuances. Globally, 7–9% of adolescents report an attempt in the past year, with the Americas showing a slightly higher prevalence of 8–10%. Jamaica's rate of 8.8% aligns closely with the regional average but demonstrates a reversal of the typical gender pattern: boys (9.6%) attempt more than girls (8.0%). This unusual trend may be linked to socio-cultural pressures on Jamaican males, potentially driving externalising behaviours. Methods of suicide further reflect context, as hanging dominates fatal outcomes. At the same time, ingestion appears in non-fatal attempts, reinforcing the importance of restricting access to means and promoting crisis intervention strategies.

Table2. Global, Regional, and National Adolescent Suicide Indicators (Ages 0–18)

Indicator	Global Estimate	Region of the Americas	Jamaica (2017 GSHS)-WHO 2017b	Notes
Suicide is a leading cause of death (15–29 years)	2nd–3rd leading cause	Rising trend since 2000	Rare among under-19 but present annually	Mortality undercounts possible
Adolescent suicidal ideation (12 mos)	14–16%	18–22%	24.8% (31.5% girls, 17.5% boys)	Jamaica is higher than global/regional averages
Adolescent suicide attempts (12 mos)	7–9%	8–10%	8.8% (9.6% boys, 8.0% girls)	Male attempt rates are slightly higher
Predominant method	Hanging, poisoning	Hanging, firearms, ingestion	Hanging (fatal), ingestion (non-fatal)	Access to means shapes outcomes

Note. Data compiled from PAHO (2017a, 2017b), Holder-Nevins et al. (2012), and Ilic & Ilic (2022, 2022b). Jamaican estimates are based on school-based surveys.

Table 3 summarises sources of secondary data, their contributions, and key limitations, illustrating why a narrative synthesis was appropriate given fragmented youth suicide data. School-based surveys, such as the 2017 Global School-based Student Health Survey (GSHS), provide valuable insight into suicidal ideation and attempts among in-school youth. Their strength lies in national representativeness and gender-disaggregated data; however, they exclude vulnerable out-of-school populations and may be subject to recall or self-report bias. Peer-reviewed studies add depth through clinical and medico-legal insights, as seen in studies

by Holder-Nevins et al. (2012); however, they often rely on small, context-specific samples and may not accurately reflect current trends. Together, these sources reveal both breadth and limitations in the evidence base.

International agencies, such as the WHO and PAHO, contribute standardised frameworks and cross-country comparability, allowing Jamaica's data to be situated within wider global and regional patterns. Their reports are essential for benchmarking national progress against international targets, such as the Sustainable Development Goals. However, they often lack the granularity to capture Jamaica's unique socio-cultural risk factors, including stigma and community dynamics. Government reports, such as those issued by the Ministry of Health and Wellness (MOHW) or the Jamaica Information Service (JIS), provide authoritative statistics and inform policy discourse. However, these may be affected by political framing or under-reporting, especially given sensitivities surrounding suicide.

Mortality statistics from the Registrar General's Department remain critical for establishing official suicide counts, but their utility for adolescent-specific analysis is limited. They often undercount cases due to misclassification (e.g., being coded as accidents) and a lack of disaggregation under the age of 19. This matter creates a gap in understanding the accurate scale of suicide among Jamaican youth, especially in comparison with self-reported survey data that reveal a higher prevalence of ideation and attempts. The table, therefore, underscores the need for triangulation, which involves combining surveys, academic research, international benchmarks, government records, and mortality data to construct a more accurate picture. Only through this multi-source approach can effective prevention policies be designed and evaluated.

Table3. Sources of Secondary Data on Suicide Among Jamaicans Aged 0–18

Source Type	Contribution	Example	Strengths	Limitations
School-based surveys	Provide self-reported data on ideation and attempts	GSHS 2017 (WHO, 2017)	Nationally representative, gender-disaggregated	Excludes out-of-school youth; recall bias
Peer-reviewed studies	Clinical and medico-legal insights	Holder-Nevins et al., 2012	Rigorous methodology; Caribbean focus	Small sample sizes; limited recency
International agencies	Regional and global comparisons	PAHO, WHO	Standardised data; cross-country comparability	May lack Jamaica-specific depth
Government	Policy responses	MOHW	Authoritative,	Potential under-

reports	and statistics	bulletins, JIS reports	policy-relevant	reporting; political framing
Mortality statistics	Official suicide counts	Registrar General's Department	Baseline national rates	Often not disaggregated under 19; undercounting

Table 4 highlights the prevalence of suicidal ideation and attempts among Jamaican adolescents compared to global and regional benchmarks. Jamaican youth experience disproportionately high levels of ideation, with 24.8% reporting serious consideration of suicide—well above global (14–16%) and regional (18–22%) averages. Gender differences were evident: 31.5% of girls versus 17.5% of boys reported ideation. Suicide attempts were reported by 8.8% of students, with slightly higher rates among boys (9.6%) than girls (8.0%) (PAHO, 2017a; Ilic & Ilic, 2022). Globally, between 14–16% of adolescents report suicidal thoughts in the previous year, while in the Region of the Americas, this rises to 18–22%. In Jamaica, however, nearly one in four adolescents (24.8%) reported such ideation, with a striking gender disparity: 31.5% of girls compared to 17.5% of boys. This matter suggests that Jamaican girls may be particularly vulnerable to emotional distress and internalised coping struggles. The data highlights an urgent need for gender-sensitive mental health interventions in schools and communities.

In terms of suicide attempts, Jamaica's adolescent rate of 8.8% aligns closely with the regional average of 8–10% and the global range of 7–9%. However, what is striking is the reversal of the typical gender pattern observed globally and regionally. In Jamaica, boys report slightly higher attempt rates (9.6%) than girls (8.0%), in contrast to international trends where girls often report more non-fatal attempts. This matter may reflect cultural and social pressures on boys in Jamaica, including norms of masculinity that discourage help-seeking and contribute to risk-taking behaviour. It points to the need for interventions that address male mental health in culturally relevant ways.

Taken together, the Jamaican data illustrate both convergence and divergence with international patterns. While overall attempt rates are consistent with global and regional norms, ideation rates are alarmingly higher, especially for girls. The gender reversal in attempt patterns complicates traditional assumptions about male versus female suicide risk. This dual picture suggests that while Jamaica shares some common adolescent suicide risks with other countries, it also has unique cultural and social determinants that shape outcomes. These findings underscore the importance of locally tailored prevention strategies that recognise both global evidence and national realities.

Table4. Prevalence of Suicidal Ideation and Attempts Among Adolescents (0–18 years)

Indicator	Global Estimate	Region of the Americas	Jamaica (2017 GSHS)
Suicidal ideation (12 months)	14–16%	18–22%	24.8% (31.5% girls, 17.5% boys)
Suicide attempts (12 months)	7–9%	8–10%	8.8% (9.6% boys, 8.0% girls)

Table 5 summarises methods, risk factors, and protective factors: hanging predominates as the method of death, and ingestion (pesticides/pharmaceuticals) in non-fatal attempts. Risk factors include bullying, loneliness, poor sleep, and exposure to violence. Protective factors include parental understanding, school engagement, peer support, and faith (PAHO, 2017b; Holder-Nevins et al., 2012). For non-fatal attempts, ingestion of pesticides and pharmaceuticals is more common, reflecting accessibility of household chemicals and medications. This contrast between fatal and non-fatal methods points to the critical role of means restriction in prevention strategies. Policies targeting safe storage of pesticides and controlled access to medications could significantly reduce risk.

The risk factors outlined in the table encompass both interpersonal and environmental factors that influence adolescent suicidality. Bullying and loneliness reflect peer-related vulnerabilities, while poor sleep and exposure to violence highlight individual and structural stressors. These risk factors align with broader adolescent mental health research showing how chronic stress, social exclusion, and unsafe environments escalate vulnerability. In Jamaica, where exposure to violence is a persistent social problem, its compounding effect on youth suicide risk is particularly salient. Addressing these factors requires a multisectoral approach linking health, education, and community initiatives.

Protective factors provide a critical balance by showing the resilience-building supports available to Jamaican adolescents. Parental understanding, supportive friendships, school engagement, and faith are identified as key buffers against suicidal behaviour. These factors suggest that strengthening family communication, promoting positive peer networks, and enhancing school connectedness can help mitigate risks. Additionally, the cultural role of faith highlights the importance of integrating community and religious organisations into prevention efforts. Together, these findings suggest that suicide prevention in Jamaica should not only address risks but also actively build protective social and cultural supports.

Table5. Methods, Risk Factors, and Protective Factors for Suicide Among Jamaican Adolescents

Dimension	Findings	Source
Predominant method of death	Hanging	Holder-Nevins et al., 2012
Predominant method of attempt	Ingestion (pesticides, pharmaceuticals)	Holder-Nevins et al., 2012
Key risk factors	Bullying, loneliness, poor sleep, and exposure	PAHO, 2017b
Protective factors	Parental understanding, supportive friendships, school engagement, and faith	PAHO, 2017b

Table 6 identifies challenges and opportunities for adolescent suicide prevention in Jamaica, highlighting key areas for intervention across data, gender, community, school, and policy domains (PAHO, 2017a; Holder-Nevins et al., 2012; MOHW, 2020a; JIS, 2023). The table underscores the persistent data and surveillance gaps that complicate suicide prevention among Jamaican adolescents. Limited age-disaggregated data and under-reporting due to stigma reduce the accuracy of suicide monitoring, making it difficult to identify trends and at-risk groups. This challenge is compounded by the tendency for cases to be misclassified or hidden within families and institutions. However, opportunities exist to strengthen surveillance by expanding GSHS modules and integrating data from schools, hospitals, and community-level reporting systems. Improved surveillance would provide a more reliable foundation for targeted interventions and policy development.

Gender dynamics represent another critical theme, as Jamaican boys and girls display different patterns of suicidal behaviour. Boys are more likely to use lethal methods such as hanging, while girls report higher levels of suicidal ideation. This divergence requires interventions that are both gender-sensitive and culturally relevant, moving beyond a "one-size-fits-all" approach. For boys, efforts could focus on addressing norms of masculinity, help-seeking barriers, and access to lethal means. For girls, strengthening emotional support systems, safe spaces, and mental health literacy may be more effective.

Community and school contexts also present both barriers and opportunities. High levels of violence, family instability, and stigma continue to exacerbate adolescent distress, yet Jamaica's strong schools, faith networks, and community groups can act as protective spaces. Within schools, the shortage of counsellors and limited resources hinder consistent support, but scaling up counselling services, resilience training, and peer-support initiatives could make schools pivotal in prevention. At the policy level, fragmented delivery and constrained resources weaken national efforts; however, alignment with the WHO's LIVE LIFE strategies and stronger intersectoral coordination offer a pathway forward. By leveraging existing

community assets while addressing structural challenges, Jamaica can build a more comprehensive and practical adolescent suicide prevention framework.

Table6. Challenges and Opportunities in Preventing Suicide Among Jamaican Adolescents

Theme	Challenges	Opportunities
Data and surveillance	Limited age-disaggregated data; under-reporting due to stigma	Expand GSHS modules; integrate school, hospital, and community surveillance
Gender dynamics	Boys use more lethal methods; girls report higher ideation	Develop gender-sensitive interventions
Community context	Violence, family instability, stigma	Leverage schools, faith networks, and community groups
School environment	Limited counsellors; under-resourced services	Scale up school-based counselling, resilience training, and peer support
Policy implementation	Fragmented delivery; limited resources	Align with WHO LIVE LIFE strategies; strengthen intersectoral coordination.

Regional comparison (Table 7) shows Jamaica's adolescent suicide rate at 2.5 per 100,000, lower than regional peers but rising among males. Guyana presents extremely high rates (18 per 100,000), while Trinidad and Tobago, Barbados, and Saint Lucia show moderate variations (WHO, 2021a; PAHO, 2022). The table provides a comparative view of estimated adolescent suicide rates across selected Caribbean nations, illustrating both commonalities and stark contrasts. Jamaica's estimated rate of 2.5 per 100,000 among adolescents is lower than the regional average, yet it is noted to be rising among males. This pattern suggests that while overall prevalence remains relatively modest, gendered risks are becoming more pronounced. By contrast, Trinidad and Tobago reports a more than double rate (5.8), where academic pressures and exposure to violence have been highlighted as contributing factors. These differences point to how social and cultural contexts shape adolescent mental health outcomes across the region.

Guyana stands out as a global outlier, with an estimated adolescent suicide rate of 18.0 per 100,000, among the highest worldwide. This matter underscores a severe public health crisis where structural vulnerabilities, such as poverty, access to lethal pesticides, and limited mental health infrastructure, combine to elevate risks. Barbados, with a rate of 3.2, reflects a relatively stable trend, where depression is identified as the predominant underlying factor. The lower rates in Barbados compared to Guyana highlight the role of country-level protective factors, including stronger health services and community stability. This juxtaposition illustrates the heterogeneity of suicide risk across small Caribbean states.

Saint Lucia, with a rate of 4.1, illustrates the impact of migration-driven family separation as a distinct risk factor. The absence of parents or caregivers due to overseas work can disrupt social bonds and support systems, leaving adolescents more vulnerable to emotional distress. Compared to Jamaica, Saint Lucia's rate is higher, but the drivers differ, showing that regional similarities in culture do not always translate into identical risk pathways. Taken together, the table highlights the urgent need for context-specific interventions across the Caribbean, with Guyana demanding crisis-level responses, Trinidad and Tobago requiring targeted support, and Jamaica needing proactive strategies to address emerging male vulnerabilities. This comparative evidence strengthens the case for regional cooperation in adolescent suicide prevention, while respecting national specificities.

Table7. Estimated Adolescent Suicide Rates in Selected Caribbean Nations (per 100,000, ages 10–19)

Country	Estimated Suicide Rate	Notable Trends / Observations
Jamaica	2.5	Lower than the regional average, rising among males
Trinidad & Tobago	5.8	Linked to academic stress and violence
Guyana	18	Among the highest adolescent suicide rates globally
Barbados	3.2	Stable; most cases linked to depression
Saint Lucia	4.1	Related to migration-driven family separation

Limitations

This study relies exclusively on secondary data, which may be incomplete, temporally limited, and subject to under-reporting. National mortality data for under-19s are scarce, and school-based surveys exclude out-of-school youth. Hospital and medico-legal reports may undercount non-fatal self-harm (PAHO, 2017a; Holder-Nevins et al., 2012). Nonetheless, convergence across multiple sources strengthens confidence in key findings.

Discussion

The findings highlight a paradox in Jamaica: while suicide mortality among adolescents under 19 appears relatively low, self-reported behaviours reveal a much more troubling reality. Data from the Global School-based Student Health Survey (GSHS) show that nearly one in four Jamaican students reported suicidal ideation within the past 12 months, and almost one in ten reported at least one suicide attempt (PAHO, 2017a; WHO, 2017c). This stark contrast between low official death counts and high self-reported distress suggests that mortality

statistics alone significantly underestimate the scope of the problem. It is also possible that some deaths are undercounted due to stigma or misclassification, further obscuring the actual burden. Therefore, suicide must be examined not solely as a matter of mortality, but as a broader public health issue that encompasses hidden psychological suffering and risk behaviours among youth.

Gendered patterns of suicidal behaviour are especially significant in the Jamaican context (Abel et al., 2009; Bourne, 2025; Bourne et al., 2022a, 2022b; Holder-Nevins et al., 2012). Survey evidence indicates that girls report higher levels of suicidal ideation, while boys report slightly higher rates of actual suicide attempts. Importantly, boys are also more likely to use highly lethal methods, particularly hanging, which accounts for most completed suicides (Holder-Nevins et al., 2012). Using time series data from 2000 to 2019, Bourne et al. (2022a) found that Jamaican males are at least 3 times more likely to be engaged in suicide-mortality compared to Jamaican females, and this was as high as 17 times in 2001 (Bourne et al., 2022b). The gender pattern reflects a paradox: while girls may be more vulnerable to emotional distress, boys face higher fatality risks due to their method choices. Gender-sensitive prevention strategies are therefore essential, as they must address the emotional vulnerabilities of girls while also targeting the risk-taking and method access patterns seen among boys. A one-size-fits-all model would overlook these important differences in expression and outcome.

Community and environmental factors add further complexity to adolescent suicide in Jamaica. High levels of violence, economic deprivation, and family instability contribute significantly to the risk environment faced by young people. Stigma surrounding mental health remains a significant barrier, as it discourages adolescents from openly discussing emotional struggles or seeking professional help. At the same time, protective factors such as strong peer support, positive school engagement, and the influence of faith communities can buffer against risk (PAHO, 2017b; Holder-Nevins et al., 2012). However, these protective systems can also reinforce silence, as faith and cultural norms sometimes discourage conversations about suicide. Effective prevention must therefore strike a balance between leveraging community strengths and challenging harmful stigma that perpetuates secrecy.

Schools emerge as strategic platforms for suicide prevention and adolescent mental health promotion. With daily access to large numbers of young people, schools are uniquely positioned to detect distress early and provide resilience-building interventions. However,

many schools in Jamaica remain under-resourced, with limited numbers of trained guidance counsellors and psychologists available to respond to students' needs (PAHO, 2015). This gap undermines the potential of schools to play a proactive role in prevention. Expanding school-based counselling, incorporating peer-support programmes, and embedding mental health education into the curriculum would significantly strengthen Jamaica's capacity to respond to mental health needs. Investment in these areas is not optional but essential if the education system is to serve as a protective factor rather than a missed opportunity.

Policy responses in Jamaica demonstrate encouraging alignment with international best practices, but challenges remain. The Ministry of Health and Wellness has made efforts to expand community-based services and strengthen crisis intervention capacity (MOHW, 2020; JIS, 2023). These align with the WHO's LIVE LIFE strategy, which emphasises restricting access to means, ensuring responsible media reporting, promoting life skills among youth, and providing consistent follow-up care for at-risk individuals (WHO, 2021). Despite these positive steps, barriers such as fragmented service delivery, inadequate intersectoral coordination, and limited financial resources continue to constrain impact. Continuous monitoring and evaluation of policies are necessary to ensure their effectiveness in the Jamaican context. Ultimately, translating global best practice into sustained, well-resourced, and culturally relevant action is the key to reducing adolescent suicide in Jamaica.

Conclusion

Ultimately, this study establishes that adolescent suicide in Jamaica is both preventable and urgent. Although mortality figures appear low when compared with other causes of adolescent death, the evidence shows that suicidal thoughts and behaviours are far more pervasive than official statistics suggest. School-based surveys reveal that nearly one in four Jamaican adolescents has considered suicide, and almost one in ten has attempted it, highlighting a substantial hidden burden. Schools, communities, and the health system therefore hold untapped potential for early prevention, detection, and intervention. The true challenge lies not in the absence of policy frameworks but in the insufficient allocation of resources, the need for coordinated action, and culturally attuned approaches. Addressing this gap is not only a health priority but also a moral and social imperative for protecting Jamaica's young people.

Policy frameworks are indeed progressing, particularly with Jamaica's increasing alignment with the WHO's LIVE LIFE strategies. These strategies emphasise restricting access to means

of suicide, ensuring responsible media reporting, strengthening life-skills training for adolescents, and providing follow-up care for those at risk (WHO, 2021a). The Ministry of Health and Wellness (MOHW, 2020a) and other national agencies have taken steps to integrate community-based mental health services and improve crisis response. However, significant gaps remain in the areas of implementation, intersectoral coordination, and sustainable resource allocation (JIS, 2023). Moving forward, evidence-based innovations such as safe storage campaigns, gender-responsive school curricula, and improved surveillance systems can substantially strengthen prevention efforts.

Implications for Practice and Policy

Clinical Practice

Health care providers and educators are often the first point of contact for adolescents experiencing emotional distress, yet many lack specialised training in identifying suicide risk. Training programmes should emphasise not only verbal disclosures but also non-verbal cues such as withdrawal, mood changes, or declining school performance. Cultural sensitivities are significant in the Jamaican context, as stigma frequently prevents open discussion of suicidal thoughts. By equipping providers with culturally informed assessment tools and protocols, the health system can strengthen early detection and timely referral. This matter-targeted training significantly increases the likelihood of intervening before crises escalate, potentially reducing both ideation and attempts at self-harm.

Education

Schools serve as protective environments, given their daily access to large numbers of young people. Integrating structured mental health curricula, resilience-building programmes, and peer-support networks can normalise conversations about emotional well-being and reduce stigma (PAHO, 2015). Evidence demonstrates that student engagement in peer-led initiatives strengthens coping mechanisms and promotes help-seeking behaviour. In Jamaica, where guidance counselling services are under-resourced, school-wide mental health promotion could fill critical service gaps. Expanding these programmes contributes not only to suicide prevention but also to holistic student development and academic success.

Policy

Codifying suicide prevention within child health and education frameworks ensures both sustainability and accountability. Policies should incorporate mandatory reporting mechanisms, expand the mental health workforce, and enhance intersectoral coordination among ministries. While the Ministry of Health and Wellness (MOHW, 2020a) has signalled commitment, implementation remains inconsistent across sectors. Legislation formally recognising suicide prevention as a public health and child rights priority would elevate its urgency. Clear policy frameworks also provide a mandate for resource allocation and long-term planning, ensuring interventions are consistently supported.

Community

Families, faith-based institutions, and grassroots organisations are critical in shaping adolescent resilience. Engaging parents and faith leaders in culturally sensitive psychosocial interventions can reduce stigma and provide safe spaces for youth to discuss mental health concerns. Jamaica's strong tradition of community involvement provides a foundation for bridging the gap between formal health services and at-risk adolescents. Interventions must balance respect for cultural norms with strategies that challenge harmful silences around suicide. Community programmes integrating mentorship, dialogue, and family-strengthening initiatives are likely to have the most significant impact on prevention.

Regional Partnerships

Suicide among adolescents is a regional challenge, as Caribbean nations share overlapping vulnerabilities, including exposure to violence, migration pressures, and limited mental health resources. Collaboration with agencies such as PAHO and UNICEF facilitates the sharing of resources, joint training, and regional policy alignment. Jamaica can adapt best practices from neighbouring countries, particularly in areas like safe pesticide storage and community gatekeeper training. Regional networks also create economies of scale that individual nations cannot achieve independently. Strengthening these partnerships amplifies the reach and effectiveness of suicide prevention strategies.

Monitoring and Evaluation

Accurate data and continuous evaluation are essential for effective suicide prevention. Robust monitoring systems should capture adolescent-specific trends, disaggregate data by gender,

and evaluate programme outcomes. Current reliance on incomplete mortality statistics obscures the accurate scale of the problem. WHO (2021a) emphasises the importance of integrated surveillance systems linking schools, health facilities, and community sources. Implementing such systems in Jamaica will ensure interventions remain evidence-based, accountable, and responsive to emerging trends in adolescent mental health.

Recommendations

Based on the study's findings, targeted recommendations can guide more effective suicide prevention among Jamaican adolescents. First, surveillance systems must be improved to capture comprehensive data on suicide ideation, attempts, and completions. Current national statistics do not accurately reflect the scope of the problem among young people. Integrating school-based surveys, hospital reports, and community-level monitoring would allow for better-informed policy and practice. Reliable data are the cornerstone of effective prevention.

Second, gender-sensitive interventions are urgently needed. Programmes should address the distinct experiences of boys and girls, recognising that girls carry a greater burden of ideation while boys often use more lethal methods (PAHO, 2017; Holder-Nevins et al., 2012). For girls, strategies should focus on strengthening coping mechanisms and peer support networks. For boys, interventions must challenge harmful masculinities while teaching alternative ways of managing distress. This dual approach can better address the gendered nature of suicide.

Third, Jamaica must expand psychosocial support within schools. Schools are primary sites for identifying and addressing adolescent distress, yet guidance counsellor-to-student ratios remain inadequate (PAHO, 2015). Increasing the number of trained professionals, along with peer support initiatives and resilience-building curricula, would enhance protective factors. Schools can also serve as referral points to community or clinical mental health services. Without strengthening school systems, suicide prevention efforts will remain fragmented.

Fourth, community engagement must be prioritised. Parents, faith leaders, and community organisations are essential partners in reducing stigma and supporting youth at risk. Campaigns should promote mental health literacy while challenging misconceptions about suicide. Community-based programmes can provide safe spaces for adolescents to share experiences and access support. Harnessing existing networks makes prevention strategies more sustainable and culturally relevant.

Fifth, national policy must move from alignment with international frameworks to full-scale implementation. The WHO's LIVE LIFE strategy provides clear guidelines, but Jamaica must invest in sustained resource allocation, monitoring, and intersectoral collaboration (WHO, 2021). Policies should include precise accountability mechanisms and be regularly evaluated for impact. Mental health promotion should be integrated into broader public health and education strategies. Stronger governance structures will ensure continuity and effectiveness.

Finally, innovative approaches should be explored. Interventions such as restricting access to pesticides, training media professionals in responsible reporting, and using digital platforms for youth outreach could reduce suicide risks. Pilot programmes should be rigorously evaluated and scaled up where effective. Regional collaboration with other Caribbean nations may also yield shared strategies and resources. By combining traditional and innovative approaches, Jamaica can create a multifaceted and resilient prevention system.

Article History
Received: 25-Aug-2025
Accepted: 31-Aug-2025
Published: 07-Sep-2025
Revised: 15-Feb-2026

Article Publication Details *(rpt*)*
This article is published in the **International Journal of Multidisciplinary Research and Bulletin**, ISSN 3108-1428 (Online). In **Volume 4 Issue 5 (Sep-Oct) 2025**
The journal is published and managed by **IRPG**.

Acknowledgements
We sincerely thank the editors and the reviewers for their valuable suggestions on this paper.

Funding
The authors declare that no funding was received for this work.

Data availability
No datasets were generated or analyzed during the current study.

Declarations

Ethics approval and consent to participate
The author(s) declare that it is not applicable.

Consent for publication
The author(s) declare that this is not applicable.

Competing interests
The author(s) declare that they have no competing interests.

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