Mental Health Commission of Canada
Commission de la santé mentale du Canada

INTERNATIONAL INITIATIVE FOR MENTAL HEALTH LEADERSHIP

Community Action for Suicide Prevention Match: Detailed Report

Prepared by: The Mental Health Commission of Canada

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1.0 Background

On September 21-22, 2015 a group of leaders in the area of suicide prevention came together for the Community Suicide Prevention Match, at the International Initiative for Mental Health Leadership (IIMHL) Conference in Vancouver, BC to discuss, learn and collaborate with a goal of learning about approaches and practices in the area of community suicide prevention.

The match promoted discussion and collaboration and it accelerated change in the following ways:

- Emphasized the importance of the perspective of individuals with lived experience across the entire continuum (suicide attempt survivors, survivors of suicide loss, caregivers) and their full and active engagement in community suicide prevention efforts.
- Reinforced the importance of upstream investments in community suicide prevention that strengthen protective factors and build community wellness and resilience.
- Helped us to more overtly articulate the tensions around suicide prevention that hold us back and detract us from moving forward towards our goals. Some of these tensions included a focus on at risk populations versus broad upstream prevention initiatives, medical models versus community development models, and initiatives that are community-built and led versus prescriptive.
- Sparked ideas on how to incorporate innovation, risk-taking, and disruptive change to help accelerate us forward.

As a result, our match has built leadership capacity for the future in the following ways:

- The diversity and openness of the group allowed us to build on each other's expertise and help establish some important points of consensus.
- The dialogue will help inform our future work in our respective areas.
- The personal connections and network we plan to build will allow us to continue to learn from one another into the future.
- We have been able to galvanize around some common objectives for advancing community action for suicide prevention.

The following report summarizes the discussion and information shared at the match.

2.0 Objectives

The objective of the match was to outline key elements of a systematic and evidence-based approach to suicide prevention in communities, including:

a) the elements/aspects of effective comprehensive suicide prevention community models; and
b) the identification of roles and responsibilities for different players in communities.

It was our desired outcome that participants leave with concrete examples of best and promising practices and tools to begin or enhance suicide prevention activities in their communities.

3.0 Participants

This match brought together a wide range of leaders from six of the International Initiative for Mental Health Leadership (IIMHL) sponsoring countries including Canada, Australia, England, Ireland, New Zealand and the United States of America.

The match was co-chaired by Stephanie Priest, Director, Population Health Promotion and Innovation at the Public Health Agency of Canada and Ed Mantler, Vice President, Programs and Priorities at the Mental Health Commission of Canada.

A full list of participants is provided in Appendix A.

4.0 Highlights of Presentations

4.1 'Help for Life' Quebec's Strategy for Preventing Suicide (Jerome Gaudreault, Association québécoise de prévention du suicide, Canada)

Jérôme Gaudreault, Executive Director of the Association québécoise de prévention du suicide (AQPS) presented on Quebec's strategy for preventing suicide.

The AQPS was founded in 1986 by a group of suicide prevention centers and some researchers who believed it was necessary to have a better coordination of suicide prevention services throughout Quebec to share best practices and expertise. Today, the group represents more than 150 citizens and organizations that support their mission which is to:

- Inform the community about suicides (data, how to recognize signs, where to ask for help);
- Mobilise people toward suicide (World Suicide Prevention Day, National Suicide Prevention Week, Public Forum on Suicide Prevention);
- Support individuals or groups who wants to make a difference; and
- Train people who take care of vulnerable persons.

Between 1981 and 1999, Quebec saw a steadily rising number of suicides from 1,047 suicides in 1981 (rate of 17/100,000 people) to 1,620 suicides in 1999 (rate of 22.2/100,000 people).

There are a number of reasons why this trend is believed to have existed including:

- Low involvement from institutions;
- Trivialization of the phenomenon;
- Almost no funding available for prevention;
- Lack of coordination and leadership between health and social services for individuals;
- Lack of training and clinical support given to different stakeholders;
- Not enough protocols in postvention;
- Major weaknesses in the follow-up offered after an attempt;
- Underinvestment in research.

In response, the "Help for Life" strategy was developed with the following overall objectives:

- Stabilize suicide rates, then reduce them;
- Involve all partners in practical and cooperative actions; and
- Mobilize Quebecers to refuse suicide and see it as a solution.

More specifically, the strategy aimed to:

- Provide and consolidate essential services and put an end to the isolation of case workers;
- Increase professional skills;
- Intervene with groups at risk;
- Foster prevention programs among young people;
- Reduce access to and minimize risks associated with the means of suicide;
- Counteract the trivialization and the sensationalization of suicide by developing a sense of community and responsibility; and
- Intensify and diversify research.

The specific actions undertaken as part of the strategy included, among other actions:

- 24/7 telephone hotline 1-866-APPELLE (2001);
- Training in effective intervention processes (2003);
- Standardized training for gatekeepers and implementation of gatekeepers networks (2007); and
- Awareness campaigns (since 1991).

Between 1999 and 2012, the province saw a general decrease in suicides from 1,620 suicides in 1999 (rate of 22.2/100,000 people) to 1,102 suicides in 2012 (rate of 13.7/100,000 people). The greatest decrease was seen among teenagers and young adults (50% decline). While the decrease in suicides may not be solely attributable to the strategy, there are indications that it made a significant difference.

The implementation of the strategy has also led to the following outcomes in Quebec:

- General recognition that suicide can be prevented;
- Acknowledgement that suicide prevention is everyone's responsibility;
- Better collaboration between stakeholders;

- Installation of a common language; and
- Availability of funds for new projects.

The strategy was not renewed after 2005 and, to date, no intentions from the Ministry of Health and Social Services to renew the strategy has been made. The suicide statistics have been stagnating since 2007, leading the AQPS to make a public plea for renewed efforts to focus on suicide prevention within the province and raise of awareness of this issue among the population.

4.2 European Alliance Against Depression: Four-level intervention targeting depression and suicidal behaviour (Ulrich Hegerl, University of Leipzig, Germany)

Dr. Hegerl presented on the four-level intervention that is being used by the European Alliance Against Depression (EAAD).

The four-level intervention concept combines the goals i) to prevent suicidal acts and ii) to improve the care for people with depression..

The four-level intervention used by the EAAD builds on a community-based network involving a range of players (e.g. general practitioners, medical and mental health associations, self-help groups, local health authorities and stakeholders, patient and relative organizations, police, churches, social services, and schools).

Interventions are started simultaneously at four levels:

1. Primary care and mental health care (e.g. trainings);
2. General public (professional awareness campaign concerning depression);
3. Community facilitators and stakeholders (e.g. trainings); and
4. Patients, high-risk groups and relatives (e.g. info, support for self-help).

The effects of a two-years, four-level intervention were first evaluated in the project Nuremberg Alliance against Depression with respect to a control region and a one-year baseline. A significant reduction of suicidal acts (attempted + completed suicides, primary outcome, -24 %) was observed which turned out to be sustainable in the follow-up year. Later evaluations from Germany and in the context of European projects from regions in Hungary and Germany provided further evidence for the efficiency of this intervention concept.

Findings from the EU-funded project OSPI-Europe helped to further improve the four-level intervention concept of EAAD. In four European countries (Portugal, Hungary, Ireland, Germany) intervention effects were compared between intervention and control regions. A fifth level “access to lethal means” was initially established (see table below), but it was finally decided by EAAD to integrate this fifth level in the original four-levels and to continue with the optimized four-level intervention concept.

Level	Core Interventions	Optional Interventions
Level 1: Primary Care	GP workshops Informational videos/ DVDs for patients Educational videos/ DVDs for GPs	Workshops for: Pediatricians, Primary care/public health nurses Primary care Psychologists, social workers, etc.
Level 2: Public Awareness Campaign	Opening ceremony Flyer, poster Public informational events Press conference Well-known patron	Placards Poster Brochures Press kits Informational CDs Cinema spot
Level 3: Community facilitators	Workshops for: Pharmacists Priests Policemen Media guidelines for journalists	Workshops for: Teachers, geriatric care givers, midwives, counselling centre workers, hotline professionals, prison professionals, alternative practitioners, medical secretary, taxi driver, undertaker, other social workers (not primary care)
Level 4: Patients and relatives	Support for self-help groups Emergency cards for high risk patients Informational material for patients	Self-help groups for relatives/bereaved Informational videos/DVDs for high risk groups Postcards (from the EDge project)
Restriction of access to lethal means (integrated in levels 1 and 3)	Identification of hot spots If possible, construct barriers at hot spots Warnings concerning drugs with toxicity on overdose	Information at hot spots (e.g. emergency telephone number)

Evaluation of the OSPI intervention found significant changes in the number of suicidal acts after 24 months in the intervention compared to the control region in Portugal again supporting the earlier findings from Germany and Hungary. No significant effects were observed in the other countries. The systematic process and implementation analysis performed within OSPI-Europe allowed a deeper understanding of the influence of circumstantial factors on a successful implementation. It also allowed to analyse synergistic and catalytic effects, cultural/political aspects, capacity building as well as health economics. . Based on these OSPI-Europe results, EAAD further optimized intervention materials and developed implementation guidelines. In the meanwhile, alliances against depression with the four-level intervention concept have been implemented in more than 100 regions in Europe.

Dr. Hegerl highlighted a number of lessons learned about implementation:

- To combine the goals depression and suicides is extremely helpful for a variety of reasons. For example, it allows to focus on depression when addressing the general population, but more on suicidal behaviour when addressing health professionals, gatekeepers and high risk groups; furthermore, a PR-campaign will have a large resonance and create awareness when addressing depression (40 % of the population is affected directly or indirectly) but much less when addressing suicide. This resonance will facilitate the implementation of measure targeting suicide prevention. A broad campaign targeting suicide might even be risky. Finally, both are partly overlapping, large goals with much room for improvement and there are simple economic reasons to combine them.
- Do not broaden the target from depression to mental health because precision and evidence base will decrease and many of the intervention effects (e.g. destigmatization effects of PR-campaign, improved help seeking behaviour) will generalize anyway to other mental disorders;
- Engage in activities at the four levels simultaneously to create synergistic and catalytic effects (e.g. raises profile, influences policy, improves cross sector collaboration);
- Do not involve the pharmaceutical industry;
- Balance between bottom-up and top-down implementation and dissemination strategies ("from stakeholder to ownership"); and
- Build on existing material.

- There is a large pool of EAAD intervention materials (many available in 10 languages):
- Professional public relations material (posters, brochures, cinema and TV spots, flyers, videos);
- Educational packages (media guide, 5 hour and 3 day training programs for primary care practitioners; material and videos for patients/relatives; material for community facilitators);
- Train the trainer workshop packages; and
- Self-help activities (iFightDepression tool, brochures, videos, emergency card, discussion forum, sleep regulation App).

4.3 Aboriginal Suicide & Critical Incident Response Team (Kim Montgomery, Okanagan Nation Response Team, Canada)

Kim Montgomery from the Okanagan Nation Response Team presented on the approach to aboriginal suicide that has been adopted by the Okanagan Nation.

The Okanagan Nation Critical Incident Response Team has been in place for 8 years. Team members roll over every two years to prevent burnout and ensure better sustainability.

While suicide prevention efforts are important for both youth and adults, the team focuses on helping future generations.

In her view, suicide attempts are linked to the amount of grief in the community. She suggests that suicide is not only a result of a mental health issue, but has complex socio-political causes. This challenges the view that one-on-one clinical care is the best solution. Also, clinicians often lack the

cultural competence to effectively work with members of their nation. Communities need to identify people from within, who may not be clinicians. The community doesn't have adequate resources to have everyone treated by a psychiatrist and clinicians often have a lot of anxiety asking about and talking about suicide.

In the Okanagan Nation, they focus on strengths rather than mental illness. It is important to address wellness of body, mind, soul, and spirit.

There are many challenges in the community. Often youth are discharged from hospital without any referral to services. The new model ensures that a member of the Critical Incident Response Team stays in contact with people and tends to them in periods of high risk. The team works closely with the RCMP, victim services, and other groups.

To date, in the Okanagan Nation, a number of specific activities have been undertaken including:

- Training of 14 people in ASIST and CISM, including training booster sessions three times a year;
- Development of a youth game to assess their baseline level of knowledge;
- Prevention and intervention focus on Okanagan traditional teachings;
- The team networks with various agencies to incorporate a systems approach;
- Development of general awareness material (with a particular focus on developing curriculum that can apply to people of all levels of education);
- Presentations to increase awareness; and
- Client files are open up to a year and can be extended based on level of trauma.

In terms of next steps, the Okanagan Nation Critical Incident Response Team is thinking about going back to peer support groups. The Okanagan Nation had tried to put in place peer support models in the past, but had moved away from this and are now looking to revitalize those efforts. The group is also currently documenting their procedures and putting in place a sustainability plan so that the program can continue in the event of turnover of specific individuals.

4.4 Adolescent Suicide Prevention Program (Patricia Serna, North Central Community Based Services, USA)

Patricia Serna, Executive Director of North Central Community Based Services, Inc. presented on an adolescent suicide prevention program in place in an American Indian Tribe.

A small grant was received to set up a suicide prevention program for adolescents in an American Indian Tribe in the United States. The community had a population of about 3,000 and most people live in villages.

The project began with a needs assessment to determine:

- What are the issues?
- What needs to be done?
- What are the barriers? / What is stopping you?

The needs assessment was conducted by community leaders through focus groups in schools, youth centres, etc. The leaders went out and met people in their own space.

Suicide was not one of the top 10 issues that emerged. Rather, issues such as unemployment, sexual abuse, and family violence were raised. This information was fed back into the community. It was believed that if these underlying issues were addressed, the suicide problem would dissipate. The team needed to recognize that people in the communities are the real experts.

The approach included hiring more clinical staff, including part-time psychologists. They also trained community members to be case managers. Youth were identified by their peers to be helpers (that they would feel comfortable talking to). The youth chosen were not always model students, and the team needed to convince schools that they were the right choices. In the end, these helpers turned out to be the best source of referrals. Community members continued services once the project was completed, thereby building in continuity. Elders provided guidance through the process. One of the reasons that the program was successful is that it focused on training natural connectors in the community.

The program involved tracking those at risk, putting in place surveillance systems, defining attempts versus gestures, and tracking gestures, attempts and deaths by suicide.

Any referral of an adolescent at risk generated an immediate response which included police presence and contact with parents or dorm/school personnel to engage them. Very seldomly, the individual refused contact with others. The first contact continued care until the crisis was over, and followed the adolescent until they were stable. The line between the care system and the community was nearly erased. The team actively looked for people who didn't show up for an appointment.

The program reinforced that relationships are a real protective factor. If our aim is to create healthier communities, we need to strengthen families and relationships. While some new structures or processes may be required to fill in gaps, relationships are like the oil in the gears.

During the sixteen years of the Adolescent Suicide Prevention Project, there were three contributing factors that appeared to be highly related to completed suicides for this population. The first factor was a history of suicide in the family. During this time period almost 70% of the individuals who died by suicide had a family member who had completed suicide. The second factor was the involvement of alcohol in almost 60% of all suicidal acts. The third is a history of trauma with over 40% of individuals completing suicide having experienced some form of trauma.

From 1989, the year prior to the beginning of the Adolescent Suicide Prevention Project to 2005, there was a 70 percent decrease in suicidal behaviour.

4.5 United States Air Force Suicide Prevention Program (Eric Caine, University of Rochester Medical Centre, USA)

Dr. Eric Caine, from the Department of Psychiatry at the University of Rochester Medical Center presented on the United States Air Force (USAF) suicide prevention program.

He reinforced that there is an urgent need to reduce suicide rates and that the best way to accomplish this is through a public health approach. To make as large a difference as possible, it is important to reach beyond clinic and hospital walls into communities.

In his view the public health approach is the right way forward as:

- People intent on suicide often do not seek help;
- Seemingly "normal" people kill themselves;
- Fatal attempts often are first attempts; and
- Risk factors are NOT predictive.

Between 1996 and 2007, the United States Air Force (USAF) implemented a suicide prevention program that had the following characteristics:

- Public health-community orientation;
- Broad involvement of key leaders;
- Consistent leadership involvement; and
- Common risk model.

The program consisted of 11 initiatives clustering in four areas:

- Increase awareness and knowledge
- Increase early help seeking
- Change social norms
- Change selected policies

The outcomes of the program were very successful showing a 33% risk reduction in suicide; a 51% risk reduction in homicide and an 18% risk reduction in accidental death. The program also had positive impacts on incidents of severe and moderate family violence.

Dr. Caine reinforced that when suicide prevention efforts target specific populations through various sites (e.g. middle and high schools, workplaces, medical settings), there will remain populations likely to be missed through these efforts. That is why effective prevention will involve multiple complementary components. High risk groups could be targeted in specific settings such as targeting perpetrators of violence through courts and jails.

Dr. Caine presented an ecological model of mental health and social risks for violence to self and others that contains four layers:

- Societal (e.g. economic safety nets, stigma, access to lethal means);
- Community (e.g. high unemployment, crime levels, low community cohesion);

- Relationship (e.g. violent parental conflict, financial stress, work stress, family history of violence or suicide); and
- Individual (e.g. mental health problems and illnesses, alcohol/substance misuse, adverse childhood events).

Protective factors and interventions could also be classified according to these four layers.

Premature death in early and young adulthood due to homicide, motor vehicle death, self-inflicted poisoning, and suicide have a number of commonalities. These include disadvantaged economic and social factors, disruptive family factors, alcohol and substance misuse, school difficulties, mental health problems, emerging behavioural problems, legal system involvements, emergency room visits, and visits to mental health and addiction treatment centres. In his view, suicide prevention depends on promoting a community culture of safety and involves integrated approaches to injury and violence prevention.

A number of "framing questions" for the designers of suicide prevention programs were posed for consideration:

- What are the broad goals and specific objectives of the intervention and the program?
- Where does this program fit in an overall framework (schema, model) of suicide prevention and clinical intervention?
- Who do we expect to reach with this effort?
- Who will we miss?
- What will we be changing?
- How will we measure those changes and use that information to evaluate the program?
- How confident are we of our findings?
- Can the program and its results be "exported" widely?
- Can the program be sustained after its ardent founders have moved on?

4.6 School-Based Interventions (Richard Mckeon, substance Abuse and Mental Health Services Administration & Elly Stout, Suicide Prevention Resource Center, USA)

Richard McKeon from the Substance Abuse and Mental Health Services Administration (SAMHSA) and Elly Stout from the Suicide Prevention Resource Center (SPRC) provided an overview of the current state of research on school-based interventions for suicide.

They stated that recently we've seen some encouraging results with respect to school-based and community interventions for suicide. In SAMHSA's national evaluation for their Garrett Lee Smith (GLS) suicide prevention grants, counties where grantees conducted training saw reduced youth suicide deaths in the first year, while youth mortality from other causes remained constant. However, this effect disappeared after the first year, suggesting that interventions need to be better integrated into organizations and systems to have sustained impact.

Most of evaluations of particular programs have involved school-based gatekeeper training (QPR and ASIST). But gatekeeper skills fade over time, so booster sessions may be required. As was highlighted by Dr. Caine, school-based approaches do miss a high risk group of youth who have dropped out. Dropping out of school is a risk factor for suicide in adults. An evolving approach is to work across multiple systems and some exploration has already been done in mental health services, courts, foster care, addictions treatment, etc. The concept of changing the risk trajectory is really important.

One important finding has been that gatekeeper training in schools is not enough. Adult gatekeepers are not effective for high school students, and engaging youth as peer supports is critical.

Several key programs and resources have been evaluated for school-based prevention programming:

- "Sources of Strength" engages kids who can influence others, while also engaging trusted adults as supports. Often what youth want are peers that they can talk to;
- "Saving and Empowering Young Lives", with multiple components was used in Europe and showed promise;
- "Signs of Suicide", a classroom suicide prevention program used in the US has demonstrated a reduction in suicide;
- SAMHSA has also developed a toolkit for high school suicide prevention; and
- A postvention school toolkit was developed by SPRC and the American Foundation for Suicide (AFSP).

Evaluated programs shown to be effective typically include the following components or characteristics:

- Awareness/education curriculum;
- Teen screening;
- Gatekeeper training (QPR most popular);
- Peer leadership (e.g. "Sources of Strength"); and
- Skills training (focused on general life skills, used in some tribal areas).

The school environment can influence risk (high pressure, bullying, etc.), so any approaches to reducing suicide will need to address the broader climate in order to have the biggest impact. Focusing on making the school environment more supportive, engaging youth, and encouraging them to stay in school, creates opportunities to impact broader outcomes. A challenge is that schools have so much to focus on (e.g. nutrition, physical activity, sexuality, etc.) that it is hard to compete for space on the agenda.

There was some discussion about the degree to which teaching youth coping skills could be an effective approach to reducing suicide. There is currently no evidence that teaching young children coping skills reduces suicide rates, but it could have an impact, as often suicide attempters have lower coping skills. Many countries are implementing programs to increase kids' coping skills. For example, the Public Health Agency of Canada's program "Passport Skills for Life", which focuses on 16 and 17 year olds, improves coping skills.

The research has also found that school programs not linked to the broader community didn't get the same synergies. The definition of a community does not need to be a geographic unit. But youth do need connections beyond the school-system, to family, the healthcare system, etc.

An important recommendation was that more focus should be placed on ‘upstream’ efforts, to bring hope, skills and support to the millions of youth that are struggling. Focusing efforts solely on identifying high risk kids and intervening will save a few lives but not have optimal impact.

4.7 Disruptive Innovation in Suicide Prevention through Lived Expertise (Eduardo Vega, Mental Health Association of San Francisco, USA)

Eduardo Vega, Chief Executive Officer of the Mental Health Association of San Francisco, presented on policy, programs and practices driven by and reflecting the experiences of suicide attempters and survivors, through the lens of lived experience.

In the US, a range of policies have been released/undertaken over the last number of years such as:

- Organization for Attempters and Survivors of Suicide in Interfaith Services Conference (2000);
- National Strategy on Suicide Prevention;
- National Suicide Prevention Lifeline Consumer-Survivor Subcommittee (2005);
- SAMHSA Survivors of Suicide Attempts report (2008);
- National Action Alliance on Suicide Prevention (2010) ;
- National Strategy on Suicide Prevention revision;
- National Action Alliance for Suicide Prevention Suicide Attempt Survivor Task Force; and
- Suicide Attempt Survivor Task Force Document.

Programs directed to Attempters and Survivors include:

- “feeling blue”;
- Suicide attempt survivor support groups (therapist driven, mixed, and pure peer models);
- After an Attempt;
- Active Minds on Campus;
- Inpatient Peer Bridging / “Do Send a Card”; and
- Tonglen Project.

Practices that support suicide attempters and survivors include:

- Addressing stigma;
- Supporting disclosure such as in crisis centres; and
- Engaging in advocacy, activism and peer support.

When the National Action Alliance for Suicide Prevention Suicide Attempt Survivors Task Force was formed, it reflected the following core values:

- Inspire hope, meaning and purpose;
- Preserve dignity, counter stigma, stereotypes, and discrimination;
- Connect people to peer supports;
- Promote community connectedness;
- Engage and support family and friends;
- Respect and support cultural, spiritual beliefs and traditions;
- Promote choice and collaboration; and
- Provide timely access to care and support.

The presentation reflected the importance of two key messages. One was the importance of putting dignity first to support individual’s recovery, defy low expectations, support self-determination, encourage risks and differences, celebrate cognitive diversity, and recognize individual paths. The other

was the importance of creating and promoting messages of hope and recovery. Suicide attempters and survivors bring great value to society. The experiences of suicidal moments can be positive and transformative. This can be reflected by focusing on promoting recovery rather than just preventing death.

He outlined a suicide prevention framework approach that involves 6 parts with implications for practice, programs and policy. This is summarized in the table below.

Part	Practice Recommendation	Program Recommendation	Policy Recommendation
Part 1: Self-help, Peer Support and inclusion	Every attempt survivor should receive information about self-advocacy	Develop, evaluate and promote support groups for persons who have lived through a suicidal crisis; use a peer leader or co-facilitator	Agencies and organizations at all levels should explicitly endorse, or require, inclusion of attempt survivors in suicide prevention efforts
Part 2: Family, Friends, and Support Network	Every attempt survivor should define their own support network Offer training and educational materials to the attempt survivor's supports	Develop, disseminate and promote programs specifically intended to help the family and friends of attempt survivors	
Part 3: Medical and Mental Health Services and Supports	Mental health providers should integrate principles of collaborative assessment and treatment planning into their practices Professional clinical education should include training on providing treatment to someone in a suicidal crisis or recovering from crisis	Suicide prevention organizations should support and further develop resources like HelpPRO to help people identify therapists who are willing and able to help people in crisis	Protocols for addressing safety and crisis planning should be based on principles of informed and collaborative care (coercion to be avoided at all costs)
Part 4: Crisis and	Training for healthcare providers and emergency	Make Peer specialists available in emergency departments to help	Upon intake and discharge, patients as well as family/friends

Emergency Care	department staff should include information about helping suicidal patients in ways that are collaborative, respectful and preserve dignity	support and advocate for patients experiencing a suicidal crisis	should be given information and resources that can help them understand the treatment process, patients' rights and options for support
Part 5: Systems Linkages and Continuity of Care	Research and evaluation studies must be conducted to examine and improve new supports like online forums	Students who are coping with suicidal thoughts or mental/ behavioural health challenges should have access to a peer specialist to provide support and connect them to resources for additional care	Hospitals and emergency departments should partner with community providers and peer supports to establish formal ties that can facilitate continuity of care practices
Part 6: Community Outreach and Education	People with personal experience from a suicidal crisis should be encouraged to publicly share their stories of recovery, and they should receive support and positive recognition for doing so	Develop a network of professionals with lived experience to initiate and implement research projects to support suicide attempt survivors	Suicide prevention communications efforts should engage attempt survivors throughout the process of developing, implementing and evaluating initiatives or campaigns

In terms of the future, Eduardo hopes to see suicide attempters and survivors:

- Be active agents of hope in communities worldwide;
- Engage at every level of suicide prevention policy, planning and programs;
- Disclose openly in high-profile settings;
- Provide valued peer support, mentoring and related services broadly; and
- Define true impacts for reduction of suicide deaths.

5.0 Summary of Discussion

5.1 Guiding Principles

A key objective of the match was to identify the elements/aspects of effective comprehensive suicide prevention community models. Following the presentations on the various community-based models or approaches for suicide prevention, participants were challenged to identify the key elements or common themes underpinning the approaches.

A thorough analysis and discussion generated consensus on the following 13 elements that should be incorporated into any effective approach to suicide prevention undertaken at the community level.

1. Comprehensive: multiple interventions geared towards a wide range of individuals across a variety of settings.
2. Measurement and Evaluation: includes a component of measurement of outcomes and evaluation of interventions to help determine the effectiveness of the program and inform future interventions.
3. Sustainable: designed in a manner to allow for continued funding and leadership of initiatives after the program or project under study has been completed.
4. Span The Continuum: interventions should address suicide prevention across the entire spectrum including prevention, intervention, and postvention services.
5. Collaboration/Coordination: programs should be designed in a way that enhance collaboration among stakeholders, and get the entire community involved.
6. Flexible: while there is a tension between approaches that are sufficiently standardized to allow for comparisons between communities or track progress over time, it is important to ensure interventions can be tailored to the community in which they are being implemented.
7. Engage People With Lived Experience: suicide attempt survivors, survivors of suicide loss, persons with lived experience, individuals bereaved by suicide and caregivers have an important role to play in guiding community-based suicide prevention efforts.
8. Community Centered: initiatives should ideally be community led, tailored to the community's current level of readiness and engage and empower local stakeholders to drive initiatives forward.
9. Culturally Appropriate: interventions need to be designed, implemented and evaluated in a manner that is culturally responsive and appropriate for the community overall as well as for specific sub-populations.
10. Recovery Oriented: community suicide prevention efforts should focus on providing citizens with hope, treating them with dignity and including them in meaningful ways in decision-making.
11. Innovative: in order to advance suicide prevention efforts globally, creative and innovative ideas need to be attempted, evaluated, and shared with other jurisdictions.
12. Strengths Based: a focus on building upon existing strengths rather than trying to identify and close gaps.
13. Evidence Informed: interventions selected for implementation should be evidence-informed. Different kinds of evidence may inform the selection of interventions including those outside of traditional peer-reviewed quantitative studies.

5.2 Values

The group also felt it was important to articulate the values that should underpin any community suicide prevention interventions. Important values raised by the group included:

- Dignity;
- Listening;
- Empathy;
- Reciprocity;
- Human/personal connection;
- Fostering trust; and
- Respect.

5.3 Settings/Stakeholders

In his earlier presentation, Dr. Caine reviewed various populations that could potentially be captured by targeting interventions at various settings, and also reviewed populations that would likely be missed. These are summarized below.

Sites	Populations Potentially Captured	Populations Likely To Be Missed
Middle and High Schools	Adolescents attending school	School dropouts; youth in legal trouble
Universities	Vulnerable individuals with new onset or recurrent mental disorders	Young adults not pursuing further education, or unemployed
Organized Work Sites	Those employed in organized work sites, men and women in the middle years	Workers in small businesses, union/hiring halls, day labor, unemployed workers, immigrant/migrant labor, underground workers

Medical Settings	Those with health insurance; those that are willing to access traditional medical settings	Un/under insured; low "utilizers" of health care (men); utilizers of nontraditional health care
Community NGOs (e.g., United Way)	Those targeted for service by the NGO funding source; those in private homeless shelters	Anyone outside perceived scope of agency
Religious/Faith Organizations	Regular attendees	Non-participants & drop outs
Governmental Agencies, including Courts & Criminal Justice Settings (governmental agencies as public health venues)	Recipients of county level social support and Medicaid services, including those with serious mental illness; shelter populations; state paid unemployment insurance; Medicare Perpetrators & victims of intimate partner violence; probationers; groups with psychiatric and chemical dependency conditions	Chronically unemployed; persons outside traditional workforce; persons not eligible for benefits Failure to gain access to clinical MH and chemical dependency treatment settings
Social Media	Youth and young adults; hidden populations	People who do not use the Internet – elders, persons with lower education or financial disadvantage

Dr. Caine also reviewed various high-risk populations and potential interventions that could be targeted to these groups within various settings. These are summarized below.

High-Risk Groups	Sites	Potential Interventions	Comments
High Risk Youth— "drop outs," violent youth, & foster care youth	Community centers, police, jails, foster services	Comprehensive family and youth services, integrated across community and gov't systems	Missed in schools; requires careful integration and coordination not evident in most communities; funding issues central; insurance barriers
People with severe, persisting mental disorders	Mental health treatment settings; courts, jails, prisons	Fostering of early interventions; assertive community treatments; linkages among courts, clinics, and other agencies	Comprehensive systems of care and assertive community follow-up; "Project Link" example—coordination of housing, courts, and mental health settings critical to success
Men & women with alcohol and substance disorders; perpetrators of domestic violence; victims of domestic violence	Chemical dependency treatment settings; courts & jails	Integration of mental health and prevention services into chemical dependency programs; court integrated mental health services	Dependent on development of integrated services for mental illness and chemical abuse; rapid access to care for those in need crucial; insurance barriers
Depressed women and men	Primary care settings	Enhanced detection, treatment, and follow up of emerging symptoms	Requires education of patients & providers re recognition and treatment; subsyndromal conditions important

Elders with pain, disability, despair (& depression)	Primary care offices, residential settings; Agency on Aging outreach programs	Pre-emptive treatment of pain and increasing medically related disability	Can miss socially isolated elders and elders who do not express their needs openly
Suicidal people, including patients with personality d/o, varying mood disturbances, and chemical dependency problems	Emergency rooms, intensive care units, inpatient psychiatric and medical services – need for novel approaches to case identification and follow-up	Community outreach for contacting "no-shows," reminder cards, assertive case management; surveillance as case identification	Those high in ideation and attempts in the context of personality disorders often are 'frequent fliers' to emergency rooms who fail to use standard systems of care; major ethical questions; insurance barriers

It was generally agreed that comprehensive approaches must include both:

- Community interventions; and
- Health system interventions.

Participants could envisage roles with a community suicide prevention strategy for:

- Public health officials;
- Schools;
- Youth;
- Existing suicide prevention groups in the community;
- Peer groups/individuals with lived experience;
- Law enforcement (e.g. mobile crisis teams, loss teams, police);
- Criminal and juvenile justice system (e.g. judges, correctional officers, parole/probation officers, prosecutors);
- Faith communities/spiritual leaders;
- Funeral home directors;
- Crisis intervention teams;
- Legislators/elected officials;
- Stakeholders able to influence means restriction (e.g. gun shops/gun clubs, bridge authorities, railroads); and
- Pharmacists/pharmaceutical companies (e.g. drop off programs; packaging; dispensing).

Within communities, it is important to target both formal and informal leaders as well as influencers and people with positional power. It is important to consider the need to engage specific individuals as well as organizations.

Several participants noted that the appropriate stakeholders to engage and populations to target will be community specific. As such, it is important to seek advice from the community to identify relevant stakeholders. Also, the high-risk groups will likely also vary by community, impacting which populations we are trying to reach.

A robust discussion was had on the role of media. The media can be powerful as a mechanism to changing perceptions and needs to be leveraged. Celebrity impact cannot be underestimated as a powerful change agent. But we also need to be careful that the media doesn't sensationalize events. Several countries have media guidelines in effect, including the Mental Health Commission of Canada's "Mindset" guidelines.

It was also reinforced that we are all messengers. We can't be afraid to speak out for fear of saying the wrong things. Our fear doesn't translate into reality much of the time, and there is a greater gain to be had by speaking out about suicide.

5.4 Measurement

The group had some structured discussion on the role of empirical evidence in defining success.

The first part of the discussion was on strategies and techniques for evaluating multi-system models. Several ideas were generated including setting up simulation models.

The group raised the importance of having an independent evaluation conducted.

Several challenges regarding evaluation were raised including:

- Lack of funding for evaluation; and
- Lag in publication results, which can be 7-9 years.

There is a tension between the need for real-time data and peer reviewed research. There is also a tension between what is valued by researchers and communities. To be useful for communities, we need to make evaluations understandable so that communities can use it for programming. Action research can be a way to stimulate community engagement. More qualitative research could be conducted. Also, we should seek ways to disseminate results in a way that doesn't highlight the community in a negative way.

Several participants reinforced the importance of being clear about what your objectives are, as this will drive what you evaluate. Progress should be monitored against a target.

It was suggested that we could develop a tool to assess how far along we are along the continuum (as a community or as a country). This could be similar to the organizational self-assessment tool developed by the Zero Suicide in Healthcare group.

In cases where the community does not have capacity for measurement and evaluation, they could partner with academics or grad students. The Injury Control Research Center for Suicide Prevention (ICRC-S) has a training institute and there is a request for application (RFA) process to get funding. The Canadian Depression Research and Intervention Network (CDRIN) also has a training program for researchers to link with people with lived experience.

The group also identified several key indicators that could facilitate measuring the success of community suicide prevention approaches:

- tracking fatal/non fatal overdoses, suicide attempts, suicide deaths;
- changes in behaviour, knowledge, attitudes and culture;
- upstream indicators like school drop outs, intimate partner violence;
- number of gatekeepers trained and number of referrals by gatekeepers; and
- policy changes.

It was reinforced again that we need to be vigilant about tracking and preventing suicide attempts because it helps people to acquire capacity. There was also a recognition that there is a lag in the availability of suicide data.

5.5 Disrupters

A robust impromptu conversation emerged during the match about what disrupters are required in order for us to see more dramatic change with respect to community suicide prevention. Participants discussed the success that the Zero Suicide in Healthcare initiative has had in creating an international declaration and social movement for healthcare organizations to coalesce behind.

While some participants were uncomfortable with taking a social movement approach, there was general agreement that we need to be more assertive in getting engaged. Activism/advocacy is needed. And given the number of deaths, and number of attempts each year, it is surprising that we are not more vocal about the urgent need. To date, it has been primarily survivors of suicide loss that have been advocating for change. More can be done to activate community action on suicide prevention, and not only when driven by a crisis.

Some suggested that a community activation plan could be used, documenting various stakeholder groups, determining how to engage with them and strategizing about which messages will resonate best.

5.6 Building Leadership

Our match has built leadership capacity for the future in the following ways:

- The diversity and openness of the group allowed us to build on each other's expertise and help establish some important points of consensus.
- The dialogue will help inform our future work in our respective areas.
- The personal connections and network we plan to build will allow us to continue to learn from one another into the future.
- We have been able to galvanize around some common objectives for advancing community action for suicide prevention.

We hope that this work will help inform the next IIMHL match in Australia so that they can build on our foundation. A suggestion was put forward to have each country sponsor a youth to attend the next IIMHL suicide prevention match as a way to groom future leaders.

5.7 Staying Connected

Participants spent some time discussing what has been effective for the Zero Suicide in Healthcare group as they have gained momentum over the past number of years and have been able to continue the conversation actively between IIMHL meetings. Some of the perceived strengths on which this success is based include:

- Founded on a compelling goal that is optimistic, aspirational, aims high and is bold;
- Had funding;
- Based on structures already in existence;
- Started with a framework;
- Went on a roadshow;
- Developed an online toolkit with practical tools; and
- Started with existing knowledge.

There was a desire on the part of participants to identify ways to remain connected after the match. Key questions about the nature and purpose of the group included:

- What is our mechanism to stay connected?
- Will we create work product?
- Should we choose goals to strive toward?

Some suggested mechanisms to stay connected included:

- Webinar reporting out on this meeting;
- Have SPRC archive resources;
- Keep our online platform, BaseCamp, up and running;
- Learning collaboratives to share successes/challenges with monthly calls; and
- A LinkedIn group (although a group formed last time but didn't have lasting power).

The group felt it was important to specifically find some ways to best leverage the IIMHL experience so that the next community suicide prevention match that will take place in Australia in two years, will not need to start over from the beginning. We hope to share our findings and outcomes with the group so that they can build on our foundation. We will also look for opportunities to have the next group join our online platform now, so that they can get oriented to the individuals, organizations, and resources amassed to date.

The group acknowledged that in order to ensure that we are able to stay connected, we will need someone to step forward and make the commitment to lead our efforts. Individuals from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Mental Health Commission of Canada (MHCC) have been identified to maintain momentum on the outcomes.

On the subject of potential work products that the group could co-develop, a suggestion was put forward to create a flexible blueprint that could be implemented in various communities. It would map out an activation process with actions that could be undertaken by specific stakeholders in the community. An approach might be to put this blueprint in place in our individual countries, on some sensible scale, and the report back on what we achieved.

6.0 Next Steps

There were a number of key actions that were determined based on group consensus:

- Create a detailed report on the match for distribution to participants and for posting on the IIMHL website. Once the report has been drafted, we will identify groups for circulation, and invite feedback on the document prior to posting. This will help inform the next match scheduled for Australia so that the next group can build on the work of the group from Vancouver.
- SAMHSA will host a webinar over the next 6 months to share our findings with a broader group of international stakeholders interested in suicide prevention.
- Establish and grow a diverse international network of individuals, groups, and organizations interested in community suicide prevention. Individuals from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Mental Health Commission of Canada (MHCC) have been identified to maintain momentum on the outcomes.
- Develop a blueprint for community action on suicide prevention. The guiding principles of a systematic, comprehensive suicide prevention approach as well as underlying values were developed at this match by consensus. This will serve as the foundation for the blueprint. It is precisely because taking action to prevent suicide is complex and difficult that we need a systematic and comprehensive approach to guide our efforts.
- Look to stimulate bold conversations that will activate communities and advance the growth of community engagement in suicide prevention. These bold conversations may involve engaging the media as a powerful ally, not being reluctant to undertake public awareness campaigns,

finding champions in communities and with decision-makers, empowering communities to speak out about what's working and what's not, and encouraging people with lived experience to share their stories. We need to speak out with inclusive messages and language and not be hindered by the fear that saying the wrong thing is worse than saying nothing. We are all messengers – this change will also require us as leaders to model this approach. Stimulating a new kind of conversation may be part of the disruptive change require to propel us forward.

Appendices

Appendix A: Participant List

Hosts

Ed Mantler
Vice President, Programs and Priorities
Mental Health Commission of Canada
Canada

Stephanie Priest
Director, Population Health Promotion and Innovation Division
Public Health Agency of Canada
Canada

Visitors

Lisa Archibald
Manager
Te Ara Korowai Inc.
New Zealand

Eric Caine
Director, Injury control Research Center for Suicide Prevention
University of Rochester Medical Center
USA

Genevieve Creighton
Research Manager, Men's Depression and Suicide Network
University of British Columbia
Canada

Dammy (Diana) Damstrom-Albach
Coordinator, S.A.F.E.R.
Vancouver Coastal Health
Canada

Linda Frizzell
Consulting Services
Rural and Indian Health
USA

Krystian Fykirt
Chief Executive Officer
MyMind
Ireland

Jérôme Gaudreault
Executive Director
Association québécoise de prévention du suicide
Canada

Ulrich Hegerl
Chair and Medical Director of the Department of Psychiatry and Psychotherapy
Universität Leipzig
Germany

Naveet Jassal
Counsellor, Aftercare
Indian Subcontinent Crises and Support Service
Australia

David Klonsky
Associate Professor
University of British Columbia
Canada

Karen Lascelles
Suicide Prevention Lead Nurse
Oxford Health
England

Richard McKeon
Chief, Suicide Prevention Branch
Substance Abuse and Mental Health Services Administration
USA

Heather McNeill
Regional Policy Analyst, Western Region
Public Health Agency of Canada
Canada

Brian Mishara
Professor and Director, Centre for Research and Intervention on Suicide and Euthanasia
Université du Québec à Montréal
Canada

Kim Montgomery
Response Team Lead
Okanagan Nation Alliance
Canada

Robert Olson
Librarian and Writer, Information Services Lead
Centre for Suicide Prevention
Canada

Richard Ramsay
President
LivingWorks Education
Canada

Thomas Saias
Professor
Université du Québec à Montréal
Canada

Patricia Serna
Executive Director
North Central Community Based Services
USA

Shannon Stone
Mental Health Programs Consultant
First Nations Health Authority
Canada

Ellyson Stout
Prevention Support Program Manager
Suicide Prevention Resource Centre
USA

Karla Thorpe
Director, Prevention and Promotion Initiatives
Mental Health Commission of Canada
Canada

Eduardo Vega
Executive Director
Mental Health Association of San Francisco
USA

Jennifer Ward
Survivor Chair
Canadian Association for Suicide Prevention
Canada

Peter Watson
Clinical Director
Counties Manukau Health
New Zealand

Jennifer White
Associate Professor, School of Child and Youth Care
University of Victoria
Canada

Kassandra Woods
Policy Analyst
Assembly of First Nations
Canada

Appendix B: Tools and Resources

B1. Strategies

- United Nation's Prevention Of Suicide: Guidelines for the Formulation and Implementation of National Strategies
- Scottish Suicide Prevention Strategy 2013-2016
- New Zealand Suicide Prevention Strategy 2006-2016
- Forging an Agenda for Suicide Prevention in the United States
- 'Help for Life' Quebec's Strategy for Preventing Suicide (http://publications.msss.gouv.qc.ca/acrobat/f/documentation/1997/97-237-a.pdf)
- Making it Safer: A Health Centre's Strategy for Suicide Prevention
- Preventing suicide in England A cross-government outcomes strategy to save lives
- Preventing suicide in England: A cross-government outcomes strategy to save lives: assessment of impact on equalities
- Preventing suicide in England: Two years on. Second Annual report on the cross-government outcomes strategy to save lives

B2. Community-Based Models/Approaches

- SPRC/Jed Foundation Comprehensive Approach
- Optimizing Suicide Prevention Programs and Their Implementation in Europe (OSPI Europe): an evidence-based multi-level approach
- Alliances against depression – A community based approach to target depression and to prevent suicidal behavior
- Factsheet: European Alliance Against Depression
- The iFightDepression website
- European Alliance Against Depression Flyer
- Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study
- The US Air Force Suicide Prevention Program: Implications for Public Health Policy

B3. First Nations/Aboriginal Resources

- Working Together to Address Suicide in First Nations Communities
- Preventing Youth Suicide in First Nations
- First Nations Mental Wellness Continuum Framework
- Suicide Prevention in Rural, Tribal Communities: The Intersection of Challenge and Possibility

- Culturally Responsive Suicide Prevention in Indigenous Communities: Unexamined Assumptions and New Possibilities
- Outcome Evaluation of a Public Health Approach to Suicide Prevention in an American Indian Tribal Nation
- Hope, Help, and Healing: A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide

B4. Youth/School-Based Resources

- School-Based Strategies to Reduce Suicidal Ideation, Suicide Attempts, and Discrimination Among Sexual Minority and Heterosexual Adolescents in Western Canada
- Expanding and Democratizing the Agenda for Preventing Youth Suicide: Youth Participation, Cultural Responsiveness, and Social Transformation
- School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial
- Youth Suicide Prevention Plan for Canada: A Systematic Review of Reviews
- Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Suicide Mortality
- U.S. Summary of Resources for Youth Violence and Suicide Prevention
- Adolescent Suicide Prevention Program Manual: A Public Health Model For Native American Communities
- A guide to campus mental health action planning

B5. Research

- Differentiating Suicide Attempters from Suicide Ideators: A Critical Frontier for Suicidology Research
- The Three-Step Theory (3ST): A New Theory of Suicide Rooted in the “Ideation-to-Action” Framework
- Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism
- One followed by many? Long-term effects of a celebrity suicide on the number of suicidal acts on the German railway net

B6. Lived Experience

- The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience
- Scottish Recovery Network’s Experts by Experience: Values Framework for Peer Working (http://www.scottishrecovery.net/images/stories/downloads/srn_peer_values_framework_publication.pdf)

B7. Media

- Role of media reports in completed and prevented suicide: Werther v. Papageno effects
- *Mindset: Reporting on Mental Health* Media Guide (http://www.mindset-mediaguide.ca/)
- Australian Media Guide on Using Recovery Oriented Language (http://mob.mhcc.org.au/media/5902/mhcc-recovery-oriented-language-guide-final-web.pdf)
- Samaritans Media Guidelines for Reporting Suicide
- TtC Media Leaflet NEWS (Time to change)
- Media Guide: Take care – be aware (EAAD)

B8. Other

- Suicide-Safer Communities: Recognizing community commitments to suicide-safety (https://www.livingworks.net/community/suicide-safer-communities/)
- Strengthening the Safety Net: A Report on the Suicide Prevention, Intervention and Postvention Initiative for British Columbia (https://suicidepipinitiative.files.wordpress.com/2009/05/suicide-pip-initiative-full-report.pdf)
- Plea for suicide prevention in Quebec (http://www.aqps.info/media/upload/Plaidoyer_AQPS_ANG_Final_Mai2014.pdf)
- Quebec training programs (in French) (http://www.aqps.info/se-former/)
- Guidance for developing a local suicide prevention plan. Information for public health staff in local authorities
- Identifying and responding to suicide clusters and contagion a practice resource (public health England
- Prompts for local leaders on suicide prevention
- Policy Briefing Preventing suicide in England: One year on