Preventing suicide
A community engagement toolkit

Pilot version 1.0

World Health Organization

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Foreword

Suicides take a high toll. Over 800 000 people die due to suicide every year and it is the second leading cause of death in 15-29-year-olds. There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide. The impact on families, friends and communities is devastating and far-reaching, even long after persons dear to them have taken their own lives. Social, psychological, cultural and other factors can interact to lead a person to suicidal behaviour and the stigma attached to suicide means that many people feel unable to seek help. Most suicides occur in low- and middle-income countries where resources and services, if they do exist, are often scarce and limited for early identification, treatment and support of people in need. These striking facts and the lack of implemented timely interventions make suicide a serious global public health problem that needs to be tackled imperatively.

Communities can play a critical role in suicide prevention. They can provide social support to vulnerable individuals and engage in follow-up care, fight stigma and support those bereaved by suicide. They can help give individuals a sense of belonging and a feeling of connectedness by being part of a community. Lastly, communities can also implement specific suicide prevention strategies relevant to them.

Facilitating community engagement in suicide prevention is an important task. Whereas governments need to take a lead and develop and implement comprehensive multisectoral suicide prevention strategies, communities can incorporate and enhance these efforts with their local community needs, priorities and circumstances.

The Mental Health Commission of Canada launched #308conversations which is a grassroots initiative inviting each of Canada's 308 Members of Parliament and other community leaders to hold a conversation in their community about suicide prevention. The initiative represents a participatory approach to connecting communities, sharing best practices, identifying challenges, and taking meaningful action to reduce suicide and the impact of suicidal behaviours in Canada. Interested community members, people with lived experience and stakeholders share what is working and identify gaps in access, treatment and support.

The World Health Organization has worked collaboratively with the Mental Health Commission of Canada to adapt this participatory approach for global use. The toolkit is a step-by-step guide for communities to engage in suicide prevention activities and have ownership of the process and keep efforts sustained. It is not a manual for initiating specific interventions, but describes an active and participatory bottom-up process by which communities identify, prioritize and implement activities that are important and appropriate to their local context and can influence and shape policy and services.

We hope that the pilot version will be used, after necessary adaptation, in many countries and contexts. We hope to receive feedback so that the final product can be strengthened and become more effective and user-friendly.

Together, we are working towards the ultimate goal of reducing suicide. The Member States of the World Health Organization have committed themselves in the Mental Health Action Plan 2013-2020 to work towards the global target of reducing the suicide rate in countries by 10% by 2020. The suicide rate is among the agreed indicators for the United Nations Sustainable Development Goals health target 3.4 by 2030 to reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being. These targets are unlikely to be achieved unless communities are actively engaged in efforts for suicide prevention.

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Suicide prevention: the role of communities

Introduction

Communities play a crucial role in suicide prevention. This toolkit follows on from the World Health Organization (WHO) report *Preventing suicide: a global imperative* (WHO, 2014) by providing practical steps for engaging communities in suicide prevention activities.

Community engagement is an active and participatory bottom-up process by which communities can influence and shape policy and services (McLeroy et al., 2003). Communities can accomplish this by initiating activities that are important and appropriate to their local context. However, although increasingly gaining recognition as innovative approaches to both public health and mental health, community engagement techniques often lack clear evidence and guidelines for their successful execution and design (Mendel et al., 2011). When implemented adequately, community engagement projects can be very effective in tackling mental health challenges and preventing suicide in particular. Such approaches are often relatively cost-effective and are therefore particularly appealing to low- and middle-income countries where stigma and taboo often limit access to quality care for suicidal behaviours.

When dealing with sensitives issues such as suicide prevention, it may be difficult to know where or how to initiate action. This toolkit therefore provides some practical suggestions that can be used by communities worldwide, regardless of the resources at their disposal or their current state of progress in suicide prevention efforts.

Understanding suicide

Globally, over 800 000 people die of suicide every year and it is the second leading cause of death in 15–29-year-olds (WHO, 2014). However, since suicide is a sensitive issue, it is very likely that it is under-reported because of stigma, criminalization in some countries and weak surveillance systems.

Some 75% of all cases of suicide globally occur in low- and middle-income countries. In high-income countries, three times as many men die by suicide than women, but in low- and middle-income countries the male-to-female ratio is much lower at 1.5 men to each woman. Suicide rates are highest in persons aged 70 years or older for both men and women in almost all regions of the world. In some regions, suicide rates increase steadily with age, while in others there is a peak in suicide rates among young adults. In low- and middle-income countries, young adults and elderly women have much higher suicide rates than their counterparts in high-income countries, while middle-aged men in high-income countries have much higher suicide rates than those in low- and middle-income countries. Globally, suicides account for 50% of all violent deaths (i.e. from interpersonal violence, armed conflict and suicide) in men, and 71% of such deaths in women (WHO, 2014).

Social, psychological, cultural and other factors can interact to increase the risk of suicidal behaviour. Risk factors for suicide include, for instance, previous suicide attempt(s), mental health problems and disorders, harmful use of alcohol or other substances, job loss or financial loss, trauma or abuse, and chronic pain or illness. Unfortunately, suicide prevention is too often a low priority for

governments and policy-makers. Suicide prevention needs to be prioritized on the global public health and public policy agendas. Awareness of suicide as a public health issue needs to be raised through a multidimensional approach that takes account of these social, psychological and cultural impacts.

It is important to understand the local context in each community in order to determine which groups may be most vulnerable to suicide. This allows community suicide prevention activities to be targeted at those who are most at risk of suicide.

Why it is important to prevent suicide

In 2013, the *Mental Health Action Plan 2013–2020* was adopted by the World Health Assembly (WHO, 2013). This action plan outlines suicide prevention as a priority, with the global target of reducing the rate of suicide in countries by 10% by 2020. In the Sustainable Development Goals (SDGs) for 2030, suicide is a proposed indicator for health target 3.4 which is to reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.

Suicides are preventable. Comprehensive multisectoral strategies for the prevention of suicide are essential to achieving suicide reduction worldwide, and community-level approaches should be employed as part of an effective strategy. The prevention of suicide is not only important for individuals and families but also benefits the well-being of communities, the health-care system and society at large.

Preventing suicide can have a positive impact on communities by:

- promoting health and well-being of community members;
- empowering communities to identify and facilitate interventions;
- building capacity of local health-care providers and other gatekeepers.

Why communities play an important role in preventing suicide

Governments need to take a lead in suicide prevention in order to develop and implement comprehensive multisectoral national suicide prevention strategies. In some countries, multi-level community suicide prevention programmes are being implemented and it has been noted that synergistic effects can arise when different activities and measures are implemented simultaneously (Harris et al., 2016). However, variations in the suicide rates within countries (e.g. by geographical regions) suggest that top-down suicide prevention must go hand-in-hand with local bottom-up processes. Hence, communities play an essential role in suicide prevention when they provide bridges between community needs, national policies and evidence-based interventions that are adapted to local circumstances.

Suicide is shrouded in stigma, shame and misunderstanding. This means that people often do not or cannot seek adequate help. Prevention of suicide cannot be accomplished by one person, organization or institution alone; it requires support from the whole community. The community contribution is essential to any national suicide prevention strategy. Communities can reduce risk and reinforce protective factors by providing social support to vulnerable individuals, engaging in follow-up care, raising awareness, fighting stigma and supporting those bereaved by suicide. Community members can also raise the issue that registering cases of

suicide and suicide attempts is important. In some cases, community members or representatives may take on the role of identifying people at risk of suicidal behaviour or emerging suicide clusters, which is often called the "gatekeeper" role. Perhaps most importantly, communities can help by giving individuals a sense of belonging. Social support within communities can help protect vulnerable persons from suicide by building social connectedness and improving skills for coping with difficulties. It is essential to understand that the community itself is best placed to identify local needs and priorities (Kral et al., 2009; Coppens et al., 2014).

A toolkit for community engagement in suicide prevention

Community members and stakeholders wishing to engage in suicide prevention often have to identify priorities and strategies themselves. In some cases, they may find useful and sustained resources to support persons who attempted suicide, those bereaved by suicide, and those at risk or in crisis situations. Often, however, this is not the case and communities find themselves inadequately prepared for or overwhelmed by the task of establishing successful suicide prevention strategies. Stigma and taboo about suicide may present barriers to sustainable long-term suicide prevention.

Against this background, this toolkit aims to assist with identifying and implementing suicide prevention priorities and directing appropriate community activities towards the whole community, specific groups and/or individuals. The toolkit provides guidance for establishing supportive networks to assist communities in suicide prevention activities and can enhance activities that may already be in place. The document is a guide for communities to engage in suicide prevention activities, not a model for comprehensive community suicide prevention that specifies the core components of a community model, nor is it a blueprint for nations to implement comprehensive community suicide prevention.

Anyone wishing to initiate an activity within their community should be able to use this toolkit. The targeted community could be defined by geography, or by social factors such as age, sex or vulnerability (e.g. indigenous peoples, refugees, military, prisons, LGBTI,[1] workplace).

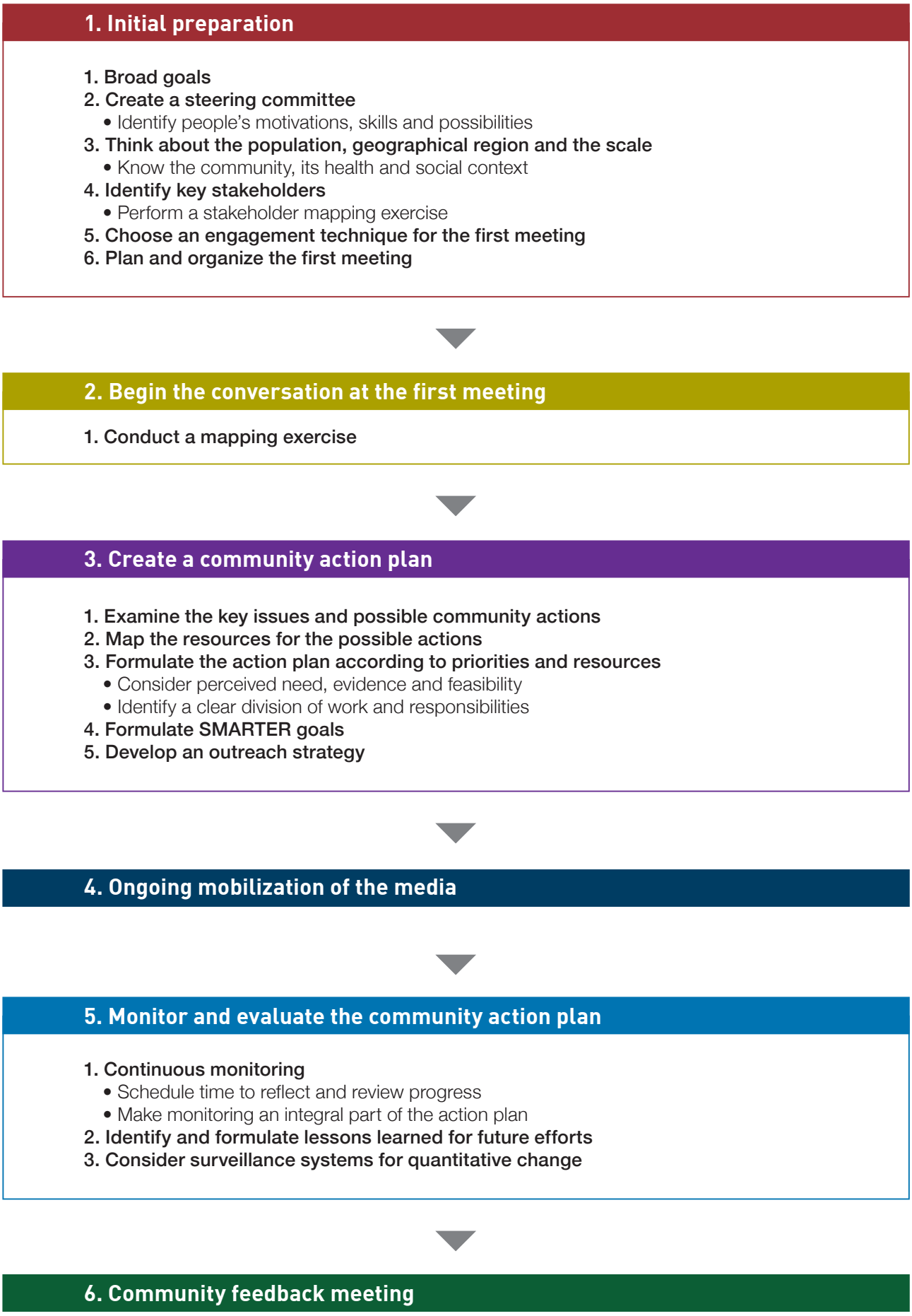
The toolkit provides step-by-step guidance according to the following key areas (Figure 1):

1. Initial preparation
2. Begin the conversation at the first meeting
3. Create a community action plan
4. Ongoing mobilization of the media
5. Monitor and evaluate the community action plan
6. Community feedback meeting.

Each section provides advice on how to move forward with community engagement and suggests tools that can be used to further the process of building a suicide prevention action plan that is relevant to the community. This toolkit is not exhaustive, and many other tools can be developed and used. Each community can adapt and design its own plan, tools and activities to ensure that these best fit the community and are acceptable and appropriate to the local context.

[1] LGBTI = Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersexed persons.

Figure 1. Overview of the community engagement process



Initial preparation

It is important to be prepared before starting to engage the community as a whole. This section provides practical guidance on how a group of individuals interested in taking collective action can get started. It considers broad goals and initial analyses as well as the choice of an engagement technique for the first community meeting.

Broad goals

Many people, groups and organizations are interested in suicide prevention within their local context and some would like to support vulnerable persons and other community members who, for instance, have been bereaved by suicide. Common broad goals (Annex 1.1) which often motivate these interested stakeholders and leaders include (Suicide Prevention Australia, 2014):

- preventing deaths by suicide and suicide attempts;
- creating a supportive community environment;
- developing a short-term or long-term plan to provide ongoing suicide prevention efforts in the community.

Create a steering committee

Initial efforts to take the lead in suicide prevention often emerge from within the community. Initial action may come from an organization, an institution or even a motivated individual. Without support, however, individuals may sometimes find it difficult to continue so it is important to enable them to connect with others. A good way to do this is to create a steering committee of enthusiastic persons who are motivated to engage in suicide prevention. The steering committee will typically bring together a group of like-minded people with different skills and ideas who share similar concerns. Members of the steering committee could, for instance, come from the following backgrounds (Mental Health Commission of Canada, 2015; Capire Consulting Group, 2016; Suicide Prevention Australia, 2014):

- community leaders, politicians, parliamentarians, or representatives;
- health or mental health workers, including doctors, nurses, health promotion officers, health administrative authorities;
- community development or social workers;
- teachers or other school staff;
- spiritual or religious leaders;
- traditional healers or community elders;
- military officers;
- police, firefighters, or other first-line responders;
- youth workers or groups, or those working with older persons;
- community members who have lost a loved one, friend or colleague to suicide;
- individuals with lived experience;
- business leaders;
- women's groups;
- medical associations;
- sports organizations;
- local mental health support agencies or charities;
- organizations concerned with community well-being or suicide prevention;
- other nongovernmental organizations such as Rotary and Lions Clubs;
- volunteer groups.

As each community will approach suicide prevention in different ways, each steering committee will be unique. However, a steering committee of around 10 people for planning and organizing the first meeting and starting a conversation about suicide will ensure that the group is manageable and that work can be done.

The members of the steering committee (Annex 1.2) should be willing to commit time and effort to the process. They should create a shared motivation and vision for action, identify the desired goals, ensure coordination and ownership of the process and keep suicide prevention efforts moving. All interested parties and community members should be invited to the first meeting at which the whole community comes together.

Eventually, some stakeholders who cannot dedicate time to the steering committee could be called upon to carry out specific tasks with shorter time frames according to their expertise (Suicide Prevention Australia, 2014). For such purposes, subcommittees could be created with responsibility for certain tasks or for working on specific activities. Engaging service user groups and local volunteers can also help when planning activities and putting them into practice (Harris et al., 2016).

It is often helpful to write down the reasons, broad goals, potential benefits and expected long-term effects of community engagement (Lane & Tribe, 2010) (Annex 1.3).

Engaging in suicide prevention activities, regardless of one's personal links to the topic, can often be difficult and complex. It is very important to keep in mind the safety of those participating in suicide prevention, particularly if they or their loved ones have previously experienced suicidal behaviour. It may be worth considering training in, for instance, psychological first aid (WHO, 2011), supervision or self-care for members of the steering committee or subcommittees, or the risk and protective factors and warning signs of suicide (Annex 1.4, 1.5, 1.6).

Consider the population, geographical region and scale of activities

Besides the broad goals, it is also worth considering the scale of the community engagement and the population or region to be involved. Although preliminary ideas about the community and suicide prevention activities need to be adapted continuously as additional information is gathered, there must be some preparation to ensure that pitfalls and barriers are identified early and that ways are found to overcome them.

Developing and facilitating appropriate suicide prevention for a community requires an understanding of the available data, awareness of data limitations, and a commitment to improving data quality to more accurately reflect the effectiveness of specific activities (WHO, 2014). Before initiating the first meeting with the community or before starting activities, it is essential to get to know the community and its relation to suicide and suicide prevention (Annex 1.7) – e.g. by finding out whether a suicide has recently occurred, whether suicide prevention programmes are already in place, or whether the community generally avoids addressing suicide. Otherwise there is a risk that time will be wasted, people may be reluctant to become involved, or inadequate engagement techniques may be chosen (Lane & Tribe, 2010). Even if the initiative comes from within the community, which may be the case particularly in low-resource countries, it is worth carrying out some preparatory analysis.

When considering the community, the following factors should be taken into account:

Suicide in the community:
- numbers of suicides and suicide attempts;
- means of suicide in the community, also according to sex and age;
- access to means of suicide;
- infrastructure and "hot spots" (sites frequently chosen for suicide);
- risk and protective factors (Annex 1.4, 1.5) present in, and relevant to, the community.

Sociocultural context:
- stigma and cultural or religious beliefs about suicide;
- channels of communication within the community and prominent media;
- social, political, racial or economic tensions;
- most pressing needs and problems in the community.

Health and welfare services, including suicide prevention programmes:
- access to health services;
- quality of health services;
- existing or previous suicide prevention programmes, services or campaigns;
- schools and potential suicide prevention programmes;
- police and firefighters and potential suicide prevention programmes.

In particular, the following factors should be kept in mind:
- geography (e.g. urban versus rural);
- vulnerability (e.g. refugees and migrants, persons who have experienced abuse, trauma, conflict or disaster);
- ethnic or cultural groups (e.g. indigenous peoples);
- social groups (e.g. prisoners, LGBTI persons, farmers);
- religious groups (e.g. people of different religious beliefs);
- age groups (e.g. older persons, the young, young women, middle-aged men);
- patterns of alcohol and substance abuse.

One way of conducting an initial analysis of the community is through the community readiness model (Tri-Ethnic Center for Prevention Research, 2014) (Annex 1.8). The model categorizes the readiness of communities for change according to different stages and uses five dimensions – i.e. existence of efforts and community knowledge of efforts, leadership, community climate, community knowledge of the issue, and resources – which are rated individually to estimate the overall readiness of a given community. This will later inform the choice of activities in suicide prevention.

Another possibility would be to start informal (or formal) face-to-face interviews with potential stakeholders. Such information could then be used when developing initial actions.

It should be noted that, in some situations, national data may not help in determining the geographical regions or the demographic groups that need prioritization for community engagement efforts. For instance, suicides by self-ingestion of pesticides primarily occur in rural areas; hence, measures to restrict access to this means of suicide would probably not be a primary focus of suicide prevention programmes in urban areas. Also, suicide among indigenous peoples tends to be higher than among the general population but this may not show in national suicide rates.

Identify key stakeholders

It is also important to identify key stakeholders, and thus potential collaborators, within the community. Developing a network in the community can serve the purpose of moving from isolated suicide prevention efforts that may already be ongoing to a concerted effort. Stakeholders may be organizations, institutions or individuals (see list under “Create a steering committee”).

It is necessary to pay attention to the characteristics of different stakeholders. A stakeholder mapping exercise (Annex 1.9) may help in obtaining a clearer picture by analysing items such as:

- ongoing engagement with suicide prevention;
- potential reasons to engage in suicide prevention;
- potential aversion to engaging in suicide prevention;
- relations with other persons, groups or institutions in the community;
- resources (human and financial);
- expertise;
- skills and strengths of different individuals or groups;
- weaknesses.

Examples of relevant stakeholders

Politicians and parliamentarians

Politicians could help by expressing support or by lobbying for government policy changes. Local governments have the power to make change and can play an important role in preventing suicide in the community. Obtaining municipal support can help build suicide prevention into the fabric of a community. Local decision-makers and public officials are well placed to help unlock opportunities, build partnerships and may know who else is doing similar work. In addition, policy-makers play a key role supporting policies that fund and implement programmes and services in the community.

Ultimately, public policy and decision-making is influenced by politics, evidence and local interests. Therefore, communicating with policy makers and opinion leaders about suicide prevention takes place through different forms of engagement and messages. In the planning stages, it is important to identify opportunities to engage politicians and other opinion leaders meaningfully. It should be noted that there could be challenges when engaging with politicians as their commitments or positions are likely to change over time.

Health-care providers and health-care administrators

In many communities, public health providers are typically responsible for efforts to prevent both injury and suicide, so these are key players in suicide prevention within the health-care network. Involving health-care providers in suicide prevention planning, activities and evaluations can also be beneficial for:

- supporting training opportunities for all health-care professionals;
- developing strategies for increasing case registration and reporting of suicide and suicide attempts;
- improving assessment and management of suicidal behaviours, depression, alcohol use disorders and other mental and substance use disorders;
- improving the availability of essential medicines;
- improving the availability and quality of school health services;

- developing policies to standardize procedures and offering in-service training for assessment and management of suicidal behaviours among persons receiving care in community or primary health-care settings (including emergency departments, mental health settings and addiction treatment centres).

Community and faith-based organizations

Community and faith-based organizations are integral to the functioning of a community. Community and faith-based organizations are public or private nonprofit organizations (including organizations such as Rotary and Lions Clubs, nongovernmental organizations, churches or other faith-based institutions) that represent a community or a significant segment of a community and are engaged in areas such as health, human services, art and culture, libraries, and youth and community development.

Community and faith-based organizations represent fellow citizens and regularly engage at grassroots level with them. Such organizations will have established communication networks, programmes and interventions that are targeted to residents of the community. A community and faith-based organization partner can help reach out to residents, establish credibility with community members, offset costs and access human and financial resources.

Relevant community and faith-based organizations should be involved at the outset of the conversation on suicide prevention. This will allow flexibility and ensure that each community and faith-based organization plays a role that is consistent with its priorities.

Choose an engagement technique for the first meeting

By following the preparatory steps outlined above and taking into account a few key considerations, it should be easier to begin the conversation in the form of a meeting with the community. The engagement technique (Annex 1.10) for the first meeting should be chosen according to the exact circumstances identified in the initial preparation. The degree of formality of the language or whether invitations are sent out by post or email should also be considered. Engagement techniques should be adapted to the culture and interests of the community and its leaders and stakeholders. Locally-organized campaigns in the local media, with the appearance of local stakeholders, usually work well. Well-known local personalities who live in the community often appear more trustworthy than unknown individuals.

Examples of engagement techniques for a first meeting include:

- roundtable;
- workshop;
- town hall meeting;
- discussion forum.

World Suicide Prevention Day, which is held on 10 September each year and often involves community activities, could be an opportunity to have a first meeting with the community. In Lebanon in 2016, for instance, an “Into the dawn walk” by the seaside was organized at 5:00 a.m. with participants carrying lighted candles. In Nepal, in addition to a rally and candle lighting, an interactive programme was organized with interested individuals (ranging from academics to

clinicians, volunteers and survivors) and involved interactive activities with the media. In 2015, Band-Aids on which “#howru” (representing “How are you?”) was written were distributed in Singapore to promote conversations about personal well-being and suicide.

It must be noted that involving different stakeholders and community members can be difficult at times. When organizing the first meeting and engaging the community, it is important to consider some of the following barriers (Peterson et al., 2016; Swainston & Summerbell, 2008):

- limited advocacy experience of the people involved in the activities;
- stigma or taboo linked to suicide and its prevention;
- lack of accurate information about suicide cases or an emerging suicide cluster;
- lack of resources, such as time, professional expertise and money;
- complicated and bureaucratic communication with civic and public organizations;
- lack of trust from community or volunteer organizations;
- dissatisfaction with health and community services;
- potential interest of some stakeholders to dominate decision-making processes and to influence activities.

Preliminary and continuous confrontation with potential challenges will help reduce these barriers. Strategies to counteract challenges or barriers to community engagement in suicide prevention must often be decided case by case.

In communities where suicide is surrounded by silence and stigma it may be worth taking steps to raise awareness before having the first meeting. In such instances, the following engagement techniques, prior to organizing a first meeting, could be used:

- social media campaigns;
- traditional media campaigns, such as posters, billboards, television and radio;
- training sessions;
- road shows;
- street plays;
- symposia.

Ongoing mobilization of the media throughout the community engagement process plays an important role (see ”Ongoing mobilization of the media” below).

Plan and organize the first meeting

All stakeholders interested in being part of a community effort in suicide prevention, as well as community members in general, should be invited (Annex 1.11) to the first meeting (see list under “Create a steering committee”).

The first meeting could cover the following:

- information about the reasons for, or events that have led to, the meeting;
- a description of current trends in suicide and suicide attempts in the community;
- a description of what is already being done in suicide prevention in the community;
- mapping of the key issues of, and resources for, suicide prevention in the community and discussion of how each individual or group could be involved;

- discussion of what the goals of a suicide prevention action group should be (with a clear indication that specific goals would be eventually decided by the members of the action group);
- determination of who will continue to meet as an action group and when.

An agenda (Annex 1.12) should be created on the basis of the items above. A member of the steering committee could act as moderator of the first meeting to help the discussion stay on topic and to make sure that everyone is heard (Annex 1.13). A secretary and/or record-keeper should generate accurate notes as a basis for follow-up after the first meeting. Organizing the first meeting also means addressing meeting logistics, such as finding a space to meet, sending out invitations and advertising the meeting (Annex 1.14). When the steering committee or the subcommittees feel they need guidance, someone familiar with leadership issues, advisory groups or researchers could be asked to provide support (Harris et al., 2016).

General guidance points for the first meeting include the following (Mental Health Commission of Canada, 2015):

- *Safety:* Ensure that conversations are conducted in a supportive way.
- *Mental health support:* Ensure that there is support available for attendees who need assistance because discussion of suicide issues can trigger difficult emotions.
- *Flexibility:* Allow community members to adjust the format according to the circumstances.
- *Resources:* Offer suggestions for identifying local suicide prevention resources and supports to strengthen activities.
- *Champions:* Identify champions within a community who can host or facilitate the first meeting or make presentations based on their expertise.
- *Confidentiality:* Ensure that participants feel confident that their privacy is being respected. Confidentiality also applies to the people at risk of suicide with whom the members of the steering committee will engage, such as in an emerging suicide cluster.

Begin the conversation at the first meeting

This section provides practical guidance on how a community can move to action by starting the conversation about suicide at the first community meeting. Community members need to be able to voice their concerns and explain what they feel are the most pressing needs in suicide prevention in their community. This is part of the process of identifying gaps, as well as resources and activities that may already be available in the community.

Conduct a mapping exercise

An important first step is to have a conversation about suicide in the community to understand thoroughly the impact that suicide has and the issues that are specific to the local situation with regard to suicide prevention. For instance, in rural communities of agricultural areas in low- and middle-income countries, a key problem may be easy and ready access to pesticides as a means of self-harm and suicide. Hence, potential activities in such a community should target farmers and their families accordingly.

One of way of obtaining a better understanding of the factors relating to suicide is to conduct a mapping exercise (Annex 2.1). This tool can be as simple as drawing on a large piece of paper, to encourage participation in areas where literacy is low, but can be made more complex as necessary (Archer & Cottingham, 2012).

First, participants should consider common means of suicide in the community and their physical location, such as “hot spots” (sites frequently chosen for suicide). Second, the physical location of the available social, health and suicide prevention services should be identified. Third, the accessibility, features and quality of the identified services should be discussed. Finally, participants should discuss the strengths and weaknesses of suicide prevention in the community – such as resources, existing programmes, potential gaps, local issues, and the role of the media.

Some examples of questions to ask in order to animate the discussion could be as follows:

- Where are locations with ready access to means of suicide (e.g. pesticides, firearms, high buildings or bridges)?
- Where are the medical and social services situated? Has there been training on assessment, management and follow-up of suicidal behaviours?
- Where are local schools situated? Do they have education about mental health and/or suicide prevention programmes?
- Where are the locations of different media channels (e.g. print, television, radio)? Have media professionals been trained in responsible reporting about suicide?
- Which outlets sell alcoholic beverages and what are the opening hours?
- What are the current gaps in services and infrastructure?

These questions and more should be driven by the meeting participants. A facilitator should encourage the generation of thoughts during the mapping exercise. Once the mapping is complete, there should be a better understanding of where the gaps are, what is most needed and who are most vulnerable to suicide.

Case study: #308conversations

The Mental Health Commission of Canada (MHCC) initiated efforts to engage the community with the #308conversations initiative (Box 1). Members of Parliament were invited to conduct community discussions on suicide prevention with support and resources provided. More than 40 conversations have since taken place across the country (Mental Health Commission of Canada, 2015).

Box 1. #308conversations: a case study

Each year in Canada, nearly 4000 people die by suicide. In an effort to raise awareness about suicide prevention, mobilize national leadership and address this pressing public health issue on a national scale, the Mental Health Commission of Canada (MHCC) spearheaded a Canada-wide dialogue called #308conversations.

Beginning in 2014, the MHCC offered all 308 federally-elected Members of Parliament support and resources to host community conversations on suicide prevention. In doing so, the MHCC devised a means to identify successful initiatives at local level and inform future plans for a community-based model of suicide prevention.

Guided by *Changing directions, changing lives: The Mental Health Strategy for Canada*, the MHCC is a catalyst for improving the mental health system and changing the attitudes and behaviour of Canadians around mental health issues. Suicide prevention is a priority area for the MHCC and is an important area of focus in the Mental Health Strategy for Canada.

The overall goal of the #308conversations campaign was to offer an evidence-informed, community-based suicide prevention programme, with the aim of:

1) offering a participatory, bottom-up approach within a community;
2) sharing best practices on suicide prevention, postvention and intervention;
3) identifying challenges and opportunities in addressing suicide prevention at the community level; and
4) taking meaningful action to reduce suicide and the harmful impact of suicide and related behaviours.

#308conversations focused on raising awareness among Members of Parliament. To maximize awareness and benefit, Members of Parliament were encouraged to collaborate with one another and identify champions within the community to participate in town hall meetings. In numerous instances, two or more Members of Parliament joined in hosting suicide prevention meetings in communities where one central event made the most sense geographically.

The design of each event was determined by the community hosts and varied according to the availability of space, participants and resources. While mental health and suicide prevention were central topics at all meetings, each #308conversations event was unique and relevant to specific community contexts.

#308conversations were variably structured as roundtables, town halls meetings, world cafés, working groups and presentations. Some meetings included guest speakers from local mental health organizations, bereaved survivors, and community members occupying

roles that increase their opportunity to identify people with suicidal thoughts and behaviours.

The #308conversations programme recognized that Members of Parliament would be in a good position to identify the needs of their communities. The campaign included evidence-based components, including:

- educating the hosts on the prevalence of suicide in Canada, including at-risk groups, and the impact that deaths by suicide can have on a community;
- developing a safety video that highlighted the importance of hosting a safe and effective meeting;
- helping to identify and mobilize supporters and champions.

The #308conversations campaign recognized the need for stakeholders (Members of Parliament and their staff) to have accessible and practical tools to support their efforts. To this end, the following were included in a toolkit:

- background information
- news release example (Annex 2)
- links to partner resources
- op-ed example (Annex 2)
- links to postvention resources
- meeting signage
- discussion guide
- facilitator questions
- roll-out process for the event (Annex 2)
- suggested agenda for the event (Annex 2)
- presentation example
- “thank you” letter (Annex 2).

Available in both French and English, the tools and examples could be downloaded as templates to be completed by meeting hosts, and could be modified to meet the needs of communities.

#308conversations was embraced by social media. The @MHCC_308 twitter handle had over 550 followers and a growing online community. The #308conversations hashtag was being regularly mobilized by suicide prevention stakeholders to draw attention to suicide prevention-related tweets, community resources and other suicide prevention events. There was also some use of traditional media, including press releases and newsletter articles.

#308conversations had at least one conversation take place in every region of Canada. Each event produced insights, best practices and recommendations around addressing suicide in Canada. Although each community was unique, and certain populations faced specific challenges, common themes clearly dominated the discussions.

Underlying many of the challenges identified in each report were three significant elements, as follows:

1. Communities called for a National Suicide Prevention Strategy for Canada.
2. Participants felt that the reduction of stigma continued to be a main priority because stigma was an underlying challenge to suicide prevention.
3. Efforts to address immediate suicide crises often revealed a lack of resources for programmes focused on prevention.

Opportunities such as peer support were also discussed. Multiple #308conversations participants, many of whom were suicide attempt survivors or bereaved family members, saw peer support as something positive, beneficial and important for recovery. The MHCC`s *Guidelines for the practice and training of peer support* (Sunderland et al., 2013) notes that peer support is a supportive relationship between people who have lived experience in common. This common experience might be related to their own mental health in the case of suicide attempt survivors, or the death of a loved one in the case of bereaved survivors. Research and anecdotal information from #308conversations indicate that peer support can help persons gain control over their symptoms, reduce instances of hospitalization and improve quality of life through social connection and support.

Because of the success of the events, continued interest in participation from Members of Parliament and community involvement, the MHCC decided to continue #308conversations from May 2014 to May 2015. Communities have continued to host conversations into 2016.

The MHCC received diverse feedback from #308conversations events ranging from formal reports to suicide prevention resources, to handwritten personal accounts and suggestions. The diversity of materials enriches the depth of knowledge of this truly Canada-wide perspective.

Create a community action plan

This section provides practical steps for examining, prioritizing and implementing activities on suicide prevention relevant to the community according to the specific goals chosen.

The steering committee and the stakeholders who committed to being part of the prioritization and implementation process should reconvene, in accordance with the discussions during the first meeting. The steering committee should take the lead in organizing future meetings and should provide opportunities to discuss how to move forward towards community action. Points to consider are as follows:

- the motivation of individuals or groups in being involved in the steering committee, and what they hope to achieve;
- the resources (e.g. expertise, time, money) that each individual or group can bring to the steering committee;
- the skills and strengths of different individuals or groups.

Importantly, a lot of time will need to be spent on examining the key issues raised during the first meeting as they relate to the local context and on developing an appropriate community action plan.

Examine the key issues and possible community actions

During the mapping process, the key issues related to suicide prevention in a given community will have been mapped. An effective community action plan for suicide prevention must include actions that correspond to the most pertinent issues that need to be tackled. The issues raised in the mapping exercise should therefore be clarified and integrated into the community action plan. They should be compared with the broader goals and the scope determined earlier.

A review of community engagement processes used elsewhere (Annex 3.1) – including their successes, lessons learned, approaches and scale – can help in determining the structure and scope of one's own activities. It is recommended to identify activities that have been shown to be effective and are relevant to one's own community (Annex 3.2).

Issues that a community may wish to address in its action plan could include (Allen et al, 2014):

- stigma around suicide due to religious or cultural beliefs within the community;
- lack of understanding of suicide within the community;
- ready access to the means of suicide (e.g. pesticides, firearms);
- social stressors (e.g. stress among school or university students during examinations);
- local media outlets that sensationalize suicide through inappropriate reporting;
- lack of support and services available for those vulnerable to or bereaved by suicide.

Persons in need of support and services may include those who:

- have lost a loved one to suicide;
- have made previous suicide attempts;
- have mental health problems and challenges;
- have experienced harmful use of alcohol or other substances;
- have suffered financial loss;
- have experienced chronic pain;
- have a family history of suicide;
- have suffered abuse or violence.

The list of possible issues may be long, and many communities will have experience more than one of these issues at the same time. The mapping exercise during the first meeting will help to identify the key issues that relate to a given community.

The next step is to examine the issues that were identified (Annex 3.3) and to discuss which of them may require action. Some issues may be beyond the community's control and ability, but the steering committee can still play an important role in raising awareness about these (e.g. surveillance system). Ongoing suicide prevention efforts within the community should also be recognized and the action plan can build upon them. Programmes for which there is evidence of effectiveness should receive particular attention.

Examples of activities that could be undertaken include the following (Zalsman et al., 2016; Capire Consulting Group, 2016; Fleischmann et al., 2016; Petersen et al., 2016; WHO, 2014; Suicide Prevention Australia, 2014; Hegerl et al., 2009):

Restricting access to means of suicide

- ***Community interventions for safer access to pesticide.*** Pesticides are among the most important means of suicide, accounting for a substantial proportion of all suicides worldwide. Pesticides are of particular concern in rural areas of low- and middle-income countries. It is therefore important for communities to determine the most common means of suicide in their local contexts. Engaging the community in reducing people's access to pesticides in contexts where suicides are impulsive, alongside community education and awareness programmes, is important (WHO, 2016b). Restricting access to the means of suicide, such as pesticides or firearms, has been shown to be effective in preventing suicide (WHO, 2014).

Responsible media reporting and public awareness-raising

- ***Establish media and communications protocols.*** Media outlets such as local radio stations, television and newspapers can be useful channels for publicizing public health messages about suicide, suicide prevention, help-seeking, and where to seek help. At the same time, it is important to ensure that the media report responsibly about suicide and that they have proper communication protocols in place (WHO, 2008a). Responsible reporting of suicide in the media has been shown to be effective in limiting imitation among vulnerable people (WHO, 2014).

- ***Reduce stigma by increasing dialogue about suicide.*** Suicide prevention involves the whole community, and social change can be achieved only by addressing the community as a whole through educational programmes and by increasing awareness of suicide. A community launch and announcement of suicide prevention as a priority can signal local commitment to reducing suicide. The effort can further be promoted by a talk from a health professional or representative of a support group of persons who have lost a loved one to suicide or have lived experience of self-harm, or by a community art initiative to promote health (Mohatt et al., 2013). Increasing dialogue about suicide in order to reduce stigma is a commonly employed activity in suicide prevention.

School-based suicide prevention programmes

- ***Provide mental health awareness and skills training in the school setting.*** Suicidal behaviours among adolescents are often a major problem. It is important for adolescents to raise mental health awareness and to enhance the skills needed to deal with adverse life events, stress and suicidal behaviours (Wasserman et al., 2015; Aseltine et al., 2007; Wilcox et al., 2008; Kutcher et al., 2016). School-based interventions have been shown to be effective in suicide prevention (WHO, 2015).

- ***Integrate young people into the design of prevention programmes, including school peer support programmes.*** As with other groups, young people can be key to the design and implementation of suicide prevention programmes aimed at them. They can identify the risk factors inherent in their community that should be integrated into the planning processes of community engagement efforts. Particularly when resources are low, young people can participate in the design of peer support programmes (Illback et al., 2010; Scott, 2011).

Introducing alcohol policies

- ***Prevent and reduce harmful use of alcohol and drug use.*** Communities can raise awareness and provide community care and support, including self-help and peer network groups, for individuals and their families affected by alcohol or drug-use problems. Communities can also prevent the selling of alcohol to under-age drinkers and support alcohol-free environments (e.g. during special events such as youth sports events) (WHO, 2010). In schools, life skills programmes can be implemented for prevention. These are commonly-used activities with relevance to suicide prevention because all substance use disorders increase the risk of suicide.

Early identification, treatment and follow-up of suicidal behaviours

- ***Train community health workers and primary health care workers to assess and manage suicidal behaviours, as well as emotional distress, chronic pain, and mental and substance use disorders and provide follow-up to those who made a suicide attempt.*** Education and training of health workers is important to ensure that timely and effective help is provided to those most in need. Also, after a hospital visit or treatment, people often lack social support and can feel isolated once they leave care. Systematic follow-up is of utmost importance to ensure that psychosocial support is provided (WHO, 2016c). This has been shown to be effective in suicide prevention (WHO, 2015).

- ***Train community leaders and gatekeepers to be effective resources.*** Leadership is a key factor for success in community engagement for suicide prevention. In a community there are formal and informal leaders (e.g. police, politicians, religious leaders) who play an important role in uniting the community and bringing people together to achieve a common goal. It is important to ensure that these leaders and other prominent members of the community (e.g. nurses, teachers, firefighters), who can act as gatekeepers, are educated about suicide prevention and play an active role in identifying persons at risk of suicide within the community (Kral et al., 2009). Gatekeeper training is a common activity in suicide prevention.

- ***Promote crisis support services and help-seeking behaviour.*** Suicidal behaviour often occurs when a person is in crisis. Communities can play an important role in highlighting the availability of helplines, support groups and other crisis intervention services. They can help to lobby for having or increasing the availability of these services. They can also encourage persons in crisis to seek help and access these services. Promoting crisis support services and help-seeking behaviour are common activities in suicide prevention.

Follow-up care and community support

- ***Start a self-help group for bereaved families.*** A self-help group of those bereaved by suicide can provide an opportunity to be with other people who have been through the same experience, to gain strength and understanding from others within the group and to provide the same to others. The group may also take on an educational role, providing information on the grief process, on facts relating to suicide, and on the roles of various health professionals (WHO, 2008b). It is suggested that such activities go hand-in-hand with professional guidance to ensure the quality of the support. Starting self-help groups for survivors (those who are left behind after a suicide) is commonly done in communities.

- ***Set up support for persons with lived experience of self-harm.*** The community can assist with supporting those who have made a suicide attempt. Organizing community events and setting up support programmes or self-help groups can ensure that individuals or families are not isolated and can thus reduce their vulnerability and risk of suicide. Persons who previously experienced self-harm can provide insight into how to support those who may be currently affected. It is suggested that such activities go hand-in-hand with professional guidance to ensure the quality of the support. Setting up support within the community is an important element in the follow-up of someone who has attempted suicide.

- ***Respond to the aftermath of a suicide for vulnerable groups and preventing suicide clusters.*** Providing training to staff and volunteers in schools, colleges, workplaces, or centres and homes for older persons can help provide support following a suicide attempt or suicide. In the aftermath of a suicide, people who are affected can have feelings of grief, shame, guilt or anger, and can become vulnerable to suicide themselves. Support is needed to promote healing and to prevent a potential suicide cluster, which is a chain of suicides where one seems to set off others (CDC, 2001; Public Health England, 2015). This is a common activity in suicide prevention.

- ***Create a directory, link all local services and programmes, and map pathways.*** A community often has an array of support services and programmes that can help to support those at risk of suicide or to provide follow-up care, particularly to those who have attempted suicide. These resources may be in the form of counselling and other primary care services, or they may be social or sports clubs and events, and they often have the potential to increase connectedness. A relevant activity would be to help promote these services and programmes within the community and ensure they are well linked, provide good quality services, have knowledge about the risk factors for suicide, can refer when necessary, and are easy to access. This is a common activity in suicide prevention.

Programmes targeted at older persons

- ***Prevention programmes targeted at older persons.*** One challenge in community mobilization can be that resources are unevenly distributed. For instance, a relatively small proportion of resources may be focused on suicides among older persons. Communities can establish suicide prevention programmes targeted at older persons by raising awareness about the issue (including among health workers and staff working with older persons), educating about healthy ageing and promoting social and community support which can assess and assist in improving life conditions (Erlangsen et al., 2011). Activities and programmes that foster a sense of purpose, resilience and other protective factors could be implemented (SAMHSA, 2015). This is a common activity in suicide prevention.

Programmes in the workplace

- ***Initiate suicide prevention activities in the workplace.*** In today's rapidly changing environment, employees are often hesitant to communicate that they are experiencing difficulties for fear that it may jeopardize their employment or career advancement. While worker suicide is a result of the complex interaction between individual vulnerabilities, stressful working conditions and living conditions, the workplace can also fulfil a supportive or even gatekeeper function. This can be done by introducing employers to the issue through awareness campaigns and by providing practical guidance on how they can assist and support someone experiencing a crisis. Moreover, communities can collaborate with companies to train designated employers or employees to become gatekeepers (WHO, 2006).

These examples are not an exhaustive list, and many more actions are possible. Therefore, further examination of the key issues affecting the community is essential, taking relevant risk factors for suicide into account, as well as finding out about other communities that have had similar issues and their efforts to combat suicide (Kral et al., 2009), which could then be adopted or adapted for the action plan.

Map the resources for the possible actions

Once the community has determined the possible actions, the next step is to consider the resources required in relation to each action. It is necessary to map the resources needed, identify where they can be found within the community, and assess their current availability (Annex 3.4). Questions to keep in mind when discussing resources include the following:

- Who should be involved in the planning, implementation, evaluation and advocacy of the actions?
- What human resources are available?
- What are the costs of the actions? How much funding is needed for implementation?
- What potential sources of funding are available? Is there a government programme that can be accessed? Are there any funding proposals that could be developed?
- Which organizations should be involved? What would be the added value of having them involved?
- Is there a need for any physical space (e.g. a community centre, a public space)?

- Can any resources be utilized for free (e.g. radio and television air time, announcements)?
- What time resources are needed from the steering committee and subcommittees?
- What is the timeline for the activities? Is there an ideal time to implement the activities?

Formulate an action plan according to priorities and resources

Following the mapping exercise, the examination of key issues and identification of possible activities for implementation, it is essential to prioritize these actions within an action plan.

If the steering committee decided to address all the key issues and conduct all actions simultaneously, it would become overstretched. By focusing on an adequate amount of actions for a given community at a time (e.g. one or two actions to begin with), efforts and resources can be concentrated to ensure optimal effectiveness. Future actions can then build on these initial efforts so that all goals can eventually be achieved.

To prioritize these actions, a simple ranking could be agreed upon, but a number of prioritization tools can also be used to facilitate this process and help with weighing community needs and evidence-based activities. One example of such a tool is a three-dimensional prioritization matrix (Annex 3.5), which asks participants to rate activities along three dimensions – perceived need, evidence, and feasibility (which includes human and financial resources and time frame). Each activity can be awarded a maximum of five points in each of the three dimensions. The sum of points for each activity should provide guidance on their prioritization.

The action plan should be in written form, with all details of actions needed (Archer & Cottingham, 2012). Moreover, the plan should provide a clear division of work and should assign responsibilities according to the resources available. Taking this point very seriously should prove helpful throughout the process.

Formulate SMARTER goals in the action plan

While there are different approaches to setting goals, one compelling way of ensuring that they are achievable and practical is to use the SMARTER goals (Annex 3.6). More precisely, these goals help in structuring the activity. Stating the goals beforehand can facilitate flexibility of the plan if any of the elements change (Capire Consulting Group, 2016).

SMARTER goals are the following (Mindstrong, 2016):

1. SPECIFIC
   Goals should be precise and clear and state exactly what they want to accomplish (Who, What, Where, Why).
   Example: Community health workers are trained to assess and manage suicidal behaviours.
2. MEASURABLE
   Goals should establish concrete criteria for measuring the progress toward the attainment of each goal set.
   Example: Reduced number of suicides in the community, increased public awareness about suicide.
3. ACHIEVABLE
   Goals should be attainable. They meet the common-sense test that they require a change in current practices or behaviour that is achievable.
   Example: Media professionals are trained to report responsibly about suicide.
4. RELEVANT
   Goals should be relevant to the target group and to the needs and priorities identified.
   Example: A self-help support group for survivors of suicide is created in the community.
5. TIMING
   Goals should have a clear and adjustable time frame during which they will be achieved.
   Example: A milestone is reached after six months.
6. EVALUATE
   Goals should be regularly evaluated and adjusted as needed to account for changes and lessons learned over time.
   Example: Community feedback meetings are taking place or surveys are conducted on a regular basis.
7. RESPONSIBILITY
   Goals should define a clear division of labour with a precise statement of who is responsible for implementation, monitoring and evaluation.
   Example: The action group has assigned clear responsibilities and tasks among its members.

Progress towards achieving the goals can be measured through regular meetings of the action group, both at the conclusion of a major activity and at other timely intervals when measuring progress is useful.

Develop an outreach strategy to promote the suicide prevention activities and community events

It is essential that the steering committee is successful in reaching out to the wider community in order to promote activities and raise awareness. When choosing an outreach strategy (Annex 3.7), the degree of stigmatization as well as cultural, religious, historical and economic factors need to be taken into consideration. The outreach strategy also needs to be adapted to the available resources.

Some approaches could include one or more of the following (Mental Health Commission of Canada, 2015):

- direct mail;
- newspapers;
- online (e.g. email, website, mailing list, social media);
- traditional print media (e.g. brochures, booklets, flyers);
- television advertisements;
- radio announcements;
- traditional meeting places (e.g. markets, concerts);
- advertisements in public transport (e.g. buses).

Ongoing mobilization of the media

The media play an important role in building public opinion and attitudes (Borinstein, 1992; Kalafatelis & Dowden, 1997; Philo, 1994). Media interest can, at times, be very high, particularly during events such as World Suicide Prevention Day on 10 September. While it is important that communities utilize the opportunity to work with the media as a channel to promote their efforts and messages, it should be noted that engagement with the media in the field of suicide prevention can be challenging. In particular, it is important that the media report cases of suicide responsibly in order to avoid imitation of suicidal acts by vulnerable persons. Media engagement is even more challenging when stigma and myths about suicide continue to exist. Given the powerful influence of the media, community engagement efforts on suicide prevention should consider ways to mobilize the media successfully (Annex 4.1).

Tips for successfully working with the local media

1. Work with the local media to develop media campaigns that inform about suicide and its prevention, promote mental health and reduce stigma. Strengthen health promotion messages on the link between stressors, mental health and physical health.
2. Encourage the local media to report responsibly about suicide (WHO, 2008a).
3. Invite the local media to participate in the community activities.
4. Encourage the local media to develop a communication strategy that includes the development and distribution of a press information kit that provides a resource for reporting responsibly on suicide and contact information for local spokespersons. Share available resources on suicide and the media.
5. Encourage the media to follow a code of ethics regarding suicide.
6. Implement a media monitoring process to collect information about appropriate coverage of suicide and provide constructive feedback on misleading or hurtful depictions of suicide.
7. Develop a process for nominating local media for existing media awards for excellence in reporting, or collaborate to establish new awards to recognize journalists.
8. Involve media professionals in a workshop on the responsible reporting of suicide.

Responsible media reporting

Several sources of guidance on responsible reporting of suicide are available for media professionals, including a WHO resource booklet (WHO, 2008a). Guidance includes:

- Take the opportunity to educate the public about suicide.
- Provide information about where to seek help.
- Avoid language which sensationalizes or normalizes suicide, or presents it as a solution to a problem.
- Avoid prominent placement and undue repetition of stories about suicide.
- Exercise caution in using photographs or video footage.
- Avoid explicit description of the method used in a suicide or attempted suicide.
- Avoid providing detailed information about the site of a suicide or attempted suicide.
- Word headlines carefully and avoid oversimplification.
- Take particular care in reporting the suicide of a celebrity and avoid melodramatic depictions of suicide or its aftermath.
- Show due consideration for people bereaved by suicide. Recognize that media professionals themselves may be affected by stories about suicide.

Monitor and evaluate the community action plan

Once an action plan has been created and actions are being implemented, it is important to check progress against the action plan and timeline, adjust for changes in a timely manner, change focus, adapt the action plan as necessary, and document obstacles and lessons learned. Monitoring and evaluation involve measuring the real impact of an intervention and assessing its effectiveness and cost-effectiveness (Acosta et al., 2013; Capire Consulting Group, 2016).

While a lot of effort goes into implementing the activities, evaluation should ideally be integrated into the community action plan throughout the development stages. It is important to find out what actually works, whether it helps people or hinders them, who it is most suitable and useful for, and if it can be adapted for use by other communities.

Monitoring and evaluation are important to community engagement efforts for the following reasons (Capire Consulting Group, 2016):

1. **continuous monitoring** to gauge how the action plan is progressing and if any adjustments and changes are required along the way;
2. **lessons learned** to help inform other suicide prevention efforts in the same community or in others;
3. **surveillance systems and quantitative change** to survey overall trends in the number of suicides and suicide attempts.

Continuous monitoring

Monitoring should ideally be integrated into the whole implementation process of the suicide prevention action plan. The objectives, targets and indicators to define what determines success, as well as the process and intervals for evaluation, should be outlined beforehand. There could be regular checks throughout to see if the activities are on track to achieve what they are intended to, and if any new possibilities have emerged or a change of direction is necessary. This can be done in a number of ways (Annex 5.1) (Capire Consulting Group, 2016; Suicide Prevention Australia, 2014). For instance:

- During meetings of the steering committee and subcommittees, set aside at least five minutes to check the progress of activities.
- Regularly ask all members involved in planning the activities what challenges they have been facing and if they suggested any changes to the activities.
- If changes are required, revise the overall objective in line with new opportunities and challenges.
- Set small incremental benchmarks (e.g. number of people attending an event, amount of radio/media air time, number of people reached with a message) to check progress throughout the process.
- If an activity is not reaching its target audience or no longer seems effective, address how it can be changed or adapted.

Scheduling time to reflect and review progress allows for refinements to the overall action plan and ensures that progress is monitored along the way. Monitoring should be part of the action plan from the planning and development stages; this will help ensure that the qualitative evaluation will also stay on track.

Lessons learned for future efforts

Review of the challenges faced and lessons learned when planning and implementing any activity of the community action plan is an important part of learning for future activities. While monitoring occurs throughout the planning and implementation process, reflecting on and documenting lessons learned after an event, programme, activity or series of activities is important to ensure that improvements can be made as necessary. Ensure that lessons learned are documented, not only for use by the steering committee in future activities, but also so that other communities can learn from them.

Consistent methods of evaluation should be selected in order to yield comparable data (Annex 5.2). Suggested methods of collecting and documenting lessons learned are as follows:

- Ask the participants who are involved in the activity to write down what they found worked or did not work, and note their take-away messages (e.g. by using a feedback form or survey).
- Ask the steering committee and subcommittees to reflect on their learning and take-away messages, as well as on the participants' feedback (e.g. in a workshop or through interviews).
- Look at various indicators, such as the quality or completeness of implementation of the activities, total number of activities implemented, number of persons who participated, satisfaction, and collaboration of stakeholders.

Another option would be to have a focus group discussion (Annex 5.3). A focus group is a small group of 6–10 persons led by a skilled moderator who facilitates an open and free-flowing discussion. It is important to prepare these sessions well because a diverse group of strangers should be selected as participants, a set of around 10 predetermined questions (which should not be shared with the participants before the discussion) needs to be carefully selected, and a moderator must be chosen along with someone to take notes/record the discussion (Elliot & Associates, 2005). Participants could include, for instance, community leaders, teachers, nurses or other health workers, religious leaders, farmers and administrative officers.

Three types of questions (Elliot & Associates, 2005) should help in addressing a given theme, such as suicide in the community and activities for its prevention, namely:

- Engagement questions: introduce participants to and make them comfortable with the topic of discussion. For example:
  - What do the participants know about suicide? What do they know about suicide prevention?
  - Are there any suicide prevention activities that the participants know of? What do they think about the suicide prevention activities implemented in their community according to the action plan?
- Exploration questions: get to the core of the discussion. For example:
  - What are the gaps in services and infrastructure at present?
  - What are the barriers to suicide prevention in the community?
  - What is the participants' perception of the effectiveness of the suicide prevention activities in reducing suicide?
- Exit question: check to see if anything was missed in the discussion. For example:
  - Would anyone like to add anything?
  - Are there any further questions?

It usually takes more than one focus group (around three of them) on a given topic to produce valid results (Elliot & Associates, 2005).

Surveillance systems and quantitative change

Beyond routine monitoring of the action plan to see how it is progressing, surveillance systems look at quantitative data. Quantitative data provide a broader picture of overall trends in numbers of suicides and suicide attempts over a period in a given community. Thus, reliable and good-quality data allow for monitoring of trends over time, and can also demonstrate the effectiveness of an intervention in reducing suicide and suicide attempts. However, suicide is a rare event and one cannot necessarily expect there to be a statistically significant change on the level of a single community. The occurrence of suicide clusters may further complicate the picture. Further indicators – such as the number of people trained, number of people referred, or number of people participating in activities – need to be used.

While the direction and potential changes of surveillance systems will belong to health care, policy and research, it is important to integrate considerations for surveillance systems within the community action plan to take account of the need to contribute ultimately to wider regional, national or global surveillance structures. The WHO report *Preventing suicide: a global imperative* (WHO, 2014) stated the importance of having a functional surveillance system as part of a comprehensive suicide prevention strategy in any country. The ultimate goal of any intervention in the area of suicide prevention is to reduce suicides and suicide attempts, which means that good-quality data need to be available.

If possible, communities (e.g. community health workers, police) should see whether they can start surveillance by routinely collecting information on suicide and suicide attempts in their area – with a view to contributing to a wider surveillance system. This can be done by assigning the role of data collection to designated persons in the community (Annex 5.4). Once a month, these persons should consult potential sources of suicide-related information, and visit relevant institutions as appropriate, to obtain the number of cases of suicide and suicide attempts and compile data on suicide. Potential sources of information include:

- hospital records;
- community leaders;
- general practitioners, community health workers and nurses;
- gatekeepers, such as teachers, police and firefighters;
- cremation grounds and cemeteries;
- designated members of the community;
- religious leaders.

It is important that any conversation about a suicide or attempted suicide remains fully confidential and that the data records are kept in a safe place.

These efforts to contribute to wider surveillance can become part of a nationwide vital registration system (which formally documents all vital events in a population). The national data can then be reported to the WHO Mortality Database (http://www.who.int/healthinfo/mortality_data/en/, accessed 14 October 2016). WHO also provides guidance on how to register injury mortality, including suicide, in mortuaries and hospitals (WHO, 2012). Equally, information on establishing or strengthening a hospital-based registration system for suicide attempts and self-harm presentations has been made available in a practice manual (WHO, 2016a). In addition, the STEPS approach to noncommunicable disease risk factor surveillance (http://www.who.int/chp/steps/en/, accessed 14 October 2016) provides a tool for obtaining nationally representative population-based data on risk factors, including suicide attempts, in a country.

Community feedback meeting

One important way of both evaluating the activities and signalling a landmark in the engagement process is a community feedback meeting (Annex 6.1). As with the initial meeting at the beginning of the process, the idea is to gather the entire community together and talk about, as well as assess, the impact of the activities. The feedback meeting can collect the lessons learned and provide some directions for moving forward. An appropriate time for holding such a meeting could be once an activity has been fully implemented.

There are many ways to conduct a feedback meeting, and the appropriate one will depend on the characteristics of the community and the features of the suicide prevention activities. It could be similar to the first meeting in its structure, or it could be just a small presentation and discussion. In order to receive feedback from the community, survey forms could be distributed.

Resources for community suicide prevention

General suicide prevention resources

- Preventing suicide: a global imperative. Geneva: World Health Organization (http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/, accessed 14 October 2016).
- Preventing Suicide: a resource series. Geneva: World Health Organization (http://www.who.int/mental_health/resources/preventingsuicide/en/, accessed 14 October 2016).
- Public health action for the prevention of suicide: a framework. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/75166/1/9789241503570_eng.pdf, accessed 14 October 2016).
- Suicide Prevention Australia. Website (https://www.suicidepreventionaust.org/, accessed 14 October 2016).
- Living is for everyone. A National Suicide Prevention Strategy project managed by On the Line, Australia, on behalf of the Department of Health. Website (http://www.livingisforeveryone.com.au/, accessed 14 October 2016).
- Working to prevent suicide. New Zealand Ministry of Health (http://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide, accessed 14 October 2016).
- Catalogue du CRES – Centre de Ressources en Suicidologie, France (in French) (http://cresuicidologie.docressources.fr/opac/index.php, accessed 14 October 2016).
- Suicide prevention resources. Substance Abuse and Mental Health Services Administration (SAMHSA), USA (http://www.integration.samhsa.gov/clinical-practice/suicide-prevention#community, accessed 14 October 2016).
- Tips for funding your program: determining your needs and developing a plan. Newton (MA): Suicide Prevention Resource Centre (http://www.sprc.org/sites/sprc.org/files/library/fundingtips.pdf, accessed 14 October 2016).

Engaging key stakeholders in the suicide prevention process

- Prompts and suggestions for speaking with local leaders on suicide prevention. Department of Health, United Kingdom (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/137641/Prompts-for-local-leaders-on-suicide-prevention.pdf, accessed 14 October 2016).
- Identifying promising partners. Newton (MA): Suicide Prevention Resource Centre (http://www.sprc.org/resources-programs/identifying-promising-partners, accessed 14 October 2016).
- #308conversations. Mental Health Commission of Canada (http://www.mentalhealthcommission.ca/English/initiatives/11884/308conversations, accessed 14 October 2016).
- Community engagement toolkit. The Social Planning and Research Council of British Columbia, Canada (http://www.sparc.bc.ca/sprout-resources-for-social-change, accessed 14 October 2016).

Examples of community suicide prevention programmes

- A community-based suicide prevention planning manual for designing a program just right for your community. Pocatello (ID): Idaho State University (http://www.isu.edu/irh/projects/ysp/CommunitySuicidePrevention/4Prevention Planning/PreventionPlanning.pdf, accessed 14 October 2016).
- Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities. London: Public Health England (https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan, accessed 14 October 2016).
- How to implement a 4-level community-based intervention targeting depression and suicidal behaviour. Leipzig: European Alliance Against Depression (www.eaad.net/uploads/media/EAAD_Manual_web.pdf, accessed 14 October 2016).
- A framework for suicide prevention planning. Winnipeg: Manitoba Health & Healthy Living (http://suicideprevention.ca/wp-content/uploads/2014/05/suicide_prevention_framework.pdf, accessed 14 October 2016).

General community engagement resources (not suicide-related)

- Participatory vulnerability analysis: a step-by-step guide for field staff. London: ActionAid International (http://www.livestock-emergency.net/userfiles/file/assessment-review/ActionAid.pdf, accessed 14 October 2016).
- Village Book Training Manual: Community led planning and development. Yangon: ActionAid Myanmar (http://www.actionaid.org/publications/village-book-training-manual-community-led-and-planning-process?width=960&inline=true, accessed 14 October 2016).
- Community toolbox. Lawrence (KS): Work Group for Community Health and Development, University of Kansas (http://ctb.ku.edu/en/table-of-contents/overview/model-for-community-change-and-improvement, accessed 14 October 2016).
- Emerging action principles for designing and planning community change. Gaithersburg (MD): Community Science (http://communityscience.com/pdfs/CS_Vol1-1_2015_v9_fugr5.pdf, accessed 14 October 2016).
- Community planning toolkit. Belfast: Community Places (http://www.communityplanningtoolkit.org/working-together, accessed 14 October 2016).
- Communities that Care (CTC) model. Seattle (WA): Social Development Research Group, University of Washington (http://www.sdrg.org/CTCInterventions.asp, accessed 14 October 2016).
- Community development handbook: a tool to build community capacity. Victoriaville: Canadian Community Economic Development Network (https://ccednet-rcdec.ca/en/toolbox/community-development-handbook-tool-build-community-capacity, accessed 14 October 2016).
- Asset mapping for asset-based community development. Website. Vibrant Communities Canada (http://vibrantcanada.ca/resource-library/community-asset-building/using-asset-mapping-asset-based-community-development, accessed 14 October 2016).
- Community readiness for community change. Fort Collins (CO): Tri-Ethnic Centre for Prevention Research, Colorado State University (http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf, accessed 14 October 2016).
- Active Implementation Hub. Chapel Hill (NC): National Implementation Research Network, University of North Carolina (http://implementation.fpg.unc.edu/, accessed 14 October 2016).

Reducing stigma and raising awareness about mental health and suicide

- Safe and effective messaging. Newton (MA): Suicide Prevention Resource Center (http://www.sprc.org/sites/default/files/migrate/library/SafeMessagingrevised.pdf, accessed 14 October 2016).
- Time to Change campaign. Website (http://www.time-to-change.org.uk/, accessed 14 October 2016).

Reducing access to means of suicide

- Methods of suicide: international data derived from the WHO mortality database. Geneva: World Health Organization (http://www.who.int/bulletin/volumes/86/9/07-043489/en/, accessed 14 October 2016).
- Limits on analgesic packaging. Newton (MA): Suicide Prevention Resource Centre (http://www.sprc.org/resources-programs/reduced-analgesic-packaging, accessed 14 October 2016).
- Preventing suicides in public places: a practice resource. London: Public Health England (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/481224/Preventing_suicides_in_public_places.pdf, accessed 14 October 2016).
- Emergency Department Means Restriction Education. Substance Abuse and Mental Health Services Administration (SAMHSA), USA (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=15, accessed 14 October 2016).
- Safer access to pesticides for suicide prevention: experiences from community interventions. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/246233/1/WHO-MSD-MER-16.3-eng.pdf, accessed 14 October 2016).

Engaging the media to encourage responsible reporting of suicide

- Canadian Association for Suicide Prevention. Website (http://suicideprevention.ca/news-resources/media-guidelines-and-social-marketing/, accessed 14 October 2016).
- Recommendations for the media. Reporting on Suicide. Website (http://reportingonsuicide.org/, accessed 14 October 2016).
- Mindset: reporting on mental health. Canadian Journalism Forum on Violence and Trauma. Website (http://www.mindset-mediaguide.ca/, accessed 14 October 2016).
- How journalists can prevent copycat suicides. Leipzig: European Alliance Against Depression (http://www.eaad.net/uploads/media/Mediaguide_2014_01.pdf, accessed 14 October 2016).
- Preventing suicide: a resource for media professionals. Geneva: World Health Organization (http://www.who.int/mental_health/prevention/suicide/resource_media.pdf, accessed 14 October 2016).

Gatekeeper training

- Suicide prevention training. Question, Persuade, Refer. Website (http://www.qprinstitute.com, accessed 14 October 2016).
- safeTALK. LivingWorks. Website (https://www.livingworks.net/programs/safetalk/, accessed 14 October 2016).
- Applied Suicide Intervention Skills Training (ASIST). Substance Abuse and Mental Health Services Administration (SAMHSA), USA (http://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=42, accessed 14 October 2016).

Youth-specific resources

- Sources of Strength (a universal suicide prevention programme). Website (https://sourcesofstrength.org/, accessed 14 October 2016).
- Reconnecting youth: a peer group approach to building life skills. Website (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=96, accessed 14 October 2016).
- Kognito At-Risk for High School Educators. Website (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=317, accessed 14 October 2016).
- American Indian life skills development/Zuni life skills development. Website (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=81, accessed 14 October 2016).
- Lifelines curriculum. Website (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=37, accessed 14 October 2016).
- Multisystemic therapy with psychiatric supports (MST-Psychiatric). Website (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=17, accessed 14 October 2016).
- Model Adolescent Suicide Prevention Program (MASPP). Website (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=251, accessed 14 October 2016).
- Sandbox Project. Teen Mental Health.org. Website (http://teenmentalhealth.org/care/health-professionals/, accessed 14 October 2016).
- Together to Live. Ottawa: Centre for Excellence for Child and Youth Mental Health. Website (www.togethertolive.ca, accessed 14 October 2016).
- Preventing suicide: lesbian, gay, bisexual and trans young people: toolkits for nurses. London: Public Health England. Website (https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people, accessed 14 October 2016).
- Headspace National Youth Mental Health Foundation Ltd, Australian Government Department of Health and Ageing. Website (http://headspace.org.au/resource-library/, accessed 14 October 2016).
- Preventing suicide: a resource for teachers and other school staff. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/66801/1/WHO_MNH_MBD_00.3.pdf, accessed 14 October 2016).

Resources for indigenous peoples

- Solutions that work: what the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. Crawley, Western Australia: University of Western Australia (http://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf, accessed 14 November 2016)
- Suicide Prevention Program. Indian Health Service, the Federal Health Program for American Indians and Alaska Natives, USA. Website (https://www.ihs.gov/suicideprevention/, accessed 14 October 2016).
- QUNGASVIK toolbox. Fairbanks (AK): University of Alaska. Website (https://www.uaf.edu/canhr/projects/elluam/Qungasvik.pdf, accessed 14 October 2016).
- Promoting Community Conversations About Research to End Suicide (PC CARES) initiated, developed, and implemented by indigenous communities in Alaska. Fairbanks (AK): University of Alaska, and Amherst (MA): University of Massachusetts. Website (http://www.pc-cares.org/about/, accessed 14 October 2016).

- White Mountain Apache Tribe and Johns Hopkins University collaboration to reduce youth suicide, including a tribally-mandated surveillance system, emergency department screening, and a multi-tiered suicide prevention program for youth. Baltimore (MD): Center for American Indian Health, Johns Hopkins Bloomberg School of Public Health. Website (http://caih.jhu.edu/programs/, accessed 14 October 2016).
- North-South Partnership for Children between First Nation chiefs, elders and youth living in remote communities in northwestern Ontario with caring individuals and voluntary organizations based in southern Ontario. Guelph: North-South Partnership for Children.Website (http://northsouthpartnership.net/index.php?option=com_k2&view=item&layout=item&id=109&Itemid=567, accessed 14 October 2016).

Resources for refugees and migrants

- Refugee Suicide Prevention Training Toolkit. Boston (MA): Refugee Health Technical Assistance Center. Website (http://refugeehealthta.org/physical-mental-health/mental-health/suicide/suicide-prevention-toolkit/, accessed 14 October 2016).
- Addressing mental health, PTSD, and suicide in refugee communities. Clearwater (FL): Gulf Coast Jewish Family & Community Services. Webinar (https://gulfcoastjewishfamilyandcommunityservices.org/refugee/2014/08/05/1202998/, accessed 14 October 2016).

Resources for older persons

- Overview of resources by Suicide Prevention Resource Center (http://ccsme.org/userfiles/files/B2%20Older%20Adults%20Prevention.pdf, accessed 14 October 2016).
- Senior's Suicide Prevention Resource Toolkit. Calgary: Centre for Suicide Prevention (https://suicideinfo.ca/LinkClick.aspx?fileticket=cmFwRL4DMJw=, accessed 14 October 2016).

Resources for workplaces

- Preventing suicide: a resource at work. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/43502/1/9241594381_eng.pdf, accessed 14 October 2016).
- Psychological First Aid. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/44615/1/9789241548205_eng.pdf, accessed 14 October 2016).

Postvention: supporting those affected by a suicide and preventing imitation

- Preventing suicide: how to start a survivors' group. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/44801/1/9789241597067_eng.pdf, accessed 14 October 2016).
- Suicide Postvention Toolkit: a guide for secondary schools. Headspace National Youth Mental Health Foundation Ltd, Australian Government Department of Health and Ageing. Website (http://headspace.org.au/assets/School-Support/Compressed-Postvention-Toolkit-May-2012-FA2-LR.pdf, accessed 14 October 2016).
- Identifying and responding to suicide clusters and contagion: a practice resource. London: Public Health England (https://www.gov.uk/government/publications/suicide-prevention-identifying-and-responding-to-suicide-clusters, accessed 14 October 2016).
- Substance Abuse and Mental Health Services Administration, USA. SAMHSA news: Suicide cluster prevention on campus (http://newsletter.samhsa.gov/2015/12/03/suicide-cluster-prevention-on-campus/, accessed 14 October 2016).

- SOS: a handbook for survivors of suicide. Washington (DC): American Association of Suicidology (http://www.suicidology.org/Portals/14/docs/Survivors/Loss%20Survivors/SOS_handbook.pdf , accessed 14 October 2016).
- Hope and healing: a practical guide for survivors of suicide. Calgary: British Columbia Ministry of Health (http://www.health.gov.bc.ca/library/publications/year/2007/HopeandHealing.pdf, accessed 14 October 2016).
- Surviving a suicide loss: a financial guide. Greenwood Village (CO): National Endowment for Financial Education (http://afsp.org/wp-content/uploads/2016/02/survivingasuicideloss_afinancialguide.pdf, accessed 14 October 2016).
- After a suicide attempt: a guide for family and friends. Winnipeg: Canadian Association for Suicide Prevention (http://suicideprevention.ca/wp-content/uploads/2014/05/CASP-After-Suicide-Attempt-12-1575.pdf, accessed 14 October 2016).
- Support After Suicide Partnership. Website (http://www.supportaftersuicide.org.uk/, accessed 14 October 2016).

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WHO (2016b). Safer access to pesticides for suicide prevention: experiences from community interventions. Geneva: World Health Organization.

WHO (2016c). mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0. Geneva: World Health Organization.

Annex 1: Tools for the community engagement toolkit

1. Initial preparation

1.1 Determine broad goals

Examples:

- *Preventing deaths by suicide and suicide attempts.*
- *Creating a supportive community environment.*
- *Developing a short- or long-term plan to provide ongoing suicide prevention efforts in your community.*

Broad goal	Priority ranking

1.2 Create a steering committee

Name	Description/ motivation	Resources	Availability	Contact details	Contacted? Response?

1.3 Steering committee: reasons, broad goals, potential benefits and long-term effects

Write down the reasons why you wish to initiate suicide prevention activities within your community:

Write down a clarification of the broad goals:

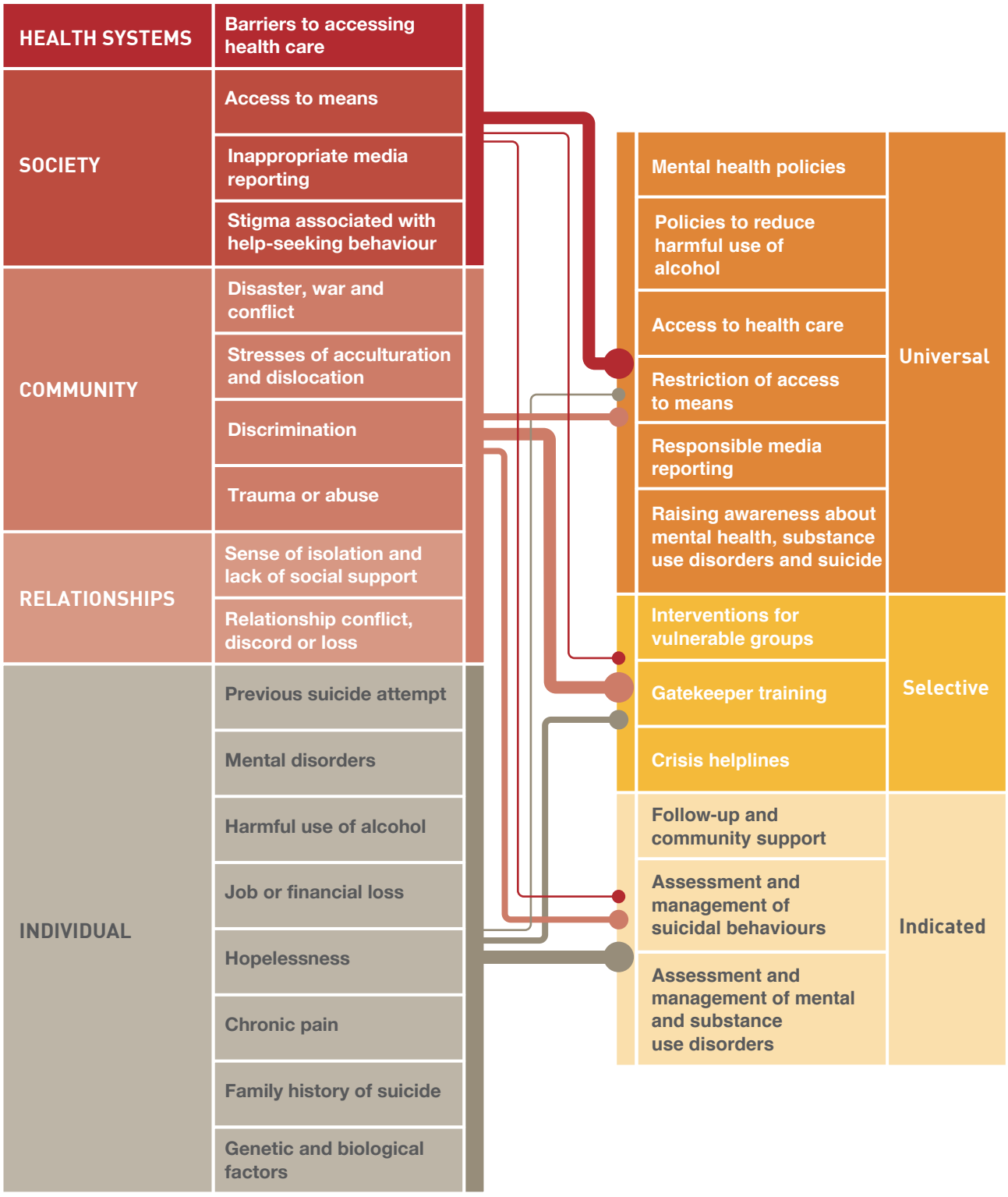
Write down the potential benefits of the prevention activities for the community:

Write down the expected long-term effects of the community engagement:

1.4 Key risk factors for suicide

Figure A1 outlines the key risk factors for suicide and the interventions that can be applied.

Figure A1. Key risk factors for suicide aligned with relevant interventions



Source: Preventing suicide: a global imperative. Geneva: World Health Organization; 2014:31.

1.5 Protective factors for suicide

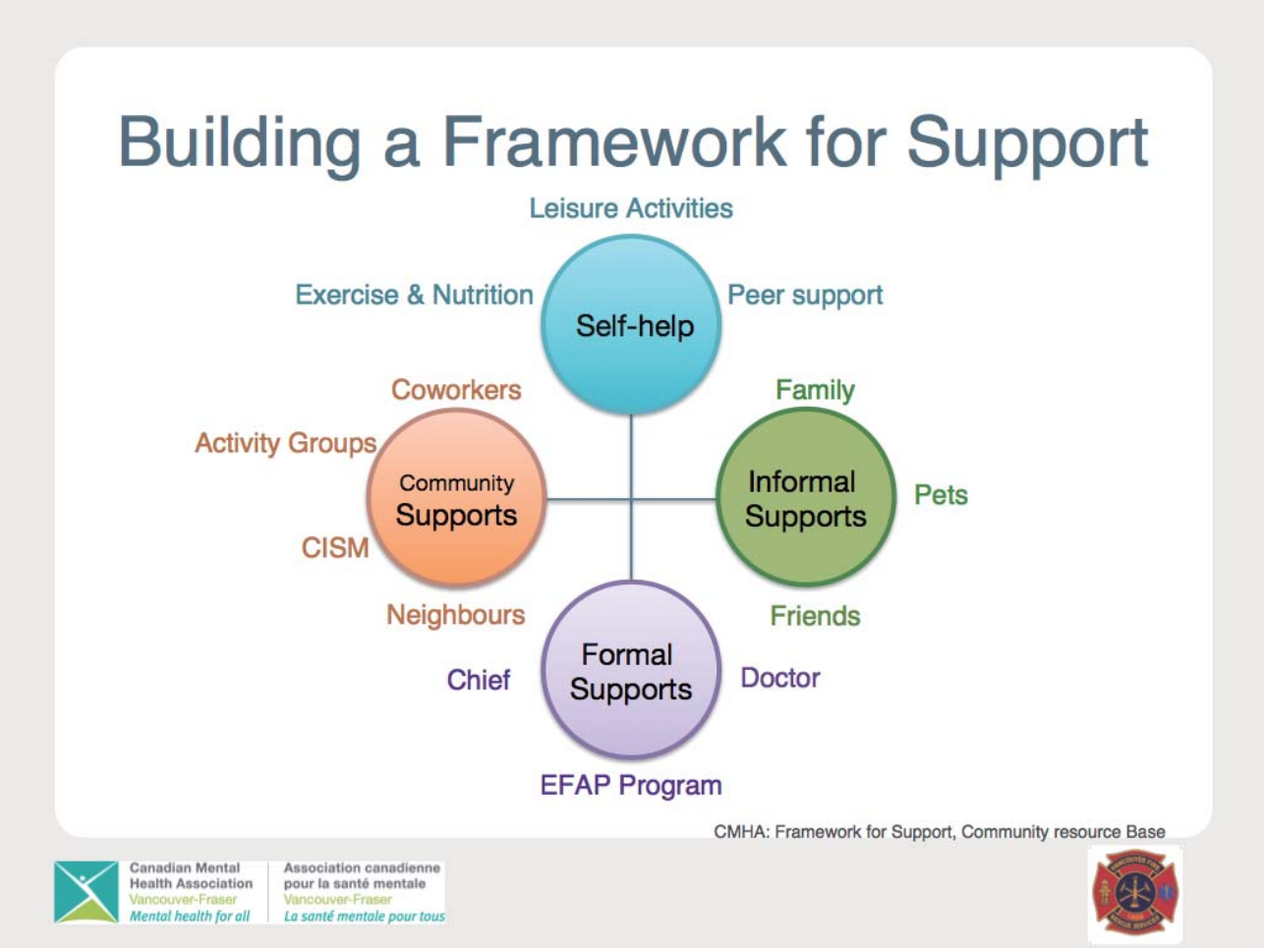
Protective factors for suicide include:

- strong personal relationships;
- religious or spiritual beliefs;
- lifestyle practice of positive coping strategies and well-being.

Source: Preventing suicide: a global imperative. Geneva: World Health Organization; 2014:44.

Figure A2 shows the structure of a framework for suicide support.

Figure A2. Building a framework for support



Source: Canadian Mental Health Association Vancouver-Fraser Branch, Resilient Minds – Building the Psychological Strength of Fire Fighters program.

1.6 Warning signs

Warning signs of suicide are directly observable, often as very immediate and acute alerts that indicate the presence of a suicidal crisis (Van Orden, 2006). Since they are manifested through verbal, behavioural and environmental signals (Rezaie, 2011), recognizing such warning signs often requires a relatively subjective assessment. The following identified warning signs can be of help in this context:

- threatening to kill oneself;
- making indirect statements, such as “no one will miss me when I am gone”, or referring to death as a place to go;
- looking for ways to kill oneself (e.g. seeking access to pills, firearms, pesticides);
- describing suicide as a solution to a problem;
- giving away valued possessions;
- saying goodbye to close friends or family members.

Reacting to warning signs

- If you observe someone who is in immediate danger of suicide, seek help as soon as possible (e.g. call an emergency number, a mental health professional, or a suicide hotline). You can also try to take the person to an emergency centre or hospital, if appropriate.
- Do not leave the person alone.
- Remove all means of suicide.
- Try to find out if the person is under the influence of alcohol or drugs or has taken an overdose. If so, act accordingly by calling an emergency number.
- Be direct. Speak openly and matter-of-factly about suicide. Ask whether the person is thinking of killing him/herself. Asking someone about their intent to die will not cause that person to attempt suicide.
- Seek help from professionals, trusted individuals and/or people who are in very close contact with the person. Share your concerns.
- Do not underestimate the threat of suicide. Do not say things like “It’s not so bad” or “Things will get better soon”.
- Do not be judgemental.
- Get involved and be interactive.

Sources: Van Orden KA, Joiner TE Jr, Hollar D, Rudd M, Mandrusiak M, Silverman MM. A test of the effectiveness of a list of warning signs for the public. Suicide and Life-Threatening Behaviour. 2006;36(3):272–87.
Rezaie L, Khazaie H, Soleimani A, Schwebel DC. Self-immolation a predictable method of suicide: a comparison study of warning signs for suicide by self-immolation and by self-poisoning. Burns. 2011;37(8):1419–26.

1.7 Know the community

Think about: geographical location, vulnerability, ethnicity, socioeconomic groups, indigenous groups, cultural groups, religious groups, refugees, age groups, patterns of alcohol and substance abuse.

Describe the population you wish to involve in suicide prevention:

Have there been suicides and suicide attempts in the community? If yes, how many? Which ages, which sex? What are the risk factors, and what are the protective factors relevant to your community (see sections 1.4 and 1.5 of this annex)? Which means of suicide are mostly used in your community?

What are the cultural and religious beliefs and the socioeconomic situation in your community and how do you think they may relate to suicide prevention?

Describe the communication infrastructure and the resources of your community. What are the most prominent channels of communication in your community? Which are the most prominent media outlets in your community?

Describe the resources of your community for suicide prevention. What could be barriers to your activities?

What is the quality of services for persons who made a suicide attempt or who are bereaved by suicide, and to what extent can persons access these services? Are there any existing programmes in place? If there are existing services, have the service providers received training?

What do you think are the most urgent needs for suicide prevention in your community?

1.8 Community readiness assessment

Score the following dimensions of community readiness according to your research (informal discussions, reading, etc.):

Dimension	Score (maximum: 5)
Degree of community readiness and community knowledge	
Leadership	
Community climate	
Community knowledge of the issue	
Resources	

Explanations of the dimensions:

Degree of community readiness and community knowledge: How much does the community know about the current suicide prevention programmes and activities?

Leadership: What is leadership's attitude towards addressing suicide prevention?

Community climate: What is the community's attitude toward addressing suicide prevention?

Community knowledge of the issue: How much does the community know about suicide prevention?

Resources: What resources are being used or could be used to address suicide prevention?

Source: Community readiness for community change. Fort Collins (CO): Tri-Ethnic Center for Prevention Research; 2014 (http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf, accessed 14 October 2016).

1.9 Stakeholder mapping exercise

Examples of stakeholders:

Politicians; parliamentarians; health-care providers; community and faith-based organizations; community members who have a lost a loved one, friend or colleague to suicide; persons with lived experience; community leaders; community development or social workers; teachers or other school staff; traditional healers or community elders; military officers; police, firefighters, or other first-line responders; sports organizations; youth workers or those working with older persons; local mental health support agencies or charities; organizations concerned with community well-being; volunteer groups; business leaders.

Stakeholder	Description	Resources, skills, expertise and weaknesses	Role in community	Network in community and relationship to other groups and stakeholders	Relationship with suicide prevention, reasons for aversion, reasons to engage	Contact details

1.10 Choose an engagement technique for the first meeting

Describe your community's attitudes to suicide prevention:

Write down important cultural or religious beliefs, social and economic circumstances and common channels of communication that should be kept in mind when contacting your community:

What barriers could you be facing when engaging with the community?

Examples: Limited advocacy experience; stigma or taboo linked to suicide and its prevention; lack of accurate information on suicide cases or an emerging suicide cluster; lack of resources such as time, professional expertise and money; complicated and bureaucratic communication with civic and public organizations; dissatisfaction with health and community services; potential interest of some stakeholders to dominate decision-making processes and influence activities.

Do you need to organize an awareness-raising event before the first meeting (e.g. as a result of the readiness model assessment)? If yes, what kind of event do you have in mind?

Examples: Social media campaign; traditional media campaign, such as billboard posters, television and radio; inspirational speeches, training sessions; road shows; street theatre; symposia.

What engagement technique will you use for the first meeting?

Example of techniques: Roundtable, workshop, town hall meeting, discussion forum.

How will you inform the public about the meeting? How will you reach out to the community?

Examples: Public notices, posters, emails, official invitations via post, radio announcements.

1.11 Plan and organize the first meeting

(See Annex 2 for key items to consider in an example from the #308conversations case study).

Task	Progress
Invitations sent	
Venue booked	
Logistics organized (e.g. projector, chairs, information leaflets)	
Agenda prepared	
Opening organized (e.g. guest speaker, presenter)	
Closing organized	
Outreach organized (e.g. connected with media, journalists invited)	
Role of the moderator of the meeting allocated	
Role of record-keeper/note-taker allocated	

1.12 Prepare the agenda

Example (see Annex 2 for an example from the #308conversations case study):

1. *Welcome and introductions.*
2. *Why community members have come together today:*
   - *Why are we here?*
   - *Group discussion on the issue of suicide in the community.*
3. *Information sharing: What is each person/group/organization already doing in suicide prevention and how do they want to assist in attaining the goals of the group?*
4. *Mapping exercise (see tool in section 2). The meeting participants should work together to map the impact that suicide has had on different parts of the community, as well as identify potential resources and services to assist persons who are vulnerable to suicide.*
5. *Determine who will continue to meet as part of a steering committee and how regularly. Note down contact details, including of persons who may not be part of the steering committee but who may become involved in future efforts.*
6. *Concluding remarks.*

Source: Suicide Prevention Australia. Communities matter: a toolkit for community driven suicide prevention (A resource for small towns) Version 1. Gladesville: New South Wales Mental Health Commission; 2014 (https://communitiesmatter.suicidepreventionaust.org, accessed 24 June 2016).

Write your agenda here:

1.13 Questions that the moderator could take into consideration

1. How do we best overcome stigma surrounding suicide and mental distress – both as individuals and as a community?
   - What are some ideas for dispelling stigma related to suicide?
   - What is your greatest hope?

2. How do we ensure that people in our region are comfortable with discussing suicide prevention and mental distress and can do so in a safe manner?
   - What are the biggest fears when talking about suicide (in your home, in your place of work, during your recreational activities)?
   - What do you need in order to feel more comfortable?

3. An immense range of resources is available to promote mental health and prevent suicide. How do we get these tools into the hands of the people who need them?
   - What is one thing you could do tomorrow?

1.14 Public notice for the first meeting

Example:

Community meeting on suicide prevention
(Name) will be hosting a community conversation for interested citizens to discuss suicide prevention in the community. This will be an opportunity to hear from, and engage with, local experts, health-care providers, police, teachers, social workers, service providers, survivors of suicide, persons with lived experience, faith-based community leaders/groups, military representatives, and community and business leaders.

This community meeting is designed to gather valuable insight and ideas on suicide prevention. The goal is to share the best ideas and work together to create lasting solutions for our community.

The idea is to bring interested community members, associations and stakeholders together to share what is working in suicide prevention in our community, where the gaps are, and what each of us can do. On the basis of our discussions, an action group will be formed to plan further activities.

Date:

Time:

Place:

Write your public notice here:

2. Begin the conversation in the first meeting

2.1 Conduct a mapping exercise

Instructions: Make sure to provide a piece of paper or a flipchart and pen for each group.

1. Gather people in a common area during the first meeting and encourage everyone to participate.
2. Explain the purpose of the exercise and how it is useful to analyse and understand the situation in the community with regard to suicide and its prevention.
3. Talk about the means of suicide commonly used in the community (e.g. pesticides, firearms) and ask participants to locate prominent suicide "hotspots" – i.e. sites frequently chosen to take one's life (e.g. bridges).
4. Ask participants to locate the available social, health and suicide prevention services (e.g. schools, hospitals, crisis centres, places of worship).
5. Ask participants to talk about the accessibility, features, and quality of the services they identified.
6. Ask participants about the role of local media in suicide prevention.
7. Ask participants to identify risk and protective factors for suicide within their community (see sections 1.4 and 1.5 for an overview of risk and protective factors).
8. Discuss strengths and weaknesses for suicide prevention in the community, such as resources, potential gaps and local concerns (e.g. suicide among young people, indigenous persons or refugees).

See also, for instance, participatory mapping in the Participatory learning and action toolkit. Paris: Business for Social Responsibility; 2012 (https://herproject.org/downloads/curriculum-resources/herproject-pla-toolkit.pdf, accessed 14 October 2016).

3. Create a community action plan

3.1 Look at examples of community engagement that have been carried out elsewhere

Name of community engagement project	Location	Targeted population and scope	Activities implemented	Outcomes	Lessons learned	Relevance to my community activities	Helpful resources and/or contact details

3.2 Identify activities that have been shown to be effective and are relevant to your community

Write down activities that have been shown to be effective and indicate their relevance to your community:

3.3 Examine the key issues and possible community actions

Example:

Key issues	***Possible community actions***
Stigma surrounding suicide due to religious or cultural beliefs present within the community	• *Reduce stigma by increasing dialogue on suicide and mental health*
Lack of understanding of suicide and mental health within the community	• *Train community health workers and primary health care workers to assess, manage and follow up suicidal behaviours* • *Train community leaders and gatekeepers to be effective resources* • *Promote crisis support services and helpseeking behaviour*
Ready access to the means of suicide (e.g. pesticides, firearms)	• *Community interventions for safer access to pesticides*
Social stressors (e.g. stress among school or university students during examinations)	• *Provide mental health awareness and skills training in school settings* • *Integrate young people into the design of prevention programmes, including school peer support programmes*
Local media who sensationalize suicide through inappropriate reporting	• *Establish media and communication protocols*
Lack of support and services for persons who are vulnerable to or bereaved by suicide	• *Set up support for bereaved families and those with lived experience of self-harm* • *Respond to vulnerable groups in the aftermath of a suicide* • *Target prevention programmes at older persons* • *Create a directory, link all local services and programmes, and map pathways*

Key issues	***Possible community actions***

3.4 Map the resources for the possible actions

Person	Expertise/ Resources	Motivation	Availability	Assigned task

3.5 Formulate an action plan according to priorities and resources

One example of a way to select activities for the action plan is a three-dimensional tool that takes into account perceived need, evidence and feasibility:

1. Write down the activities which you would like to rank in the left column.
2. Rank each of these activities according to each of the three dimensions by allocating points (0 points is lowest and 5 points is highest).
3. For each activity, sum up the points received in each of the three dimensions.
4. Discuss the results.
5. Select the activities for the action plan accordingly.

Activity	**Perceived need** (0–5 points)	**Evidence** (0–5 points)	**Feasibility: human and financial resources, time-frame** (0–5 points)	**Sum of all points** (maximum 15 points)

List the activities in order, starting with the one that received the most points:

3.6 Determine SMARTER goals

Write down your SMARTER goals (Specific, Measurable, Achievable, Relevant, Timing, Evaluate, Responsibility):

3.7 Determine your outreach strategy

Describe the cultural, religious, social, historical and economic factors in the community, as well as stigmatization of suicide. Note how these factors relate to suicide prevention and to your outreach strategy. Consider the resources of the action group.

Write down your outreach strategy:

Examples: Direct mail, newspapers, online (e.g. email, website, mailing list, social media), traditional print media (e.g. brochure, booklet, flyer), television advertisement, community announcement on the radio, traditional meeting places (e.g. markets, concerts), advertisement on public transport (e.g. buses)

4. Ongoing mobilization of the media

4.1 Work with media professionals

Write down the media professionals or agencies you would like to work with (see Annex 2 for examples of a news release and an Op-ed from the #308converstations case study):

Name	Contact details	Contacted?	Response?

5. Monitor and evaluate the community action plan

5.1 Continuous monitoring

Example: During meetings of the community action group, at least five minutes should be set aside to check the progress of activities. Regularly ask all members involved in planning the activities what challenges they have been facing and if they suggest any changes to the activities. If changes are required, revise the overall objective in line with new opportunities and challenges. Set small incremental benchmarks (e.g. the number of people attending an event, amount of radio/media coverage, number of people reached with a message) to check progress throughout the process. If an activity is not reaching its target audience or no longer seems effective, address how it can be changed or adapted.

Goal	Monitoring strategy	Situation before activities	Situation after activities

5.2 Document the lessons learned

Examples:

- *Ask the participants who are involved in the activity to write down what they found worked or did not work in the activity and their take-away messages (e.g. use a survey).*
- *Ask the steering committee and subcommittees to reflect on what they learned and their take-away messages as well as on participants' feedback (e.g. in a workshop, or through interviews).*
- *Review the implementation of the activities, noting the total number of activities implemented, the number of persons who participated, their satisfaction, and the collaboration of stakeholders.*
- *Conduct focus group discussions (see section 5.3).*

Write down the lessons learned:

5.3.Focus group discussion

How are focus group participants recruited?

Example: Nomination (e.g. persons who are familiar with the topic and known for their ability to share their opinions respectfully), random selection (from a large but defined group such as a school), all members of the same group, persons with the same role/job title, volunteers (e.g. recruited through flyers).

Write down the list of participants in the focus group discussion:

Who will be the moderator? Who will take notes or record the discussion?

What topics will be discussed?

Examples: Participants' perception of suicide in the community, reasons for and methods of suicide in the community, the implementation of suicide prevention activities.

What will be engagement, exploration and exit questions?

Examples:

<u>Engagement questions:</u> What do the participants know about suicide and its prevention? Do the participants know of any suicide prevention activities? What do they think about the suicide prevention activities implemented in their community according to the action plan?
<u>Exploration questions:</u> What are the gaps in services and infrastructure at present? What are the barriers to suicide prevention in the community? What is the participants' perception of the effectiveness of the suicide prevention activities in reducing suicide?
<u>Exit questions:</u> Would anyone like to add anything? Are there any questions left?

See also, for instance, Guidelines for conducting a focus group (https://assessment.trinity.duke.edu/documents/How_to_Conduct_a_Focus_Group.pdf, accessed 14 October 2016).

5.4 Surveillance systems and quantitative change

Assign the role of data collection on suicide and suicide attempts to designated persons in the community and write their names here:

Request the designated persons to consult hospital records and visit community leaders, general practitioners, community health workers, nurses, gatekeepers (e.g. teachers, police, firefighters), cremation grounds and cemeteries, designated members in the community, and religious leaders once per month. Write down the number of cases of suicide and suicide attempts in the community each month:

6. Community feedback meeting

6.1 Organize the community feedback meeting

Task	Progress
Invitations sent	
Venue booked	
Decided how to receive feedback from community members	
Logistics organized (e.g. projector, chairs, information leaflets)	
Agenda prepared	
Opening organized (e.g. guest speaker, presenter)	
Closing organized	
Outreach organized (e.g. connected with media, journalists invited)	
Role of the moderator of the meeting allocated	
Role of record-keeping/note-taking allocated	

Annex 2: Tools from #308conversations

1. News release template (for adaptation to the local situation)

FOR IMMEDIATE RELEASE

(Name of host organization) hosts suicide prevention community meeting: #308conversations

CITY, DATE – (Name of organization) will host a community conversation about suicide prevention at (building location), (date). This community meeting is part of the #308conversations initiative launched by the Mental Health Commission of Canada (MHCC), and is designed to gather valuable insight and ideas on suicide prevention across Canada. Community meetings or "conversations" will be hosted by organizations across Canada.

"#308conversations is about bringing interested community members, associations and stakeholders together to share what's working, where the gaps are when it comes to suicide prevention and what each of us can do to help," said (host organization). "We all have a role to play."

Between May 2014 and May 2015, organizations from across Canada will invite local experts, service providers, health-care providers, local police, teachers, social workers, service clubs, survivors, faith-based community leaders/groups, military representatives, veterans and community leadership, as well as interested citizens to discuss suicide prevention.

"#308conversations is designed to gather valuable insight and ideas on suicide prevention across Canada, with the goal of sharing the best ideas and working together to create lasting solutions that will serve our communities," said Louise Bradley, CEO of the MHCC. "The Mental Health Commission of Canada will gather the results of these meetings to produce a working community model that can be shared as a resource for communities across Canada. At the same time, Canadians will also learn new information on the actions and initiatives taking place in their own communities."

Date:

Time:

Place: (building, room)

For more information on #308conversations, please visit:
www.mentalhealthcommission.ca/308conversations.

Follow the conversation on Twitter: #308conversations or @MHCC_308

Source: #308conversatioans. Ottawa: Mental Health Commission of Canada (www.mentalhealthcommission.ca/308conversations, accessed 21 October 2016).

2. Op-ed template (for adaptation to the local situation)

Time for a conversation about suicide?

Every year, in Canada, nearly 3900 people die as a result of suicide and many more attempt to end their lives. No part of society is immune from suicide. Suicide is a public health issue that affects us all. Suicide is one of the top 10 causes of death in Canada and, among young persons aged 15–24 years, it is the second leading cause of death after accidents. The estimated financial cost of a suicide ranges from $433 000 to $4 131 000 per individual, depending on potential years of life lost, income level and the effects on survivors. The emotional cost to the bereaved survivors of suicide is immeasurable. The suicide of one person has the potential to impact the lives 7 to 10 others significantly and places them at higher risk of suicide themselves?

But it's not all bad news. The good news is that the prevention of suicide is possible. While the causes of suicide are complex, we know that the promotion of good mental health, the prevention of mental illness and a reduction of stigma all contribute to mental wellness and the reduction of suicide and its consequences. We can all play a role in reducing suicides and we all have a collective responsibility to do so.

We must play a role in preventing suicide in our own communities. Suicide is an issue that is still surrounded by fear, shame and silence, but by breaking the stigma and openly addressing the factors that contribute to suicide we can all help to prevent it. By educating ourselves about the warning signs and recognizing risk factors, by agreeing to participate in a training programme, by reaching out to a fellow human in need we can all prevent suicide.

We are convening a meeting in our community to discuss suicide prevention and what we can do locally and individually. We invite you to join us and take some time from your busy schedule to see what you can do to help and make yourself aware of what is happening in our own community on this important issue. The meeting will be held on XXX at XXX. We look forward to seeing you there.

Sincerely,
(name)

Source: #308conversations. Ottawa: Mental Health Commission of Canada (www.mentalhealthcommission.ca/308conversations, accessed 21 October 2016).

3. Suggested roll-out for the event

Outlined below are key items to consider when planning and implementing your #308conversations community meeting.

#308conversations checklist		
Date	✓	**Activity**
3 weeks before the meeting		
		Choose a date
		Book a location
		Choose a meeting format (panel, town hall, roundtable, etc.)
		Confirm audiovisual materials needed
		Invite stakeholders, high-profile community advocates, panelists
		Secure mental health first aider
		Customize materials in #308conversations event kit – also available online at www.mentalhealthcommissionofcanada.ca/308conversations
		Notify community organizations of the location and date for posting on their websites
		Create content for social media (refer to social media primer for tips)
		Post meeting posters in high traffic areas
2 weeks before the meeting		
		Distribute materials to community papers and media
		Place public notice in community papers and local calendar of events
		Issue news release
1 week before the meeting		
		Promote the event through social media – #308conversations
		Contact media to arrange interviews
		Draft and deliver agenda for the meeting
		Print feedback forms for all participants
A final checklist of meeting materials		
		Coffee, tea, water
		Location signs and tape
		Boxes of paper tissues
		Table for local information material
		Identify meeting note-taker
		Sign-up sheet for participants
		PowerPoint slides
		Review the discussion guide
		Photo/media release waivers for participants
		Printed feedback form with pens and pencils
		Audiovisual materials
1 week after the meeting		
		Draft thank you letters to invited guests (see template)
		Submit feedback to mental health groups

Source: #308conversations. Ottawa: Mental Health Commission of Canada (www.mentalhealthcommission.ca/308conversations, accessed 21 October 2016).

Suggested Tick Tock (for adaptation to the local situation)

Date: (Day), (Month), (Year), (Location), (City)

#308conversations: public conversation – (Organizer name) invites all community members to engage in a community conversation initiated by (name) at (location) to help in the development of a community model on suicide prevention.

Upon arrival:
Insert details if applicable (i.e. directions, parking, registration)

Event scenario:
Meetings will be held in a community centre, library, school gymnasium or another accessible location of the organizer's choice. The set-up of the room shoiuld reflect the meeting format (panel, town hall). Coffee, tea, water and cookies could be offered to attendees.

Contact information:

Organizing staff and volunteers		
(Name)	(Number)	(email)
(Host name)		
(Name)	(Number)	(email)
Stakeholders (if applicable)		
(Name)	(Number)	(email)

Source: #308conversations. Ottawa: Mental Health Commission of Canada (www.mentalhealthcommission.ca/308conversations, accessed 21 October 2016).

4. Suggested agenda for the event

Set-up		
(time – 90 minutes before the event)		Staff arrive at location Audiovisual set-up at (location) Tables and chairs set-up Registration table and information table set-up, feedback form on every chair Coffee and tea, refreshments set-up
Event		
(time – 30 minutes before)		Special guests and stakeholders arrive at (location)
(time – 15 minutes before)		Doors open and registration begins
(time – 90 minutes)	5 minutes	Facilitator - welcomes guests - introduces MHCC/VIP/stakeholders (if applicable) - explains meeting format - states media policies*
	10 minutes	Importance of the #308conversations process Introduction to topics of discussion
	15 minutes 15 minutes 15 minutes 15 minutes 25 minutes	Draft discussion topic 1 Draft discussion topic 2 Draft discussion topic 3 Draft discussion topic 4 Final gathering of suggestions (what works well, where are the gaps?)
	5 minutes	Organizer delivers closing remarks
(time – 15 minutes)		Coffee and tea service continue
Event conclusion		
(time)		Room clear-up and removal of equipment

***Note to media:**
Media are welcome to attend the meeting; however, for reasons of privacy, no recording devices will be permitted inside the meeting room. On-the-record interviews should take place before or after the meeting.

Source: #308conversations. Ottawa: Mental Health Commission of Canada (www.mentalhealthcommission.ca/308conversations, accessed 21 October 2016).

5. Thank you letter (for adaptation to the local situation)

Name
Address
City, province, postal code

Dear (name),
On behalf of (organization) and the (host), we wish to thank you for your participation on (date) in our community conversation about suicide prevention, intervention and postvention.

Our community meeting was part of the #308conversations initiative launched by the Mental Health Commission of Canada, and was designed to gather valuable insight and ideas on suicide prevention in our area. Your contribution to this discussion was appreciated and noted.

Once again, we wish to thank you for your participation on this new initiative for suicide prevention.

Sincerely,
(name)

Source: #308conversations. Ottawa: Mental Health Commission of Canada (www.mentalhealthcommission.ca/308conversations, accessed 21 October 2016).