Preventing suicide

A community engagement toolkit

World Health Organization

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Foreword

Suicides take a high toll. Over 800 000 people die by 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 dies of suicide there may be 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 urgently.

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 their situation.

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

The Mental Health Commission of Canada launched the grassroots initiative #308conversations by 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. This toolkit is a step-by-step guide for communities to engage in suicide prevention activities, take ownership of the process and keep efforts sustained. The toolkit is not a manual for initiating specific interventions; rather, it 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 that can influence and shape policy and services.

We hope that the community engagement toolkit will be used in many countries and contexts. 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, namely "by 2030 reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being". This target is unlikely to be achieved unless communities are actively engaged in efforts for suicide prevention.

Dr Shekhar Saxena
Director
Department of Mental Health
and Substance Abuse
World Health Organization

Louise Bradley
President and Chief Executive Officer
Mental Health Commission of Canada

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SUPERVISION AND GUIDANCE
Shekhar Saxena (WHO), Louise Bradley (Mental Health Commission of Canada)

PROJECT COORDINATION AND EDITING
Alexandra Fleischmann (WHO)

TECHNICAL CONTRIBUTION AND DRAFTING
Ed Mantler, Jennifer Vornbrock, Karla Thorpe, Stephanie Machel, Megan Schellenberg, Samuel Breau, Aimee LeBlanc (all from the Mental Health Commission of Canada), Lakshmi Vijayakumar (India), Sutapa Howlader (Australia), Anna Frühauf (Germany), Elisabet Arribas-Ibar (Spain)

REVIEW OF PILOT AND/OR FINAL VERSION
Shaazneen Ali (Maldives), Ralph Aquila (USA), Ella Arensman (Ireland), Jeffrey Aron (USA), José Ayuso-Mateos (Spain), Agnes Becker (United Kingdom), José M Bertolote (Brazil), Renzo Bonn (Italy), Robert Bossarte (USA), Pamela Collins (USA), Diego De Leo (Australia), Paolo Del Vecchio (USA), Geert Dom (Belgium), Rabih El Chammay (Lebanon), Jacqueline Garrick (USA), Ulrich Hegerl (Germany), Helen Herrman (Australia), Juliane Hug (Germany), Hiroto Ito (Japan), Roy A Kallivayalil (India), Zurab Kekelidze (Russian Federation), Nicole Koburger (Germany), Elisabeth Kohls (Germany), Kairi Kolves (Australia), Ilana Lapidos (USA), Nancy Liu (USA), Richard McKeon (USA), Roberto Mezzina (Italy), Nerges Mistry (India), Yutaka Motohashi (Japan), Elise Paul (USA), Sara Pedersini (Switzerland), Michael R Phillips (China), György Purebl (Hungary), Jessica Spagnolo (Canada), Graham Thornicroft (United Kingdom), Mónika D Tóth (Hungary), Nadja Van Ginneken (United Kingdom), Laetitia Van Haren (United Kingdom), Simon Vasseur Bacle (France), Danuta Wasserman (Sweden), Megan Williams (USA)

USE OF THE PILOT VERSION
Sujit John, Lakshmi Vijayakumar, Neha Lamech (India), Merab Mulindi (Kenya), Kedar Marahatta (Nepal), Edwin Bolastig, Gerard Hutchinson (Trinidad and Tobago), Robert Bossarte (USA)

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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 in general 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 sensitive 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, problematic substance use, job loss or financial loss, trauma or abuse, and chronic pain or illness, including cancer, diabetes and HIV/AIDS. 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 the 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 (Wasserman, 2016).

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, multilevel 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 so-called “gatekeeper” role of identifying people at risk of suicidal behaviour or noting emerging suicide clusters. Perhaps most importantly, communities can help by giving people 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 (Coppens et al., 2014; Kral et al., 2009).

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 or in enhancing activities that may already be in place. The document is a guide for communities to engage in suicide prevention activities; it is 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 groups, refugees, minorities, military, prisons, workplaces, LGBTI,[1] socially deprived or isolated persons).

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 this material or design its own plan, tools and activities to ensure that these best fit the community and are acceptable and appropriate to the local context.

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

Figure 1. Overview of the community engagement process

1. Initial preparation

1. Know the community and foster a supportive community environment
2. Consider the scale, population, services and information available
3. Define broad goals
4. Form a steering committee
5. Identify key stakeholders
6. Choose an engagement technique for the first meeting
7. Plan and organize the first meeting

1. 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 the community environment, broad goals and initial analyses, as well as the choice of an engagement technique for the first community meeting.

1. Know the community and foster a supportive community environment

Suicide is a sensitive issue that is shrouded in silence, taboo and stigma in the majority of societies. Communities should feel ready to bring suicide out of the shadows before taking any action. Therefore, it is very important to know the community and foster a supportive community environment (Annex 1.1) for suicide prevention from the beginning of the process. Every community is different, and understanding its perceptions and attitudes towards health, and to suicide in particular – as well as its religious beliefs, sociocultural context and stigma around suicide and mental health – is fundamental for success. Fostering a supportive community environment is an ongoing process. Awareness-raising and sensitization about suicide among members of the community could mean providing information about suicide and its prevention, the burden of suicide attempts and suicide, risk and protective factors, vulnerable groups, or the role that communities can play in suicide prevention. This would allow communities to intervene in minimal ways first, with the available human and economic resources, before building up to large-scale community-wide actions.

Awareness raising could take the following forms:

- social media campaigns;
- traditional media campaigns (e.g. on television or radio);
- community town hall meetings;
- workshops or webinars;
- banners, posters, billboards or advertisements;
- road shows;
- street plays, drama or theatre;
- training sessions;
- symposia.

Connecting individuals, groups and organizations who share suicide prevention as a common interest and developing networks and partnerships are also important steps. Before setting up a first meeting with the community at large, initial discussions could take place with smaller groups to explore beliefs, thoughts, perceptions, attitudes and feelings about suicide and cultural issues. These initial discussions could include, for instance, meetings with groups for women, men, youth or older persons, meetings in schools or workplaces, talks with health or social workers, or with volunteers or other subgroups of the community, such as minority groups. Networks and partnerships contribute to building and strengthening the commitment to work together to address suicide.

Also, in this initial phase, it could be helpful to identify and bring on board a champion (a distinguished or recognized member of the community or a celebrity) who speaks out about suicide and the importance of preventing it. This person could tell his or her own story or how they or someone close to them managed to cope with adverse circumstances. This could help to capture the attention of community members and make it easier for them to start a conversation about suicide.

The media play an important role in awareness-raising and sensitization of the community. Ongoing mobilization of the media throughout the community engagement process is essential (see the section on Ongoing mobilization of the media) to ensure that information is disseminated widely. Mobilizing the media should be seen as natural step in the process of the community engagement.

2. Consider the scale of engagement, population, services and information available

It is 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.

Before initiating the first meeting with the community or before starting activities, it is essential to find out whether a suicide has occurred recently, which services are available, 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.

Developing and facilitating appropriate suicide prevention for a community also requires an understanding of the available data, and awareness of data limitations, and a commitment to improving data quality so that it more accurately reflects the effectiveness of specific activities (WHO, 2014).

When considering the community, the following factors (Annex 1.2) should be taken into account:

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;
- mental health awareness or suicide prevention programmes in schools;
- training of specialized and non-specialized health workers;
- gatekeeper training (e.g. for police or firefighters).

Communications system in the community:
- channels of communication within the community;
- prominent media;
- guidelines for responsible reporting of suicide by the media.

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 1.7 and 1.8) present in, and relevant to, the community.

Potential data sources:
- police statistics;
- records of community health services or facilities;
- coroners’ reports;
- databases from crisis lines;
- district surveillance;
- national surveillance systems.

The following are of particular importance:
- age groups (e.g. older persons, the young, young women, middle-aged men);
- vulnerability (e.g. refugees, migrants, minorities, persons who have experienced abuse, trauma, conflict or disaster);
- alcohol or substance abuse;
- 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);
- geography (e.g. urban versus rural).

One way of conducting an initial analysis of the community is through the community readiness model (Edwards et al., 2000) (Annex 1.3). The model categorizes the readiness of communities for change according to different stages and uses five dimensions – i.e. 1) existence of efforts and community knowledge of efforts, 2) leadership, 3) community climate, 4) community knowledge of the issue, and 5) 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 (which could be complementary) would be to start informal (or formal) face-to-face interviews with potential stakeholders or to hold focus group discussions. 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.

3. Define 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. As a starting point, they could be asked what they would like to change or what differences they would like to see. This could help in formulating initial ideas and broad goals.

Common broad goals (Annex 1.4) which often motivate interested stakeholders and leaders should be based on the needs felt in the community and could include the following (Suicide Prevention Australia, 2014):

- being able to talk about suicide;
- knowing where to seek help and assisting others in seeking help;
- establishing self-help groups or helping others who have lost someone or who are affected;
- preventing deaths by suicide and suicide attempts;
- promoting mental health and well-being;
- educating about early identification and management of suicidal behaviours;
- developing a short-term or long-term plan to provide ongoing suicide prevention efforts in the community.

As the process of community engagement evolves, broad goals can become more specific, and small actions involving less time and fewer resources can turn into bigger, more comprehensive actions with a long-term perspective.

4. Form a steering committee

Initial efforts to take the lead in suicide prevention can emerge 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 (Capire Consulting Group, 2016; Mental Health Commission of Canada, 2015; Suicide Prevention Australia, 2014):

- community leaders, politicians, parliamentarians, or representatives;
- workers in health, mental health or substance use, 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 youth or student groups;
- older peoples' groups, or those working with older people;
- peer supporters;
- community members who have lost a loved one, friend or colleague to suicide;
- individuals with lived experience who made a suicide attempt;
- business leaders;
- women`s and men's groups;
- indigenous peoples;
- refugees;
- minorities and ethnic groups in the community;
- support groups for alcohol problems;
- 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 1.5) should be willing to commit time and effort to the process and meet regularly. They should create a shared motivation and vision for action, identify the desired goals, ensure coordination and ownership of the process, keep suicide prevention efforts moving and ensure oversight of the progress made. For each of these elements, it would be important to assign roles and responsibilities among the members. This is to guarantee the sustainability of the process and to avoid conflicts. 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 for community engagement and its broad goals, potential benefits and expected long-term effects (Lane & Tribe, 2010) (Annex 1.6).

If the members of the steering committee feel they need orientation or they are interested to learn more about suicide and its prevention, an orientation or information session or a training workshop can be carried out. This session could provide information about risk and protective factors, warning signs, the burden, and vulnerable groups as well as effective interventions (Annex 1.5-1.7). Inviting an expert or compiling a resource directory could be considered.

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 1.7-1.9).

5. Identify key stakeholders

It is important to identify key stakeholders, and thus potential collaborators who could also join the steering committee, 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 Form a steering committee, above).

It is necessary to pay attention to the characteristics of different stakeholders. A stakeholder mapping exercise (Annex 1.10) 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;
- level of influence (e.g. on policy and practice).

Examples of relevant stakeholders

Politicians and parliamentarians

Politicians could be invited to support actions or interventions in communities or they could help 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;

- enabling them to recognize and address their own need for mental health support;
- 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.

6. 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 1.11) 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 or champions who live in the community often appear more trustworthy than unknown persons.

Examples of engagement techniques for a first meeting include:

- a roundtable;
- a workshop;
- a town hall meeting;
- a 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. Disagreements about roles and responsibilities may arise but conflict resolution approaches may help manage difficulties. Facing conflict is a way of consciously improving relationships, situations or processes. The ABC Triangle (Attitude-Behaviour-Context), for instance, provides an analysis of even very complex conflict situations. This analysis is based on the premise that conflicts have three major components – the context or situation, the behaviour of those involved, and their attitudes – and that these three factors influence each other. Through a dialogue between stakeholders, key issues related to each component should be identified to understand everyone's interest and needs, and to handle and resolve the conflict (Galtung, 1985).

When organizing the first meeting and engaging the community, it is important to consider some of the following barriers (National Institute for Health and Care Excellence, 2014; Petersen et al., 2016):

- stigma or taboo linked to suicide and its prevention (for instance, suicide may be perceived as a private matter not to be discussed with others);
- lack of trust from community members or volunteer organizations;
- reluctance of community members to become involved;
- a feeling that national services should manage the issue;
- lack of awareness that suicide is a serious public health problem;
- limited advocacy experience of the people involved in the activities;
- 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 or dissatisfaction with health and community services;
- potential interest of some stakeholders to dominate decision-making processes and to influence activities;
- difficulty in finding a time that is suitable for all/most members of the community.

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.

7. 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 1.12) to the first meeting (see list under *Create a steering committee,* above).

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 1.13) should be created on the basis of the items above.

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).

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 1.14). A secretary and/or record-keeper should take 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 1.15). The meeting can be announced through posters, by volunteers going door-to-door, or at different events or gatherings (such as religious, cultural, school or sports meetings).

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.

Box 1. A case study from India

The state of Tamil Nadu is reported to account for 12% of the suicide burden in India. The Schizophrenia Research Foundation (SCARF) engaged the communities of three adjoining villages in the Tamil Nadu district of Pudukottai. The villages all had high numbers of suicides.

When discussing strategies and how to prepare a first meeting with the community, it was felt that a better understanding of suicide was needed. Hence, an awareness session on suicide was organized. External resource persons who were volunteers from SNEHA, a nongovernmental organization focusing on suicide prevention, were invited. The awareness session addressed life stressors, negative emotions, coping mechanisms for dealing with negative emotions, and how to approach a person who may be depressed or suicidal.

In order to announce the first public meeting with the community and to invite everyone interested to participate, posters were created and displayed. Stakeholders, such as government officials, health service providers and nongovernmental organizations were also invited. Some 250 persons attended the meeting at which external resource persons from SNEHA and SCARF were present.

Many members of the community took the floor, both in plenary and small groups, and discussed what they felt were the main causes of suicide, such as debt, domestic disputes, relationship problems, unemployment and failure in examinations. They highlighted the need to raise children in a supportive environment where they receive an education and secure jobs which result in financial and emotional stability and prevent suicide.

A map of community resources was drawn on the floor with coloured chalk powder and salt. Members of youth and women's groups of the three villages, teachers from the local high school and a representative of a local nongovernmental organization formed the steering committee. The committee then considered ideas for interventions based on what had been discussed in the public meeting and based on the following broad goals:

- Understand the phenomenon of suicide and its consequences.
- Provide emotional/psychological support to young people and parents, as well as to those who have attempted suicide.
- Prevent suicidal behaviours in children and adolescents.

Resources and actions already available in the community for suicide prevention and support were identified. After further discussion of the available evidence and possible actions, the steering committee decided to take three actions:

1. Implement a Befrienders programme (providing emotional support) for persons who had attempted suicide.
2. Implement a school mental health programme, with a focus on identifying and supporting children who are experiencing emotional difficulties due to stressors at home or school, and integrate life skills training and a career guidance programme within this framework.
3. Establish a survivors group for family members who have lost someone to suicide.

The community decided to roll out the actions in a phased manner beginning with the Befrienders programme which aims to provide emotional support for one year to persons who have attempted suicide. Six volunteers received two days of training from volunteers of SNEHA on how to engage a person with suicidal ideation, provide emotional support, ensure confidentiality, and when and where to refer someone to specialized services. It was decided to offer the Befrienders programme to persons who attempted suicide when they received medical attention at a local primary-care hospital. They would be informed about the service by hospital staff and, if interested, they were to contact the numbers that they had been given. Alternatively, if acceptable, their number would be passed on to a volunteer. Additionally, the names and telephone numbers of the volunteers would be displayed in the wards of the hospital. The other activities were planned for later.

The community action plan was closely monitored with process and outcome indicators chosen by the community. The following indicators were identified by the steering committee to track the progress and success of the Befrienders programme:

- the number of suicide attempts from the three villages registered at the medical facility;
- the number of suicide attempters who agreed to participate in the programme;
- the number of persons who received the service;
- the number of persons with whom the proposed number of contacts was made;
- the number of persons who attempted suicide again.

The media were kept up to date with the activities in the community. The press covered community events and meetings that were conducted as part of the programme. The media support was crucial to engage the community and to increase awareness and sensitization.

After three months into the programme, the community felt engaged and had moved from a passive role to an active one. Awareness had increased and perceptions of suicide had changed. The community recognized the importance of suicide prevention programmes and of supporting community members through such programmes. Challenges identified during the process were linked to lack of knowledge about mental health and suicide, stigma, and inadequate human and economic resources. Participation in voluntary activities was limited as people could not forego their wages. Also, the social structures and customs of the villages restricted interaction between upper- and lower-caste persons, which led to duplication of services. In addition, evidence was not a priority in the decision-making process which was driven by subjective emotions. In this context, the role of an external resource person/agency must be highlighted as it can provide the necessary guidance and focus to enable the community to make informed choices.

2. Begin the conversation at the first meeting

1. Conduct a mapping exercise

2. Begin the conversation at the first meeting

This section provides practical guidance on how a community can move towards action by starting the conversation about suicide at the first community meeting. All community members should feel comfortable 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.

1. Conduct a mapping exercise

An important first step in the conversation about suicide in the community is to understand thoroughly the impact that suicide has and the prevention issues that are specific to the local situation. 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 way to obtain 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 others 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.

Box 2. A case study from Canada

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 to engage communities.

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 the local level and inform future plans for a community-based model of suicide prevention. More than 40 conversations have since taken place across the country (Mental Health Commission of Canada, 2015).

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 hall 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 on 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 continued to host conversations.

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.

3. Create a community action plan

1. Examine the key issues and possible community actions
2. Map the resources for the possible actions
3. Mobilize resources
4. Formulate the action plan according to priorities and resources
5. Formulate SMARTER goals in the action plan
6. Develop an outreach strategy to promote the suicide prevention activities and community events

3. 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 of the first meeting. The steering committee should take the lead in organizing future meetings and should provide opportunities to discuss how to move forward to 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 difficulties, barriers and facilitating factors experienced;
- 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 the development of an appropriate community action plan.

1. 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;
- access to easily available and ready means of suicide (e.g. pesticides, firearms);
- easy availability of alcohol due to unrestricted sale and production;
- 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 who are vulnerable to or bereaved by suicide;
- lack of trained health workers in the community or district health facilities;
- lack of psychosocial counselling (e.g. in the community, at schools, at social centres).

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 or illness;
- have a family history of suicide;
- have suffered abuse or violence.

The list of possible issues may be long, and many communities will have experienced 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. a 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 potential activities are listed below. These are meant to be adapted to the local circumstances, based on needs, target groups and available resources of each community (Capire Consulting Group, 2016; Fleischmann et al., 2016; Hegerl et al., 2009; Petersen et al., 2016; Suicide Prevention Australia, 2014; WHO, 2014; Zalsman et al., 2016):

Raise public awareness and provide information

Raise awareness and reduce stigma. Suicide prevention involves the whole community. Social change, including by understanding suicide and changing beliefs and perceptions about suicide, can be achieved only by addressing the community as a whole – by starting to talk about suicide, increasing awareness of suicide and through educational programmes. Different kinds of public events can be organized, such as street plays or theatres, awareness sessions or campaigns or an awareness week, public events, fundraising events, newspaper articles, radio or television programmes, debates, roundtable discussions, conferences, or meetings about suicide and its prevention. In addition, an array of different places could be taken into consideration – such as schools, workplaces, military premises, prisons, places of worship, cultural or other events or gatherings. The effort can further be promoted by a talk from a champion, 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, for instance, by a community art initiative to promote health (Mohatt et al., 2013). A community launch and announcement of suicide prevention as a priority can signal local commitment to reducing suicide and help develop support and engagement in the community. Increasing dialogue about suicide in order to reduce stigma is a commonly employed 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 identify services and resource persons (e.g. health workers or gatekeepers) and to map service pathways, and then to help promote these services and programmes within the community and ensure that they are well linked, provide good quality services and care, 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.

Promote crisis support services and help-seeking behaviour. Suicidal behaviour often occurs when a person is in crisis. Communities, for instance in collaboration with the media, can play an important role in highlighting the availability of crisis lines, 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 the services. Promoting crisis support services and help-seeking behaviour are common activities in suicide prevention.

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. It is important to

engage the community in reducing people's access to pesticides in contexts where suicides are impulsive, and to provide community education, awareness programmes and training of retailers and pesticide users (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, 2017a). Training can be organized for journalists and one can work with local radio stations and newspapers to enhance efforts for suicide prevention together. Responsible reporting of suicide in the media has been shown to be effective in limiting imitation among vulnerable people (WHO, 2014).

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 to raise mental health awareness in adolescents and to enhance the skills needed to deal with adverse life events, stress and suicidal behaviours (Aseltine et al., 2007; Kutcher et al., 2016; Wasserman et al., 2015; Wilcox et al., 2008). School-based interventions have been shown to be effective in suicide prevention (WHO, 2015).

Integrating 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 can 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 – using, for instance, the WHO mhGAP Intervention Guide (WHO, 2016c; WHO, 2017b) – 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 when 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, general physicians, social workers, teachers, police, firefighters, prison and military officers, employers), who can act as gatekeepers, receive training and 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.

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, 2008). It is suggested that such activities, such as establishing a self-help group, 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.

Responding to the aftermath of a suicide for vulnerable groups and preventing suicide clusters. Providing training to staff and volunteers in, for instance, 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). Preparing a plan for response, training and support in the aftermath of suicide is a common activity for suicide prevention as such a plan can prevent suicide clusters.

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 or caring for 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), including in nursing homes or older peoples' residences. 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 this 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 (e.g. on mental health in the workplace) and by providing practical guidance on how they can assist and support someone experiencing a crisis or suicidal thoughts. 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.

2. 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 (e.g. human, financial, infrastructure), 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:

General considerations:

- Which organizations should be involved? What would be the added value of having them involved?
- What is the timeline for the activities? Is there an ideal time to implement the activities?

Human resources:

- What human resources are available?
- Who should be involved in the planning, implementation, evaluation and advocacy of the actions?
- What time resources are needed from the steering committee and subcommittees?

Financial resources:

- What are the costs of the actions? How much funding is needed for implementation?
- Can any resources be utilized for free (e.g. radio and television air time, announcements)?
- 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?

Infrastructure:

- Is there a need for any physical space (e.g. a community centre, a public space)?

Adequate and sustained financing is a critical factor in the creation of a viable action plan. Financing is the mechanism by which goals are translated into tangible actions through the allocation of resources. It is necessary to map services and identify their financing systems in order to understand the level of current resources and how they are used. Existing resources then need to be allocated to achieve the greatest possible benefits (WHO, 2003).

3. Mobilize resources

If a community lacks financial resources, a number of effective fundraising methods can be used to obtain financing for the implementation of the action plan.

Resource mobilization is the process of raising different types of support for the community. Methods of resource mobilization may include:

- submitting proposals to a donor (e.g. for grants or funding programmes);
- requesting technical support from, for instance, nongovernmental organizations, universities, research groups, national or international organizations;
- aligning the fundraising strategy of the community with the goals of foundations, organizations and business groups;
- organizing fundraising events such as coffee mornings or pre-work coffee mornings where there are information leaflets or posters and where donations for suicide prevention activities can be made (e.g. in a collection box);

- collecting in-kind contributions such as used clothes, furniture, books, vehicles or even buildings which can be sold and turned into financial support;
- placing donation boxes in highly frequented public places;
- promoting timesharing as volunteer support where volunteers provide their time and resources to support the suicide prevention action plan (this can bring the community together in a charitable way around the theme of mutual help and support);
- organizing sponsored events such as runs or walks;
- trying "matched giving" whereby employers pledge to match whatever their employees have raised, which is a way to double the donations rapidly.

4. 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: 1) perceived need, 2) evidence and 3) 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.

Regarding the time frame, some activities (e.g. surveillance or psychosocial support) must be ongoing, while others (e.g. training of health workers or information sessions for community members) can take place at regular intervals.

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 roles and responsibilities according to the resources available. Taking this point very seriously should prove helpful throughout the process.

5. 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.

6. 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, should 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).

Box 3. A case study from Kenya

Kenya has limited data available on the number of people who attempt or die by suicide. Suicide is illegal in Kenya and is surrounded by stigma and taboo, thus increasing the likelihood of underreporting or not reporting cases at all, especially of attempted suicide. Out of fear of legal action and because of cultural and religious beliefs, suicide may often be wrongly documented as accidental or other cause of death. To create awareness and sensitize people on suicide and its prevention, Befrienders Kenya, a local nongovernmental organization, mobilized community opinion leaders and took steps to address this critical public health issue in Mashimoni, Mathare, in Nairobi county. Befrienders Kenya facilitated the process of community engagement using the community engagement toolkit.

After initial preparations such as planning sessions and visits to the community by the implementing team, a discussion took place to understand how much the community knew about suicide and to find out what their perceptions, attitudes, ideas and beliefs on suicide were. The discussion brought together a religious leader, a teacher, community health workers, young people, the area assistant chief and a business community representative. From the discussion it became clear that suicide was relatively common in the community, especially among unemployed young people who engaged in taking drugs and abusing alcohol, thus increasing their risk of suicide and early pregnancies which are common in the area. The discussion participants highlighted the fact that there was a need for an in-depth understanding of suicide and the reasons for suicidal behaviour, to increase public awareness about suicide and to provide education about it.

A steering committee, comprising young people, religious leaders, community health workers, teachers, business representatives and the government administration was formed to facilitate the process of community engagement and to form the link to the wider community. The steering committee spearheaded the community actions in the suicide prevention efforts. The committee identified the key stakeholders, prepared the logistics and content for the first meeting, and developed the community action plan, including definition of the broad goals and identification of actions and resources. Befrienders Kenya compiled data from various sources, including the internet, Kenya Bureau of Statistics, the Ministry of Health and Mathare Mental and Referral Hospital; however, data on suicide, self-harm and suicide attempts were very limited, not only for the identified area but for the country as a whole.

The first public meeting held in the community was attended by 240 participants. The topics covered included understanding suicide, drug and alcohol abuse, and mental health, as well as an account of a lived experience from a person bereaved by suicide. The message that came from all the meeting facilitators was that suicides were preventable and the community, as well as individuals, could play a role in suicide prevention. The community was sensitized on warning signs of suicide and measures to be taken in case a risk for suicide was suspected. Depression was highlighted as a major mental health issue with strong associations with suicide.

One key outcome of the first meeting was that there was a need to change attitudes, perceptions and beliefs, to be able to help reduce stigma, and to enable affected individuals and families to access support. Participants expressed satisfaction with the topics presented and felt that they had learned a lot that had not been talked about before. The final impression was that participants started to change their perceptions and their way of thinking about suicide and began to consider suicide prevention.

The steering committee and Befrienders Kenya formulated an action plan in line with the priorities of the community and the available resources, although finances and lack of trained personnel

stood out as issues of concern. The broad goals were to reduce the number of suicides in the community, to reduce stigma and to train community leaders.

Aligned with the broad goals, the planned actions were:

1. to train community health workers to identify vulnerable individuals and groups, and manage suicidal behaviours;
2. to increase awareness and sensitization of suicide and its prevention through more community dialogue which would also help reduce stigma; and
3. to train community leaders to identify persons at risk of suicide and assist them to access help.

The community action plan described all the details of each action and assigned general responsibilities. Considering the resources needed in each action, the committee mapped the available resources in the community and main stakeholders were identified to implement the actions. The distribution of tasks was considered important to ensure the sustainability of the action plan. Once the action plan was developed, it was shared with the community.

During the feedback meeting, it became clear that a substantial number of community members had had a change in their mindset regarding suicide. During discussions, they acknowledged the association of suicide with mental health issues and that suicide required attention just as any other health issue. The community recognized that those affected by suicide required encouragement and support while those with suicidal thoughts needed to be listened to and referred to appropriate service providers.

The need to create support groups for those bereaved by suicide and for suicide attempters was identified as a key action point. This would give affected individuals a chance to share experiences and provide support to one another as well as help each other to seek appropriate help.

It also became clear that the community can play a significant role in the prevention of suicide as it can provide a platform for education and awareness-raising. All agreed that everyone is a stakeholder when it comes to suicide prevention since everyone is affected in some way or another.

4. Ongoing mobilization of the media

1. Tips for successfully working with the local media
2. Responsible media reporting

4. Ongoing mobilization of the media

The media play an important role in building public opinion and attitudes (Borinstein, 1992; Kalafatelis & Dowden, 1997; Philo et al., 1994). Media interest can, at times, be very high, particularly during events on 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).

1. Tips for working successfully 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, 2017a).
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.

2. Responsible media reporting

Several sources of guidance on responsible reporting of suicide are available for media professionals, including a WHO resource booklet (WHO, 2017a). Guidance includes:

- Do provide accurate information about where to seek help;
- Do educate the public about the facts of suicide and suicide prevention, without spreading myths;
- Do report stories of how to cope with life stressors or suicidal thoughts, and how to get help;
- Do apply particular caution when reporting celebrity suicides;
- Do apply caution when interviewing bereaved family or friends;
- Do recognize that media professionals themselves may be affected by stories about suicide;
- Don't place stories about suicide prominently and do not unduly repeat such stories;
- Don't use language which sensationalizes or normalizes suicide, or presents it as a constructive solution to problems;
- Don't explicitly describe the method used;
- Don't provide details about the site/location;
- Don't use sensational headlines;
- Don't use photographs, video footage or social media links.

Box 4. A case study from Trinidad and Tobago

Suicide remains one of the major public health problems in Trinidad and Tobago. Chaguanas, the largest district in Trinidad, accounts for approximately 25% of the country's suicides. To identify those most frequently involved in dealing with suicidal behaviours and who would be interested in working on suicide prevention in the community, discussion meetings were organized. Different stakeholders in the community were contacted, such as the mayor´s office, police service, mental health service providers, religious leaders, business representatives and alcoholics anonymous groups. It was acknowledged that young people in the school system were vulnerable to suicide because of drug use, poor supervision, family problems and undiagnosed mental disorders.

A steering committee emerged from the meetings. This included a social worker, a community nurse from the mental health service, a senior nurse of the emergency service, a manager of the primary care service, a police officer, a guidance officer, a teacher, two local government councilors, and two managers of nongovernmental organizations. Several meetings were held to identify the mechanisms by which the group could engage persons in the community. It was known that suicide was a major problem but data were not accessible or generally known.

A first community meeting was organized and announced by the media. Some 25 participants attended. The agenda included an overview of suicide statistics and information about signs and risk factors. A mapping exercise about resources was conducted at the meeting. Strategies discussed included increasing awareness of suicide and its prevention in the community, identification of students at risk, and workplace interventions. Generally, there was a sense of powerlessness, an acknowledgment of the significant social stigma and a repeated concern that police and health workers lacked training in dealing with suicide, and that there was little information about the scale of the problem and the ways in which the community could help with prevention.

An action group was created within the steering group and regular meetings were held to discuss the community action plan. The group established four broad goals:

- to identify vulnerable individuals/groups in the community;
- to set up a surveillance system;
- to provide expeditious clinical support to individuals and families, including those who had recently lost a relative or close friend to suicide;
- to train first responders, police, fire services and emergency paramedical staff in suicide prevention and intervention strategies.

The following actions were selected for the action plan:

1. Actions for groups identified as particularly vulnerable, namely:
   - adolescents: training and sensitization of teachers/parents to raise awareness about mental health in adolescents;
   - young adults: implementation of employee assistance programmes and establishment of recreational venues;
   - older persons: training and sensitization of professionals from pension and social service divisions, retirement groups, geriatric homes, and the hospital services.
2. Setting up a surveillance system for suicide in the district through collaboration between health, police and fire services.
3. Provision of information about pathways to care if problem behaviours are identified.
4. Training for gatekeepers who are in contact with people at risk.

More specifically, for adolescents, outreach to schools and liaison with principals and guidance officers in the primary and secondary schools in the area were envisaged, as well as working with parent/teacher organizations to raise awareness about mental health. Recreational activities would be used to raise awareness and invite participation from coaches, facilitators and youth clubs.

Young adults would be targeted through employer consultations, employee assistance programmes and recreational venues that were popular in Chaguanas. Outreach information, training for employee assistance providers, and prevention of substance use through Alcoholics Anonymous and Narcotics Anonymous groups and health services would be part of the prevention programme for this subpopulation. Relationship and family counselling was also thought to be a priority but it was felt that this could be managed through existing religious and community organizations interacting with families.

Older persons were to be targeted through retirement groups, geriatric homes and hospital services. The pension and social service divisions in the district would receive training and sensitization.

Regular community meetings and workshops were set up to engage the community in suicide prevention and to update the action group on changes that might affect the implementation of the suicide prevention action plan. It was agreed that the media were to provide whatever support was needed. A public and social media campaign was planned to involve popular personalities living in the district to promote the theme of suicide prevention.

Because of the engagement there was hope and enthusiasm that the actions would benefit the community, helping it to become more aware of mental health issues, reducing suicides and creating a greater and more participatory community spirit. The mayor's office and local government would reinforce the message of suicide prevention through local government projects and initiatives. It was hoped that there would be more and earlier recognition and treatment of mental health problems, particularly of depression and substance abuse.

5. Monitor and evaluate the community action plan

1. Continuous monitoring
2. Evaluation to formulate lessons learned for future efforts
3. Surveillance systems and quantitative change

5. 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).

- Monitoring refers to the routine tracking of the action plan. It is essential to assess how well the plan is being implemented so that any problems that are identified can be rectified on an ongoing basis (WHO, 2007).
- Evaluation refers to a process of systematic appraisal to assess the value, worth or effectiveness of the plan (WHO, 2007).

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 really 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 complementary and to some extent they overlap rather than being entirely distinct processes. Information collected through monitoring usually feeds into systematic evaluations, and monitoring also involves some appraisal of information that can be used for informing the development of plans (WHO, 2007).

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. **evaluation to formulate 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.

1. 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 time to check the progress of activities. Look at whether (WHO, 2007):
    - the activities planned have been completed;
    - the time frames set for each activity are being observed;
    - the inputs planned have been realized;
    - the outputs of the activities have been achieved;
    - the targets of the various strategies have been reached.

- 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 or indicators (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.

2. Evaluation to formulate 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. Make sure 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 or 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).

3. 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 31 January 2018). 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 31 January 2018) provides a tool for obtaining nationally representative population-based data on risk factors, including suicide attempts, in a country.

Box 5. A case study from Nepal

In Nepal, one of the districts worst affected by the devastating earthquake in 2015 was Sindhupalchok where the number of suicide cases increased from 58 to 72 within two years. The Chautara municipality of the Sindhupalchok district chose to engage the community in suicide prevention.

A preparatory meeting included the ward chair of the community, local police officers, health workers, local leaders and members of nongovernmental organizations. They explored the burden of suicide in the community and the services available. The district health administrators and the local stakeholders were informed of the objectives of the planned activity along with the sequence of events to involve the community.

Initial discussions with school teachers, members of nongovernmental organizations, residents, health workers and female community health volunteers highlighted the lack of awareness of suicide and training on suicide prevention, as well as inadequate and ineffective management and follow-up of cases. There was no education of school children about mental health and suicide prevention.

On the basis of discussions and preparatory meetings, a steering committee was formed to identify stakeholders, set up broad goals for suicide prevention and develop a community action plan. The committee was composed of the ward chair of the community, school principals, chairs of local nongovernmental organizations, residents and female community health volunteers. Steering committee members pointed out the weak social support mechanisms and failure to provide basic services. After the earthquake, the number of suicide cases in the community had increased because people who had lost all support had no one to turn to.

A one-day orientation session was organized for the steering committee because of members' lack of expertise about suicide and its prevention. This session explained how to assess people with suicidal thoughts, plans or acts of self-harm and how to encourage them to seek appropriate medical care or psychosocial support. The self-harm/suicide module of the WHO Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) was adapted and used for the orientation session.

A first community meeting was held at the ward office meeting hall. Community members and key stakeholders were invited with the help of a local nongovernmental organization, social mobilizers and female community health volunteers. In total, 69 participants were present. The agenda included an introduction to suicide, the need for urgent action, objectives, potential activities in suicide prevention, the role of the community, and mapping of existing activities in the community. Key issues were identified as follows:

- easy availability of insecticides and pesticides in the community;
- easy availability of alcohol due to unrestricted production and sale;
- lack of trained health workers in the community or district health facilities;
- interpersonal disputes among families/community members;
- no psychological counselling available at schools;
- lack of psychosocial counselling in the community;
- inappropriate reporting of suicide by the media.

In subsequent meetings, the steering committee and key stakeholders arrived at the following broad goals:

- Prevent suicide attempts and suicide in the community.
- Develop a responsive health and social protection system to help people with suicidal behaviours.
- Increase awareness and reduce the stigma associated with suicide and mental health problems.

The community action plan was based on the prioritization of key issues identified during the meeting with the community. For every key issue, resource mapping and possible community actions were drafted. Actions were prioritized using a three-dimensional prioritization matrix. The agreed actions were:

1. Restrict the availability of pesticides in the community.
2. Train health workers in the community or district health facilities.
3. Mobilize the media to increase awareness and reduce stigma.
4. Provide help in the case of interpersonal disputes among families/community members.
5. Provide psychological support in schools.
6. Provide community psychosocial support.
7. Restrict the production and sale of alcohol.

A focal person was selected to lead the activities in coordination with governmental and nongovernmental stakeholders. As suicide prevention needs a multi-sectoral approach, robust coordination was essential under the leadership of the focal person.

Based on the above actions, the outreach strategy of the steering committee was to conduct awareness-raising campaigns on suicide and suicide prevention through local media such as radio, television and newspapers. Jingles (short songs) on suicide prevention were transmitted through local radio. The steering committee was confident of mobilizing the media in the community to raise awareness of suicide and train the media professionals on responsible reporting of suicide.

It was felt in the community that the engagement made people understand suicide better and encouraged them to talk more about it. Major barriers to implementation were financial constraints and lack of trained human resources. Health facilities at the community would need to be able to provide primary care and look after referrals from the community. Health workers in the community should be able to provide psychosocial support and receive mentoring and supervision.

6. Community feedback meeting

6. 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 can be distributed.

Box 6. A case study from the United States of America

Suicide is among the leading causes of death in the United States of America. The State of West Virginia ranks fourteenth in US state suicide rates, with an age-adjusted rate of 18.4 per 100 000 population in 2015. The University of West Virginia in partnership with Healthy Harrison, a community-based nonprofit organization in Harrison County, decided to work collaboratively on the implementation of the community engagement toolkit focusing on local needs, values and resources available in the area.

An initial discussion was held with members from the local communities to address the process, define goals and map activities. Members of this group included mental health professionals, health service administrators, suicide prevention specialists, faith-based community members, and law enforcement representatives. Initially, the group did not report a great awareness of suicide. However, the discussion helped identify populations at risk and the main factors associated with suicide locally, such as opioid use, hopelessness, loss of purpose, and barriers in access to mental health services, especially when involuntary treatment is required.

Stakeholders and potential partners who would be valuable collaborators in suicide prevention activities were identified. Key partners included local employers, colleges for higher education, regional youth services, churches, country clubs, recreational facilities and local veterans' organizations. Places frequented by high-risk groups, such as middle-aged men who were isolated or abusing substances, were identified as particularly important (e.g. workplaces, bars). Opportunities for deployment of prevention programmes designed to address access to highly lethal means, such as firearms, were also discussed and recognized as factors unique to this area.

Existing resources were mapped and important gaps in prevention programmes were identified, such as lack of communication between groups and about mental health and suicide prevention, poorly connected services, potential changes to the involvement of emergency medical services as well as fire and police services, and a need for proactive health services.

In the process of developing the community action plan, the steering committee established the following broad goals for suicide prevention:

- Prevent suicide with the resources and services available.
- Identify and support efforts to destigmatize mental health and suicide prevention.

- Create a roadmap for getting people who are in need into care.
- Foster a sense of purpose and hope among those experiencing distress.
- Plan for involving law enforcement and first responders in innovative models of caregiving and community engagement.
- Provide support to family members and survivors.

Importantly, the Healthy Harrison group felt strongly that the target population should be persons at risk for suicide who were currently outside of the mental health services system and that the aim should be to identify and support them.

Harrison County covers a relatively large area with more than 10 cities and smaller towns. The distance between population centres and the awareness of differences in resources and administration across communities in this area presented challenges to identifying a common strategy that could be adopted for the larger group. When creating an action plan the challenge was to think about local actions in a comparatively large area. Further, there was awareness of the activities of state and regional suicide prevention programmes that were already operating in this area. As a result, there was an emphasis on the identification of broad categories of action that could be adopted or modified depending on local needs, resources and existing programmes. The action plan included the following:

1. Integrate strategies and programmes supported by existing local and national programmes.
2. Develop strategies for elevating suicide prevention to a top priority in the area and the identify local partners (e.g. faith-based, senior services) to create a network of support and services.
3. Search funding to run programmes and activities through the involvement of local partners and businesses.
4. Coordinate with local health providers to support transitions in care and the creation of a roadmap for seeking help.

Community members realized that they could work together to prevent suicide. It became clear that it was very important to address feelings of hopelessness and despair. Continued public discussion about the suicide preventive actions and the development of a funding strategy would be needed.

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 31 January 2018).
- Preventing suicide: a resource series. Geneva: World Health Organization (http://www.who.int/mental_health/resources/preventingsuicide/en/, accessed 31 January 2018).
- 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 31 January 2018).
- WHO MiNDbank. Geneva: World Health Organization (http://www.mindbank.info, accessed 31 January 2018).
- Suicide Prevention Australia. Website (https://www.suicidepreventionaust.org/, accessed 31 January 2018).
- Living is for everyone. A National Suicide Prevention Strategy project managed by On the Line, Australia, on behalf of the Department of Health (http://www.livingisforeveryone.com.au/, accessed 31 January 2018).
- Working to prevent suicide. New Zealand Ministry of Health (http://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide, accessed 31 January 2018).
- Catalogue du CRES - Centre de Ressources en Suicidologie, France (in French) (http://cresuicidologie.docressources.fr/opac/index.php, accessed 31 January 2018).
- Suicide prevention resources. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA) (https://www.integration.samhsa.gov/clinical-practice/suicide-prevention, accessed 31 January 2018).
- 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 31 January 2018).
- International Association for Suicide Prevention (IASP). Website (https://www.iasp.info, accessed 31 January 2018).
- Australian Institute for Suicide Research and Prevention. Website (https://www.griffith.edu.au/health/australian-institute-suicide-research-prevention, accessed 31 January 2018).
- Beijing Suicide Research and Prevention Center, China. Website (http://www.crisis.org.cn, accessed 31 January 2018).
- Japan Support Center for Suicide Countermeasures. Website (http://www.ncnp.go.jp/nimh/english/j_yobou.html, accessed 31 January 2018).
- National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP). Website (http://www.ki.se/en/nasp/startpage, accessed 31 January 2018).
- National Suicide Research Foundation, Ireland. Website (http://www.nsrf.ie, accessed 31 January 2018).

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 31 January 2018).
- Identifying promising partners. Newton (MA): Suicide Prevention Resource Centre (http://www.sprc.org/resources-programs/identifying-promising-partners, accessed 31 January 2018).
- #308conversations. Mental Health Commission of Canada (http://www.mentalhealthcommission.ca/English/initiatives/11884/308conversations, accessed 31 January 2018).
- Community engagement toolkit. The Social Planning and Research Council of British Columbia, Canada (http://www.sparc.bc.ca/wp-content/uploads/2017/03/community-engagement-toolkit.pdf, accessed 31 January 2018).

Examples of other 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/4PreventionPlanning/PreventionPlanning.pdf, accessed 31 January 2018).
• 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 31 January 2018).
• How to implement a 4-level community-based intervention targeting depression and suicidal behaviour. Leipzig: European Alliance Against Depression (http://www.eaad.net/uploads/media/EAAD_Manual_web_02.pdf, accessed 31 January 2018).
• A framework for suicide prevention planning. Winnipeg: Manitoba Health & Healthy Living (http://suicideprevention.ca/wp-content/uploads/2014/05/suicide_prevention_framework.pdf, accessed 31 January 2018).
• Operation Save Lives: education in suicide prevention. Stockholm, Karolinska Institutet (http://ki.se/en/nasp/operation-save-lives-education-in-suicide-prevention, accessed 31 January 2018).
• Suicide prevention in Stockholm County. Stockholm, Karolinska Institutet (http://ki.se/en/nasp/suicide-prevention-in-stockholm-county-spis, accessed 31 January 2018).

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 31 January 2018).
• 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 31 January 2018).
• 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 31 January 2018).
• 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 31 January 2018).
• Community planning toolkit. Belfast: Community Places (http://www.communityplanningtoolkit.org/working-together, accessed 31 January 2018).
• Communities that Care (CTC) model. Seattle (WA): Social Development Research Group, University of Washington (http://www.sdrg.org/CTCInterventions.asp, accessed 31 January 2018).
• 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 31 January 2018).
• Asset mapping for asset-based community development. Vibrant Communities Canada (http://vibrantcanada.ca/resource-library/community-asset-building/using-asset-mapping-asset-based-community-development, accessed 31 January 2018).
• Active Implementation Hub. Chapel Hill (NC): National Implementation Research Network, University of North Carolina (http://implementation.fpg.unc.edu/, accessed 31 January 2018).

Financing

• Mental health policy and service guidance package: mental health financing. Geneva: World Health Organization (http://www.who.int/mental_health/policy/services/6_financing_WEB_07.pdf?ua=1, accessed 31 January 2018).

Monitoring and evaluation

• Mental health policy and service guidance package: monitoring and evaluation of mental health policies and plans. Geneva: World Health Organization (http://www.who.int/entity/mental_health/policy/services/14-monitoring%20evaluation_HKprinter.pdf?ua=1, accessed 31 January 2018).
• A guide to real-world evaluations of primary care interventions: some practical advice. Agency for Healthcare Research and Quality, United States Department of Health and Human Services (https://www.pcmh.ahrq.gov/sites/default/files/attachments/PCMH_Evaluation_Guide.pdf, accessed 31 January 2018).

• Handbook on monitoring and evaluation of human resources for health: with special applications for low- and middle-income countries. Geneva: World Health Organization (http://www.euro.who.int/__data/assets/pdf_file/0011/200009/Handbook-on-monitoring-and-evaluation-of-human-resources-Eng.pdf, accessed 31 January 2018).
• Guidelines for developing monitoring and evaluation plans for human resources for health. Washington (DC): United States Agency for International Development (https://www.capacityplus.org/files/resources/guidelines-HRH-monitoring-and-evaluation-plans.pdf, accessed 31 January 2018)
• Handbook on planning, monitoring and evaluating for development results. New York (NY): United National Development Programme (http://web.undp.org/evaluation/handbook/documents/english/pme-handbook.pdf, accessed 31 January 2018).

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 31 January 2018).
• Time to Change campaign. Website (http://www.time-to-change.org.uk/, accessed 31 January 2018).

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 31 January 2018).
• Limits on analgesic packaging. Newton (MA): Suicide Prevention Resource Centre (http://www.sprc.org/resources-programs/reduced-analgesic-packaging, accessed 31 January 2018).
• 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 31 January 2018).
• 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 31 January 2018).

Engaging the media to encourage responsible reporting of suicide

• Preventing suicide: a resource for media professionals, update 2017. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/258814/1/WHO-MSD-MER-17.5-eng.pdf?ua=1, accessed 31 January 2018).
• Canadian Association for Suicide Prevention. Website (http://suicideprevention.ca/news-resources/media-guidelines-and-social-marketing/, accessed 31 January 2018).
• Recommendations for the media. Reporting on Suicide. Website (http://reportingonsuicide.org/, accessed 31 January 2018).
• Mindset: reporting on mental health. Canadian Journalism Forum on Violence and Trauma. Website (http://www.mindset-mediaguide.ca/, accessed 31 January 2018).
• How journalists can prevent copycat suicides. Leipzig: European Alliance Against Depression (http://www.eaad.net/uploads/media/Mediaguide_2017.pdf, accessed 31 January 2018).

Gatekeeper training

• Suicide prevention training. Question, Persuade, Refer. Website (http://www.qprinstitute.com, accessed 31 January 2018).
• safeTALK. LivingWorks. Website (https://www.livingworks.net/programs/safetalk/, accessed 31 January 2018).
• Applied Suicide Intervention Skills Training (ASIST). Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA) (http://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=42, accessed 31 January 2018).

Persons who have attempted suicide

• A guide for medical providers in the emergency department: taking care of suicide attempt survivors. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA) (http://www.theconnectprogram.org/sites/default/files/site-content/docs/AfterAnAttempt-ER.pdf,accessed 31 January 2018).

• After an attempt: a guide for taking care of yourself after your treatment in the emergency department. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA) (http://www.theconnectprogram.org/sites/default/files/site-content/docs/AfterAnAttempt-Survivor.pdf, accessed 31 January 2018).
• After an attempt: a guide for taking care of your family member after treatment in the emergency department. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA) (http://www.theconnectprogram.org/sites/default/files/site-content/docs/AfterAnAttempt-Family.pdf, accessed 31 January 2018).
• Working with the suicidal patient: a guide for health professionals. Consortium for Organizational Mental Health, Canada (http://www.sfu.ca/content/dam/sfu/carmha/resources/wwsp/WWSP.pdf, accessed 31 January 2018).
• Emergency care of a suicidal person. Stockholm: Karolinska Institutet (http://ki.se/en/nasp/emergency-care-of-a-suicidal-person-aosp, accessed 31 January 2018).

Youth-specific resources

• Sources of Strength (a universal suicide prevention programme). Website (https://sourcesofstrength.org/, accessed 31 January 2018).
• Reconnecting youth: a peer group approach to building life skills. Website (https://www.sprc.org/resources-programs/reconnecting-youth-peer-group-approach-building-life-skills, accessed 31 January 2018).
• Kognito At-Risk for High School Educators. Website (https://kognito.com/products/at-risk-for-high-school-educators, accessed 31 January 2018).
• American Indian life skills development curriculum/Zuni life skills development. Website (https://uwpress.wisc.edu/books/0129.htm, accessed 31 January 2018).
• Lifelines: a comprehensive suicide awareness and responsiveness program for teens. Website (https://www.hazelden.org/web/public/lifelines.page, accessed 31 January 2018).
• Multisystemic Therapy (MST). Website (http://www.mstservices.com/, accessed 31 January 2018).
• Model Adolescent Suicide Prevention Program (MASPP). Website (https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=251, accessed 31 January 2018).
• Sandbox Project. Teen Mental Health.org. Website (http://teenmentalhealth.org/care/health-professionals/, accessed 31 January 2018).
• Together to live. Ottawa: Centre for Excellence for Child and Youth Mental Health (www.togethertolive.ca, accessed 31 January 2018).
• Preventing suicide: lesbian, gay, bisexual and trans young people: toolkits for nurses. London: Public Health England (https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people, accessed 31 January 2018).
• Headspace National Youth Mental Health Foundation Ltd, Australian Government Department of Health and Ageing. Website (http://headspace.org.au/resource-library/, accessed 31 January 2018).
• 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 31 January 2018).
• Youth Aware of Mental Health (YAM). Website (http://www.y-a-m.org, accessed 31 January 2018).

Resources for indigenous peoples

• Suicide Prevention Program. Indian Health Service, the Federal Health Program for American Indians and Alaska Natives, USA. Website (https://www.ihs.gov/suicideprevention/, accessed 31 January 2018).
• QUNGASVIK toolbox. Fairbanks (AK): University of Alaska (https://www.uaf.edu/canhr/projects/elluam/Qungasvik.pdf, accessed 31 January 2018).
• 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 31 January 2018).
• 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 31 January 2018).

Resources for refugees and migrants

- Refugee suicide prevention training toolkit. Boston (MA): Refugee Health Technical Assistance Center (http://refugeehealthta.org/physical-mental-health/mental-health/suicide/suicide-prevention-toolkit/, accessed 31 January 2018).
- 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 31 January 2018).

Resources for older persons

- Overview of resources by Suicide Prevention Resource Center. Website (https://www.sprc.org/populations/older-adults, accessed 31 January 2018).
- Senior's suicide prevention resource toolkit. Calgary: Centre for Suicide Prevention (https://suicideinfo.ca/LinkClick.aspx?fileticket=cmFwRL4DMJw=, accessed 31 January 2018).

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 31 January 2018).
- Psychological first aid. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/44615/1/9789241548205_eng.pdf, accessed 31 January 2018).

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 31 January 2018).
- Suicide postvention toolkit: a guide for secondary schools. Headspace National Youth Mental Health Foundation Ltd, Australian Government Department of Health and Ageing (http://headspace.org.au/assets/School-Support/Compressed-Postvention-Toolkit-May-2012-FA2-LR.pdf, accessed 31 January 2018).
- 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 31 January 2018).
- SAMHSA news: Suicide cluster prevention on campus. Rockville (MD): Substance Abuse and Mental Health Services Administration. (http://newsletter.samhsa.gov/2015/12/03/suicide-cluster-prevention-on-campus/, accessed 31 January 2018).
- 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 31 January 2018).
- 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 31 January 2018).
- 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 31 January 2018).
- 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 31 January 2018).
- Support After Suicide Partnership. Website (http://www.supportaftersuicide.org.uk/, accessed 31 January 2018).

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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.

WHO (2017a). Preventing suicide: a resource for media professionals, update 2017. Geneva: World Health Organization.

WHO (2017b). mhGAP training manuals (http://www.who.int/mental_health/mhgap/training_manuals/en/, accessed 31 January 2018).

Annex 1: Tools for the community engagement toolkit

1. Initial preparation

1.1 Know the community and foster a supportive community environment

A community's level of preparedness to address a sensitive issue such as suicide can vary. The social and cultural environment or climate in a community can be more or less conducive to becoming active in suicide prevention. From the beginning, it is very important to know the community and to foster a supportive community environment for suicide prevention.

Examples:

- *Explore beliefs, thoughts, perceptions, attitudes and feelings about suicide, and about those who die by suicide, those who attempt suicide, and their families.*
- *Explore religious and cultural issues about suicide.*
- *Explore burial and mourning practices for someone who died by suicide.*
- *Explore concerns about health and health care.*
- *Explore the socioeconomic situation in the community.*
- *Explore social, cultural, political, ethnic or economic tensions.*
- *Start talking about suicide in smaller groups (e.g. women's, men's, youth or older peoples' groups).*
- *Provide information to increase knowledge about suicide and its prevention and about where to seek help.*
- *Raise awareness about suicide (e.g. through media campaigns, street plays, banners, posters, town hall meetings).*
- *Have a champion speak out about suicide.*
- *Bring the media on board.*
- *Connect stakeholders and create spaces for dialogue.*
- *Build partnerships.*

Write down activities that could be undertaken in your community to foster a supportive community environment:

_____

_____

_____

_____

_____

1.2 Consider the scale, population, services and information about suicide

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

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 1.7 and 1.8 of this annex)? Which methods of suicide are mostly used in your community?

_____

_____

_____

Is there good access to quality health and mental health services in your community? Have health workers (specialized and non-specialized) been trained in suicide prevention? Has there been gatekeeper training (e.g. for police, firefighters, teachers)?

_____

_____

_____

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?

_____

_____

_____

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? Are there guidelines for responsible reporting of suicide by the media and have media professionals been trained?

_____

_____

_____

Describe your community's resources for suicide prevention. What could be barriers and facilitating factors for your activities?

_____

_____

_____

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

_____

_____

_____

1.3 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 the leadership's attitude towards addressing suicide prevention?

Community climate: What is the community`s attitude towards addressing suicide prevention?

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

Resources: What resources (e.g. human, financial, infrastructure) are being used or could be used to address suicide prevention?

Source: Edwards RW, Jumper-Thurman P, Plested BA, Oetting ER, Swanson L (2000). Community readiness: research to practice. Journal of Community Psychology. 28(3):291-307.

If a community scores low in readiness, the activities of section 1.1 to foster a supportive community environment could be considered.

1.4 Define broad goals

Examples:

- *Be able to talk about suicide.*
- *Know where to seek help and assist others in seeking help.*
- *Establish self-help groups or help others who have lost someone or who are affected.*
- *Prevent deaths by suicide and suicide attempts.*
- *Promote mental health and well-being.*
- *Educate about early identification and management of suicidal behaviours.*
- *Develop a short-or long-term plan to provide ongoing suicide prevention efforts in your community.*

Broad goal	Priority ranking

1.5 Form a steering committee

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

1.6 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 an explanation 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:

_____

_____

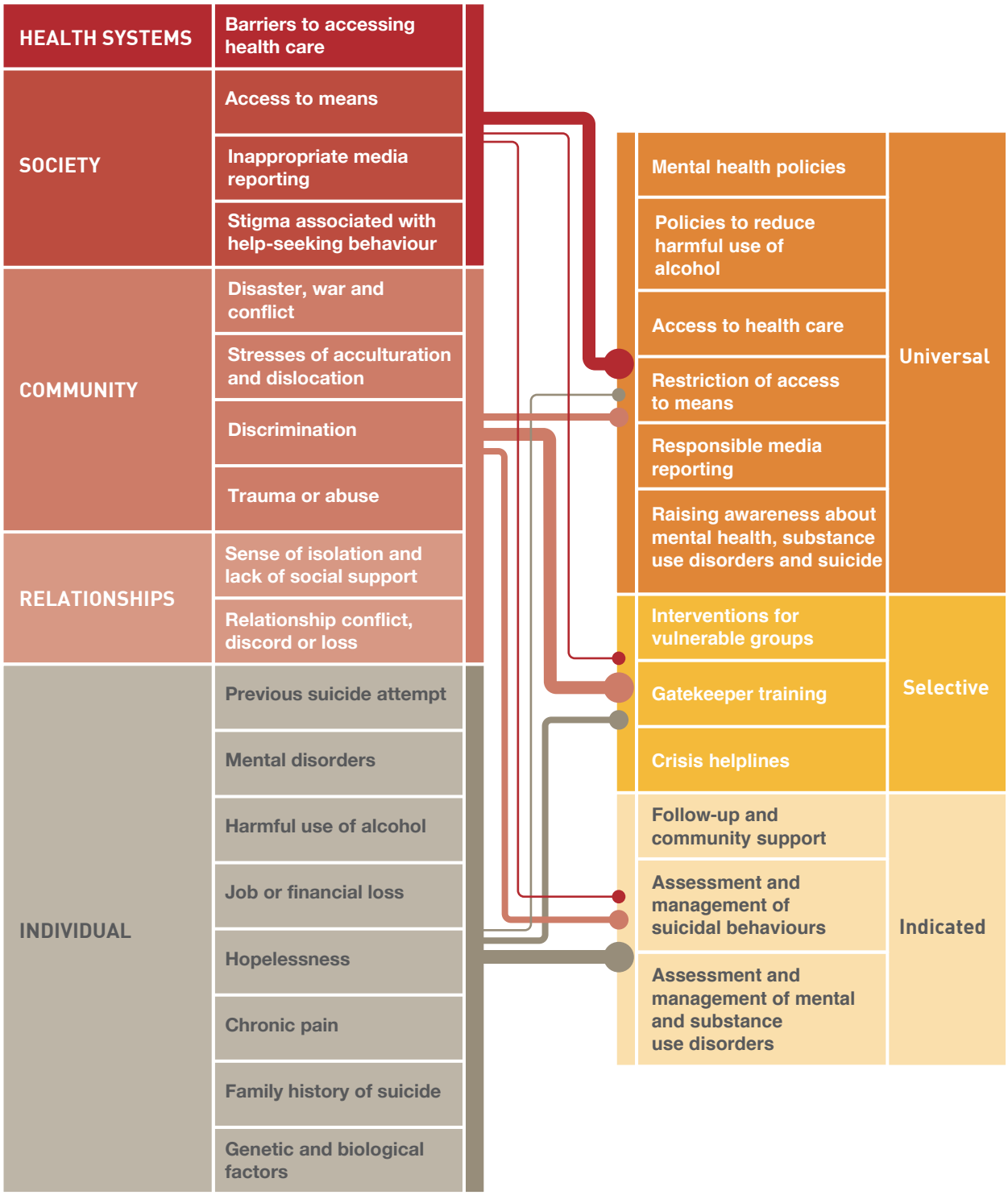
_____

1.7 Key risk factors for suicide

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

This could be used for an exercise for listing on a separate sheet the most relevant risk factors in the community, adding examples.

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



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

1.8 Protective factors for suicide

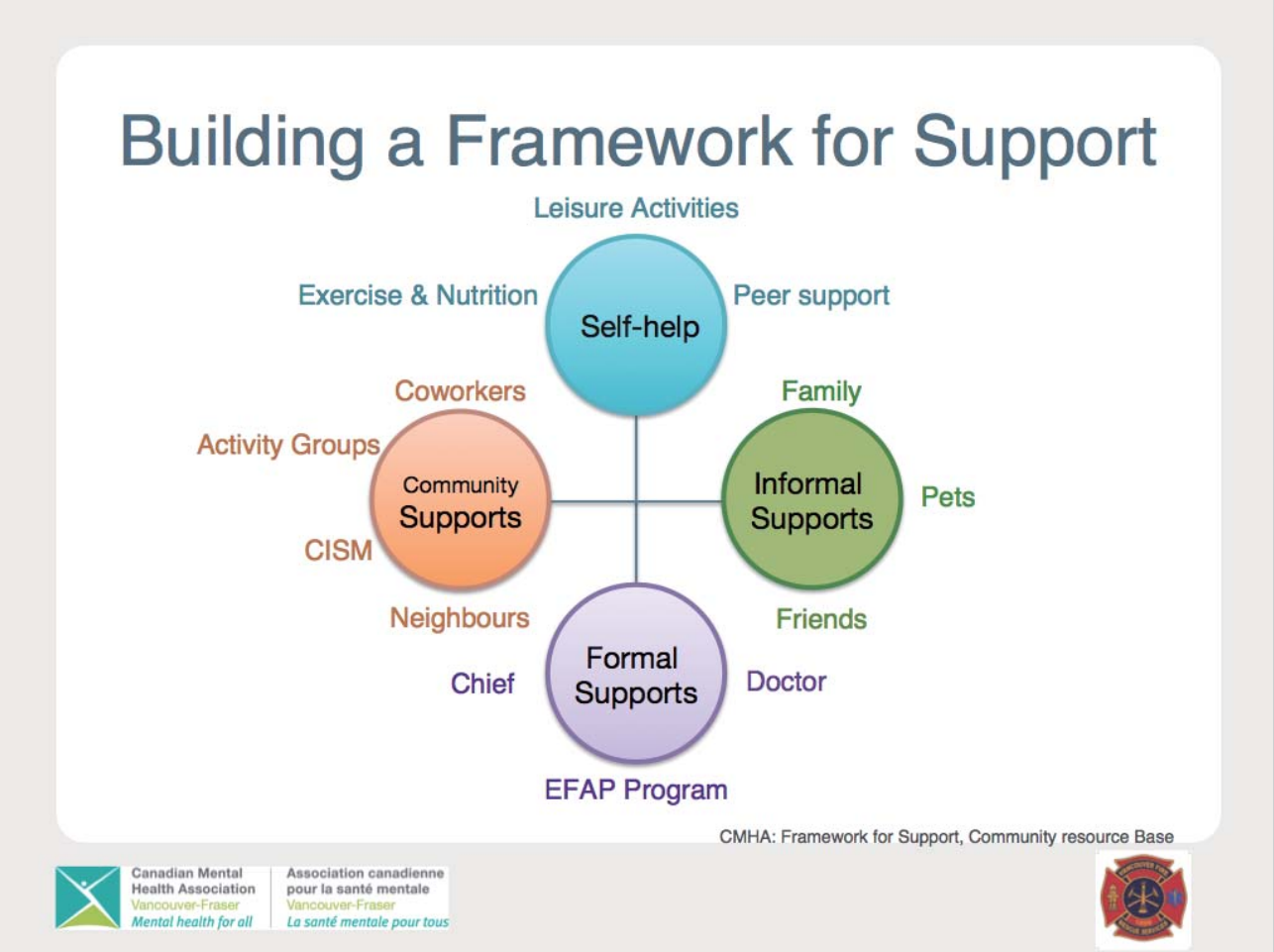
Protective factors for suicide include:

- strong personal relationships;
- religious or spiritual beliefs;
- lifestyle practise of positive coping strategies (including problem-solving and stress management skills) and well-being.

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

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

Figure A2. Building a framework for support



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

1.9 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 known 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 committing 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", "Things will get better soon", or "Pull yourself together".
- 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 Behavior. 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.

1.10 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 of self-harm or suicide; 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

1.11 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 face 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; lack of communication skills to speak about suicide in a non-judgemental, non-stigmatizing manner; lack of 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?

Examples 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.

_____

_____

_____

1.12 Plan and organize the first meeting

(See Annex 2 for examples of key items to consider 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	

1.13 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 section 2). The meeting participants should work together to map the impact that suicide has had on different parts of the community, and to 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 31 January 2018).

Write your agenda here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

1.14 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?

1.15 Public notice for the first meeting

The first meeting could be announced, for instance, by email, by going door-to-door, or through handouts or flyers on the street, in restaurants or in health facilities.

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: Participatory learning and action toolkit: for application in BSR's Global Programs; 2012 (https://herproject.org/files/toolkits/HERproject-Participatory-Learning.pdf, accessed 31 January 2018).

3. Create a community action plan

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

Name of community engage-ment project	Location	Targeted population and scope	Activities implemen-ted	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 help-seeking 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 way to select activities for the action plan is to use 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**[1] (0-5 points)	**Feasibility:** human and financial resources, time frame (0-5 points)	**Sum of all points** (maximum 15 points)

[1] The infographics page derived from the report *Preventing suicide: a global imperative* (WHO, 2014) provides an overview of effective preventive measures (http://www.who.int/entity/mental_health/suicide-prevention/infographics_2017.pdf?ua=1, accessed 31 January 2018).

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 the 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, banner, infographic, tips sheet, quiz), television advertisement, community announcement on the radio, traditional meeting places (e.g. markets, concerts), advertisement on public transport (e.g. buses).

_____

_____

_____

Examples of awareness messages or slogans:

- *"Suicide is a serious public health problem".*
- *"Suicides are preventable".*
- *"Every suicide is a tragedy that affects families, communities and entire countries".*
- *"Everyone plays a role in suicide prevention".*
- *"Suicide prevention is everybody's business".*
- *"You can do something to prevent suicide: offer to talk".*
- *"Recognizing warning signs of suicide can save lives".*
- *"It is a sign of strength to ask for help".*
- *"You are not alone, there is hope and help".*

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 #308conversations 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. 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?

Examples: 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:

Engagement questions: 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?
Exploration questions: What are the gaps in services and infrastructure at present? What are the barriers to suicide prevention in the community? What are the participants' perceptions of the effectiveness of the suicide prevention activities in reducing suicide?
Exit questions: Would anyone like to add anything? Are there any questions left?

_____

_____

_____

See also, for instance: Introduction to conducting focus groups (https://permanent.access.gpo.gov/gpo1916/focus_group.pdf, accessed 31 January 2018).

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-keeper/note-taker 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 (month, year) and (month, year), 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: #308conversations. Ottawa: Mental Health Commission of Canada (www.mentalhealthcommission.ca/308conversations, accessed 31 January 2018).

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 have a significant impact on the lives of 7 to 10 others 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 31 January 2018).

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.mentalhealthcommission.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 31 January 2018).

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 lay-out of the room should 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 31 January 2018).

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 before the event)	5 minutes 10 minutes 15 minutes 15 minutes 15 minutes 15 minutes 25 minutes 5 minutes	Facilitator - welcomes guests - introduces MHCC/VIP/stakeholders (if applicable) - explains meeting format - states media policies* Importance of the #308conversations process Introduction to topics of discussion Draft discussion topic1 Draft discussion topic 2 Draft discussion topic 3 Draft discussion topic 4 Final gathering of suggestions (what works well, where are the gaps?) Organizer delivers closing remarks
(time - 15 minutes before)		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 31 January 2018).

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 31 January 2018).

For more information, please contact:
Department of Mental Health and Substance Abuse
World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Switzerland

http://www.who.int/mental_health/suicide-prevention

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