

TRANSFORMING COMMUNITIES

Key Elements for the Implementation
of Comprehensive Community-Based
Suicide Prevention



This report advances Objective 5.2 of the National Strategy for Suicide Prevention: Encourage community-based setting to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors. To download a copy of the NSSP, please visit www.actionallianceforsuicideprevention.org

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ABOUT THE NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

The National Action Alliance for Suicide Prevention is the public-private partnership working to advance the National Strategy for Suicide Prevention and make suicide prevention a national priority. The Substance Abuse and Mental Health Services Administration provides funding to EDC to operate and manage the Secretariat for the Action Alliance which was launched in 2010. Learn more at actionallianceforsuicideprevention.org and join the conversation on suicide prevention by following the Action Alliance on Facebook, Twitter, and YouTube. Learn more at <http://actionallianceforsuicideprevention.org>

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FOREWORD

MESSAGE FROM CO-LEADS

As co-leads of the Transforming Communities Priority Area Work Group of the National Action Alliance for Suicide Prevention (Action Alliance), we are delighted to introduce *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*. Developed based on a review and synthesis of relevant programs, guidance, and models related to community-based suicide prevention, the paper presents seven key elements that should guide program planning and implementation.

Suicide remains one of the 10 leading causes of death in the United States, claiming more than 44,000 lives in 2015 alone and causing tremendous pain and loss to communities across the country. Since 2000, suicide rates have increased by almost 30 percent in the United States. Community-based programs, policies, and services can play an important role in suicide prevention—but many communities may not know where to start or what they can do.

Transforming Communities is intended to help provide a foundation for the implementation of successful community-based suicide prevention efforts. The paper is being jointly released with [*Preventing Suicide: A Technical Package of Policy, Programs, and Practices*](#), another important resource for communities by the Centers for Disease Control and Prevention (CDC). Both documents emphasize the need for comprehensive efforts that combine multiple strategies working together to prevent suicide. While *Transforming Communities* identifies seven key elements that should guide program planning and implementation, the CDC technical package provides specific, evidence-based strategies for communities to consider as a part of their comprehensive approach to suicide prevention. Together, the two resources address how communities can implement suicide prevention efforts and what they can do.



The Action Alliance for Suicide Prevention, the nation's only public-private partnership to advance the National Strategy for Suicide Prevention, and the American Foundation for Suicide Prevention (AFSP), the nation's largest suicide prevention organization, have jointly set a goal of **reducing the annual suicide rate in the United States by 20 percent by 2025**. We hope that the guidance provided in these two resources help us achieve this goal, thereby reducing the tremendous toll of suicide on our society and improving the health and well-being of millions of Americans nationwide.

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EXECUTIVE SUMMARY

INTRODUCTION

The National Strategy for Suicide Prevention (National Strategy) emphasizes the important role that community-based programs and services can play in suicide prevention. However, many communities may need guidance on how to implement an effective suicide prevention effort. Transforming communities to prevent suicide is a priority area for the National Action Alliance for Suicide Prevention (Action Alliance), the public-private partnership that supports implementation of the National Strategy. In May 2016, the Action Alliance formed a work group dedicated to community-based suicide prevention.* This paper presents the results of the group's work.

REVIEWED PROGRAMS, GUIDANCE, AND MODELS

The work group reviewed several information sources relevant to community-based suicide prevention, including the following:

- **Program descriptions and findings** from comprehensive community-based suicide prevention programs, such as the U.S. Air Force Suicide Prevention Program and the European Alliance Against Depression
- **Existing guidance** for community-based suicide prevention, including the Centers for Disease Control and Prevention's technical package on suicide prevention, the Suicide Prevention Resource Center's (SPRC) Effective Suicide Prevention Model, and guidance from the World Health Organization
- **Planning models** used for the prevention of suicide and other problems, such as the CONNECT Suicide Prevention model created by the National Alliance on Mental Illness chapter in New Hampshire, and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework
- **Broader models** for community prevention and health improvement, such as the Collective Impact Model



KEY ELEMENTS FOR COMPREHENSIVE COMMUNITY-BASED SUICIDE PREVENTION

Based on this review, the group identified seven key elements for the successful implementation of comprehensive community-based suicide prevention:

1. **Unity**— Attainment and maintenance of broad-based momentum around a shared vision
2. **Planning**— Use of a strategic planning process that lays out stakeholder roles and intended outcomes
3. **Integration**— Use of multiple, integrated suicide prevention strategies
4. **Fit**— Alignment of activities with context, culture, and readiness
5. **Communication**— Clear, open, and consistent communication
6. **Data**— Use of surveillance and evaluation data to guide action, assess progress, and make changes
7. **Sustainability**— A focus on long-lasting change

These elements comprise key considerations that should guide community-based suicide prevention.

* Co-led by Robert Gebbia, CEO of the American Foundation for Suicide Prevention; James Mercy, director of the Division of Violence Prevention at the Centers for Disease Control and Prevention, and Jerry Reed, director of the Suicide Prevention Resource Center (see full member list in Appendix 7), the group met via conference call from May to September 2016 to review relevant research, models, and guidance. The group subsequently met in person in Washington, DC, to discuss findings and recommendations.

CONCLUSIONS AND NEXT STEPS

The seven key elements for the implementation of comprehensive community-based suicide prevention presented in this paper are meant as broad guidance for the field. These elements can help bridge the gap between theory and practice by synthesizing current knowledge and providing an umbrella under which a comprehensive community-level process can be organized.

Although this document is meant to guide the work of communities, it is not a step-by-step implementation guide. In order to apply this guidance, communities will need implementation resources, such as user-friendly toolkits, websites, and/or training programs.

Possible next steps could include the development of the following:

- **A website** providing step-by-step implementation guidance, including templates, tools, examples from the field, and lessons learned
- **Online courses** addressing each of the seven key elements
- **Training and technical assistance supports** at the national or state levels



INTRODUCTION AND OVERVIEW

The community is a key setting for suicide prevention. Community-based programs can contribute to suicide prevention in numerous ways, such as by the following examples:

- **Supporting the development of life skills and positive social connections** that strengthen individuals and help them successfully navigate life's challenges
- **Helping to identify persons who may be at risk** for suicide and to connect them to appropriate sources of assistance and care
- **Ensuring that effective crisis services are available**
- **Developing linkages** with clinical systems, health care providers, and programs in the community to ensure seamless and continuous care for individuals at risk
- **Reducing access to lethal means** for those in suicidal crisis
- **Providing support** to those who have been bereaved by suicide

The National Strategy for Suicide Prevention (National Strategy) emphasizes the important role that communities can play in suicide prevention. It notes that a wide range of community partners (e.g., schools, workplaces, faith-based organizations, businesses, law enforcement, health care systems, and others), working together, can deliver prevention programs and services to high-risk groups at the local level, and that “greater coordination among community and clinical preventive service providers can have synergistic effects in preventing suicide and related behaviors.”¹

Transforming communities to prevent suicide is one of three priority areas currently championed by the National Action Alliance for Suicide Prevention (Action Alliance), the public-private partnership that supports implementation of the National Strategy.** This priority area focuses on providing guidance to states and communities to support the implementation of community-based suicide prevention efforts. The need for this guidance was identified in a recent review of progress towards achievement of the National Strategy, conducted by an Action Alliance advisory group. Findings from the implementation review indicated that states and communities would benefit from a “full range of comprehensive, coordinated, and effective suicide prevention efforts across all relevant settings and populations.”²

** The other two priority areas are Transforming Health Systems and Changing the Conversation.

ABOUT THIS DOCUMENT

In May 2016, the Action Alliance created the Transforming Communities Priority Work Group to identify ways to help communities implement effective suicide prevention programs (see participant list in Appendix 7). This paper presents the results of their work.

Co-led by Robert Gebbia, CEO of the American Foundation for Suicide Prevention (AFSP); James Mercy, director of the Division of Violence Prevention at the Centers for Disease Control and Prevention (CDC); and Jerry Reed, director of the Suicide Prevention Resource Center (SPRC) at Education Development Center, Inc. (EDC), the group was tasked with developing a paper on community-based suicide prevention. The group communicated via conference calls from May to September 2016 to discuss the contents and scope of the document. Members agreed that the paper would review and synthesize existing evidence, models, and guidance to identify a set of key elements that should guide community-based suicide prevention. This guidance would be broadly based, rather than a list of strategies or a step-by-step implementation guide, so that it could be used to inform the development of additional tools, resources, and supports to help communities apply the elements in their own unique settings.

This broad approach recognizes that, unlike health care systems, communities are open and fluid. They can encompass diverse locations, groups, and settings; different demographic and cultural groups; and geographic areas of different sizes. Some community settings may be more defined, such as a school, workplace, health clinic, or place of worship. Others may be more open or fluid settings or groupings, such as neighborhoods, cities, or states or groups of people who share common characteristics or goals. Suicide prevention guidance for communities must recognize this diversity and be adaptable to different cultures and contexts.

As suicide is affected by a combination of factors (e.g., individual, family, community, societal), suicide prevention efforts are more likely to succeed if they combine multiple strategies that work together to prevent suicide.^{3,4} Therefore, the work group sought to identify and review information relevant to the development of *comprehensive* community-based programs—that is, programs that combine multiple, integrated suicide prevention strategies—rather than programs more narrow in focus (e.g., a suicide prevention training program for gatekeepers).

The work group reviewed information from various sources and met in person in September 2016 to discuss findings and recommendations. This paper presents the results of their work. It describes the information sources reviewed (see appendices for detailed descriptions) and presents a set of seven key elements for comprehensive community-based suicide prevention derived from the review process. Potential next steps for helping communities apply this guidance, such as the development of user-friendly implementation guides and resources, are discussed in the last part of this document.

REVIEWED PROGRAMS, GUIDANCE, AND MODELS

This section provides a brief overview of the information sources reviewed by the work group (see Table 1). For more detailed descriptions, see the indicated Appendices.

Table 1. Information sources reviewed by the work group

Comprehensive Community-Based Suicide Prevention Programs (Appendix 1)	
Program	Where Implemented
U.S. Air Force Suicide Prevention Program (ASFSP)	U.S. Air Force
Model Adolescent Suicide Prevention Program (MASPP)	Western Athabaskan Tribal Nation, New Mexico
Help for Life Program	Province of Québec, Canada
European Alliance Against Depression (EAAD)	Europe (many countries)
Optimizing Suicide Prevention Programs and Their Implementation in Europe (OSPI-Europe)	Germany, Hungary, Ireland, and Portugal
LifeSpan Program	New South Wales, Australia
Suicide Prevention Guidance (Appendix 2)	
Guidance	Source
Preventing Suicide: A Technical Package of Policy, Programs, and Practices	Centers for Disease Control and Prevention
SPRC Effective Suicide Prevention Model	Suicide Prevention Resource Center
LivingWorks Suicide-Safer Communities Designation	LivingWorks partnership, Alberta, Canada
Public Health Action for the Prevention of Suicide: A Framework, 2012	World Health Organization (WHO)
Preventing Suicide: A Global Initiative, 2014	
Guidance from Match Meeting on Community Suicide Prevention, September 2015	International Initiative for Mental Health Leadership
Guidance on Preventing Suicide in Community and Custodial Settings (under development)	United Kingdom National Institute for Health and Care Excellence

Planning Models Used in Prevention (Appendix 3)

Model	Source
SPRC Strategic Planning Approach to Suicide Prevention	Suicide Prevention Resource Center
CONNECT Community Suicide Prevention, Intervention, and Postvention Model	National Alliance on Mental Illness chapter in New Hampshire
SAMHSA Strategic Prevention Framework (SPF) for preventing substance abuse and misuse	Substance Abuse and Mental Health Services Administration (SAMHSA)
Communities That Care (CTC) model, focusing on youth violence, alcohol and tobacco use, and delinquency	University of Washington
Getting to Outcomes® (GTO) toolkit for preventing negative behaviors	RAND Corporation and University of South Carolina

Community Health Improvement Models (Appendix 4)

Model	Source
Collective Impact Model	FSG consulting firm
Community Health improvement Navigator	CDC
County Health Rankings and Roadmaps Action Cycle	Robert Wood Johnson Foundation

Other Information Reviewed (Appendix 5)

Findings from systematic reviews: - Mann, J. J., Apter, A., Bertolote J., Beautrais, A., Currier, D., Haas, A., . . . Hendin, H. (2005). Suicide prevention strategies: A systematic review. <i>Journal of the American Medical Association</i>, 294(16), 2064–2074. - Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., . . . Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. <i>Lancet Psychiatry</i>, 3(7), 646–659.	Findings from published evaluations of Garrett Lee Smith Suicide Prevention Programs: - Godoy Garraza, L., Walrath, C., Goldston, D. B., Reid, H., & McKeon, R. (2015). Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on suicide attempts among youths. <i>JAMA Psychiatry</i>, 72(11), 1143–1149. - Walrath, C., Garraza, L. G., Reid, H., Goldston, D. B., & McKeon, R. (2015). Impact of the Garrett Lee Smith youth suicide prevention program on suicide mortality. <i>American Journal of Public Health</i>, 105(5), 986–993.
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Other Resources Reviewed (Appendix 6)

- Asset-Based Community Development, ABCD Institute - Coalition Primers and Toolkits, Community Anti-Drug Coalition of America - Coming Together to Care: A Suicide Prevention Toolkit for Texas Communities, Texas Suicide Prevention Council	- Communities Matter Toolkit, Mental Health Commission of New South Wales and Suicide Prevention Australia Community Tool Box, University of Kansas - National Registry of Evidence-Based Programs and Practices, SAMHSA - Preventing Suicide: A Community Engagement Toolkit, Pilot Version 1.0, WHO
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COMPREHENSIVE COMMUNITY-BASED SUICIDE PREVENTION PROGRAMS

The work group reviewed information from five comprehensive community-based programs conducted in the United States, Canada, Australia, and Europe (see Appendix 1). All of these community-based programs used a multi-level approach that combined multiple, integrated strategies for suicide prevention. All were based on extensive research, including literature reviews, expert consultation, and community involvement. And although a few of these programs are still being evaluated (and the Australian program was only recently launched), they are all theoretically sound, and available evaluation results indicate that the programs were effective in reducing suicide deaths and/or attempts.

The first two programs were conducted in the United States. Started in 1996, the **U.S. Air Force Suicide Prevention Program (AFSPP)** is a well-known example of a successful comprehensive community-based suicide prevention program. Developed in response to an increase in suicide rates in the U.S. Air Force, the program combined 11 main initiatives that sought to strengthen social support, promote the development of coping skills, and change policies and norms to encourage help-seeking behaviors.^{5, 6} Program evaluation suggested that the program reduced the risk of suicide among Air Force personnel by one-third.⁵ Program participation was also linked to decreases in homicide, family violence (including severe family violence), and accidental death—other adverse outcomes that share risk factors with suicide.

The second program, **Model Adolescent Suicide Prevention Program**, was developed in response to an increase in suicidal activity among young people in the Western Athabaskan Tribal Nation, a small American Indian tribe in rural New Mexico.⁷ Informed by extensive consultation with community members and various key stakeholders, the program included several integrated suicide prevention strategies, such as community education, surveillance, school-based activities, and the use of “natural helpers,” or neighborhood volunteers of various ages who provided peer training, advocacy, referrals, and counseling (in coordination with professional mental health staff). Evaluation findings indicate that suicide attempts decreased from an average of 19.5 per year before the program began (1988–1989) to 4 attempts during 2002.⁷ (Deaths from suicide remained stable during this time period, at 1 to 2 per year.)

Another example of a comprehensive program is **Help for Life**, a suicide prevention initiative carried out in Québec, Canada, to implement the province’s suicide prevention strategy, issued in 1998.⁸ Developed based on an extensive consultation process involving almost 40 organizations, the five-year strategy gave priority to seven suicide prevention strategies, including training, crisis management, and limiting access to lethal means. As a result of this program, a provincial hotline was established, suicide prevention centers were set up in every region of the province, mental health treatment and follow-up for people who attempt suicide were improved, barriers were installed on key bridges and railway trestles, and training for staff at youth protection agencies was improved. The program is credited with contributing to a decrease in suicides in the province from 22.2 per 100,000 in 1999 to 13.7 per 100,000 in 2012.⁹

In Europe, the most widely adopted suicide prevention program is the **European Alliance Against Depression (EAAD)**, which focuses on both depression care and suicide prevention. Launched in 2004 with funding from the European Commission, EAAD built on the success and lessons learned from the Nuremberg Alliance Against Depression (NAAD).¹⁰ EAAD seeks to improve care for depression and to prevent suicide by carrying out programs featuring a four-level approach addressing the training of primary care providers, public awareness campaigns, gatekeeper training, and support for affected persons and high-risk groups.¹¹ Initially implemented in 17 European countries, EAAD has been adopted in numerous European regions.¹²

The EADD approach informed the development of a suicide prevention program conducted in four European regions from 2008 to 2013. To learn more about the most effective combination of strategies for preventing suicide, in 2008 the European commission launched the **Optimizing Suicide Prevention Programs and their Implementation in Europe (OSPI-Europe)** study, a five-year trial conducted in Germany, Hungary, Ireland, and Portugal.¹³ Informed by an extensive review and consultation process, the intervention included the four EAAD strategies and added a fifth strategy addressing access to lethal means.¹⁴ Although findings regarding primary outcomes (deaths and attempts) are not yet available, lessons learned from the process evaluation have been presented in recent papers and can be useful to the planning of new community-based suicide prevention programs.^{15, 16}

The last international initiative reviewed was the **LifeSpan Program** in New South Wales, Australia.¹⁷ The program is based on an integrated suicide prevention framework released in August 2015, which emphasizes a systems approach to suicide prevention.¹⁸ Developed for the NSW Mental Health Commission by the Black Dog Institute, a nonprofit mental health organization, and the National Health and Medical Research Council (NHMRC) Centre for Research Excellence in Suicide Prevention (CRESP), the framework was created based on an extensive consultation with cross-sector partners.¹⁹ Funded by a \$14.7 million grant from the Paul Ramsay Foundation,¹⁷ the program combines nine evidence-based strategies (e.g., crisis care, high-quality treatment, training, school programs, communication campaigns, media guidelines, means restriction) that will be implemented simultaneously.^{18, 20} Implementation was started in Newcastle in October 2016 and will be rolled out in three other regions over 2 ½ years.

SUICIDE PREVENTION GUIDANCE

In addition to the comprehensive community-based programs described above, many other programs, frameworks, models, and guidance can also help guide community-based suicide prevention efforts. They include the CDC technical package on suicide prevention and the Effective Suicide Prevention Model developed by SPRC (see Appendix 2 for detailed descriptions and links).

Preventing Suicide: A Technical Package of Policy, Programs, and Practices is a resource aimed at guiding and informing prevention decision making in communities and states. The package presents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on activities with the greatest potential to prevent suicide. It stresses the importance of comprehensive prevention efforts and recognizes that, ideally, the implementation of multiple strategies and approaches tailored to the social, economic, cultural, and environmental context of individuals and communities may provide opportunities to develop individual and community resilience and increase the likelihood of removing barriers to supportive and effective care.

Available online, the **SPRC Effective Suicide Prevention Model** is based on SPRC's extensive experience providing technical assistance to SAMHSA suicide prevention grantees, state suicide prevention coordinators, and others who implement community-based efforts. The model has three components: (1) a comprehensive approach to suicide prevention, which includes nine suicide prevention strategies that communities can consider in designing a multifaceted program, (2) a six-step strategic planning approach to suicide prevention, and (3) a set of five guiding principles for program success.

The work group also reviewed several other models and guidelines for community suicide prevention, including the following:

- The **LivingWorks Suicide-Safer Communities** designation developed by the LivingWorks partnership in Canada, which recognizes communities that implement concerted, strategic approaches to suicide prevention around nine 10 suicide safety pillars of action
- Suicide prevention guidance from the **World Health Organization (WHO)**
- Guiding principles and core values developed at a 2015 match meeting on Community Suicide Prevention, convened by the **International Initiative for Mental Health Leadership (IIMHL)**
- Guidelines on the prevention of suicide in community and custodial settings currently being developed by the **United Kingdom's National Institute for Health and Care Excellence (NICE)**



PLANNING MODELS USED IN PREVENTION

Several planning models have been used to guide the implementation of state and community-based suicide prevention programs (see Appendix 3). Among them are two models specific to suicide prevention: the **SPRC Strategic Planning Approach to Suicide Prevention**, a six-step process for carrying out a suicide prevention program, and the **Connect Community Suicide Prevention, Intervention, and Postvention**, a program developed by the National Alliance on Mental Illness (NAMI) chapter in New Hampshire. The program includes not only suicide prevention training but also guiding principles and protocols leading to culture change²¹ and institutionalization of best practices. Other planning models reviewed by the work group were broader in focus—that is, they were designed to address the prevention of a broader range of health problems (e.g., violence, substance abuse).

COMMUNITY HEALTH IMPROVEMENT MODELS

The work group also reviewed models for the implementation of community health improvement efforts, including insights from the **Collective Impact Model**, which was developed by the consulting firm FSG and based on the experience of community-based programs that were successful in achieving lasting social change. Described in a series of articles, this model identifies three preconditions for collective impact (an influential champion, adequate anchor funding, and a sense of urgency for change around an issue); three phases of startup and implementation; and five key elements for success. It also lists four components required for the success of a collective impact effort: (1) governance and infrastructure, (2) strategic planning, (3) community involvement, and (4) evaluation and improvement.

Other community improvement models reviewed included the Robert Wood Johnson Foundation (RWJ) **County Health Rankings and Roadmaps Action Cycle**, which features seven action steps (e.g., assess needs and resources, choose effective policies and programs, evaluate actions), and the **CDC Community Health Improvement Navigator**—a website focused on improving the health of communities.

OTHER INFORMATION AND RESOURCES REVIEWED

The work group reviewed findings from key systematic reviews and individual program evaluations of suicide prevention interventions (see Appendix 5). However, these information sources were not considered as relevant because they assessed the effectiveness of individual suicide prevention strategies (e.g., training of health care providers, lethal means restriction), rather than the implementation of community-based programs combining multiple integrated strategies. Other resources reviewed—including the recently issued WHO *Preventing Suicide: A Community Engagement Toolkit*—are described in Appendix 6.

KEY ELEMENTS

FOR THE IMPLEMENTATION OF COMPREHENSIVE COMMUNITY-BASED SUICIDE PREVENTION

This section presents seven key elements for the implementation of comprehensive community-based suicide prevention identified by the Action Alliance's Transforming Communities Priority Work Group and based on the review and synthesis of the information sources referenced in the previous section of this paper (described in greater detail in the Appendices). The seven elements are key concepts that program leaders, program planners, and others should consider when planning and implementing community-based suicide prevention efforts. The elements are not sequential implementation steps but rather key considerations that should guide all aspects of program planning and implementation.

UNITY—ATTAINMENT OF BROAD-BASED SUPPORT FOR A SHARED VISION

The programs, guidance, and models reviewed emphasize that community-based programs are more likely to succeed if they are built on a foundation of broad-based support for the achievement of a shared vision and a single agenda. All comprehensive community-based programs reviewed by the work group were implemented by a broad coalition of stakeholders, with the involvement of leaders and key influencers from various sectors with the authority and credibility to facilitate change in their respective spheres of influence. Advisory groups, coalitions, task forces, or other groupings can contribute to success in multiple ways, including ensuring the cultural appropriateness of messages and activities, promoting wide participation in program activities, and supporting sustainability over time.

In particular, communities should consider involving the following partners in their suicide prevention efforts:

- Concerned and caring community members, including individuals with lived experience (e.g., suicide attempt survivors, persons bereaved by suicide)
- Representatives from the public and private sectors, including the business community
- Members of community-based organizations, including local crisis centers
- Representatives from various settings serving diverse groups (e.g. schools, college campuses, workplaces, places of worship)
- Representatives and leaders from health care and behavioral health care systems
- Academic partners
- The local and regional news media
- Representatives from the local/state justice and corrections systems
- Spiritual and faith leaders
- First responders (e.g., law enforcement, emergency medical technicians)
- Individuals representing and working with underserved and at-risk populations
- Individuals who can advocate for changes in policies, systems, and environments that will help prevent and reduce suicide

Findings from the process evaluation of **OSPI-Europe intervention** (Appendix 1) include several specific recommendations regarding the use of advisory groups in suicide prevention. These findings indicate that plans for advisory group representation should be started before the program is launched and that they should take into account how the group could become a permanent management team that will continue to deliver the program after the initial project implementation period—thereby contributing to sustainability.¹⁵ Another key finding from OSPI-Europe regarded the need to transform advisory group members into OSPI stakeholders. Examples on how to do so included giving partners the opportunity to develop ownership of particular activities and emphasizing the value of local services at every opportunity.¹⁵

The models of community improvement described in Appendix 5 also emphasize the importance of developing a common vision and uniting in support of a single agenda. For example, the **FSG Collective Impact Model** emphasizes the importance of a shared vision for change, including developing a common understanding of the problem and a joint approach to solving it through agreed upon action. Similarly, the **RWJ County Health Rankings & Roadmaps Action Cycle** highlights the need to develop a shared vision and commitment by building relationships and developing leadership capacity. The Collective Impact model goes a step further, recommending that a backbone organization be formed and funded that is dedicated to ensuring ongoing coordination and communication among partners.



PLANNING—USE OF A STRATEGIC PLANNING PROCESS THAT LAYS OUT STAKEHOLDER ROLES AND INTENDED OUTCOMES

This element addresses how to plan a comprehensive, community-based suicide prevention effort. All reviewed programs used a strategic planning process that started by looking at key data points to better understand the suicide problem in a particular community, key high-risk groups and their risk and protective factors, and the environment in terms of existing supports and general community readiness. Although strategic planning models can vary, all programs began by reviewing or collecting data to understand the suicide problem and the community's readiness to address the problem. This approach begins by gathering data to answer a number of key questions, such as the following:

- What do we know about suicide in this community?
- Which groups are most affected?
- What are the main risk and protective factors affecting these groups?

Once these kinds of questions are answered, the group next considers the evidence-informed strategies that will be most likely to be effective in reducing risk and increasing protection. Specific goals and objectives are set for each strategy so the group will know if their efforts are making a difference and how they will evaluate efforts to assess progress toward those goals.

An existing planning model developed specifically for suicide prevention is the SPRC Strategic Planning Approach (See Appendix 2), featuring six planning steps:

1. Describe the problem and the context
2. Choose long-term goals
3. Identify key risk and protective factors on which to focus your prevention efforts
4. Select or develop interventions
5. Plan the evaluation
6. Implement, evaluate, and improve

This model was developed based on SPRC's many years of experience providing guidance and support to SAMHSA suicide prevention grantees and state suicide prevention coordinators. It emphasizes the importance of (1) using data and other information sources to understand the suicide problem in the community and (2) prioritizing key risk and protective factors on which to focus prevention efforts. More information on how to apply this model is available from **SPRC**, including a free online training course.

Other similar planning models used by community-based programs to prevent suicide and related health problems include **SAMHSA's Strategic Prevention Framework** for preventing substance abuse and misuse, the University of Washington's **Communities That Care** model, and the **Getting to Outcomes®** toolkit for preventing negative behaviors (see Appendix 3). The models of community improvement described in Appendix 5 also feature similar planning steps.

INTEGRATION—USE OF MULTIPLE INTEGRATED SUICIDE PREVENTION STRATEGIES

As suicide is affected by diverse factors at multiple levels of influence, suicide prevention interventions likely benefit from a combination of approaches. All reviewed programs combined multiple evidence-based and promising strategies that worked together to prevent suicide and other behaviors that share risk and protective factors with suicide (e.g., violence, substance abuse). These strategies were identified based on the strategic planning process described above, along with extensive literature reviews and consultations with experts and members of the community. Examples include the following:

- **U.S. Air Force Suicide Prevention Program** with 11 initiatives (Appendix 1)
- **OSPI-Europe** comprising five levels (Appendix 1)
- New South Wales **LifeSpan Program** composed of nine strategies (Appendix 1)
- **SPRC Comprehensive Approach** model with nine strategies; derived from the Air Force initiative (Appendix 2)
- **CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices** strategies (Appendix 2)

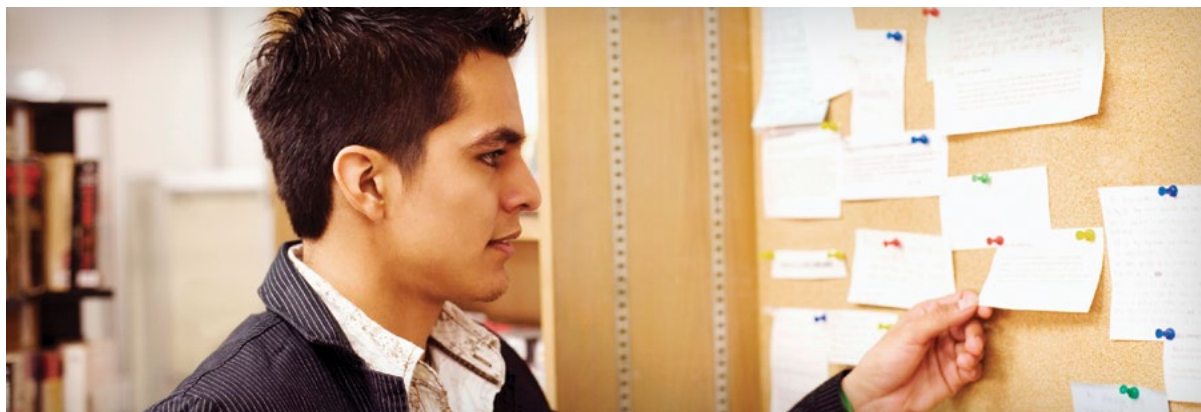
SAMHSA's NREPP (Appendix 6) is another useful source of information on programs and strategies that have been shown to be effective in improving suicide-related outcomes

Findings from the reviewed programs also indicate that community-based programs should combine strategies that are more clinically focused (e.g., providing effective care and treatment, care transitions and linkages), along with community-based efforts (e.g., identifying and assisting those at risk, promoting connectedness and support). As the New South Wales Prevention Framework notes, these community-based and clinical strategies should be used in an integrated, cohesive way.¹⁸

As suicide is a complex behavior affected by a combination of risk and protective factors, suicide prevention efforts should be conducted in close coordination with a variety of programs and services in the community (e.g., housing, employment, child protective services). For example, the Model Adolescent Suicide Prevention Program (MASPP) found that in order to prevent suicide among American Indian youth, underlying issues such as alcoholism, domestic violence, child abuse, and unemployment also must be addressed.

In selecting strategies, communities should consider a public health approach to prevention, which focuses on the particular needs of different groups: from the general

population to subgroups that may be at increased risk for suicide to individuals who are identified as being at risk. It is also important to partner with programs that support overall health and well-being across the lifespan—from childhood to the older years—particularly since the risk and protective factors for suicide are often common across other health and social issues. One of the key components of the **U.S. Air Force Suicide Prevention Program** was the development of an integrated, seamless system of prevention services addressing family advocacy, family support, mental health, and other issues related to health and social welfare. (See Appendix 1 for descriptions.)



FIT—ALIGNMENT OF ACTIVITIES WITH CONTEXT, CULTURE, AND READINESS

In addition to being comprehensive, evidence-informed, and appropriate for addressing existing risk and protective factors, suicide prevention efforts must also align with community perspectives, culture, readiness, strengths, and needs. Cultural alignment, or fit, is as important to the success of a suicide prevention effort as the use of evidence-based approaches.

As noted, suicide prevention strategies should be selected and tailored based on an assessment of the suicide problem in each community. One of the key findings of the **Model Adolescent Suicide Prevention Program** (Appendix 1) was that the community must be involved in the suicide prevention effort from the beginning in order to ensure that approaches are developed in a culturally, environmentally, and clinically appropriate manner. Culturally tailored strategies included the use of “natural helpers” from the community, as well as making clinical supports available in places frequented by individuals who may be at risk for suicide.

Another example comes from the **New South Wales LifeSpan Program** (Appendix 1). In each participating site, community leaders and organizations work together with program implementers to tailor the approaches to ensure relevance to local context and cultural appropriateness. The process particularly consider the needs of at risk and underserved groups, including culturally and linguistically diverse populations, while also considering the broader evidence base for what works.



COMMUNICATION—CLEAR, OPEN, AND CONSISTENT COMMUNICATION

All programs emphasized the importance of communication—both internally among partners and externally to key stakeholders and, more broadly, to the community. The cross-training of community stakeholders can help create a shared language and understanding that can build trust and improve results.

In addition to focusing on internal communications, all programs also included communication campaigns and educational strategies (e.g., training of health providers and gatekeepers) aimed at increasing awareness of suicide prevention programs and services, while also supporting help-seeking. Many programs also worked closely with the news media to ensure safe reporting. The work group recommends that existing best practice resources on effective communication (i.e., [Action Alliance Framework for Successful Messaging](#)) and safe reporting (i.e., [Recommendations for Reporting on Suicide](#)) be followed for all external communications efforts.

The models of community improvement presented in Appendix 5 provide other relevant insights in this area. The **FSG Collective Impact Model** suggests that open and consistent communication across partners is needed in order to build trust and ensure common objectives and motivation. Similarly, the **RWJ County Health Rankings & Roadmaps Action Cycle** suggests ways to communicate effectively with internal and external audiences, such as by creating common language and communication norms, developing a communications strategy, keeping partners informed and engaged, and telling your story.

Communication efforts can also play an important role in helping community-based programs advocate for policy changes that will support suicide prevention efforts. The **Community Tool Box** (Appendix 6) identifies several strategies (e.g., writing letters to policymakers, creating newsworthy stories) and resources for using advocacy to garner political support for community change and improvement.

DATA—USE OF SURVEILLANCE AND EVALUATION DATA TO GUIDE ACTION, ASSESS PROGRESS, AND MAKE CHANGES

All programs made use of and/or established surveillance systems to collect data that could help them better understand the suicide problem in their communities, develop data-driven strategic plans, and track progress in achieving established objectives. The data collected by these programs included tracking intermediate outcomes, such as risk and protective factors, and long-term outcomes, such as suicide ideation, attempts, and deaths. These data can support ongoing decision making and help program planners continuously monitor progress towards achieving their objectives and make adjustments as needed. Process data can also be used to hold key partners or stakeholders accountable and keep them motivated in ensuring that needed changes are occurring in their respective settings, and that all are doing their part to contribute to the larger effort.

The reviewed programs demonstrate the importance of developing surveillance systems for collecting suicide-related data. For example, the U.S. Air Force Program (in Appendix 1) established the Suicide Event Surveillance System, a central suicide database for tracking not only suicide attempts and deaths, but also potential risk factors. Another initiative within that same program was the Integrated Delivery System Consultation Assessment Tool, a regular survey used to assess behavioral health in the community overall and to identify emerging needs as they arose.

Similarly, the New South Wales LifeSpan Program (in Appendix 1) also emphasizes the importance of developing a central data collection system and common measures. Its program evaluation collects data on quantitative outcomes, including suicide-related deaths, suicide attempts, hospital utilization, and visits to primary care providers, as well as qualitative data from consumer interviews and trainings.

The RWJ Action Cycle (in Appendix 3) offers many resources that can be useful to community groups in evaluating their suicide prevention evaluation efforts. This resource provides information regarding various activities, including deciding what goals are most important to evaluate, building consensus around an evaluation plan, identifying benchmarks for success, establishing data collection and analysis systems, reviewing and sharing evaluation results, and adjusting the program.



SUSTAINABILITY—A FOCUS ON LONG-LASTING CHANGE

Ensuring long-lasting change and sustained commitment is a common concern among suicide prevention and other programs aimed at preventing related health problems or improving community health. As noted in findings from the U.S. Air Force Suicide Prevention Program, in order for comprehensive community-based approaches to be effective, program efforts must be continuously supported and monitored to ensure sustained effects.⁶ Similarly, sustainability is also an important concern identified by the **LifeSpan Program**,¹⁹ as well as several other suicide prevention models and guidance reviewed by the work group, such as the **LivingWorks Suicide-Safer Communities** designation and the guiding principles for community suicide prevention identified at the IIMHL meeting on community-based suicide prevention (see Appendix 2).

Like evaluation, sustainability is an ongoing process that should be started early and revisited throughout program planning and implementation. Several of the reviewed programs and models addressed ways to support sustainability, such as forming a broad-based advisory group that includes representatives from the public and private sectors and focusing efforts on improving policies and practices, thereby leading to lasting change.

Suicide prevention efforts that seek to change systems, policies, and environments can be particularly impactful. Examples discussed in the CDC Technical Package include ensuring that mental health conditions are covered by health insurance policies and adopting community-based policies to reduce excessive alcohol use. Community-based suicide prevention efforts should consider ways to promote the adoption of these and other environmental-level approaches that can have strong and sustained effects on suicide-related outcomes. These types of strategies should be considered as part of an integrated approach to suicide prevention, as described under the Integration element above.

CONCLUSION AND NEXT STEPS

The National Strategy emphasizes the important role that community-based programs and services can play in suicide prevention. However, many communities may need guidance on how to implement an effective suicide prevention effort. To address this need, an Action Alliance work group reviewed relevant programs, guidance, and models.

Based on this review, the work group identified seven key elements for the implementation of comprehensive community-based suicide prevention efforts:

1. **Unity**—Attainment and maintenance of broad-based momentum around a shared vision
2. **Planning**—Use of a strategic planning process that lays out stakeholder roles and intended outcomes
3. **Integration**—Use of multiple, integrated suicide prevention strategies
4. **Fit**—Alignment of activities with context, culture, and readiness
5. **Communication**—Clear, open, and consistent communication
6. **Data**—Use of surveillance and evaluation data to guide action, assess progress, and make changes
7. **Sustainability**—A focus on long-lasting change

These key elements are meant as broad guidance for the field. This information can help bridge the gap between theory and practice by synthesizing current knowledge and providing an umbrella under which a comprehensive community-level process can be organized.

Although this document is meant to guide the work of communities, it is not a step-by-step implementation guide. In order to apply this guidance, communities will need implementation resources, such as user-friendly toolkits, websites, and/or training programs.

Possible next steps will require additional public private collaboration and could include the development of the following:

- A **website** providing step-by-step implementation guidance, including templates, tools, examples from the field, and lessons learned
- **Online courses** addressing each of the seven key elements
- **Training and technical assistance supports** at the national or state levels

As communities vary in type, size, and composition, more specific guidance will need to be combined with implementation options and suggestions regarding adaptation.

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APPENDIX 1:

COMPREHENSIVE COMMUNITY-BASED SUICIDE PREVENTION PROGRAMS

U.S. AIR FORCE SUICIDE PREVENTION PROGRAM (AFSPP)

In the United States, the U.S. Air Force Suicide Prevention Program (AFSPP) is perhaps the best known example of a community-based program that has been shown to be effective in reducing suicide deaths and attempts. Launched in 1996 and fully implemented in 1997, the program has been conducted with millions of active duty Air Force personnel.

AFSPP was developed due to an increase in suicide rates between 1990 and 1995.¹ In response, the vice chief of staff mandated that suicide become a service-wide priority and formed a team representing 15 functional areas (e.g., social service providers, health care providers, prevention services, justice system) and CDC experts to study the problem and recommend an approach. The team used a data-driven model to examine existing data regarding suicide and related behaviors and developed an 11-component program (see chart on next page).

Program evaluation, which compared outcomes among personnel before (1990–1996) and after the program was started (1997–2002), suggested that the program reduced the risk of suicide among Air Force personnel by one-third.¹ Participation in the program was also linked to decreases in homicide, family violence (including severe family violence), and accidental death—other adverse outcomes that share risk factors with suicide.

The program was subsequently continued, with updated findings being published in 2010.² An analysis of data collected from 1981 to 2008 found support for the program's long-term effectiveness in preventing suicide. The authors concluded that a multifaceted, overlapping, community-based approach can be effective in reducing suicide, but that program efforts must be continuously supported and monitored to ensure sustained effects.

The community-wide program included 11 main initiatives that sought to strengthen social support, promote the development of coping skills, and change policies and norms to encourage help-seeking behaviors:²

1. **Leadership involvement:** Air Force leaders actively support the entire spectrum of suicide prevention activities; regular messages from leadership motivate the community to fully engage in suicide prevention.
2. **Professional military education:** Suicide prevention is included in all formal military training.
3. **Guidelines for commanders on use of mental health services:** Commanders receive training on how and when to use mental health services and on their role in encouraging help-seeking.
4. **Community preventive services:** The Medical Expense and Performance Reporting System was updated to track and encourage prevention activities.
5. **Community education and training:** Annual suicide prevention training is provided for all military and civilian employees.
6. **Investigative interview policy:** Changes in policies to ensure that following an arrest or investigative interview, an individual is assessed for suicide potential and that a mental health provider is contacted if there is any possibility of suicide risk.
7. **Critical incident stress management:** Establishment of a multidisciplinary team (e.g., mental health providers, medical providers, chaplains) to respond to traumatic events.
8. **Integrated Delivery System (IDS) and Community Action Information Board (CAIB):** Establishment of a seamless system of prevention services to prevent duplication, overlap, or gaps among services (e.g., family advocacy, family support, health promotion, mental health clinics, youth programs).
9. **Limited Privilege Suicide Prevention Program:** Patients at risk for suicide are afforded increased confidentiality when seen by mental health providers.
10. **IDS Consultation Assessment Tool (originally the Behavioral Health Survey):** A tool for assessing behavioral health and responding to emerging needs.
11. **Suicide Event Surveillance System:** Establishment of a central suicide event surveillance database for tracking all suicides and attempts, as well as potential risk factors for suicide.

MODEL ADOLESCENT SUICIDE PREVENTION PROGRAM (MASPP)

This community-based intervention was developed to address an increase in suicidal activity among young people in the Western Athabaskan Tribal Nation, a small American Indian tribe in rural New Mexico.³ In 1988, suicide deaths and attempts were 15 times higher among members of this tribe than among the United States population. To address this problem, from 1990 to 1994, the Indian Health Service worked with the tribal council and community to carry out a small model project to prevent suicides among adolescents. The model project focused initially on youth ages 10 to 19 years—the group identified as being most at risk for suicidal behaviors—and was later expanded to include young people ages 20 to 24 years. Over time, the project evolved into a broad-based program, which is currently a part of the tribal nation's Department of Behavioral Health. Program planning and implementation were based on the active involvement of key stakeholders, including tribal leaders, health care providers, parents, elders, and youth.

More than 50 interactive community workgroup sessions were conducted to examine questions such as the following:³

- What are the problems and issues in the community?
- What are the barriers to solving these problems?
- What can be done to solve problems and overcome barriers?

Statements and comments from these meetings were transcribed and disseminated in the community—forming the foundation for program components. At these meetings, community members noted that in order to prevent suicide, other underlying issues, such as alcoholism, domestic violence, child abuse, and unemployment, also had to be addressed.

The resulting suicide prevention program included the following integrated components:

1. Surveillance via constant data and information gathering
2. Screening and clinical interventions with extensive outreach in conventional settings (e.g., health clinics, schools, social welfare programs) as well as other sites (e.g., outdoor venues, community functions)
3. Social services (child and adult welfare activities)
4. School-based programs
5. Community education
6. The use of “natural helpers,” or neighborhood volunteers of various ages who provided peer training, advocacy, referrals, and counseling (in coordination with professional mental health staff)

Evaluation findings indicated that suicide attempts decreased from an average of 19.5 per year before the program began (1988–1989) to 4 attempts during 2002.³

HELP FOR LIFE PROGRAM, QUÉBEC, CANADA

Help for Life was a suicide prevention initiative carried out in Québec, Canada, to implement the province's suicide prevention strategy, issued in 1998.⁴ In the mid-1990s, suicide rates in the province had reached 19.5 per 100,000 people in 1995. In response, Québec's Ministry of Health and Social Services formed a task force to lead the development of a suicide prevention strategy and carried out an extensive consultation process involving almost 40 organizations. The result was a five-year plan issued in 1998.

The strategy gave priority to the following activities:⁴

- **Provide and consolidate essential services** (e.g., 24/7 hotline, crisis management, assessment and treatment of suicide risk, follow-up and monitoring, postvention) and ensure collaboration among caseworkers.
- **Increase professional skills** in the identification and treatment of depression and in the provision of adequate care for suicide risk and to individuals bereaved by suicide.
- **Intervene with groups at risk**, including men at risk of suicide and persons who have attempted suicide, by introducing targeted programs and involving gatekeepers.
- **Foster health promotion and suicide prevention programs for young people** by conducting school-based programs and ensuring the presence in each region of a response team trained to work with schools on postvention.
- **Reduce access to and minimize risks associated with means of suicide** by promoting initiatives addressing firearms, bridges and other dangerous sites, medications, and carbon monoxide.
- **Counteract the trivialization and sensationalizing of suicide** by developing a sense of community and responsibility. This included developing a communication plan to support the strategy, disseminating a code of ethics to the media, and sensitizing people in the media about suicide prevention.
- **Intensify and diversify research** by carrying out evaluation research addressing health promotion, prevention, intervention, and postvention; developing interventions tailored to different groups; and supporting basic research on suicide.

As a result of this program:

- A provincial hotline was established.
- Suicide prevention centers were set up in every region of the province.
- Mental health treatment and follow-up for people who attempt suicide were improved.
- Barriers were installed on key bridges and railway trestles.
- Training for staff at youth protection agencies was improved.

The program is credited with contributing to a decrease in suicides in the province from 22.2 per 100,000 in 1999 to 13.7 per 100,000 in 2012.⁵

EUROPEAN ALLIANCE AGAINST DEPRESSION (EAAD)

The European Alliance Against Depression (EAAD), which focuses on both depression care and suicide prevention, is perhaps the most well-known and widely implemented international community-based suicide prevention program. Launched in 2004 with funding from the European Commission, EAAD (www.eaad.net) built on the success and lessons learned from the Nuremberg Alliance Against Depression (NAAD).⁶ Conducted in Nuremberg, Germany, from 2001 to 2002, the four-level NAAD intervention was found to reduce suicidal acts (attempts and deaths) by 24 percent when compared with both a baseline year and a control region—the city of Würzburg.⁷

EAAD seeks to improve care for depression and prevent suicide by carrying out programs featuring a four-level approach:⁸

- **Level 1: Training and support of primary care providers** to improve the identification and treatment of depressed and suicidal individuals
- **Level 2: Public awareness campaigns** targeting the general public with the aim of encouraging treatment seeking
- **Level 3: Training of community facilitators** who are in contact with high-risk groups (e.g., teachers, police, clergy, social workers, persons who care for older individuals, prison workers)
- **Level 4: Support for affected persons and high-risk groups**, such as individuals with depression and suicide attempt survivors

Initially implemented in 17 European countries, EAAD has been adopted by many European countries and regions.⁹ Evaluation findings from countries that have adopted the EAAD model suggest that it can be adapted to different cultures with minor changes.¹⁰

Optimizing Suicide Prevention Programs and Their Implementation in Europe (OSPI-Europe)

To learn more about the most effective combination of strategies for preventing suicide, in 2008 the European commission launched the Optimizing Suicide Prevention Programs and Their Implementation in Europe (OSPI-Europe) study, a five-year trial conducted in Germany, Hungary, Ireland, and Portugal.¹⁰ Informed by an extensive review and consultation process,¹¹ the intervention included the four EAAD strategies and added a fifth strategy addressing access to lethal means, which focused primarily on identifying hotspots and including training of health care providers about the toxicity of certain drugs when taken in overdose.

Program evaluation compared outcomes in the four intervention regions with comparable regions that did not participate. Although findings regarding primary outcomes (deaths and attempts) are not yet available, findings regarding process evaluation and some intermediate outcomes (e.g., knowledge gains) have been presented in recent papers.

Some of the process evaluation findings address the role of the advisory group in program implementation in the four OSPI-Europe regions.¹² Using a case study method, a study examined the different models used in each of the four regions to form an advisory group. The advisory groups, which included diverse partners, played a key role in implementation, bringing together stakeholders, establishing or broadening partnerships, building capacity, and supporting sustainability. They helped facilitate the training of primary care providers and gatekeepers (Levels 1 and 3), supported public awareness campaigns by serving as dissemination channels (Level 2), helped develop interventions for people at risk for suicide (Level 4), and helped identify local suicide hotspots (Level 5). The study also found that simply recruiting representatives of key organizations to serve in an advisory capacity was not enough. It was critical to obtain buy-in from these partners—thereby transforming them into OSPI stakeholders. Elements that contributed to this process included promoting all OSPI activities as being based on EAAD’s proven approach to suicide prevention and providing benefits to partners, such as opportunities to develop new cross-sector networks.

A second paper analyzed findings from the process evaluation to explore synergistic interactions and catalytic impacts resulting from OSPI-Europe’s multilevel approach.¹³ The study looked at ways in which activities conducted at one level of the intervention helped to improve and reinforce activities at the other levels.

These types of synergistic interactions can help suicide prevention programs achieve an impact that is greater than the sum of the effects of each individual component. Examples included the following:

- In Ireland, the public launch of the OSPI intervention allowed the program to establish a solid relationship with the press, which later contributed to greater coverage of its suicide prevention activities and also prompted journalists to attend training on safe and responsible reporting.
- In Germany, the support the program provided to self-help groups encouraged these individuals to volunteer to help with the OSPI public health campaign by distributing flyers and speaking as patient advocates, thereby raising awareness of depression and promoting help-seeking.

The study also examined how some program activities may have helped to encourage, or catalyze, external suicide prevention efforts. Examples included the following:

- In Portugal, OSPI training and public awareness activities stimulated complementary efforts by professionals with a shared interest in suicide prevention (e.g., a local psychiatrist decided to provide similar training within his hospital).
- In Hungary, public awareness ads in local movie theaters generated interest in creating a new mental health drop-in center, and involvement in OSPI activities increased communication between primary care providers and mental health providers.



LIFESPAN PROGRAM, NEW SOUTH WALES, AUSTRALIA

On August 4, 2016, the Mental Health Commission of New South Wales announced the launch of its LifeSpan suicide prevention program, which will be tested in four regions across New South Wales.¹⁴ The program (www.lifespan.org.au) will test an integrated suicide prevention framework released in August 2015, which emphasizes a systems approach to suicide prevention.¹⁵ Developed for the NSW Mental Health Commission by the Black Dog Institute, a nonprofit mental health organization, and the NHMRC Centre for Research Excellence in Suicide Prevention (CRESP), the framework is based on an extensive consultation process with cross-sector partners.¹⁶ These partners included researchers, health care providers, community organizations, Indigenous health groups, and people with lived experience of mental illness and suicide.

The LifeSpan Program is being funded by a \$14.7 million grant from the Paul Ramsay Foundation.¹⁴ Black Dog Institute and CRESP are coordinating program activities, in collaboration with the NSW Department of Health, Commonwealth Primary Health Networks, NSW Department of Education, and local community organizations. Four regions were selected to participate based on a rigorous process that assessed community needs, readiness, and capacity. Implementation was started in Newcastle and is being rolled out in the four regions over 2 1/2 years.

The framework guiding the LifeSpan Program is based on a systems approach to suicide prevention, which requires all organizations and groups within a community to work together to support suicide prevention. The systems approach has four components:¹⁵

Component 1: Implement evidence-based suicide prevention strategies in local areas, simultaneously. Each community is responsible for defining what strategies will be used, based on community needs.

Component 2: Adopt a common evaluation framework across local areas. The framework notes that the success of a suicide prevention program is ultimately judged by its ability to reduce suicide deaths and attempts. This requires the development of a central data collection system, common measures, and the collection of data on process and engagement.

Component 3: Engage local communities, such as health services, schools, community agencies, worksites, rural and remote services, and the police. The framework requires alignment and integration among agencies and services to ensure that services and supports are available to people at risk and that these individuals do not slip through the cracks.

Component 4: Establish good implementation, governance, resources, and processes at central and local areas. This includes forming multi-agency suicide prevention teams at the local level, which will be resourced and supported centrally by the NSW Ministry of Health.

The program combines nine evidence-based strategies that will be implemented simultaneously:^{15,17}

1. **Aftercare and crisis care.** Appropriate and continuing care once people leave the emergency department (ED) and for those at risk in the community at any one time.
2. **Psychosocial and pharmacotherapy treatments.** High-quality treatment, such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT), for people with mental health problems (including online treatments).
3. **General practitioner capacity building and support.** Training of primary care providers in detecting depression and dealing with suicide risk.
4. **Frontline staff training.** Suicide prevention training of frontline staff every three years, including police and other first responders.
5. **Gatekeeper training.** Training for persons likely to come into contact with at-risk individuals (e.g., teachers, youth workers, friends and family, clergy, counselors). Provision of training in appropriate workplaces, in particular communities (Aboriginal communities), and across other services targeting particular populations (e.g., people who have a disability, are unemployed, are in financial crisis, and/or have been exposed to violence).
6. **School programs.** School-based peer support and mental health literacy programs.
7. **Community campaigns.** Community suicide prevention awareness programs about suicide.
8. **Media guidelines.** Responsible suicide reporting by the media.
9. **Means restriction.** Reducing access to lethal means of suicide.

In each participating site, community leaders and organizations will work together with the Black Dog Institute to tailor the approaches to ensure relevance to local context and cultural appropriateness.¹⁶ The process will particularly consider the needs of at-risk and underserved groups (e.g., lesbian, gay, bisexual, and/or transgender individuals; Aboriginal groups; and other culturally and linguistically diverse populations).

Black Dog Institute and CRESP will obtain data from each site to evaluate program outcomes.¹⁷ Quantitative outcome data will include suicide rate, attempts, hospital presentations, and visits to general practitioners. Program evaluation will also collect and analyze qualitative data, including findings from interviews with consumers and feedback from trainings.

The program has been designed to ensure sustainability and is primarily focused on improving practices. Program implementers anticipate that the program will be continued once the evaluation is completed.

SUMMARY OF MAJOR COMPONENTS ACROSS REVIEWED PROGRAMS

The following table summarizes the major components of the five reviewed programs. Please note that the table only lists elements identified by each program as a main component. If something is not listed, that does not mean the program did not include that element—only that it was not identified as a key component. For example, although evaluation was a part of all programs, some did not identify surveillance and/or evaluation as a key element or component, so it is not listed in the table.

Major Components of Reviewed Comprehensive Community-Based Suicide Prevention Programs					
	U.S. Air Force	MASPP	Help for Life, Canada	EAAD	LifeSpan Program, Australia
Education and training	Suicide prevention included in professional military education Training for commanders on mental health services Community education and training	School-based programs Community education	Training of providers School-based programs	Training and support for primary care providers Training of gatekeepers (community facilitators)	Training of primary care providers Training of frontline staff Training of gatekeepers School-based programs
Screening	Investigative review policy changed to assess for suicide risk	Screening interventions	Assessment of suicide risk		
Treatment	Ensured confidentiality when seeking mental health services	Clinical interventions	Treatment of suicide risk Follow-up and monitoring	Support for affected persons and high-risk groups	Psychosocial and pharmacotherapy treatments
Crisis care	Multidisciplinary team formed to respond to traumatic events		24/7 hotline, crisis management		Crisis care
Integration of prevention services	Seamless system of prevention services	Social services (child and adult welfare activities)	Consolidation of essential services Collaboration among caseworkers		
Surveillance and evaluation	System to track prevention activities Behavioral health survey Suicide event surveillance database	Surveillance activities	Evaluation research		
Postvention			School response teams trained in postvention		Aftercare
Access to lethal means			Reduce access to lethal means	Reduce access to lethal means (OSPI-Europe intervention)	Means restriction
Campaigns and media			Communication plan Media code of ethics	Public awareness campaigns	Community campaigns Media guidelines
Other	Leadership involvement				

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APPENDIX 2:

SUICIDE PREVENTION GUIDANCE

CDC'S TECHNICAL PACKAGE TO PREVENT SUICIDE

Preventing Suicide: A Technical Package of Policy, Programs, and Practices (available at <https://www.cdc.gov/violenceprevention/pub/technical-packages.html>) represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on activities with the greatest potential to prevent suicide.

The technical package has three components. The first component is the strategy or the preventive direction or actions to achieve the goal of preventing suicide. The second component is the approach. The approach includes the specific ways to advance the strategy. This can be accomplished through programs, policies, and practices. The evidence for each of the approaches in preventing suicide or its associated risk factors is included as the third component.

The strategies, and their accompanying approaches (policies, programs, and practices), include those with a focus on preventing the risk of suicide in the first place as well as those designed to lessen the immediate and long-term harms of suicidal behavior on individuals, families, communities, and society.

The technical package is intended as a resource to guide and inform prevention decision making in communities and states. It stresses the importance of comprehensive prevention efforts and recognizes that, ideally, the implementation of multiple strategies and approaches tailored to the social, economic, cultural, and environmental context of individuals and communities may provide opportunities to develop individual and community resilience and increase the likelihood of removing barriers to supportive and effective care.

The strategies and their accompanying approaches, arranged in order from those hypothesized to have the greatest potential for broad public health impact on suicide to those that impact subsets of the population at risk (e.g., people who have made a suicide attempt), are listed in the following table.

Preventing Suicide: A Technical Package of Policy, Programs, and Practices

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

For many of these strategies, public health agencies are well positioned to bring leadership and resources to implementation efforts. For other strategies, public health can serve as an important collaborator, for example where leadership and commitment from other sectors, such as business, labor or health care, are critical in order to implement a particular policy or program (e.g., economic supports, workplace policies, treatment to prevent re-attempts).

In keeping with good public health practice, the intent is that monitoring and evaluation will play a key role in implementation of the technical package. Moreover, as new evidence becomes available, the package can be refined to reflect the current state of the science.

SPRC EFFECTIVE SUICIDE PREVENTION MODEL

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Suicide Prevention Resource Center (SPRC; www.sprc.org) is the nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. As part of its work, SPRC provides guidance to Garrett Lee Smith Suicide Prevention grantees to support suicide prevention work in campus, state, and tribal communities.

In 2016, SPRC revised the concepts and models it had been using for more than a decade to guide the work of grantees and other program planners and integrated them into a unified model for suicide prevention. The model has three components: (1) a strategic approach to program planning, (2) a set of nine strategies for programs to consider (called the *Comprehensive Approach to Suicide Prevention*), and (3) five keys to success, or guiding principles, for doing the work. See the summary in the following table.

SPRC Effective Suicide Prevention Model

Comprehensive Approach to Suicide Prevention (9 Strategies)	Strategic Planning Approach to Suicide Prevention	Keys to Success (5 Guiding Principles)
• Connectedness • Life skills and resilience • Identify and assist • Increase help-seeking • Reduce access to means • Respond to crisis • Effective care/treatment • Care transitions/linkages • Postvention	• Describe the problem and the context • Choose long-term goals • Identify key risk and protective factors • Select or develop interventions • Plan the evaluation • Implement, evaluate, and improve	• Engaging people with lived experience • Partnerships and collaboration • Safe and effective messaging and reporting • Culturally competent approaches • Evidence-based prevention

Comprehensive Approach to Suicide Prevention

The Comprehensive Approach to Suicide Prevention was adapted from a model developed for college campuses by SPRC and The Jed Foundation. Drawing on lessons learned from the U.S. Air Force Suicide Prevention Program, the model features nine strategies that work together to address different aspects of suicide prevention. Each strategy is a broad goal that can be advanced through an array of possible activities (i.e., programs, policies, practices, and services).

The model is meant to indicate that suicide prevention should be a collective effort that includes many players and strategies. Each stakeholder group in the community should do its part, selecting the strategies that are most appropriate. Each community should identify strategies to implement using a strategic planning process—the second element in SPRC’s Effective Suicide Prevention Model.

Strategic Planning Approach to Suicide Prevention

SPRC’s Strategic Planning Approach is a six-step process that communities can undertake to plan, implement, and evaluate their suicide prevention programs. This approach focuses on the process of developing and evaluating a data-driven, comprehensive, sustained plan. It is meant to help communities develop programs that match their context; target the highest risk groups, settings, and circumstances; address changeable risk and protective factors; and are based on the best evidence.

The approach includes the following steps:

1. **Describe the problem and its context.** Use data and other sources to understand how suicide affects your community and describe the problem and its context.
2. **Choose long-term goals.** Identify a small set of long-term goals (e.g., reduce the suicide rate among a particular group).
3. **Identify key risk and protective factors.** Prioritize the key risk and protective factors on which to focus your prevention efforts.
4. **Select or develop interventions.** Find programs and practices and/or select existing or develop new interventions (activities) to change the key risk and protective factors you have prioritized.
5. **Plan the evaluation.** Use your evaluation plan to track progress toward your long-term goals, show the value of your suicide prevention efforts, and decide how to expand them.
6. **Implement, evaluate, and improve.** Implement and evaluate your activities, using your evaluation data to monitor implementation, solve problems, and enhance your prevention efforts.

Keys to Success

The planning approach also lists five keys to success, or guiding principles, for carrying out suicide prevention:

1. Engaging people with lived experience
2. Partnerships and collaboration
3. Safe and effective messaging and reporting
4. Culturally competent approaches
5. Evidence-based prevention

These principles were inspired by themes in the National Strategy for Suicide Prevention that were shared across strategic directions, as well as by SPRC's list of core competencies for suicide prevention program managers. They are overarching principles that are not addressed in the other two elements and that are specific to suicide prevention.

More information and resources regarding these components are described in the Effective Suicide Prevention section of SPRC's website (<http://www.sprc.org/effective-suicide-prevention>).



LIVINGWORKS SUICIDE-SAFER COMMUNITIES MODEL, CANADA

Inspired by the vision of a life-affirming, suicide-safer world, LivingWorks is dedicated to working with individuals, organizations, and communities to help save lives from suicide.. To address the lack of effective suicide intervention skills among clinical professionals and community helpers, a multidisciplinary group developed a workshop that would later grow into the Applied Suicide Intervention Skills Training (ASIST) program. Since 1983, over 1.25 million people in more than 30 countries and territories have used LivingWorks training programs—including suicideTALK, safeTALK, ASIST, and suicide to Hope—to support their suicide prevention activities.

In 2015, LivingWorks launched the Suicide-Safer Communities designation to recognize communities for making sustained, strategic commitments to suicide safety (<https://www.livingworks.net/community/suicide-safer-communities>).

To obtain this designation, the community must submit thorough documentation of 10 pillars of action:

1. Leadership/steering committee
2. Community background assessment
3. Suicide prevention awareness
4. Mental health and wellness promotion
5. Training
6. Suicide intervention
7. Clinical and support services
8. Suicide bereavement
9. Evaluation and dissemination
10. Capacity building and sustainability

Communities in Canada, England, Northern Ireland, and the United States have submitted letters of intent and are currently implementing activities in support of their action plan goals. The Suicide-Safer Community designation is valid for five years, at which time the community must submit an update for review.

GUIDANCE FROM WORLD HEALTH ORGANIZATION

The following documents, issued by the World Health Organization (WHO), were also reviewed.

Public Health Action for the Prevention of Suicide: A Framework, 2012

The framework for suicide prevention issued by the World Health Organization (WHO) in 2012, identifies the following as evidence-based population level strategies:¹

Prevention strategies at the general population level:

- Restrict access to means of self-harm/suicide
- Develop policies to reduce harmful use of alcohol as a component of suicide prevention
- Assist and encourage the media to follow responsible reporting practices of suicide

Prevention strategies for vulnerable sub-populations at risk:

- Gatekeeper training
- Mobilizing communities (including crisis care)
- Reaching out to individuals bereaved by suicide

Prevention strategies at the individual level:

- Identification and treatment of mental disorders
- Management of persons who attempted suicide or are at risk
- Improving case registration and conducting research
- Monitoring and evaluation

Preventing Suicide: A Global Imperative, 2014

This report notes that national suicide prevention efforts should be comprehensive, and that objectives should be designed to:²

- Enhance surveillance and research
- Identify and target vulnerable groups
- Improve the assessment and management of suicidal behavior
- Promote environmental and individual protective factors
- Increase awareness through public education
- Improve societal attitudes and beliefs and eliminate stigma towards people with mental disorders or who exhibit suicidal behaviors
- Reduce access to means of suicide
- Encourage the media to adopt better policies and practices toward reporting suicide
- Support individuals bereaved by suicide

GUIDANCE FROM INTERNATIONAL INITIATIVE FOR MENTAL HEALTH LEADERSHIP (IIMHL) MATCH MEETING ON COMMUNITY SUICIDE PREVENTION

Formed in 2003 by England, Scotland, Ireland, Sweden, United States, Canada, Australia, and New Zealand, the International Initiative for Mental Health Leadership (IIMHL; www.iimhl.com) seeks to provide better outcomes for people with mental health problems and their families. The initiative provides an international infrastructure to mental health leaders to share information, foster innovation and collaboration, and improve practices.

“Community Suicide Prevention” was the topic of the IIMHL 2015 meeting. Held in September in Vancouver, British Columbia, the meeting reviewed the evidence regarding community-based initiatives that were effective in reducing suicidal behaviors. Based on this review, the group developed a list of 13 guiding principles and 7 core values that should guide community-based suicide prevention (see the following table). As the most appropriate strategies to implement may vary by community, the two lists focus mainly on process, rather than on specific strategies that communities should implement.

IIMHL Guiding Principles and Core Values for Community Suicide Prevention

Guiding Principles	Core Values
• Comprehensive • Measurement and evaluation • Sustainable • Span the continuum (prevention/intervention/postvention) • Collaboration/coordination • Flexible (able to be tailored for the community) • Engage people with lived experience • Community centered • Culturally appropriate • Recovery oriented • Innovative • Strengths based • Evidence informed	• Dignity • Listening • Empathy • Reciprocity • Human/personal connection • Fostering trust • Respect

Participants agreed that the conversation should be continued on basecamp and in the 2017 IIMHL meeting, and they also wanted to involve more professionals working on the ground in the conversation. Content from the meeting is being presented by SAMHSA and the Canadian Mental Health Commission in a webinar series (hosted by EDC) that started in September of 2016 (total of six bi-monthly webinars).

GUIDANCE UNDER DEVELOPMENT, UNITED KINGDOM

The United Kingdom's National Institute for Health and Care Excellence (NICE) is currently developing a guideline on "**preventing suicide in community and custodial settings.**"³ NICE guidelines cover health and care in England and may also be adopted by other members of the United Kingdom. It is anticipated that the new guidelines will be available in September 2018.

The final Guideline Scope document, published on August 19, 2016, indicates that the guidelines will:

- Focus on adults, young people, and children (with specific consideration being given to the needs of high-risk groups), including those in custodial settings and those who are in contact with the criminal justice system
- Cover community settings in which suicide prevention interventions are delivered (e.g., community health and primary care settings, schools, workplaces, custodial settings, and immigration removal centers and short-term holding facilities)
- Focus on seven key areas:
 1. Local approaches to preventing suicide in community and custodial settings (e.g., use of multi-agency teams, suicide prevention plans, plans to respond to “suicide clusters”)
 2. Interventions to help staff and members of the public recognize and respond to signs of distress and crisis that may indicate someone is contemplating suicide (i.e., providing information and training to various gatekeepers)
 3. Interventions to support people in community or custodial settings or who are transferring between settings
 4. Interventions to support people who are bereaved or affected by suicide
 5. Interventions to change or reduce access to means of suicide (e.g., access to medicines, safety fences, more lighting, remove ligature points, CCTV and suicide patrols at high bridges and other sites)
 6. Local media and other awareness campaigns, including using social media interventions and face-to-face approaches to reduce stigma and encourage help-seeking
 7. Working with local media to agree on sensitive approaches to reporting on suicide and suicidal behaviors
- Not focus on clinical or therapeutic interventions (covered by another NICE guidance), staffing levels in custodial settings, interventions that aim to promote or protect mental well-being, or on national interventions to prevent suicide

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APPENDIX 3:

PLANNING MODELS USED IN SUICIDE PREVENTION

SPRC STRATEGIC PLANNING APPROACH TO SUICIDE PREVENTION

This six-step planning process is part of the Suicide Prevention Resource Center's (SPRC's) Effective Suicide Prevention Model (see description in Appendix 2; the six steps are also listed in the table on next page).

CONNECT COMMUNITY SUICIDE PREVENTION, INTERVENTION, AND POSTVENTION MODEL

Developed and operated by the National Alliance on Mental Illness (NAMI) chapter in New Hampshire, the Connect model (<http://theconnectprogram.org>) uses a socio-ecological approach that examines suicide prevention in the context of the individual, family, community, and society. The program increases the capacity of a community or organization to identify and address suicide risk and to respond to suicide.

The training includes components for the various community sectors that can contribute to suicide prevention and postvention, including gatekeepers, schools, law enforcement, social services, faith leaders, first responders, mental health and health care providers, and emergency departments. The contents include workshops in healing, safe messaging and the media, lethal means reduction, and ethical concerns.

The program includes not only suicide prevention training but also guiding principles and protocols leading to culture change¹ and institutionalization of best practices. The program has been shown to not only produce changes in individual training participants but to serve as the impetus for policy and practice changes in community programs and agencies, which can have long-lasting effects and lead to sustainability.²

Implementation phases include the following:

- Assessment (of readiness)
- Engagement (involving key decision makers/powerbrokers)
- Training (Connect training and protocols in prevention and postvention)
- Sustainability (implementing protocols, training and supporting trainers)
- Technical assistance to coalitions and organizations in the community
- Leadership and commitment

The Connect model recognizes and uses a collaborative approach based on individual and community strengths, culture, and relationships. Its evidence-based approach has been adapted and used by many cultural groups, including Hawaiian Natives.²

OTHER PLANNING MODELS USED IN SUICIDE PREVENTION

Other guidance, frameworks, and models have been developed to support community prevention efforts, which, while not focused exclusively on suicide prevention, have been used by states for suicide prevention planning. Three of these follow:

- Strategic Prevention Framework (SPF) for preventing substance abuse and misuse (SAMHSA, <http://www.samhsa.gov/capt/applying-strategic-prevention-framework>)
- Communities That Care (CTC) model that focuses on youth violence, alcohol and tobacco use, and delinquency (University of Washington, <http://www.communitiesthatcare.net>)
- Getting to Outcomes® toolkit for preventing negative behaviors (e.g., drug use, underage drinking, premarital sex) (RAND Corporation and University of South Carolina, <http://www.rand.org/health/projects/getting-to-outcomes.html>)

All models outline planning processes or steps that communities should take to plan, implement, and evaluate programs. The following table lists the steps in the five planning models reviewed.

Planning Steps in Five Models Reviewed

SPRC Strategic Planning Approach to Suicide Prevention	NAMI-NH Connect Community Suicide Prevention, Intervention, and Postvention Model	SAMHSA Strategic Prevention Framework	UW Communities that Care	RAND and USC Getting to Outcomes®
1. Describe the problem and the context 2. Choose long-term goals 3. Identify key risk and protective factors 4. Select or develop interventions 5. Plan the evaluation 6. Implement, evaluate, and improve	1. Assessment (readiness) 2. Engagement (involving key decision makers/ powerbrokers) 3. Training (Connect training and protocols in prevention and postvention) 4. Sustainability (implementing protocols, training and supporting trainers) 5. Technical assistance to coalitions and organizations in the community 6. Leadership and commitment	1. Assess needs 2. Build capacity 3. Plan 4. Implement 5. Evaluate (Also emphasizes cultural competence and sustainability)	1. Get started (activate small group of catalysts, assess community readiness, identify community leaders, invite stakeholders) 2. Get organized (learn about prevention science, write vision statement, develop timeline) 3. Develop community profile 4. Create a Community Action Plan 5. Implement and evaluate	1. Focus (choose problems) 2. Target (identify goals, population, and outcomes) 3. Adopt (find existing programs and best practices) 4. Adapt (to fit needs) 5. Resources (assess capacity) 6. Plan 7. Monitor 8. Evaluate 9. Improve 10. Sustain

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APPENDIX 4:

COMMUNITY HEALTH IMPROVEMENT MODELS

CHANNELING CHANGE: MAKING COLLECTIVE IMPACT WORK

Developed by the consulting firm FSG, which focuses on large-scale, lasting social change, the collective impact approach was first described in a paper published in 2011 in the *Stanford Review*.¹ The paper described an approach to solving large-scale social problems (e.g., improving child education, cleaning the environment) that was being implemented across health areas and found to be effective in promoting sustained change. They called the approach, which is based on better cross-section coordination among partners, a “collective impact” approach, and contrasted it with the “isolated impact” approach typically used in the nonprofit sector—which relies on the actions of an individual organization.

The authors identified five characteristics shared by organizations that have used the collective impact model:^{1,2}

1. **A common agenda.** All participants have a shared vision for change, including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
2. **Shared measurement systems.** Data collection and measurement of results are used consistently across all participants.
3. **Mutually reinforcing activities.** Activities are differentiated but coordinated through a mutually reinforcing plan of action.
4. **Continuous communication.** Communication across partners is open and consistent to build trust and ensure mutual objectives and common motivation.
5. **The presence of a backbone organization.** A separate organization with staff and a specific set of skills serves as the backbone for the entire initiative.

A follow-up paper published in 2012 identified three preconditions for collective impact:²

- An influential champion or a small group of champions
- Adequate financial resources to last for at least two to three years, usually in the form of one anchor funder
- A sense of urgency for change around an issue

Together, these three conditions create the opportunity and motivation to bring people together and keep them together until the initiative's momentum takes over. The paper described these preconditions, along with three distinct phases of startup and implementation: initiate action, organize for impact, and sustain action and impact. Finally, the authors identified four components for the success of a collective impact effort: governance and infrastructure, strategic planning, community involvement, and evaluation and improvement.

Note: The Collective Impact model was selected to guide suicide prevention in the state of Wyoming. Local and national experts developed a project to test a comprehensive community-based suicide prevention program using this model as a framework. Although initial work was conducted to convene the stakeholder group, the funding was cut due to state budget shortfalls.

CDC COMMUNITY HEALTH IMPROVEMENT NAVIGATOR

Developed by the Centers for Disease Control and Prevention (CDC), the Community Health Improvement (CHI) Navigator is a website (www.cdc.gov/chinav) for people who lead or participate in community health improvement. This resource was initially developed to help tax-exempt hospitals meet an Internal Revenue Service requirement that a Community Health Needs Assessments (CHNA) be conducted every three years to support community health improvement.³

The CHI Navigator is based on a definition of community health proposed by CDC and HHS staff in a 2014 issue of *Preventive Medicine*: “a multi-sector and multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health and quality of life of all persons who live, work, or are otherwise active in a defined community or communities.”⁴

Its website is a “one-stop-shop” that offers community stakeholders expert-vetted tools and resources for the following:

- Depicting visually the who, what, where, and how of improving community health
- Making the case for collaborative approaches to community health improvement
- Establishing and maintaining effective collaborations
- Finding interventions that work for the greatest impact on health and well-being in four action areas: socioeconomic factors/social determinants, physical environment, health behaviors, and clinical care

The Navigator tools for successful CHI are based on four underlying tenets (work together, engage the community, communicate, and sustain improved results) and five steps (assess needs and resources, choose effective policies and programs, evaluate actions, focus on what’s important, and act on what’s important). Examples from the field are provided to illustrate each tenet and step.

Although the CHI model was originally designed to address chronic diseases and their risk factors, it has been used to address other problems, including opioid dependence and violence. The model has been used by a wide variety of organizations to help communities identify what works, encourage the adoption and continued implementation of evidence-based programs, and make the case for collaboration.

COUNTY HEALTH RANKINGS AND ROADMAPS ACTION CYCLE

The Action Cycle (<http://www.countyhealthrankings.org/roadmaps/action-center>) is a part of the County Health Rankings & Roadmaps program conducted by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Composed to help groups work together to create healthier communities, the Action Cycle features six action steps:

1. **Work together.** With a shared vision and commitment to improved health, working together can yield better results than working alone. Key activities include working together to address health inequities, recruiting diverse stakeholders from multiple sectors, building relationships, and developing leadership capacity.
2. **Assess needs and resources.** One of the first steps in local health improvement is to take stock of the community's needs, resources, strengths, and assets. Activities include generating questions, identifying community assets and resources, collecting and analyzing primary and secondary data, and sharing results with the community.
3. **Focus on what's important.** Taking time to set priorities helps ensure that the community's valuable and limited resources are directed to the most important issues. Activities include: summarizing your assessment of needs and resources, analyzing root causes, brainstorming and prioritizing the issues, and finalizing and communicating priorities.
4. **Choose effective policies and programs.** Taking time to choose policies and programs that have been shown to work and that are a good fit for the community will maximize chances of success. Activities include defining goals, exploring policies and programs, considering context and impact, and selecting the best strategy.
5. **Act on what's important.** Carry out the plan by building on strengths, leveraging available resources, and responding to unique needs. Activities include building public and political will, organizing and mobilizing the community, developing and delivering a persuasive message, and sustaining the work.
6. **Evaluate actions.** Ongoing evaluation will help the community know if efforts are working as intended and achieving the desired results. Activities include deciding what goals are most important to evaluate, building consensus around an evaluation plan, identifying benchmarks for success, establishing data collection and analysis systems, reviewing and sharing evaluation results, and adjusting the program.
7. **Communicate.** Consider ways to communicate effectively and continuously with internal and external audiences. Activities include creating common language and communication norms, creating a communications strategy, keeping partners informed and engaged, and telling your story.

The Action Cycle website provides resources, such as guides for various partners, including community development organizations and community members.

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APPENDIX 5:

OTHER INFORMATION REVIEWED

FINDINGS FROM SYSTEMATIC REVIEWS

Several systematic reviews have examined the effectiveness of individual suicide prevention strategies. Although these reviews did not focus specifically on comprehensive community-based programs, findings are useful to understanding existing evidence of effectiveness regarding individual strategies. Among these reviews, the most well-known and often cited was the one conducted by Mann and colleagues in 2005 and updated in 2016.

Mann et al., 2005. Conducted by experts from 15 countries, a review by Mann and colleagues examined findings from studies and reviews published from 1966 to 2005 that had evaluated the effectiveness of five types of programs: (1) education and awareness among the general public and professionals, (2) screening, (3) treatment of mental health disorders, (4) access to lethal means, and (5) responsible reporting.¹ The review found evidence that two of these were effective in reducing rates of suicide deaths or attempts: educating physicians on how to recognize and treat depression and restricting access to lethal means. However, it did not find enough evidence that the other three types of interventions reduced these primary outcomes.

Zalsman et al., 2016. Several years later, a group of European suicide prevention experts updated the Mann 2005 review. Published in July 2016 in *Lancet Psychiatry*, the review examined findings from 164 studies published from 2005 to 2014² and found support for the following strategies:

- Restricting access to lethal means, especially with regard to control of pain-control medications (e.g., via packaging or restricting prescriptions or sales) and hot-spots for suicide by jumping (e.g., via barriers)
- School-based awareness programs
- Treatment of depression and suicidality, including the effective pharmacological and psychological treatment of depression and the use of clozapine and lithium to reduce suicidal risk among people with psychiatric disorders

The authors noted that while the previous review had not found evidence that school-based awareness programs were effective in preventing suicide, several well-designed studies had been conducted since. In particular, three large randomized controlled trials found significant effects on suicide attempts and ideation. Findings also suggested that suicide prevention programs should promote increased access to mental health services and provide follow-up of people who attempt suicide.

The review did not find sufficient evidence that other strategies, implemented alone, were effective in reducing suicide rates. These strategies included suicide screening in primary care, general public education and media guidelines, gatekeeper training, physician education, and Internet and helpline support. In many cases, this was due to the lack of high-quality studies that had measured the effect of these interventions on long-term outcomes (e.g., deaths and attempts). In some cases (e.g., gatekeeper training), it was difficult to isolate the effect of one strategy because it was usually implemented in combination with others.

The authors concluded that no single strategy was clearly superior and that combinations of strategies should be assessed. They also noted that each specific risk group may need a tailored approach, and that priority should be given to reaching out to individuals who may fail to seek medical or psychological help.

FINDINGS FROM EVALUATIONS OF GARRETT LEE SMITH SUICIDE PREVENTION PROGRAMS

ICF, the cross-site evaluation contractor for the Garrett Lee Smith (GLS) Suicide Prevention Program, has published two journal articles on the impact of GLS activities. Both showed evidence of effectiveness, although results were not sustained past one year:

- The first study compared youth mortality rates between counties that implemented GLS-funded gatekeeper training (usually QPR) and a set of matched counties.³ It found lower suicide deaths among youth ages 10 to 24 years one year after the training in the intervention counties than the comparison group (1.33 fewer deaths per 100,000) and no differences in adult suicide deaths or non-suicide youth deaths.
- The second study compared 466 counties implementing the GLS program between 2006 and 2009 with 1,161 matched counties.⁴ Program components included gatekeeper training, education and mental health awareness, screening activities, improved community partnerships and linkages to service, programs for suicide survivors, and crisis hotlines. It found lower suicide attempt rates among youth ages 16 to 23 years in GLS counties than in the comparison group (4.9 fewer attempts per 1,000 youth) in the year following implementation, and no differences in these rates among adults ages 24 years and older.

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APPENDIX 6:

OTHER RESOURCES REVIEWED

Name and URL	Description
Asset-Based Community Development (ABCD) http://www.abcdinstitute.org/	ABCD is a strategy for sustainable community-driven development, which builds on the assets already found in the community and mobilizes individuals, organizations, and institutions. At the core of ABCD is a focus on social relationships. The ABCD Institute at Northwestern University provides resources for communities on the use of this approach, including tools and an online community of practice.
Coalition Primers and Toolkits (CADCA) http://www.cadca.org/resources	CADCA (Community Anti-Drug Coalitions of America) is the national membership organization representing over 5,000 coalitions and affiliates working to make America's communities safe, healthy, and drug-free. The Resources section of its website offers tools and publications to help coalitions understand and implement the Strategic Prevention Framework to prevent and reduce alcohol, tobacco, or other drug use.
Communities Matter Toolkit (Australia) https://communitiesmatter.suicide-preventionaust.org/	This toolkit was developed by suicide prevention experts for the Mental Health Commission of New South Wales and Suicide Prevention Australia. Using plain language, the toolkit provides step-by-step guidance for developing and running a community action group focused on suicide prevention. It includes downloadable guidance documents, checklists, planning templates, an evaluation tool, and fact sheets and handouts.
Coming Together to Care: A Suicide Prevention and Postvention Toolkit for Texas Communities, 2012 http://www.texassuicideprevention.org/information-library/texas-suicide-prevention-toolkit/	Developed by the Texas Suicide Prevention Council and the Texas Youth Suicide Prevention Project, the toolkit is a comprehensive guide to prevention, intervention, and postvention strategies. It also lists local and state resources available in Texas.
Community Tool Box http://ctb.ku.edu/en/toolkits	This free online resource for building healthier communities is a public service of the Work Group for Community Health and Development at the University of Kansas. It provides information and training in the fields of community health and development via in-person workshops and training, webinars, conference sessions, a community change academy, and other means. This resource provides very comprehensive information and resources for implementing community change.
National Registry of Evidence-Based Programs and Practices (NREPP) https://www.samhsa.gov/nrepp	This searchable registry, maintained by the Substance Abuse and Mental Health Services Administration, lists programs with evidence of effectiveness in preventing or reducing behavioral health problems, including suicide.
Preventing Suicide: A Community Engagement Toolkit, Pilot Version 1.0, 2016 http://www.who.int/mental_health/suicide-prevention/community_engagement_toolkit_pilot/en/	Developed by the World Health Organization and the Mental Health Commission of Canada, this toolkit provides a step-by-step guide for communities to engage in suicide prevention activities, have ownership of the process, and keep efforts sustained. Although not a manual for initiating specific interventions, it describes an active and participatory bottom-up process for identifying, prioritizing, and implementing activities.

APPENDIX 7:

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The National Action Alliance for Suicide Prevention is the public-private partnership working to advance the *National Strategy for Suicide Prevention* and make suicide prevention a national priority. EDC operates the Secretariat for the Action Alliance through the Suicide Prevention Resource Center. Visit <http://www.ActionAllianceforSuicidePrevention.org>

