

TOOLKIT

School-based Suicide Prevention, Intervention and Postvention.

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- The scientific board of the Euregenas project;
- The participants of the Euregenas' regional network meetings*, with special thanks to VIGeZ for their contributions to the toolkit.

**These regional networks were established in five participating regions to support the development and implementation of the toolkit and involved policy-makers, public health experts, community players and stakeholders in the field of suicide prevention.*

[Icons in this toolkit are developed by Freepik and IcoMoon]



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Executive Summary

This toolkit aims at providing guidelines for school-based suicide prevention, intervention and postvention. The toolkit includes two main sections.

- 1.** The first part targets policy makers in the field of education. It provides a **POLICY FRAMEWORK** on healthy schools, including an overview of effective school-based **strategies** and **programmes** aiming at the promotion of mental health and the prevention of suicide.
- 2.** The second part offers a range of **PRACTICAL TOOLS** for school staff such as principals, teachers, and school counsellors, including:
 - **Key facts on suicidal behaviour**
 - **Intervention strategies**, describing how to identify suicidal students and how to interact with them.
 - **Postvention strategies**, to use after a suicide or suicide attempt of a student (or staff member), including a blueprint for a crisis plan.
 - **Guidelines for a classroom conversation** after a suicide or a suicide attempt of a student (or staff member).
 - **A concluding checklist**, which summarizes the main points addressed in this toolkit.

In addition to this toolkit, it can be useful to have a look at:

- **General Guidelines on Suicide Prevention**, developed by Euregenas and available on the website: www.euregenas.eu
- A number of countries have also developed specific **local and national resources and programmes** for schools on mental health promotion and suicide prevention.

This toolkit is available in several languages and can be downloaded from www.euregenas.eu



INTRODUCTION

About Euregenas

In the framework of work package 6 of the Euregenas project, suicide prevention guidelines and toolkits have been developed. The Euregenas project **aims at contributing to the prevention of suicidal thoughts and behaviours in Europe** through the development and implementation of strategies for suicide prevention at regional levels which can be of use to the European Union as examples of good practice. The project brings together **15 European partners**, representing 11 European Regions, with diverse experiences in suicide prevention. More information about the project can be found at the end of this toolkit and on the website: www.euregenas.eu

Development of this toolkit

The guidelines in the toolkit are based on an **analysis of needs** of key stakeholders conducted at regional level and a **comprehensive literature and good practice review** embedded in work package 4 of the Euregenas project.

Additionally, an international literature review of the effectiveness of school-based suicide prevention strategies and programmes was conducted, using 'Web of Science' (2000-2014).

Furthermore, **regional networks** have been established in five participating regions to support the development and implementation of these guidelines. The networks involved policy-makers, public health experts, community players and stakeholders in the field of suicide prevention.



Why a suicide prevention toolkit for schools?

- Suicide is a **leading cause of death** among young people across Europe. The prevalence appears to vary between countries, but suicidal thoughts and attempts appear to be common mental health problems among young people (Madge et al., 2008). A study among students aged 15-16 years in 17 European countries showed a median prevalence of self-harm thoughts of 7.4% (range 2.1%–15.3%) and a prevalence of a lifetime self-reported suicide attempt of 10.5% (range 4.1%–23.5%) (Kokkevi et al., 2012).
- Strategies for school-based prevention, intervention and postvention of suicidal behaviour are needed, because young people spend a considerable amount of their time at school. Suicide prevention demands a **multi-sectorial approach**, it can be an important issue not only within the health sector, but in non-health sectors such as the educational sector as well.

➔ Therefore a toolkit for schools has been developed, targeting **policy makers** on the one hand and **gatekeepers in the school environment** on the other hand, such as principals, teachers and school counsellors. It aims at offering schools background information on suicidal behaviour, an overview of school-based mental health promotion and suicide prevention strategies, good practice examples and practical instruments. As such, these guidelines provide an outline of potential contributions to the prevention of suicide within the local school environment.



PART 1

SUICIDE PREVENTION STRATEGIES WITHIN A HEALTHY SCHOOL POLICY

When developing a comprehensive and effective suicide prevention policy at school, it is essential that this policy is **embedded in a healthy school policy and in a whole school approach**.

A suicide prevention policy should include a broad range of prevention strategies acting on different levels within the school context:

- Targeting **STUDENTS** (and vulnerable students in particular), e.g. through psycho-education, skills training, monitoring their health.
- Targeting **TEACHERS and SCHOOL STAFF**, e.g. by gatekeeper training, by supporting teachers and providing a safe and healthy workplace.
- Targeting the whole **SCHOOL ENVIRONMENT**, e.g. by restricting the access to lethal methods, by strengthening the cooperation with mental health services, by improving the school culture (e.g. involving students and parents).

The following part will focus on four types of school-based prevention strategies. A mix of all these strategies is needed to ensure an effective policy.

- 1. Developing a 'healthy school **policy**' framework
- 2. Developing school-based **prevention programmes**
- 3. Paying special attention and care to **vulnerable students and staff**
- 4. **Restricting the access to lethal methods**

More background on suicide prevention strategies in general can be found in the Euregenas publication 'General Guidelines on Suicide Prevention', available on www.euregenas.eu.



STRATEGY 1

DEVELOPING A 'HEALTHY SCHOOL POLICY' FRAMEWORK

Every school should have a 'healthy school policy', including strategies aiming at **mental** health promotion and aiming at providing extra care for students and teachers at risk of mental health problems. Although little research is done on the effectiveness of general mental health promotion on the outcome of suicide, we may assume a healthy school policy may contribute to the prevention of suicide as it is aimed at improving factors such as resilience, coping skills, social inclusion, and a safe school environment, which could function as protective factors for suicidal behaviour.

Below four key points of a (mental) health school policy are addressed, including some practice examples.

1. Investing in mental health: what does it mean?
2. Supporting school safety and reduce bullying
3. Supporting teachers
4. Involving parents and mental health services



1 Investing in mental health

According to the World Health Organization (2013) **INVESTING IN MENTAL HEALTH MEANS:**

- 1.** To **increase emotional resilience and reduce vulnerability** to mental health problems through the development of personal skills, self-esteem, coping strategies, problem solving skills, and self-help, which lead to an increased capacity to cope with life transitions and stress. E.g. by developing skills training for students.
- 2.** To provide **better information, awareness and education** about mental health and illness. E.g. by setting up awareness campaigns, aiming at improving attitudes and facilitate help seeking behaviour. A starting point could be the 10th of October (World Mental Health Day).
- 3.** To **increase social inclusion and cohesion**. This aims at ensuring a warm and safe school climate and can include raising awareness and reducing stigma and discrimination (e.g. regarding minority groups), or developing supportive environments (e.g. self-help networks).
- 4.** To **provide better (and more) health and social care services**, especially for currently underserved populations with unmet needs. For example, schools should invest in accessibility of care (e.g. of mental health care centers) and school counsellors at school.
- 5.** To provide **better social protection and social support**, especially for persons at risk or affected with mental disorders, particularly those in socially disadvantaged groups. E.g. by training gatekeepers in how to identify and deal with students at risk, by providing extra support for students at risk

Research showed that positive evidence of effectiveness is obtained for prevention programmes that adopted a whole school approach, were implemented continuously for more than one year and aimed at the promotion of mental health as opposed to the prevention of mental illness (Wells, 2003).

**EXAMPLE****“PREVENTION COACHES”**

In the framework of the Flemish action plan on the prevention of suicide, the Flemish government together with regional health networks developed the ‘prevention coaches project’. In each province of Flanders, coaches assisted secondary schools in setting up an integrated mental health policy and developing an action plan targeting the school board, teachers, parents and students.

The strategy contained six components:

1. promoting mental health and creating a positive atmosphere at school;
2. improving the education of students with regard to social, and problem solving skills;
3. recognizing signals of suicidal thoughts and behaviour and counseling at-risk students within the school;
4. educating teachers, counsellors and principals;
5. developing a policy on referral for treatment outside the school;
6. striving for a broad involvement of all actors.

More than 200 schools engaged in a stepwise development and implementation of an action plan on mental health, facilitated and monitored by the prevention coaches. Over 200 school counsellors were trained in using a coaching approach in supporting schools.

② Supporting school safety and reducing bullying

Investing in mental health also means supporting school safety and building a school climate in which topics such as depression, fear and stress can be talked about and coped with. **Reducing bullying is key in ensuring a safe school climate.** Research shows that bullying (and cyberbullying), harassment and victimization among students can contribute to mental disorders and increase suicide risk (Brunstein Klomek et al., 2007). It is crucial that schools have clear anti-bullying policies and engage in anti-bullying programmes, additional to or included in the healthy school policy, in order to create a more inclusive and supportive school culture.

**EXAMPLE****“KiVa”****AIMS & COMPONENTS**

KiVa is an evidence based anti-bullying programme for primary schools developed by the University of Turku in Finland. The KiVa program involves both universal and indicated actions to prevent bullying and to tackle cases of bullying coming to attention. The universal actions are targeted at all students in a school. They refer to efforts made to influence the group norms and to build capacity in all children to behave in constructive ways, to take responsibility for not encouraging bullying, and to support the victims.

RESEARCH

KiVa has been evaluated in a large randomized controlled trial including 117 intervention schools and 117 control schools. The programme has been shown to reduce both self- and peer-reported bullying and victimization significantly (Kärnä et al., 2011a). It influences multiple forms of victimization, including verbal, physical, and cyberbullying (Salmivalli et al., 2011). In addition, positive effects on school liking, academic motivation and achievement have been reported (Salmivalli et al., 2012). KiVa also reduces anxiety and depression and has a positive impact on students' perception of their peer climate (Williford et al., 2011). Finally, Finnish data from more than 1000 schools that started the implementation of KiVa in fall 2009 showed that after the first year of implementation, both victimization and bullying had reduced significantly (Kärnä et al., 2011b).

IMPLEMENTATION

Localized information and materials about implementing and using KiVa programme is available in the UK, the US, Estonia, Belgium and the Netherlands. More information can be found at the website.

www.kivaprogram.net



3 Supporting teachers

Furthermore, **mental health of teachers** and other school staff should also be promoted and monitored at school. Care and support for school staff should be easily accessible. Initiatives on how to prevent and manage suicidal behaviour at the workplace can be found in the Euregenas toolkit “Preventing and managing suicidal behaviour. A toolkit for the workplace”, available on the Euregenas website: www.euregenas.eu

EXAMPLE

“MIND MATTERS”



‘Mind Matters’ is a programme from Australia that was adapted to Germany. It aims at developing a school culture in which all faculty members feel safe, valued, involved and useful. The programme is twofold and focuses on:

- improving the working conditions and health of teachers by working on the quality of relationships in school and in classes (e.g. working on respect and tolerance).
- improving the quality of the learning environment and the health of students by strengthening resilience and life skills as well as learning to deal with stress and difficult situations.

www.mindmatters-schule.be

4 Involving parents and mental health services

Finally, it is key that schools establish good relationships with relevant communities and stakeholders outside the school environment. By involving parents the school can work on mental health promotion and suicide prevention beyond the school context and raise awareness in the broader society on mental health issues. Furthermore, strengthening the relationship with external mental health services is essential if the schools wants to build a safe and supporting environment for both students and school staff. It enables the school to refer to services they trust and know and it offers opportunities to work together on mental health projects or programmes.

Through the involvement of all these relevant partners, collective actions against suicide can be taken.



STRATEGY 2

DEVELOPING SCHOOL-BASED PREVENTION PROGRAMMES

Once a healthy school policy is established, schools can make use of existing prevention programmes aiming at the promotion of mental health and the prevention of suicide at schools. Four types of prevention programmes are presented here: psycho-educational programmes, skills training, gatekeeper training and screening programmes.

All of these programmes have been frequently discussed in literature reviews (Cusimano et al., 2011; Katz et al., 2013; Miller et al., 2009; Robinson et al., 2013). According to research, the most promising interventions for schools appear to be gatekeeper training and screening programs, but more research is needed (Robinson et al., 2013).

All programmes in this toolkit are illustrated with practice examples, most of them are derived from the United States and included in the best practices registry of the American Suicide Prevention Resource Center (SPRC): <http://www.sprc.org/bpr/section-i-evidence-based-programs>

These programmes can serve as an inspiration and starting point to develop local, regional or national prevention programmes across Europe. A combination of these programmes will be most effective in preventing suicide. Keep in mind it is essential to always embed programmes in a broader policy and in a whole school approach!

Basic information on suicidal behaviour is included in TOOL 1 in this toolkit. It is recommended to read through this tool and get the basic facts first, before getting started with the development of (suicide) prevention programmes.



1 Psycho-educational programmes

Psycho-educational programmes focus on **improving knowledge and changing attitudes of students regarding mental health problems and suicidal behaviour**. They may also include the promotion of mental health services and helplines, as they appear to be a good channel to reach adolescents at risk of suicide.

WARNING!

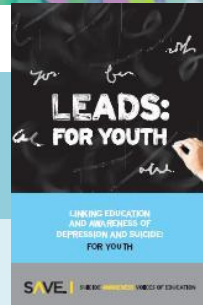
Programmes only focusing on suicidal behaviour (e.g. education about the epidemiology, myths and complexity of suicidal behaviour) show **mixed results** in changing attitudes, knowledge, and behaviour, demonstrating some improvement, but also some detrimental effects such as a decrease in desirable attitudes; a reduction in the likelihood of recommending mental health evaluations to a suicidal friend; more hopelessness and maladaptive coping responses among boys after exposure to the curriculum; and negative reactions among students with a history of suicidal behavior (Reviewed in Gould et al., 2003). A study in Flanders showed that these programmes improved knowledge about suicide and attitudes towards suicidal persons but had no effect on the use of coping styles or levels of hopelessness (Portzky & van Heeringen, 2006).

Therefore, it may be more safe and more effective for prevention purpose to focus on improving knowledge and attitudes of students regarding depression and other mental health problems in general and on the use of mental health services, instead of only focusing on psycho-education on suicidal behaviour!

Below two examples of psycho-educational programmes which focus both on depression and suicide, are described as good practices.

- **'Linking Education and Awareness of Depression and Suicide (LEADS)'**, a programme which focuses on improving knowledge of and attitudes towards depression and suicide.
- **'Signs Of Suicide (SOS)'**, a programme which focuses on improving skills to identify signals of depression and suicide.

Although being effective, it is strongly recommended to integrate these kind of programmes in broader and more general programmes.

**EXAMPLE 1****“LEADS For Youth”****AIMS & COMPONENTS**

LEADS For Youth (“Linking Education and Awareness of Depression and Suicide”) is a curriculum for secondary school students that is designed to increase knowledge of depression and suicide, to modify attitudes towards depression and suicide, to increase knowledge of suicide prevention resources, and to improve intentions to engage in help-seeking behaviors. The curriculum addresses topics such as depression and its symptoms, the link between depression and suicide, the risk and protective factors associated with suicide, the warning signs of suicide, seeking help and overcoming barriers to seeking help, and school and community suicide prevention resources. By educating students about seeking help and informing them about the resources available at local level, the intervention aims to empower students to get help for themselves or others.

Teachers implement the curriculum for 1 hour a day over a 3-day period. Each session includes classroom lecture, individual and group activities, and small-group discussions, followed by activities and homework outside of school. The intervention incorporates technology-based activities, such as a simulated blog, an email and instant messaging activity, and innovative awareness-raising projects. Implementation of LEADS is intended to occur as part of a school suicide crisis management plan.

RESEARCH

Research showed the programme was effective in improving knowledge and attitudes of depression and suicidal behaviour and the knowledge of resources (Leite et al., 2011).

IMPLEMENTATION

First implemented in 2008, the intervention has been used in more than 855 schools and has reached approximately 21,000 students. The intervention has been implemented in more than 15 States, as well as in Canada and Switzerland. More information is available on the website:

www.save.org



EXAMPLE 2



“Signs Of Suicide (SOS)”

AIMS & COMPONENTS

The SOS (‘Signs Of Suicide’) prevention programme is an award-winning programme designed for secondary school students. The programme teaches students how to identify the symptoms of depression and suicidality in themselves and their friends, and encourages help-seeking through the use of the ACT[®] technique: **Acknowledge** that there is a problem; let your friend know that you **Care**; then **Tell** a trusted adult. The programme is designed to improve knowledge of suicide as well as screen students for depression. The screening tool used was the Columbia Depression Scale (CDS).

RESEARCH

This programme has proven to be effective in reducing suicide attempts, increasing suicide knowledge and changing attitudes toward suicide, depression, and help seeking behaviors (Aseltine et al., 2004; Aseltine et al., 2007; Schilling et al., 2014).

IMPLEMENTATION

The programme is available in English, more information and contact details can be found on the website:

<http://www.mentalhealthscreening.org/programs/>



WARNING!

WORKING WITH STORIES, MOVIES OR THEATRE

Sometimes, stories, movies or theatre plays are often used to inform students about delicate issues such as suicide. However, It is recommended to be cautious when making use of stories, movies or theatre plays on suicide. Research shows that stories and reports on suicide (e.g. in newspapers) can evoke a copycat effect and increase the likelihood that vulnerable persons will develop suicidal behaviour themselves (Pirkis and Blood, 2001; Sisask and Värnik, 2012; Stack, 2000; Stack, 2005). Younger people appear to be the most vulnerable for copycat behaviour (Huh et al., 2009). Little is known about the copycat effect of fictional characters and stories, but it is recommended to avoid it or to at least bear following considerations in mind:

- Screen the story, movie or theatre play in advance. Especially, do not work with the story/movie/theatre play if it portrays suicide as a romantic or heroic act or an ideal solution to problems or if it portrays the suicide method in detail.
- It is important to know that the risk for copycat behavior is equally high when the suicide is not explicitly shown/only 'suggested'.
- Organize a classroom conversation after the movie or play in which the complexity of suicidal behaviour is stressed and coping strategies are discussed. Make sure you refer to (and promote) available help services (e.g. counsellors within the local school context, helplines and local help centers).



2 Skills training programmes

Skills training aims at **improving skills** of students: e.g. to improve protective factors such as self-esteem, coping skills, problem solving skills, decision making skills, and self-disclosure of students. It may aim also at making students more familiar with signs and symptoms of suicidal behaviour, so they can recognize them in others. ‘The Good Behaviour Game’ is presented below as an unique good practice of skills training in primary schools.

Another type of skills training programmes focus on **peer leadership training**. These programmes are similar to skills training programmes, but make use of peer leaders to deliver the programme. Training peers to help other (suicidal) peers can be an effective strategy, as young people most often seek help from social networks that most commonly are peers (Michelmores & Hindley, 2012). Peer leadership training puts students in a position to help suicidal peers by training them to respond appropriately and to seek the support of a trusted adult. It also promotes the adoption of positive coping norms within the school environment (Gould et al., 2003). However, the selection of these peers should be made very careful and these peers should be supported and monitored at all times. ‘Sources of Strength’ is the first programme of this kind and is presented below as a good practice.

**EXAMPLE****“The Good Behavior Game (GBG)”****AIMS & COMPONENTS**

The GBG is a universal classroom intervention for students aged 5-11. It is a classroom-based, teamwork, behaviour management approach to help children develop intrinsic self-regulation by rewarding teams that meet the behaviour standards set by each teacher. The goal of the programme is to create a classroom environment where children are supported by other students, and can learn in an environment without aggressive or disruptive behaviour. Students are grouped into teams with equal distribution of those with disruptive and aggressive behaviour histories. The teacher posts the rules of the game regarding student behaviour, and all teams who accumulate four or fewer infractions of acceptable student behaviour are rewarded.

RESEARCH

Research showed positive results of the GBG programme, both in the short- and the long-term. By reducing aggressive and disruptive behaviours, the GBG helps reduce risk factors associated with suicidal behaviour, as well as other behavioural outcomes, such as impulse control problems, alcohol and drug use disorders, and antisocial behaviour. Students who received the intervention were half as likely to experience suicidal ideation and suicide attempts as compared to the control group. The GBG programme resulted in a delayed onset of suicide attempts in females and a reduction in relative risk estimates by 30% for suicide attempts (Wilcox et al., 2008).

IMPLEMENTATION

The programme has been tested and implemented in the U.S. and in Belgium. More information can be found in the database of ‘Blueprints’.

<http://www.blueprintsprograms.com/>

**EXAMPLE****“Sources of Strength”****AIMS & COMPONENTS**

Sources of Strength is a best practice youth suicide prevention project that utilizes the power of **peer social networks** to prevent suicide, bullying and substance abuse. It is used for students from the age of 13 up to 25. Peer leaders, selected by school staff, are trained to encourage their friends to identify and engage with a trusted adult and to use coping resources.

Sources of Strength is a universal programme designed to increase:

- Overall adult-youth connectedness and bonding, youth help seeking from trusted adults and referrals of distressed peers to supportive adults;
- Coping skills and health promotion;
- Peer leaders knowledge of suicide prevention and how to help peers.

At the same time the programme aims at decreasing stigma surrounding suicide and mental illness, isolation and a lack of trust in adults, and injuries and self-harm related to suicide, substance abuse and violence.

Sources of Strength takes a different approach in youth suicide prevention by moving beyond a singular focus on risk factors through building multiple protective sources of support around young individuals so that when times get hard they have strengths to rely on.

RESEARCH

Research showed that trained peer leaders were four times more likely (compared with a control group) to engage an adult in cases of suicidal friends, likely due to their perception of increased adult support and acceptability of help seeking (Wyman et al., 2010). Sources of Strength provides students the opportunity to positively influence at-risk schoolmates and increase the perception among students that adults can help.

IMPLEMENTATION

More information can be found on the website where a start-up questionnaire can be filled in.

<http://sourcesofstrength.org/>

3 Gatekeeper training programmes

Teachers and school counsellors can play an important role in the detection of at-risk persons and in referring suicidal students to healthcare. Training teachers and school counsellors in how to recognize risk factors and warning signs of suicidal behaviour and how to intervene and refer in crisis situations, has proven to be an effective suicide prevention strategy (Chagnon et al., 2007, Cimini et al., 2014).

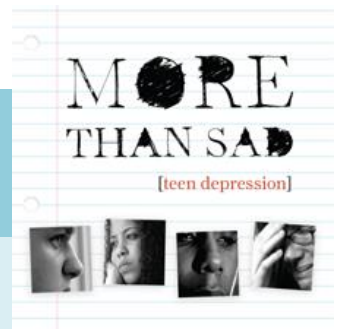
Furthermore, teachers can play a role in strengthening protective factors, creating a supportive environment, lower the threshold to healthcare for students.

Gatekeeper programmes on suicide prevention should also be integrated in the training and education of future teachers.

Below an example of a gatekeeper training programme is presented. Another example is included in the 'Trevor Project' which is presented further in this toolkit. The effectivity of these programmes have not been studied and tested yet, but they are promising interventions.

EXAMPLE

"More Than Sad"



AIMS & COMPONENTS

'More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel' is developed by the American Foundation for Suicide Prevention and designed to help educators better understand suicidal behavior in adolescents, including its causes, treatment and prevention. The programme is built around two 25-minute DVDs: *More Than Sad: Preventing Teen Suicide* and *More Than Sad: Teen Depression*. They show how a potentially life-threatening mental disorder can present in teens. Also included are a 42-page instructional manual for participants and slides for teacher trainers. An expert advisory panel guided the development of all materials. The programme is also suitable for parents and other adults who care for or work with youth. The programme answers the following questions:

- How big a problem is youth suicide? What puts teens at risk for suicide? What treatments are available?



- How can teachers help prevent youth suicide? How can teachers identify at-risk students? How else can schools decrease risk?

RESEARCH

No research is conducted yet, but the tool is promising and included in the best practices registry of the Suicide Prevention Resource Center.

IMPLEMENTATION

This tool is available in English and can be purchased at the website of the American Foundation for Suicide Prevention.

www.morethansad.org

www.afsp.org

4 Screening programmes

Teachers and counsellors should be motivated to monitor student's health by keeping a close watch on social isolation of students, relational difficulties and their school performance along the year to identify possible anomalies, as indicators for mental health.

In this framework, it is possible to make use of validated screening programmes. These programmes involve the screening of students, mostly making use of self-report questionnaires and/or individual interviews, aiming at identifying students at-risk for suicidal behaviour, in order to refer them to specialised help services if necessary.

Warning! Before getting started with screening programmes, it is essential to set up a clear system of care, both within the school (a team of school counsellors have to be available) as outside the school (enough mental health services to refer to, a good cooperation with these services). As such, students at risk can immediately get the help they need.

**EXAMPLE****“Teenscreen”****AIMS & COMPONENTS**

The TeenScreen tool, developed by Columbia University, is a universal self-report tool that assesses risk factors for suicide. The tool is focused on school-based screening, but it is also used in primary care and other settings. All youngsters in a school, with parental consent, are given a computer-based validated questionnaire that screens them for mental illnesses and suicide risk. The questionnaires include items about depression, thoughts of suicide and attempts, anxiety, and substance use and it takes about ten minutes for an adolescent to complete. Once the responses to the questionnaire have been analyzed, any adolescent identified as being at possible risk for suicide or other mental health concerns is further assessed by a health or mental health professional. The result of this assessment determines whether the adolescent could be referred for mental health services. If this is the case, parents are involved and provided with help locating the appropriate mental health services. The Columbia University TeenScreen® Program provides consultation, screening materials, software, training, and technical assistance to qualifying schools and communities. In return, TeenScreen® partners are expected to screen at least 200 youth per year and ensure that a licensed mental health professional is on-site to give immediate counseling and referral services for youth at greatest risk.

RESEARCH

The TeenScreen tool showed to be an effective predictive tool in identifying students at risk (Shaffer et al., 2004). A study of Gould et al. (2005) showed that there was no evidence of adverse effects of suicide screening and that it can be considered as a safe component of youth suicide prevention. A subsequent study found that screening appeared to increase the likelihood that adolescents would receive treatment if they were at risk for mental health disorders or suicide (Gould et al., 2009).

IMPLEMENTATION

This tool is developed and monitored by the Columbia University and not available in Europe, but it can be an inspiring good practice.



STRATEGY 3

PAYING SPECIAL ATTENTION TO VULNERABLE STUDENTS AND STAFF

Some students are at higher risk for developing suicidal thoughts and behaviour. When working on mental health in the school it is therefore important to be aware of these vulnerable groups, monitor their health, and provide extra care by developing targeted and tailored interventions towards these vulnerable population groups. These initiatives may target not only students, but also teachers and other staff members.

Which persons are at higher risk?

- The highest risk groups for developing suicidal thoughts and plans include **suicide attempters** (students who already did a suicide attempt in the past), and **persons with a psychiatric disorder** (e.g. depressive disorder, alcohol and substance use disorder, schizophrenia, bipolar disorder, eating disorder, anxiety disorder,...).
- Persons who lost a significant other by suicide (also referred to as **suicide 'survivors'**) are also at much higher risk of developing physical and psychological illnesses, and suicidal behaviour (Beautrais, 2004; Qin et al., 2002). It is essential to provide extra care for students or staff who are dealing with such loss. In the Euregenas project a catalogue of resources for suicide survivors has been developed. This catalogue is available on the website: www.euregenas.eu
- Students from **social or ethnic minorities** have been identified as vulnerable groups. For example, persons identifying as lesbian, gay or bisexual seem to be at higher risk for developing a mental disorder, suicidal ideation, substance misuse, and deliberate self-harm



than heterosexual people. Studies have reported very high rates of suicide attempts, ranging from 20 to 53% (Haas et al., 2011; McDaniel et al., 2001; Savin-Williams, 2001; van Heeringen and Vincke, 2000). The same or even more holds for **transgender students**, with studies showing high rates of suicide attempts (Dhejne et al., 2011; Mathy, 2002).

Which interventions can be developed?

- In order to know where to refer to, it is recommended that schools make an **inventory of existing initiatives** (such as local support groups, help centres, helplines or websites) for all identified vulnerable groups. This inventory can be developed together with school counsellors and mental health services in the region.
- **Raising awareness** (and in some cases fighting stigma) on vulnerable groups by educating students, teachers and mental health professionals.
- **Taking care and providing specific support** for vulnerable students through the development of support groups, the promotion of specific helplines, gatekeeper training.
- **Psycho-educational programmes** specifically targeting vulnerable students, in order to increase their resilience and improve their coping skills.

EXAMPLE

“The Trevor Project”



The Trevor Project is an American organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning or queer (LGBTQ) young people ages 13-24. Recently the project developed ‘LGBTQ on Campus for Faculty & Staff’, a 30-minute online, interactive learning experience that assists institutions of higher education in creating a safe and supportive campus community by increasing awareness and empathy for the challenges faced by LGBTQ students and by building the skills of faculty and staff to model respectful behavior, including managing classroom discussions or handling an LGBTQ-related issue. Faculty and staff who complete the training will be more aware of the challenges experienced by LGBTQ students and know how to:

- Respond when someone makes a biased comment or expresses prejudice

- Respond supportively when a student comes out as LGBTQ
- Recognize warning signs of psychological distress, including suicidal ideation
- Connect students who may be in distress with campus support services

During the training, users assume the role of faculty and staff members and engage in interactive conversations with fully-animated, emotionally-responsive virtual students. Through these conversations, users learn how to create an inclusive, supportive environment for their LGBTQ students.

www.thetrevorproject.org

STRATEGY 4

RESTRICTING THE ACCESS TO LETHAL METHODS

Strategies aimed at restricting access to lethal methods of suicide are one of the suicide prevention efforts with the most supporting evidence in reducing suicide rates (Mann et al., 2005; Sarchiapone et al., 2011). These strategies can be implemented quite quickly in comparison to other suicide prevention strategies. Within the school context it is important to secure the school environment, by limiting the available means by which students could complete suicide, for example by:

- Restricting the access to rooftops and/or installing safety fences on rooftops;
- Making hallways and stairs as safe as possible;
- Securing windows (by limiting the opening or installing effective locks);
- Reducing opportunities for unsupervised access to chemical supplies and medicine (e.g. in the schools laboratory or pharmacy).



PART 2

PRACTICAL TOOLS



TOOL 1

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Key facts on suicidal behaviour



TOOL 2

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How to identify and deal with suicidal students?



TOOL 3

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What to do after a suicide (attempt)?



TOOL 4

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Guidelines for a classroom conversation after a suicide



TOOL 1

Key facts on suicidal behaviour

Suicidal thoughts and behaviour can be defined as a complex process that can range from suicidal ideation, to planning of suicide, attempting suicide, and ending in suicide. Suicidal behaviour is the consequence of interacting biological, genetic, psychological, social, environmental and situational factors (Hawton & van Heeringen, 2009). This tool highlights the epidemiology, common myths and an explanatory model on suicidal behaviour.

1. Epidemiology

Suicide is a significant public health issue in Europe accounting for an average suicide prevalence rate of 11.8 per 100000 inhabitants (Eurostat, 2010). Suicide affects people of all ages, cultures and population groups. Suicide rates are lowest in persons under 15 years of age and highest in those aged 70 years or older for both men and women in almost all regions of the world, although the age-by-sex patterns in suicide rates between the ages of 15 and 70 years vary by region (World Health Organization, 2014).

Suicide attempts are much more common than suicides. Studies show that nonfatal suicidal acts occur at least 10 times more frequently than fatal suicides. In some European regions, non-fatal suicidal behaviours are most common among adolescents (Nock et al., 2008).

Every suicide and suicide attempt directly or indirectly also affects other people. A death by suicide has a severe impact on the **survivors**, such as spouses, parents, children, family, friends, co-workers, and peers who are left behind, both immediately and in the long-term. There is for example a higher risk for pathological grief and a higher suicide risk (Young et al., 2012). It is estimated that each suicide directly affects about six to fourteen family members and friends (Clark & Goldney, 2000; Jordan & McIntosh, 2011).



2. Common Myths

There are many misconceptions about suicidal behaviour. In the list below the most common myths are tackled.

Suicide cannot be prevented

One of the most common myths about suicidal behaviour is that it cannot be prevented. However, most people who are suicidal have mixed feelings about death. Even the most severely depressed people experience doubt, until the very last moment, and are divided between wanting to live and wanting to end their pain. Moreover, there is scientific evidence for a preventive effect of a substantial number of interventions.

Suicide is a normal reaction to an abnormal situation

Suicide is not a normal adequate reaction to e.g. extreme stressors in life. Suicide is an unusual and inadequate reaction to a rather normal situation. In life, everyone has to deal with stressful situations or negative life events, which often occur, but only few will develop suicidal thoughts and plans.

Talking about suicide with someone increases the risk of suicidal behaviour

When a person expresses suicidal thoughts, this should not be considered as merely a cry for attention, but as a cry of pain, which indicates that the person is desperate and feels strong emotional pain. Talking face-to-face in person about suicidal thoughts and plans does not increase suicidal intent or hopelessness. On the contrary, talking about suicide in a personal setting can be an effective preventive method and encourage help seeking. However, caution should be taken when talking about suicide in public e.g. in the media. In this framework, it is recommended to follow the 'Suicide Prevention Toolkit for Media Professionals', available on www.euregenas.eu

People who talk about suicide will not complete or attempt suicide

The majority of suicide attempters and suicide victims communicated their suicidal thoughts prior to the suicidal act. It is therefore of great importance to take any expression of suicidal thoughts seriously and encourage help seeking.



2. Understanding suicidal behaviour

Research has clearly shown that suicidal behaviour constitutes a complex multi-factorial problem. Suicidal behaviour never has one single cause and always develops due to an interaction between risk factors in combination with a lack of protective factors.

Risk factors include characteristics which increase the likelihood that an individual will consider, attempt, or commit suicide. Risk factors include: a psychiatric disease (e.g. depressive disorder, substance use disorder), a somatic disease (e.g. medical conditions causing chronic pain), early negative life experiences (e.g. losing a parent at an early age, abuse), personal characteristics (e.g. hopelessness, impulsiveness), and previous suicidal behaviour. Risk factors are not static during the life and may differ from country to country.

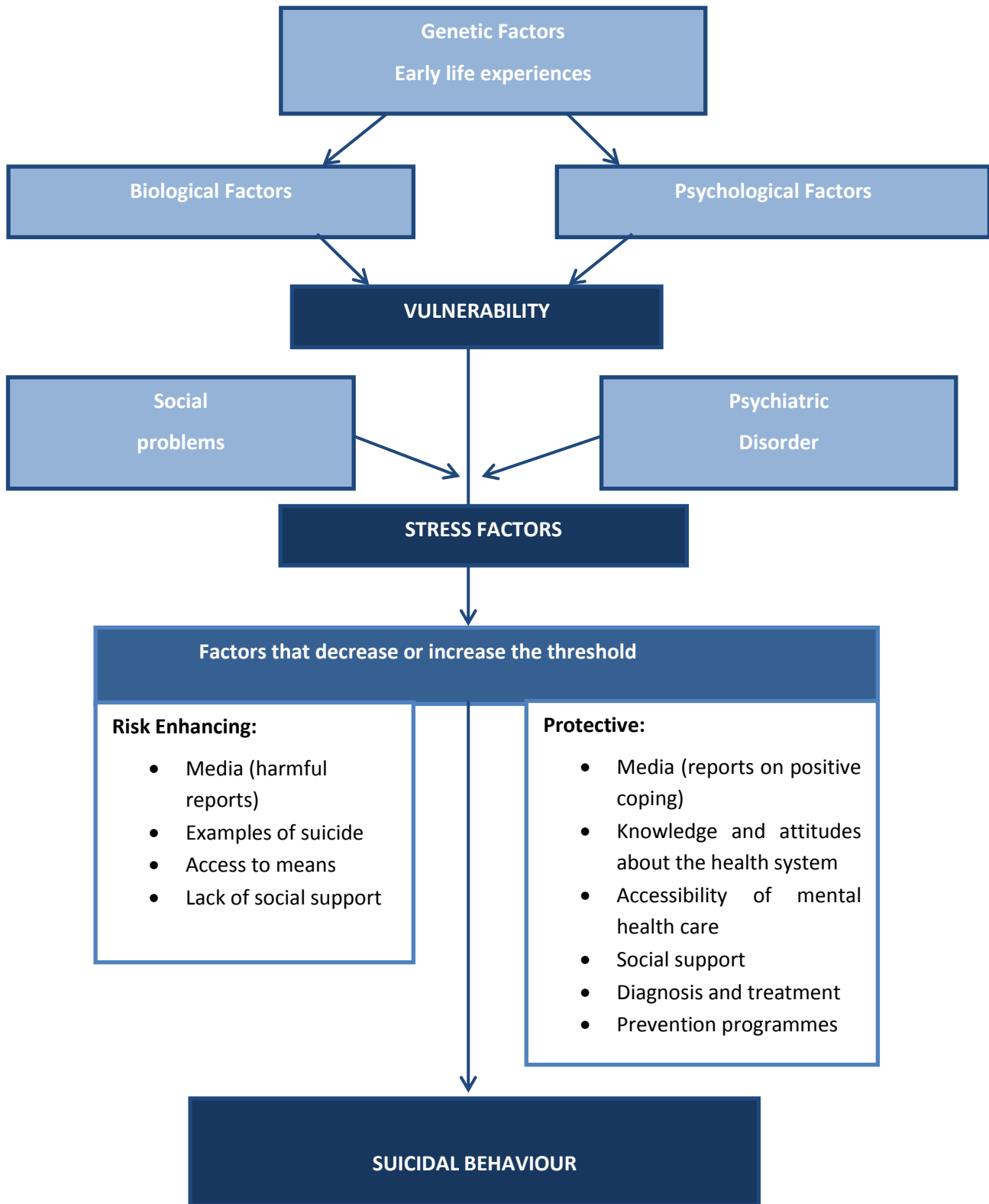
Protective factors include characteristics which make it less likely that individuals will consider, attempt, or complete suicide. Examples of potential protective factors are: positive self-image, adequate problem-solving behaviour, appropriate help-seeking behaviour, and social support.


The **model** described in Figure 1 shows an integrated model. It is based on the impact that biological, psychological, psychiatric and social risk factors may have on the development of suicidal behaviour. The model focuses on three key factors:

- **Trait-dependent factors** such as genetic, biological and psychological factors (e.g. serotonin, personality and cognitive psychological dysfunctions);
- **State-dependent characteristics**, such as depression and hopelessness, influenced by stressors in life (e.g. economic crisis, social problems, domestic violence) or by a psychiatric disorder;
- **Threshold factors**, which may have a risk enhancing or protective effect. For example, media reports on suicide can decrease the threshold to suicidal behaviour, while an accessible health system can have a protective effect and keep persons from developing suicidal behaviour.



Figure 1: An explanatory model of suicidal behaviour (adapted from van Heeringen, 2001)





TOOL 2

How to identify and deal with suicidal students

Within the prevention of suicide it is important for teachers and other school staff to be aware of strategies to detect students at risk and strategies to intervene with students at risk. Below warning signs on suicidal behaviour are listed and tips for interventions are mentioned.

1. What are the warning signs?

In 'Tool 1' risk factors were highlighted which can increase an individual's longer-term risk of developing suicidal behaviour, such as a mental disorder or a prior suicide attempt.

Besides these risk factors, suicide prevention experts have tried to define direct and indirect warning signs which may alert for suicidal behaviour in the near-term. **The clearest and direct warning signs for suicide are behaviours that indicate the person is thinking about or planning suicide, or is preoccupied or obsessed with death.** Suicide warning signs may be spoken, appear in student work, e.g. essays, in text communications, social media or reported by another student or teacher.

- Talking (or writing) about wanting to die or hurt or kill oneself (or threatening to hurt or kill oneself).
- Talking (or writing) about feeling hopeless or having no reason to live.
- Talking (or writing) about feeling trapped or in unbearable pain.
- Talking (or writing) about being a burden to others.
- Looking for ways to kill oneself, such as searching online for suicide methods or seeking access to firearms, pills or other means of suicide.

Direct signals



Other warning signs are **more indirect changes in behaviour which may indicate someone is experiencing a mental health problem**, which may include suicidal thoughts or plans.

The risk is higher if a behaviour is new or has recently increased in frequency or intensity, and if it seems related to a painful event, loss, or change. In sum, it is better to over-respond than to under-respond when any staff indicates a youth may be at risk.

- Withdrawal from family, friends and society or feeling isolated
- Deterioration in work or social functioning
- Increased alcohol or drug use
- Changes in personality, mood or behaviour. Such as extreme mood swings, acting anxious or agitated, or behaving recklessly. These can also include changes in eating or sleeping patterns
- Showing rage, uncontrolled anger, or talking about seeking revenge

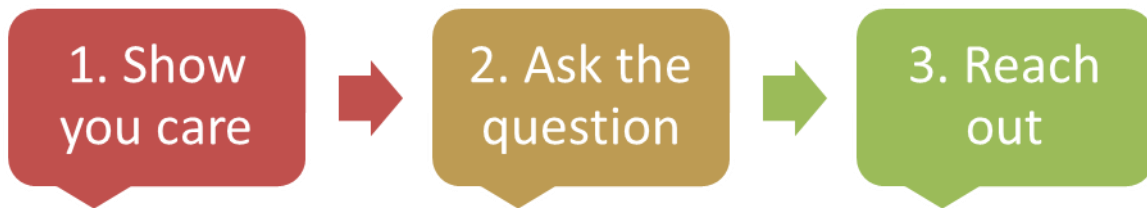
Indirect signals



2. How to respond to warning signs?

When notifying warning signs, it is important to contact a colleague, the school counsellor or the principal (depending on the school's protocol), as it is not the teacher's responsibility to counsel at-risk students. However, in some cases teachers can play a role in having a first conversation with the student and referring the student to available helping resources. In a first conversation follow the three key messages presented in the figure below. Before starting the conversation it is essential to have contact details of local or national help services ready to refer to.

Image courtesy of foto76 / FreeDigitalPhotos.net



1. Show you care

- Talk to the student in a private and confidential manner. Express that you're concerned and specify why you are concerned, by mentioning what you've noticed (e.g. specific warning signs or changes in behaviour or concentration).

2. Find the words and ask about suicidal thoughts

- It is a myth that asking about suicide puts the idea into people's head. Ask what is on the student's mind, what are his/her feelings. If the student acknowledges he/she struggles with a (mental health) problem, ask stepwise questions, beginning with general questions and moving on to specific questions, explicitly about suicide:
- **GENERAL QUESTIONS** on mental state, hope, future, (meaning of) life. Some examples:
 - "How are you doing at the moment?"
 - "How do you perceive the future?" "Which plans do you have for the future?"
 - "Do you have the idea that life is too much for you?"
 - "Do you have the idea that life isn't worth living?"
 - "Do you have hope that it gets better?"
- **SPECIFIC QUESTIONS** on suicidal thoughts and plans. Some examples:
 - "Do you ever think about death, about wanting to end your own life?"
 - "Have you had thoughts of harming or killing yourself?"
 - "Are you thinking of ending your life right now?" "Are you considering suicide?"
 - "What specific thoughts do you have?"



- “Since when do you have these thoughts?” “Did you have many thoughts in the last weeks?” “How often did you have these thoughts?” “How often do you think about it during the day?”
- “What makes you think about suicide?”
- “Do you have a specific plan in mind?” “What is your plan?” “Which methods did you think about?” “Which preparations you made?”
- “Did you ever had these feelings and thoughts before in your life? What caused it? How did you deal with it?” “Did you ever try to end your life?”

3. Reach out

- First of all, take all suicide threats seriously.
- Keep calm, listen actively (without judgment), express your care and offer your help.
- Don’t defend the ‘value of life’ or induce guilt, this doesn’t help the student.
- Stress the possibility and availability of professional help (refer to the resources) and offer help. You could offer to find telephone helpline numbers, or websites, or help in seeking a doctor or mental health professional
- Make sure the person keeps safe (until he or she gets help). Ask who they can call or rely on. If the situation is too critical, call for help (e.g. by calling a national helpline or emergency service). Don’t promise to keep the conversation confidential. When a person is at high risk, you have to get help immediately. If the crisis is acute, treat it as an emergency and call an emergency service, a suicide prevention helpline, the employee’s counselor or general practitioner, or take the person to the emergency department of the nearest hospital.

More do’s and don’ts (in English and Spanish) can be found on: www.suicideispreventable.org



TOOL 3

What to do after a suicide (attempt)

The need of a crisis plan

When a school is faced with a tragic incident such as a suicide or a suicide attempt of a student, the school team needs to know how to act in a both professional and sensitive way. In order to overcome the crisis situation, keep control and do what's best, it's essential to have a crisis plan prepared and ready, including communication guidelines for communicating with all people involved: parents, students, school staff and the media. A crisis plan can be developed by the school itself, in cooperation with mental health experts/counsellors or mental health services in the region.

Developing a crisis plan

A crisis plan will be different for each school, depending on the school structure, mental health services available, skills of the teachers,... The best way to prepare a crisis plan is to set up a team with key players of the school such as the principal, teachers, school counsellors, administrative staff... If available, it can be a good idea to get help from an external suicide prevention expert and/or mental health professional. It is essential to seek professional help in setting up a crisis plan and to establish an ongoing relationship with local mental health professionals. Below the key components and key steps of a crisis plan are presented. These steps can easily be adapted to the local context and local needs of the school.

Crisis plans should be updated frequently to stay useful and effective in the long term!



1. WHAT TO DO AFTER A SUICIDE ATTEMPT



Consult the parents and the student

- Express your concern and offer your help.
- Ask what information can be spread to teachers and students in the school. Also inform the parents and student about what the teachers and students know, if there are rumours.
- Ask whether they have been witnessing conspicuous behaviour or situations recently. Ask if there are aspects within the school-context that caused problems and should be changed (e.g. regarding bullying, school pressure, support at school...)
- Ask if (professional) help is available for the student.
- Think about who can counsel (and follow-up) the student within the school. Ask what the parents and student expect from the school and state clearly what is possible within the school context and what is not.



Organize a meeting for school staff

- Announce the news to the school staff and let them know where they can find support.



Organize a classroom conversation (optional)

- If permitted by the student and parents, talk to the class about the incident. (If not permitted, just make clear where students can get support and who they can talk to, if needed.)
- Never give details about the suicide attempt (e.g. about the method or place).
- Give general background information on suicidal behaviour (see Tool 1) and follow the guidelines for a classroom conversation (see Tool 4) in this toolkit.
- Take the students' perspective into account, in order to start from their beliefs and needs.
- Ask the student if he or she prefers to attend the classroom conversation or not.

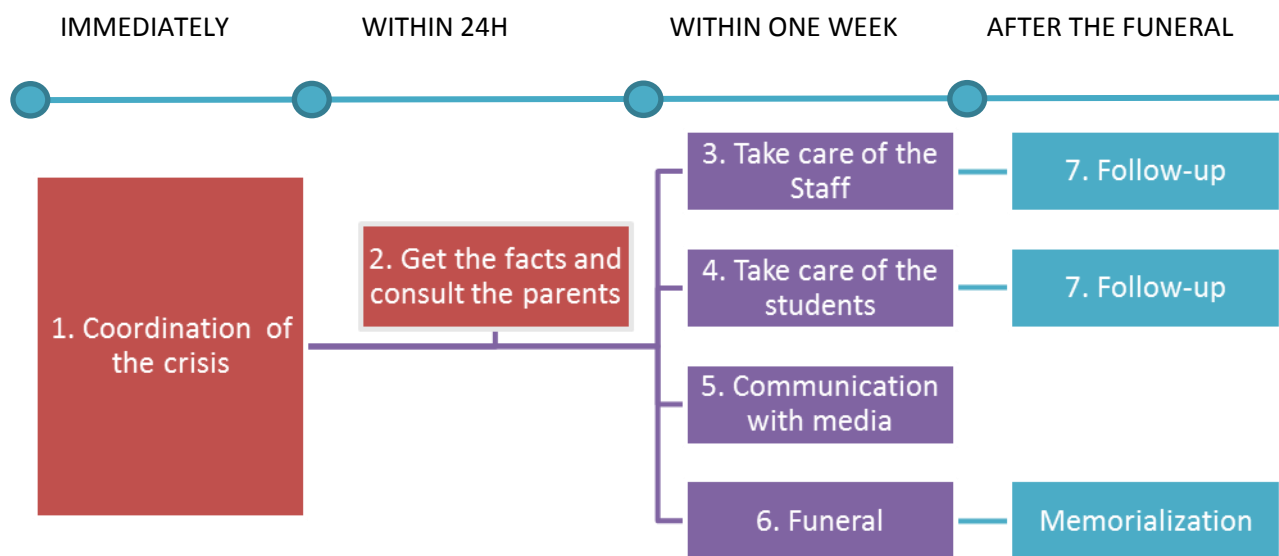
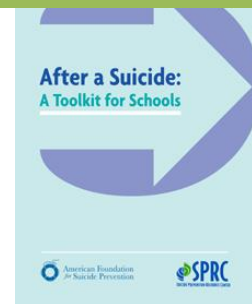


Prepare the return to school

- The return to school must be discussed with parents, school counsellors, the teacher(s) and the student.

2. WHAT TO DO AFTER A SUICIDE

Below 7 key steps are described to facilitate a crisis response after a death by suicide. The steps marked with a '*' are derived from the resource "After a suicide. A toolkit for schools." from the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center, available in English on www.sprc.org



STEP 1: COORDINATION OF THE CRISIS

The school's principal or coordinator should immediately take action to coordinate the crisis and set up a first meeting with a **crisis team**. Make sure the team includes the principal, teachers of the student, school counsellor(s), and administrative staff.

Be aware of the limitations of your expertise and capacity and those of the teachers. You may consider asking a counsellor or suicide prevention expert to assist you in managing the crisis. It is also useful to contact the local mental health centre, ask their advice and arrange how to work together during the crisis. If none of these experts or services are available, it is essential that staff is trained in how to handle crisis situations.



STEP 2: GET THE FACTS AND CONSULT THE FAMILY*

GET THE FACTS

The school's principal or coordinator should first check the facts and be sure of the official cause of death (consulting the parents or doctor, police, coroner, ... - depending on national legislation) .

If the facts are unclear, schools should communicate that it is being determined and will be communicated as soon as there is more information. Acknowledge that there are rumours (which are often inaccurate), and remind students that rumours can be deeply hurtful and unfair to the missing/deceased person, their family, and their friends.

CONSULT THE FAMILY

Information about the cause of death should not be disclosed to students until the family has been consulted. Speaking about death and suicide with the family can be a challenging job, as school staff is often not trained to do this and death and suicide may be taboo subjects, especially in some cultures or religions. In that case, consider seeking professional advice or help. If the death has been declared a suicide but the family does not want it disclosed, a staff member who has a good relationship with the family should be designated to contact them, to explain that students are already talking about the death amongst themselves, and that having adults in the school community who can talk to students about suicide and its causes can help keep students safe. Offer the family the help of the school.

In the short term, take also care of administrative issues, e.g. make sure family doesn't get any practical school letters any more (e.g. about school trips, or in the worst case, school bills).

STEP 3: TAKE CARE OF THE STAFF: COMMUNICATION & SUPPORT

As soon as possible, a meeting for all school staff must be held in which the facts are communicated clearly, the staff is informed about next steps to be taken, and the staff is informed about where to find more information. Basic information on suicidal behaviour is listed in TOOL 1 in this toolkit.

It is also important to inform staff about where they can get psychological support, if needed. If no support is available within the school, work together with external help services.



STEP 4: TAKE CARE OF THE STUDENTS: COMMUNICATION & SUPPORT

Schools should provide students with appropriate opportunities to express their emotions and identify strategies for managing them, so that the school can return to its primary focus of education. Students have to be informed about where they can get help and support, both within the school, as outside the school (help services).

As soon as possible after the staff meeting, teachers should set up a classroom conversation. Guidelines for a classroom conversation are included in TOOL 4 in this toolkit.

Taking care of the students is an important aspect of **prevention**. It facilitates the mourning process and reduces the risk of copycat behaviour. Furthermore it enables staff to identify how students are coping and which students may be at risk. Teachers should be aware of warning signs of suicidal behaviour in other students. Warning signs are listed in TOOL 2 in this toolkit. Especially, be aware of vulnerable students such as the closest friends, but also of peers with whom the student may have had conflicts.

As **parents** of students are key figures, an informative letter should be sent to the parents of all students, to inform them about the incident and to make them aware of possible risks and supporting options.

STEP 5: COMMUNICATION WITH MEDIA*

A suicide of a student can get a lot of media attention. Therefore it is important that the school prepares a media statement and designates a media spokesperson within the school. Advise staff that only the media spokesperson is authorized to speak to the media and advise students to avoid interviews with the media. The spokesperson should be aware of the harmful effects reporting on suicide may have in the media and should carefully follow the media guidelines on suicide prevention such as the importance to not dramatize the act, not mention the method or location of the suicidal act, give hope and refer to helplines. A complete toolkit for responsible reporting on suicide in the media is available on www.euregenas.eu



STEP 6: FUNERAL AND MEMORIALIZATION*

Depending on the family's wishes, help disseminate information about the **FUNERAL** to students, parents and staff (location, time, policy for releasing students during school hours).

Work with school counselors and community mental health professionals to arrange for counselors to attend the funeral and encourage parents to accompany their child to the funeral.

School communities often wish to **MEMORIALIZE** a student who has died, reflecting a basic human desire to remember those we have lost. It can be challenging for schools to strike a comfortable balance between compassionately meeting the needs of distraught students while preserving the ability of the school to fulfill its primary purpose of education. In the case of suicide, schools must also consider how to appropriately memorialize the student who has died without risking suicide contagion among those surviving students who may themselves be at risk. It is very important that schools strive to treat all deaths in the same way. Also in the long term, memorials can be organized, e.g. one year after the incident. Small gestures towards the family e.g. sending a card to parents one year after the incident, can mean a lot.

SOCIAL MEDIA such as texting, Facebook, and Twitter are rapidly becoming the primary means of communication for people of all ages, especially youth. While these communications generally take place outside of school, they can nevertheless be utilized as part of the school's response after a student's suicide. By working in partnership with key students to identify and monitor the relevant social networking sites, schools can strategically use social media to share prevention-oriented safe messaging, offer support to students who may be struggling to cope, and identify and respond to students who could be at risk themselves. It is important that the school sets out rules and guidelines about what students can (or cannot) communicate about the incident on social media sites.

STEP 7: FOLLOW-UP AND EVALUATE

Within the crisis team, it is important to evaluate the crisis response, learn from obstacles and adapt procedures accordingly.



TOOL 4

Guidelines for a classroom conversation after a suicide (attempt)

When an incident as a suicide attempt or a suicide of a student or a staff member occurs, it is important to set up a classroom conversation, as soon as possible after consulting the family. The conversation should be prepared and monitored by a teacher known and trusted by the students, if possible assisted by a school counsellor or mental health professional. Below, four aspects are mentioned which are essential to address in a classroom conversation.

Dispel rumours

- Rumours will come up. Ask students what they heard and try to dispel rumours. If available and if agreed upon with family (and with the student/teacher in case of a suicide attempt), provide correct information on the incident. In any case, stress clearly that rumours do harm.

Provide a framework on suicidal behaviour

- Stress that suicide is complex and is not caused by one single factor.
- Stress that suicide is not 'a choice', nor a heroic or romantic act.
- Stress the comorbidity with psychological problems such as depression, alcohol and drug abuse,... without stigmatising these problems.
- Stress that suicide can be preventable and there is help available.

Interact with the students

- Ensure a safe climate: stress the importance of confidentiality and honesty.
- Let the students talk about their feelings. Stress that feelings of anger and guilt are common and normal.
- Make room for questions.









Reach out

- Talk with students about what you can do when you feel sad, depressed, or hopeless or what you can do when a friend feels sad, depressed or hopeless.
- Refer to help services and ask if they would go to these services.



CONCLUDING CHECKLIST

Congratulations, you made it to the end of this toolkit. Now you should be aware of how a school can be improved and transformed into a healthy and safe place, addressing suicide prevention strategies. Below the main points of this toolkit are summarized into a practical checklist to get you right on track. Your school could be a best practice example regarding suicide prevention when:

- ① The school has a clear and comprehensive 'healthy school policy' including mental health promotion and suicide prevention strategies. 
- ② Anti-bullying policies and programmes are put into practice. 
- ③ Initiatives are taken to develop prevention programmes on mental health promotion and suicide prevention, such as psycho-education and skills training. 
- ④ Psychological help for students and school staff is available and accessible, including screening programmes (optional) and good cooperation with external help services. 
- ⑤ Gatekeepers such as teachers and school counsellors are trained in suicide prevention: they know the warning signs and know how to interact with suicidal students or colleagues and refer them to the proper health services. 
- ⑥ Special attention goes out to vulnerable students and staff members. 
- ⑦ The school is a safe environment, in which the access to lethal means for suicide is limited. 
- ⑧ A crisis plan is ready in case of the suicide or a suicide attempt of a student or staff member 

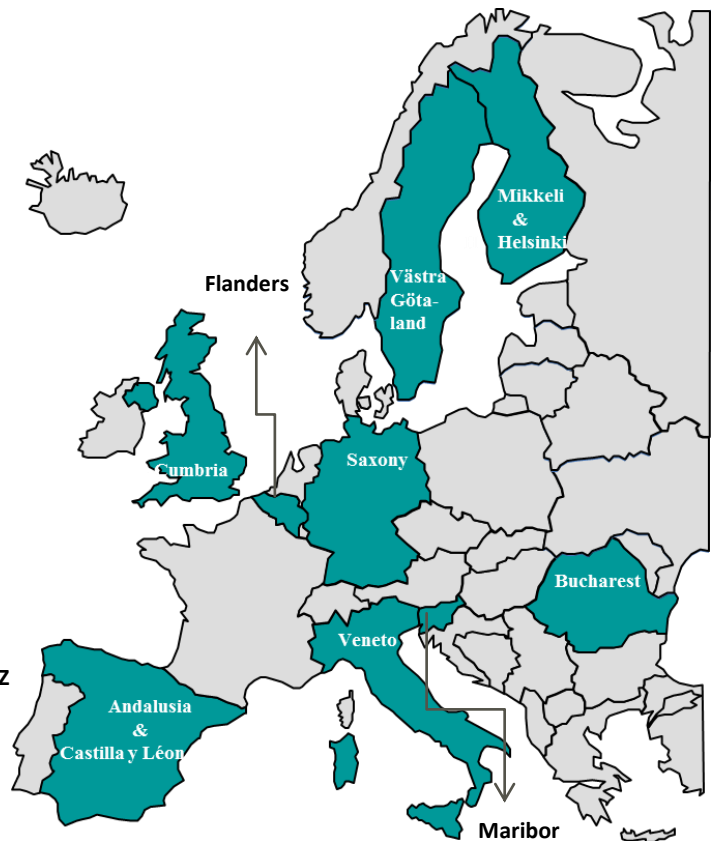


About the Euregenas project

The **Euregenas project** aims at contributing to the prevention of suicidal thoughts and behaviours in **Europe** through the development and implementation of strategies for suicide prevention at regional levels which can be of use to the European Union as examples of good practice. The project brings together **15 European partners**, representing 11 European Regions, with diverse experiences in suicide prevention (see Figure 1).

Figure 1 – The Euregenas Regions

- University Hospital Verona (**AOUI-VR**) – Italy
- Flemish Agency for Care and Health (**VAZG**) – Belgium
- Region Västra Götaland (**VGR**) - Sweden
- Romtens Foundation (**ROMTENS**) - Romania
- National Institute for Health and Welfare (**THL**) - Finland
- Unit for Suicide Research, University Ghent (**UGENT**) – Belgium
- Fundación Intras (**INTRAS**) – Spain
- Servicio Andaluz de Salud (**SAS**) – Spain
- Fundación Pública Andaluza Progreso Y Salud (**FPS**) - Spain
- Mikkeli University of Applied Sciences (**MAMK**) - Finland
- Technische Universität Dresden (**TUD**) – Germany
- National Institute of Public Health, Regional Unit Maribor (**NIJZ MB**)– Slovenia
- West Sweden (**WS**) – Sweden
- De Leo Fund (**DELEOFUND**) – Italy
- Cumbria County Council - UK





In line with the '*Second Programme of Community Action in the Field of Health*' (European Commission, 2008-2013, see <http://ec.europa.eu/health/programme/policy/2008-2013/>), the project promotes the use of regional cluster management as innovative method to improve the existing services.

By encouraging regional interventions and campaigns dedicated to both target groups and non-health stakeholders, **the project aims at implementing the Mental Health Pact** in relation to:

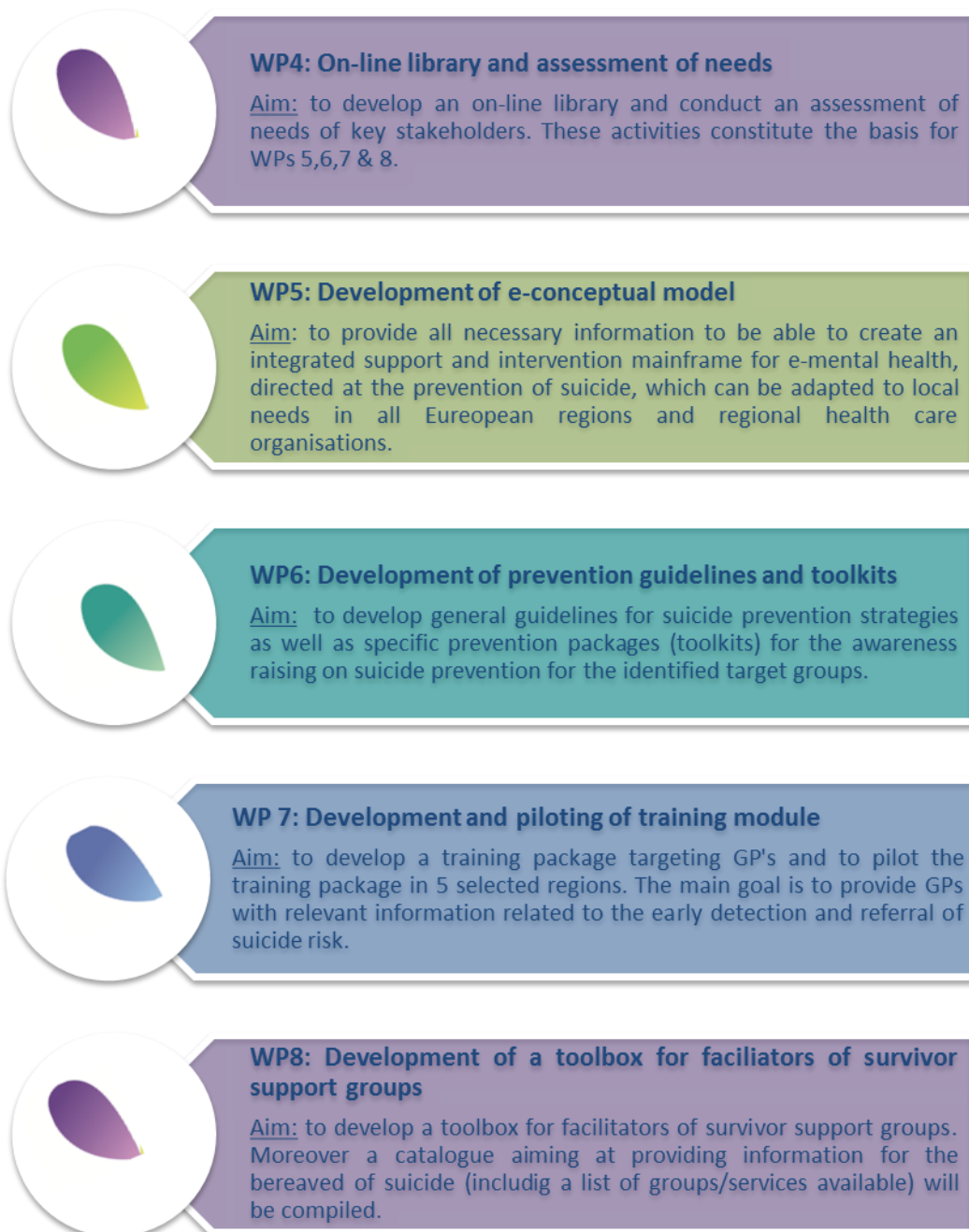
- 1) Prevention of suicide
- 2) De-stigmatization of mental health disorders
- 3) Promoting health in youth

The **specific objectives** of the Euregenas project are the following:

- To identify and catalogue good practices of existing actions and strategies on suicide prevention at a regional and local level;
- To carry out a stakeholders' needs analysis;
- To develop and disseminate guidelines and toolkits on suicide prevention and awareness raising strategies;
- To develop the technical specifications for an integrated model for e-mental healthcare oriented at suicide prevention;
- To improve knowledge and capabilities among local and regional professionals (i.e. psychologists, psychiatrists, GPs).

The project aims at meeting its specific objectives by a **series of Work Packages (WP)**. The Euregenas project includes eight work packages: 3 horizontal work packages, respectively on coordination, dissemination and evaluation and 5 vertical core work packages (see Figure 2).

Figure 2: the Euregenas core work packages



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