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Title:
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Date:
2019-05-10

Citation:
Williamson, M., Schlichthorst, M., Jordan, H., Too, L. S., Pirkis, J. & Reifels, L. (2019). Community suicide prevention networks: A literature scoping review

Persistent Link:
https://hdl.handle.net/11343/240409

Report

Community Suicide Prevention Networks: A Literature Scoping Review

Submitted to Wesley Mission

10 May 2019

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Background

Suicide is a significant concern for the Australian population, claiming the lives of 3128 men and women in 2017 (1). Wesley Mission, through its Wesley LifeForce Suicide Prevention Networks program (Wesley LifeForce program) has been working with the community to support the development of local community suicide prevention networks since 2007 (2). Wesley Mission defines a network as 'A union of people and organisations, working together to change the outcome relating to a specific problem.' Networks are further described as being community based and as being 'for the people, by the people' (3). In this report, we refer to this notion as 'community led'. While the aims and objectives of each network vary, reflecting the unique identity of each community, there is a common thread: a focus on interagency cooperation and raising community awareness. Wesley LifeForce network functions typically include activities that seek to:

- identify and bring together community participants with an interest or responsibility in suicide prevention, mental health issues and/or mental health promotion
- facilitate the exchange of information
- co-ordinate suicide prevention activities to maximise impact
- encourage sharing of skills and learning
- raise community awareness of suicide risk and protective factors and help create pathways (2).

The Wesley LifeForce program's objective is to assist network development so that local communities are empowered to take action to tackle suicide (3). Wesley employs a team of community development coordinators to support the establishment of the networks and provides ongoing assistance as required. Most LifeForce networks become independent, self-actuating community entities which develop and implement activities, projects and services for suicide prevention, postvention and crisis intervention (2).

The Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne was commissioned by Wesley Mission to evaluate the outcomes of community suicide prevention networks set up through the Wesley LifeForce program (4, 5). To inform the evaluation plan, a literature scoping review was conducted with a focus on studies that examined community suicide prevention networks (4).

While previous literature scoping work has been undertaken by AISRAP in 2015 (6) and Omeh in 2018 (7) under the auspices of Wesley Mission, both of these reviews were somewhat limited in scope and not systematic. The 2018 Omeh report sought to outline relevant literature on the effectiveness of networks (or community coalitions) that are focused on suicide prevention activities. The Omeh report identified no literature measuring the effectiveness of networks in preventing suicide. Rather, it drew on the broader literature on community coalitions, which are not specific to suicide prevention. In this literature the primary focus is on internal network processes and functioning rather than on outcomes. The Omeh report also drew on literature pertaining to community suicide prevention initiatives that are not network-based, and concluded that community empowerment or control over suicide prevention initiatives is likely to be a key ingredient in successful suicide prevention (7).

Similarly, the literature scoping work undertaken by AISRAP (6) referred to four studies of evidence-based approaches to suicide prevention which were not network-based (8-11). The AISRAP report outlined relevant literature on suicide prevention activities more generally, including methodological challenges to evaluation and two Australian examples of suicide prevention programs which had been evaluated. Common methodological challenges to evaluating suicide prevention programs noted include the length of time required for measurable effects to appear, difficulties in attributing causation, and social desirability effects when measuring attitudinal changes. The AISRAP report concluded that there had not been an evaluation of a multi-modal, multi-intervention, volunteer driven, community suicide prevention initiative such as the Wesley Lifeforce Suicide Prevention Networks (6).

Review methodology

This scoping review was designed and conducted following the methodological framework for scoping studies developed by Arksey and O'Malley (12) and later revised by Levac et al. (13, 14). The general review process incorporated the recommended stages of identifying the research question; identifying relevant studies; study selection; and charting and summarising findings.

Identifying the research question

Two research questions were developed:

1. What types of community led suicide prevention networks currently exist?
2. What do we know about their effectiveness?

These exploratory questions align with the broad framework approach of a scoping review and generated an overview of research undertaken on this topic. In the context of this review, we focus on networks that are community led, meaning the network is motivated from within the community and not initiated by organisations or Government bodies. Professional networks that limit membership by professional role or affiliation were excluded. Similarly, community-based interventions that do not bring people or organisations together were excluded.

Identifying relevant studies

This scoping review included a systematic search of peer reviewed articles, a search of the grey literature, website searches and expert consultations to identify eligible studies. The systematic search of four academic literature databases was conducted on 27 March 2019 for articles published between 2000 and 2018, using Medline/PubMed (Ovid interface), PsycINFO (OVID interface), and Scopus (Elsevier interface). Bibliographies of included papers were also searched. Grey literature was sourced to include research that had not been peer-reviewed. This was done by searching websites, using web search engines and consulting content experts in this field.

Search terms were developed relating to the three key areas underpinning the literature review: suicide, network structures and evaluation studies. The following search terms were used as a starting point to develop a search string for each of the three areas.

- Tier 1: Evaluation, effectiveness, impact
- Tier 2: Suicide or related terms such as mental health, intentional self-harm
- Tier 3: Network or related terms such as coalition, group, community, collaborative, alliance, partnership, affiliation.

The alternative terms for the three tiers were tested and refined in a number of test searches to yield a more comprehensive and inclusive list of records that was manageable under the given project timelines. Boolean operators were used to combine the search terms. We used the "OR" operator to combine terms within a tier and the "AND" operator to combine the tiers. Search term forms were adjusted to fit the requirements of the different databases. Table 1 lists the search terms by tier.

Table 1: Search strategy for academic databases

Tier	Search String
1	suicid* OR self-harm OR 'self harm'
2	evaluat* OR effective*
3	network OR coalition OR 'community partnership' OR 'community network' OR 'community approach'
Combined	1 AND 2 AND 3

Study selection

All records resulting from our searches in the different databases were imported into Endnote (version X9) and screened for inclusion in two stages. In the first stage, two researchers (MW and MS) screened titles and abstracts for potential inclusion. In stage 2, the full text pdfs of retrieved articles were screened independently by the same two researchers. Discrepancies were resolved in a meeting between the two researchers.

Articles were eligible if they featured a network initiative with a focus on suicide prevention and a measure of impact. The network initiative had to be community led, not primarily based within an organisation or professional body; have suicide prevention as part of its focus; and had to provide evidence for measured impact. The impact measure, however, was not limited to suicide.

Articles had to be published between 2000 to 2018 (inclusive) to be eligible. For grey literature or articles identified through alternative sources no restriction on date of publishing was set as this was not feasible. We also placed no restriction on the study design, with both qualitative and quantitative studies being eligible. There were further no restrictions placed on the type of interventions or activities conducted by networks.

Charting of eligible studies

We used a data extraction table to collate all relevant information contained in the included studies. Table 2 provides a brief summary of the identified studies, including their target population, study objectives, type of network initiatives, and the focus of related evaluation efforts, all of which are subsequently summarised in text.

Summary of findings

We identified 710 records through academic database searches and 9 records through other sources including grey literature searches, website searches, Google searches and expert consultations. Following the removal of duplicates, a total of 568 records were screened by title and abstract information. This led to the exclusion of 544 articles. The remaining 24 articles were read in full text by MW and MS who then reached consensus on the inclusion of 3 articles as per the selection criteria, two of which are from the same network. The search process is outlined in Figure 1.

Figure 1: PRISMA Flow Diagram illustrating the literature search process

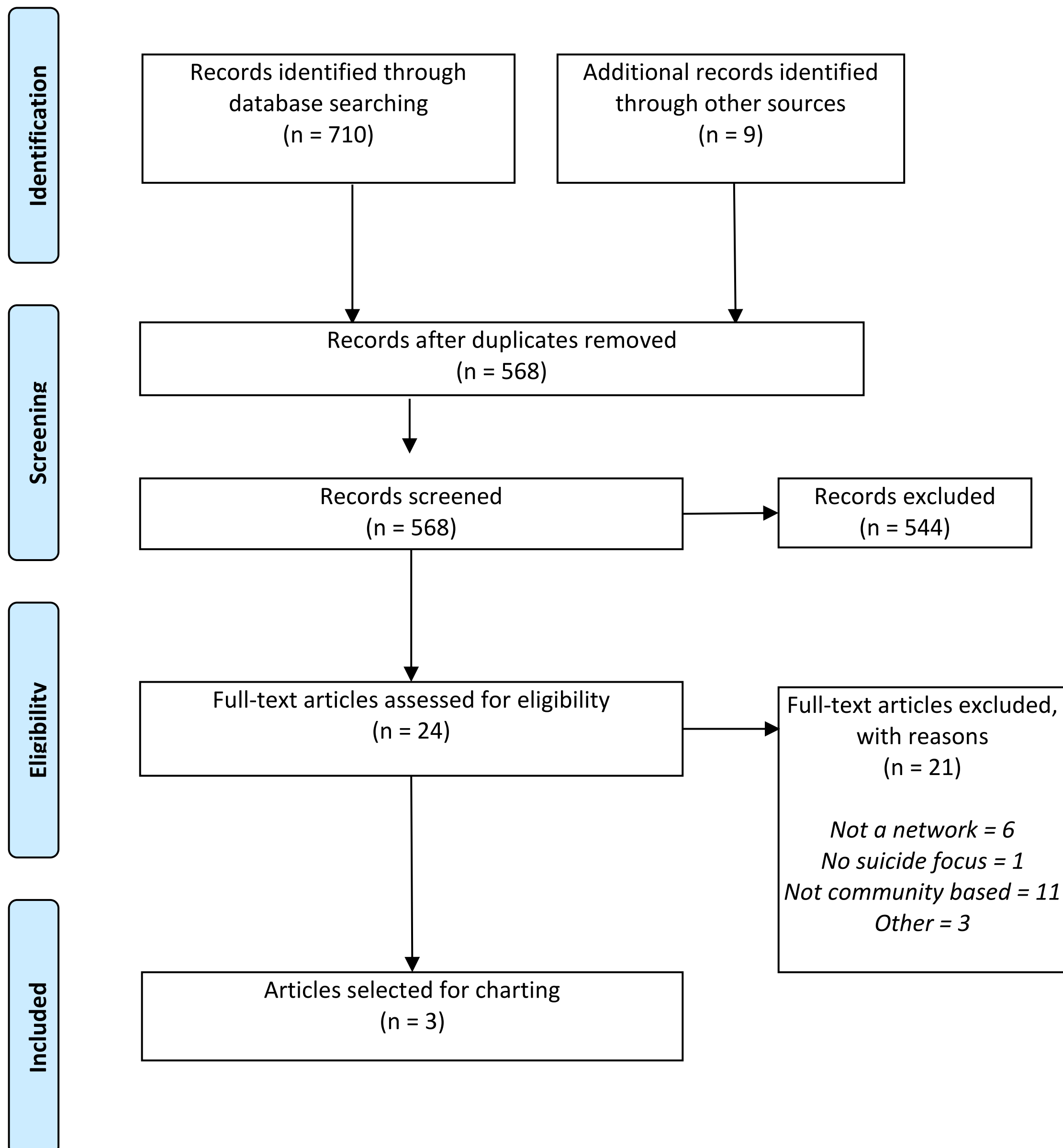

Table 2: Description of included studies

Study reference	Setting/ Target population	Study objective	Type of network initiative	Evaluation Focus
Evaluation Report: Cores Community Response to Eliminating Suicide; September 2009, Success Works PRY Ltd.	Australia, Tasmania/ rural commun-ities	Description of the CORES programs and reporting evaluation findings	Community led program that aims to build and empower communities to take ownership of suicide prevention activities within the community; and offers training and education sessions to grow the community of support volunteers	Output and outcome evaluation of five pilot sites (largely qualitative)
Jones, Walker, Miles, De Silva & Zimitat (2015). A rural, community-based suicide awareness and intervention program. Rural & Remote Health, 15(2).	Australia, Tasmania/ rural commun-ities	Report on the Community Response to Eliminating Suicide (CORES) program benefits and feasibility of community-based suicide intervention in rural communities	See above	Suicide Awareness and Intervention Program (SAIP) training evaluation (pre-post and follow up)
Summary of the Healthy and Resilient Communities Program Evaluation, April 2018, Centre for Rural Health, University of Tasmania **http://www.rawtas.com.au/f.ashx/HaRC-Executive-Summary-Evaluation-2018.pdf**	Australia, Tasmania/ rural commun-ities	Presentation of evaluation findings from the Healthy and Resilient Communities (HaRC) program across selected network sites	Non-profit organisation helping individuals, families and the community through mental health issues with a focus on suicide prevention; recruiting local community members to support them in setting up suicide prevention community initiatives	Process and impact evaluation of four local network sites (mixed methods)

Two of the three eligible studies were focussed on the Community Response to Suicide (CORES) program while the third described the Healthy and Resilient Communities (HaRC) program administered through Rural Alive and Well (RAW). Both network initiatives have been evaluated to varying degrees. Table 2 provides a brief description of the included studies and network initiatives, with details of the network design and evaluation findings provided below.

CORES was conceived as a holistic approach to suicide awareness that involves building local leadership and social networks to find solutions to improve the general health and wellbeing of the whole community. The aims of the program were to: (i) gather local people in the community to examine and understand their community, (ii) foster an understanding of suicide, (iii) develop the skills of local people to identify and respond to suicide at an early stage, (iv) engage local people in the delivery of the program, (v) identify people at risk and link them to community and professional support services and (vi) empower the local community to own and manage the program. CORES is managed by Kentish Regional Clinic (KRC) in Tasmania. The CORES model is based around a comprehensive community package which involves the delivery of one-day suicide intervention training to members of different communities. Community members are trained to be able to recognise people at risk and refer them into available services. Community ownership is at the heart of the CORES program and so-called champions within the community

need to be committed to generate interest for community-based services. Volunteers from the community are recruited to become non-professional support workers. KRC supports communities to set up their training and services network.

The first study presents evaluation findings regarding the outputs and outcomes of five CORES pilot sites (15). This evaluation was mainly qualitative in nature and participants included staff members from KRC, the five pilot sites and five non-pilot sites, stakeholders and participants of training sessions. The evaluation found that the program raised awareness about the risks and social implications of suicide for those who completed the training. This level of awareness was also correlated with the length of time the program had been running in the community. The study found the CORES initiative substantially strengthened social capital by bringing people together to undertake the one-day training; developing a network of local CORES teams; and connecting and strengthening links between individuals and between community organisations. The implementation of the CORES program was found to decrease social isolation amongst community members through successfully intervening with people at risk, and through normalising help-seeking behaviour and linking people with available services which then averted a suicide crisis or prevented a suicide. This latter finding is based on reports from volunteer workers in the community and their perceptions of the effect that their work in the community had. This effect was not measured on the basis of community level data.

In the second study, Jones et al. (2015) present findings from the evaluation of the CORES 1-day Suicide Awareness and Intervention Program (SAIP) training (16). The SAIP training program seeks to train local teams to provide support to their community. The SAIP training program evaluation used pre and post-training surveys and follow-up questionnaires which included questions relating to previous knowledge or training in suicide awareness and intervention; the level of comfort in talking about suicide to people who may be at risk; and participants' confidence in their ability to provide appropriate assistance to family members, friends, colleagues or strangers. The evaluation found that the SAIP training program improved awareness and knowledge of suicide, confidence in discussing suicide and recognising when and how to refer someone at risk of suicide. This evaluation was entirely focussed on the training program and its participants.

Rural, Alive and Well (RAW) is a non-profit organisation helping individuals, families and the community through mental health issues with a focus on suicide prevention (17). RAW provides support and training for communities that wish to implement community led suicide prevention programs. RAW introduced the Healthy and Resilient Communities (HaRC) initiative in 2016 (funded by the Ian Potter Foundation, TasNetworks, and the Cape Hope Foundation). Working alongside twenty communities in rural Tasmania over a three-year period, RAW actively enables and supports the development and implementation of locally owned suicide prevention strategies and projects designed to boost greater community resilience. Central to this initiative is the establishment of local community well-being and suicide prevention groups and the implementation of locally identified and owned community projects. Examples include facilitated partnerships within local communities; initiatives designed to build local community well-being; suicide prevention and community well-being projects embedded in the local community; community capacity building to identify key risk signs and equip communities with suicide knowledge and prevention techniques. The critical philosophy underpinning this project is to inspire the community to come together to improve outcomes in their local area.

The HaRC program evaluation involved four local network sites across Tasmania and was conducted using a mixed methods approach (17). This approach was chosen to allow a deeper understanding of program processes and impacts. A modified version of the Communities Advancing Resilience Toolkit (CART) survey tool was used as the primary quantitative data collection method. Focus group interviews were conducted at each of the test sites to gain a richer understanding of the participants' experiences and beliefs and answer evaluation questions. The evaluation found that aligning the components of the HaRC program with community readiness had a major influence on the program achieving its goals. Preparedness, community knowledge, leadership capacity, connectivity, awareness of health services and resources available were key factors for increasing levels of engagement with the HaRC program. The test sites reported having stronger partnerships within the community; more active suicide prevention and community well-being initiatives; and enhanced capacity within the community to identify suicide risk signs and take preventative measures.

Discussion

Our scoping review found only limited published evidence for evaluated community led suicide prevention networks that are compatible to the Wesley LifeForce Networks model of suicide prevention. The three included studies which looked at two Australian network initiatives based in Tasmania were smaller in scale than the Wesley LifeForce program. These initiatives also showed a strong focus on training community members as gatekeepers within their community. However, based on the limited published evidence available to date, it would appear that the Wesley LifeForce Networks model may be unique in its size, geographical spread, diversity of communities it serves and in the range of suicide prevention initiatives that it includes.

The three evaluations of the two initiatives were conducted after only one year of implementing the network initiatives and covered a limited number of sites. This restricted the evaluations to focus on process and implementation aspects, which means that long term outcomes and community level impacts were not directly assessed. Positive effects of network activities were primarily based on volunteer or staff reports.

We conclude that the evaluation of suicide prevention network outcomes as it pertains to community health is currently largely missing from the literature. To understand long term benefits of suicide prevention networks to the community it is therefore imperative to evaluate ultimate outcomes where possible alongside other short and midterm outcomes, which would add important knowledge to the current suicide prevention literature. Wesley LifeForce could lead the way in this area and become an example for other network initiatives nationally or internationally to follow.

Other relevant programs and studies

Whilst not fitting our search criteria for this review, we found six other studies of suicide prevention initiatives that had been referred to as networks in the literature, but which were not community led. These networks were typically implemented by non-profit or government organisations external to the community. However, since these network initiatives also included some community led components, they may be interesting to consider to gain a better understanding of Wesley Mission's unique position within the space of suicide prevention networks.

The Garrett Lee Smith Youth Suicide Prevention Program (GLS program) in the US is a funding scheme supporting development and implementation of state-wide, tribal and campus youth suicide prevention and early intervention strategies (18). Funding provides program implementation support and directs grantees to evaluate program effectiveness locally and through a cross-site evaluation to Congress. The program aligns with the National Strategy of Suicide Prevention goals (19). Program activities of the grantees include outreach and awareness, gatekeeper training, screening programs, direct services, coalitions and partnerships, life skills and wellness development, policy and protocol development, training of mental health professionals and clinical staff, hotlines and helplines and means restriction (18). A study of grantee spending showed that the bulk of funds go towards outreach and awareness, and gatekeeper training which are mostly community driven (18). Four evaluation studies were published focussing on different components of the GLS program (20-23), which are briefly outlined below.

Condron et al. (2015) evaluated the gatekeeper training program in terms of its effectiveness (21). A quantitative survey (the Training Utilization and Preservation Survey) was administered to individuals who participated in a training activity as part of the GLS Program. The survey found that time spent interacting with youths was positively correlated with the number of gatekeeper identifications and knowledge about service receipt. Gatekeepers who participated in longer trainings identified proportionately more at-risk youths than participants in shorter trainings (21).

Garraza et al. (2015) conducted a large scale comparative study of 466 counties implementing the GLS program and 1161 compatible counties that were not exposed to the GLS program (22). Results showed that in the year following program implementation counties implementing the comprehensive GLS program activities had significantly lower suicide attempt rates among youths 16 to 23 years of age than did similar counties that did not implement GLS program activities (4.9 fewer attempts per 1000 youths [95%CI, 1.8-8.0]; p = .003). There was no significant difference in suicide attempt rates among individuals older than 23 years during that same period. There was no evidence of longer-term differences in suicide attempt rates (22).

Another study using the same data looked at the effect of implementing GLS gatekeeper training on youth suicide rates and equally found significantly lower suicide rates among the population aged 10 to 24 years in the year after GLS training than in similar counties that did not implement GLS training (1.33 fewer deaths per 100 000; p = .02) (20).

The 2018 evaluation report to Congress focussed on evaluating the activities grantees had implemented over the funding period (18). While the implementation of the GLS programs did not result in a statistically significant reduction of suicide rates in the community, the directional trend was for a lower suicide rate.

The final GLS study, looked at feedback from coalition members at a single site as a case study and provided recommendations for developing and implementing campus-based suicide prevention initiatives (23).

Another government suicide prevention initiative that was implemented in a community setting but not community led is the Suicide Prevention Action NETwork (SUPRANET) in the Netherlands (24). This is a Government initiated program that is being implemented across regions which includes local community led components. This initiative was started in January 2016 in seven pilot regions. A multilevel evaluation plan has been devised for the program with a trial to be completed in 2018 (24).

The limited findings from this literature review suggest that the implementation of suicide prevention networks, whether initiated by government, organisations or through communities have positive effects on suicide awareness, early detection and linking those in need with services. A link between suicide prevention networks and reduced suicide rates has so far only been found for government initiated youth suicide prevention networks (20, 22).

Limitations

In conducting this literature scoping review, we encountered certain barriers and limitations. The development of inclusive search terms can be challenging. We found that studies focussing on initiatives that qualify as a network as per our selection criteria use different terminology to define themselves. They may not refer to their initiatives as being a ‘network’. Alternative terminology such as ‘community coalition’ or ‘community initiative’ were also used but this was inconsistent across studies. Some studies may refer to activities as a ‘program’ rather than a network initiative. In addition, many government-organised mental health service coalitions would use the term network, however, these would not qualify for inclusion in our review. The inconsistency in the terminology and absence of international agreement on terminology may have impacted the search findings and as a result, we may have missed some publications.

Another challenge is that most community led networks for suicide prevention do not have published materials describing their aim and purpose and even less material is available on the evaluation of these networks in the public domain. As these network initiatives grow from the bottom up and often rely on volunteer workers, it is likely that the resources and knowledge base for documentation and evaluation is missing. This in conjunction with the inconsistency in terminology makes it difficult to find community led network initiatives. A broad and systematic grey literature and alternative sources search combined with knowledge of experts in the field may be the most effective means of identifying existing initiatives.

Our grey literature search was not systematic and relied on expert knowledge to guide the search for existing programs. We acknowledge a bias towards Australian based programs due to the experts we consulted and that there may be other initiatives that we have not been able to find through this search process.

Conclusions

In summary, the existing evidence from three evaluations of two community led suicide prevention network initiatives was limited. These evaluations primarily focussed on process, implementation and capacity building aspects. No community level data were collected to investigate if suicidal behaviour or suicide rates had declined. A link between suicide prevention networks and reduced suicide rates has so far only been found for Government initiated youth suicide prevention networks. To understand the long-term benefit of suicide prevention networks to the community it is therefore imperative to evaluate ultimate outcomes where possible alongside other short and midterm outcomes as this would add important knowledge to the current suicide prevention literature. Wesley LifeForce could lead the way in this area and become an example for other network initiatives nationally or internationally.

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