

Suicide Prevention:

Guidelines for Public Awareness
and Education Activities

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Guidelines Checklist

PUBLIC AWARENESS AND EDUCATION FOR SUICIDE PREVENTION

A. Planning and Development (See Section A)

- Involve people with various perspectives and experiences with suicide when creating public awareness and education materials, a campaign or an event.
- Use appropriate and sensitive language when discussing suicide.
- Consider all who will be exposed to the message and the potentially negative and unintended impacts.
- Before and after public release, test and evaluate new campaigns or presentations for their positive outcomes, and to gauge any unintended messages or outcomes.
- Use a comprehensive, responsible approach to planning for a presentation or an event.

B. Help-Seeking (See Section B)

- Ensure messages clearly outline the desired behaviour of seeking help, as well as normalize and affirm this behaviour. Suggesting that suicide is a common event or an inevitable outcome is inaccurate and potentially harmful.
- Encourage help-seeking by providing information about accessible and suicide-intervention trained service providers.
- Make others aware of when and how to ask about suicide.

C. Risk and Protective Factors (See Section C)

- Outline the range of risk factors related to suicide. Presenting suicide as a simple or inexplicable act is misleading and may cause people to assume it is a common response to a stressful situation.
- Wherever possible, educate about protective factors.

D. Stigma (See Section D)

- Highlight positive models of persons who are overcoming suicidal thoughts, feelings and/or actions.
- Before using media, be familiar with the media guidelines for reporting suicide and share them with media personnel.

E. Personal Stories (See Section E)

- Prepare someone who will share a personal story at a suicide prevention event.
- Present a view of the deceased person that includes positive traits as well as risk factors. Distinguish between the qualities and accomplishments of the deceased and his or her final act of suicide. Avoid glorifying, romanticizing or idealizing the person or the death.
- Balance the personal story with the key suicide prevention messages.
- Although a prevailing belief may be that the afterlife is a much better place, this should not be emphasized publicly.
- Communicate suicide's painful and permanent consequences.
- Avoid overt details about means and place of death.
- Emphasize help-seeking and resources, as well as hope and recovery through statements that celebrate and affirm life.
- Link those who share their stories, and those in the audience, to supports to help cope with difficult emotions that may surface.
- Before an interview, review the media guidelines. Check with interviewers as to their awareness of the media guidelines for suicide reporting.

F. Memorializing (See Section F)

- The messages offered at a public memorial event should affirm life. Emphasize that suicide is largely a preventable death and actions can be taken to prevent it.
- Responses to a suicide death need to reflect local cultural practices and beliefs as a way to support healing, connection and community solidarity.
- When web pages are created in honour of one who has died by suicide, include life-affirming messages and local and provincial resources to promote help-seeking.
- Erecting and showcasing public, permanent memorials for those who have died by suicide is discouraged. This statement is not intended to inform the creation of memorials that honour the extraordinary accomplishments of one who happened to die by suicide.

Guidelines for Public Awareness and Education

BACKGROUND

From a population health perspective, death by suicide in the overall population is rare compared to common causes of death such as heart disease and cancer. At the same time, these statistics do not reflect the prevalence of suicidal feelings, thoughts and actions in the general population. The reality is that most people, at one point in their lives, have suicidal feelings and thoughts.

Due to the many different factors that lead people to suicide, the prevention of suicide involves multifaceted responses. The World Health Organization (WHO) lists a series of promotion, prevention, intervention, and postvention activities ranging from healthy families and homes in which to bring up children and youth, through to the successful treatment of mental illnesses, to reducing factors that lead to increased risk of suicide.¹ In addition, the WHO stresses that education and awareness-raising about suicide and its prevention are essential elements in suicide prevention strategies.²

The common objectives of public awareness and education for suicide prevention are: to improve recognition of when someone is depressed or suicidal; to improve help-seeking and access to care; and to reduce stigma.³

There is a growing body of research that suggests that caution should be exercised in the area of public messaging for the goal of suicide prevention.⁴ Some research shows that media reports on suicide, for example, can be linked to “suicide contagion,” the spread of suicidal actions or deaths following a suicide among youth and young adults (age 24 and younger).^{5 6}

Therefore, people working in the area of suicide prevention have a responsibility to become familiar with best practice and evidence-based programs that lower the potential risk of the contagion effect of public messages, as well as to increase the likelihood that messages will reflect the most recent knowledge about effective messaging for suicide prevention.⁷

Even though advocacy includes an education and awareness-raising component, advocacy efforts differ from public education and awareness in that the main outcome of advocacy is to increase support from the general public, politicians, funding bodies and service providers in dedicating more resources to reducing suicide. In such cases and targeted settings, messaging about the prevalence of suicide is an appropriate and effective approach to influence greater attention to the issue of suicide and the need for services. At the same time, the benefits of such messaging must be weighed against the potential risk of normalizing suicide by presenting it as a common event.⁸

“...Advocates may want to consider raising political awareness among legislators... While suicide is a relatively rare event, it may be useful to increase awareness among politicians that suicide is more prevalent than homicide...”

Highlighting suicide’s prevalence in these cases would be a very different strategy than what might be used with vulnerable populations. For persons at risk themselves, sending a message that suicide is a rare event and/or rarely-used solution to a problem may be part of a campaign to promote alternative approaches to personal or mental illness crises.”⁹

PURPOSE OF THE GUIDELINES

This document was created to support the use of leading and promising practice in public awareness and education efforts for suicide prevention. It is intended to guide and enhance creative and effective education and awareness campaigns. It is hoped that these campaigns will be developed with thoughtful and careful consideration and deliberation of any benefits and risks – with the guiding principle to do no harm.

In certain areas, the nature of the evidence is limited and, at times, contradictory. Therefore, practical wisdom, professional judgment and consideration of multiple sources of knowledge are valuable to include in the planning and creation of messages on suicide prevention. For this reason, the quotes selected for this paper represent the diversity of perspectives on public education and awareness for suicide prevention.

Guidelines for Public Awareness and Education for Suicide Prevention

SECTION A

Planning and Development

- Involve those bereaved by suicide and other experts, including researchers, medical professionals, clinicians, suicide attempt survivors and policy makers in the development of public awareness and education materials, campaigns or events. Clearly outline your desired goals and objectives at the outset of planning to assess whether your strategy is likely to accomplish them.
- Use appropriate and sensitive language when discussing suicide.¹⁰ Use “died by” versus “committed” or “successful” suicide. The word “committed” implies a criminal aspect to the act of suicide. The word “successful” does not accurately reflect the tragedy that every suicide represents. For this same reason, use “non-fatal” instead of “failed” suicide attempt. To avoid implying that suicide is a common event, use “increasing rates” versus “suicide epidemic.” For more information, see *What’s in a Word? The Language of Suicide*.¹¹
- Consider all who will be exposed to the message and the potentially negative and unintended impact (ie. suicide contagion due to normalizing, glorifying or simplifying suicide) on various groups when shaping key public messages for a specific target group.

Example: A recent study looked at the impact on youth of TV and billboard public service announcements (PSAs) that linked depression and suicide. Findings suggested that youth with depressive and suicidal symptoms perceived PSAs as less useful, and led to an overestimated link between depression and suicide, and a reduced interest in seeking help.¹³

“ Certain American Indian nations have very high rates of suicide. A campaign via popular Indian radio stations that highlights the high prevalence may inadvertently normalize suicide and send the message that such behaviour is expected and inevitable. Groups with high rates may get the message that they have experienced an expected behaviour, and the groups with lower rates are simply ‘lagging behind’ on what is seen to be inevitable.”¹²

- Before and after public release, test and evaluate new campaigns or presentations for their positive outcomes, and to gauge any unintended messages or outcomes.¹⁴

*Example: Conduct focus groups with people of various cultures, genders and age groups, ranging from youth to seniors, as well as those who have been bereaved by suicide and those who have experienced suicidal thoughts, feelings and/or actions. Have them review specific materials and messages to elicit their reactions and opinions, looking for any responses that indicate adverse effects. Consider a planning process model – see *Developing and Marketing Your Suicide Prevention Message: A Strategic Approach*.¹⁵*

- Use a comprehensive, responsible approach when planning for a presentation or an event:
 - Consider whether the timing of the presentation is appropriate in light of any recent suicide deaths in the community.
 - Depending on your audience, gauge whether the content of your presentation is age-appropriate.
 - Prepare a list of local suicide prevention resources to provide to the audience. Before distributing them, contact the resources to confirm they are suicide-intervention trained and available to respond.
 - Enlist support people to be there, who are able to do suicide intervention and to respond to issues that might surface. Limit the size of your audience so that support people can easily identify and support individuals in distress during and after a presentation.

SECTION B

Help-Seeking

- Messages aimed at increasing help-seeking should clearly outline the desired behaviour of seeking help, as well as normalize and affirm this behaviour.¹⁶ Suggesting that suicide is a common event or an inevitability of a certain illness, situation, or population is inaccurate and potentially harmful. This type of messaging can increase the likelihood that people view suicide as “more normal, and thus, more acceptable” and may reduce help-seeking.¹⁷

Example: A conflicting message would be: “Suicide is the second leading cause of death among youth ages 15 to 24. If you or someone you know is thinking of suicide, get help.” A positive message that avoids sending a mixed message would be: “Seeking help from a caring and capable friend or professional is a smart and safe action when feeling distressed or suicidal.”

“ There is an understandable, but misguided, tendency to try to mobilize action against a problem by depicting it as regrettably frequent...Although these claims may be both true and well intentioned, the campaign’s creators have missed something critically important: Within the statement ‘Many people are doing this undesirable thing’ lurks the powerful and undercutting normative message ‘Many people are doing this.’”¹⁸

- Encourage help-seeking by providing information about accessible and suicide-intervention trained service providers. In Manitoba, emphasize that there is help available through the *Manitoba Suicide Line* (1-877-435-7170).¹⁹ For a list of national resources see page 13. Highlight stories of well-known people who sought help when feeling suicidal and benefitted from this action. Suggest alternatives to suicide for coping with emotional distress, problematic substance use or gambling, relationship problems and other stressful issues.²⁰

Example: List resources that are accessible through various means: telephone, Internet or walk-in services. The literacy level and spoken language of the audience should be considered when recommending resources. Ensure the resources are age-friendly and accessible for seniors.

- Make others aware of when and how to ask about suicide. Highlight signs like expressing a desire to die, threatening suicide, abusing substances, putting affairs in order by writing a will or giving away valued possessions, showing changes in behaviour, mood and/or appearance, intentionally harming themselves or seeming sad, withdrawn or depressed.²² For more information on the signs of suicide, see the *Centre for Suicide Prevention*²³ and the *Canadian Association for Suicide Prevention (CASP)*.²⁴ For information on the age-related signs of suicide for older adults, see the *Canadian Coalition for Seniors' Mental Health*.²⁵

SECTION C

Risk and Protective Factors

- Outline the range of risk factors related to suicide. Presenting suicide as a simple or inexplicable act is misleading and may cause people to assume it is a common response to a stressful situation.²⁶ Whenever possible, point to the complexity of suicide and the underlying risk factors – not just the triggering factors.

Example: Even though a person's suicide may have been triggered by a recent loss or stressful incident, their history likely held pre-existing risk factors such as: mental illness (ex: depression, bipolar disorder, anxiety, psychosis, borderline personality disorder); substance abuse or gambling problems; previous suicide attempts; past or recent trauma; family history of suicide or suicidal behaviours; aggression or impulsiveness; recent discharge from hospital for mental health issues; and inadequate support.

- Wherever possible, educate about protective factors.²⁹ These are internal and external factors that reduce the likelihood of suicide, such as problem-solving skills; strong family and social support; sense of personal, cultural, and/or spiritual identity; and easy access to appropriate services. For a full description, see *Risk and Protective Factors*.³⁰

Example: Give examples of positive personal stories, and the coping strategies people use when feeling distressed or suicidal. Offer opportunities to learn new skills for problem-solving and coping with stress.

“ We must try to help kids understand that the happiest people are not those with the fewest problems, but those with the best coping skills. We need to tell kids that stressful times are inevitable, that they can recognize problems in each other and that they must never keep the secret of someone's plans for self-harm, because help is available.”²¹

“ Changes in attitude throughout history, gender and age differences, socio-economic factors, influence of race and ethnicity, and the impact of religion. ...All of them can actually have a considerable effect on suicide rates, and all of them should be taken into account when interpreting suicide trends and designing anti-suicide strategies. In fact, both risk and protective factors may vary remarkably in different cultures. The need for an integrative approach is evident today more than ever, and this fact calls for more concerted and co-ordinated, multidisciplinary approaches to suicide prevention.”²⁷

“ The recommendations suggest that, whenever possible, stories include the important role of mental disorders, such as depression and substance abuse, as precursors to the act. This information...provides context for the act but also opens the possibility for information about treatment. Nearly all of the mental disorders that precede suicide are treatable, and if vulnerable individuals [seek] care rather than focusing on suicide as a solution to their problems, many suicides might be prevented.”²⁸

SECTION D

Stigma

- When the intended outcome of a public awareness and education activity is stigma reduction, research indicates that campaigns highlighting the success stories of people recovering from mental illness are most effective in affecting attitudes toward that population.^{31 32}

Based on this research, as well as the concepts of social learning theory suggesting suicide may be a learned behaviour through modelling, strategies that highlight positive models of people overcoming suicidal thoughts, feelings and/or actions are expected to have a positive effect and promote help-seeking.³³

- The media is often used to increase awareness of, and to educate the public about, suicide prevention. When engaging and partnering with media, it is important to be familiar with the media guidelines and to share them with media personnel.³⁴ For media guidelines, see *Suicide and Mental Illness in the Media*³⁵ and *Media Guidelines and Social Marketing*.³⁶

SECTION E

Personal Stories

Background:

Those bereaved by the death of a loved one by suicide may choose to share their stories publicly. Personal stories can serve as an important resource when the motivation for telling them is to increase public awareness and education, and to reduce further suicides. Alternatively, grief experts warn that when the primary motivation for publicly sharing a personal story is to find personal healing from the death of a loved one, or to fulfill a personal need for care, this act is not recommended as it's neither a safe nor appropriate way to achieve these goals.³⁷

Effective personal testimonies are educational and inspirational for the public and validate others who are bereaved by suicide. Breaking the silence around suicide can serve to reduce the shame and stigma that continue to surround suicide. For more information, see *Fighting the Stigma of Suicide: A Coming of Age*.³⁸

At the same time, much research warrants caution when speaking publicly or with the media about suicide. To avoid any potential harmful effects on those who are vulnerable to a contagion effect, consideration should be given to the following recommendations:

- In preparation for the event, organizers are encouraged to provide support to those who will be sharing their personal stories. Helpful actions may include offering to act as an audience for them to rehearse their stories, discussing the key objectives and messages of the event, and establishing a vision for how their personal stories aim to strengthen the event's expected outcomes.
- Present a view of the deceased person that includes positive traits as well as risk factors (ex: drug abuse, mental illness, trauma).³⁹ To reduce normalization of suicide, distinguish between the qualities and accomplishments of the deceased and his or her final act of suicide.⁴⁰ Avoid glorifying, romanticizing or idealizing the person or the death.⁴¹
- When using personal stories as part of a presentation or an event, make every effort to balance the personal story with the key messages. Overemphasizing the personal story of someone who has died by suicide could overshadow the vital components of suicide prevention education. These include: how to determine if a person may be suicidal, ways to help, the risk and protective factors affecting suicide, and the importance of seeking help when distressed.

- Although a prevailing belief may be that the afterlife is a much better place, this belief should not be emphasized publicly. For those in the audience who are dealing with suicidal thoughts, “the lure of finding peace or escape through death may add to the attractiveness of suicide.”⁴²
- Communicate suicide's painful and permanent consequences. It is a tragedy that results in significant loss, grief, trauma and is a missed opportunity for the deceased to live out his or her life and experience the potential it holds, and for the memories that will never be made.
- Through statements that celebrate and affirm life, emphasize help-seeking and resources, as well as hope and recovery.
- Avoid overt details about means and place of death. This can encourage imitation by others.⁴³
- The media is often invited to cover public events and to interview people with personal stories. Before an interview, review the media guidelines to be aware of the impact of media on suicide contagion.⁴⁴ Check with interviewers as to their awareness of the media guidelines for suicide reporting. For more information on media, see *Reporting on Suicide: Recommendations for the Media*⁴⁵, *Media Guidelines and Social Marketing*⁴⁶ and *Recommendations for Reporting on Suicide*⁴⁷.
- Link persons who share their stories, and members of the audience, to supports for debriefing and help to cope with difficult emotions that may surface.

SECTION F

Memorializing

Background:

The main purpose of personal ceremonies or observances is for loved ones of the deceased to collectively celebrate the person's life and to grieve his or her passing. The following discussion and guidelines do not attempt to inform these types of personal, cultural, traditional, religious or spiritual practices.

Public memorials are held or erected for those who die by many other means. They are often meant to increase awareness and education about, and essentially to eradicate, the force that took the person's life. Prominent examples include cancer, war or drunk driving.

There is little consensus about public memorials for those who have died by suicide. Some assert that society only contributes to stigma and taboo if public memorials are discouraged for those who die by suicide.⁴⁸ People who are apprehensive of public memorials for suicide victims caution about the risk of encouraging further suicides by those who interpret memorials as giving positive attention and honour to those who die by suicide, and honouring suicide itself.⁴⁹ Some literature on memorializing those who experience traumatic deaths warns about a harmful triggering effect that permanent memorials may have on those directly affected by, or involved in, a death by such means.⁵⁰ For an in-depth look at schools and suicide deaths, see *After a Suicide: A Toolkit for Schools*.⁵¹

To mitigate the potential harmful effects of these activities, the following recommendations should be considered:

- The messages offered at public memorial events should affirm life by reflecting on the value and worth of the lives of those who have died by suicide, as well as the importance of every life. A crucial message for the public is that suicide is largely a preventable death, and that individual and social action can be taken to prevent it.⁵² If an event's focus is largely on death and loss, there is a risk that this vital and hopeful message will not be conveyed. For further information on this issue, see *After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances*.⁵³
- When preparing for a public memorial event, the recommendations in the *Personal Stories* section should be considered when telling the story of a deceased person or persons.
- Responses to a suicide death need to reflect local cultural practices and beliefs as a way to support healing, connection and community solidarity.
- When Facebook or other websites are used to create pages in honour of one who has died by suicide, post a link to resources and provide the administrator of the site with these guidelines and encourage him or her to include local and provincial resources to promote help-seeking and life-affirming messages.
- Erecting and showcasing public, permanent (ex: physical) memorials for those who have died by suicide is regularly discouraged throughout the literature on honouring traumatic deaths.⁵⁴ The physical reminder may have an impact on re-traumatization.⁵⁵ In addition, permanent memorials may be misinterpreted as glorifying suicide and those who die by suicide.⁵⁶ A danger exists in the unintended message that dying by suicide results in gains like public attention and notoriety. Vulnerable people may interpret this as meaning they are worth more in death than in life.⁵⁷

There is a distinction between memorials erected because someone has died by suicide, and memorials dedicated to someone for their accomplishments in life and contributions to society, regardless of the way he or she died. Therefore, this recommendation is not intended to be a statement to inform the erection of physical memorials that honour the life and extraordinary accomplishments of one who happened to die by suicide.

QUESTIONS?

Please contact the Mental Health and Spiritual Health Care Branch of Healthy Living, Seniors and Consumer Affairs at 204-788-6659.

This information is available in alternate formats upon request.

“ News coverage is less likely to contribute to suicide contagion when reports of community expressions of grief (ex: public eulogies, flying flags at half-mast, erecting permanent public memorials) are minimized. Such actions may contribute to suicide contagion by suggesting... that society is honouring the suicidal behaviour of the deceased rather than mourning the person’s death.”⁵⁸

“There have been several cases where dedicating public memorials after a suicide has facilitated the suicidal acts of others, usually youth (CDC, 1988). Consequently, dedicating memorials in public settings, such as park benches, flag poles...soon after a suicide, is discouraged.”⁵⁹

Endnotes

1. World Health Organization. (2008). Preventing Suicide: A Resource for Media Professionals. Retrieved on May 5, 2010, from www.who.int/mental_health/prevention/suicide/resource_media.pdf
2. Ibid.
3. Dumesnil, H., & Verger, P. (2009). Public awareness campaigns about depression and suicide: A review. *Psychiatric Services*, 60 (9), 1203-1213.
4. Ibid.
5. Gould, M. S. (1990). Suicide clusters and media exposure. In S. J. Blumenthal & D. J. Kupfer (Eds.), *Suicide over the life cycle* (pp.517-532). Washington, DC: American Psychiatric Press.
6. Gould, M. S., Jamieson, P. & Romer, D. (2003). Media contagion and suicide among the young. *American Behavioral Scientist*, 46(9), 1269-1284.
7. Suicide Prevention Resource Centre (SPRC) (2006). Safe and effective messaging for suicide prevention. Retrieved on May 5, 2010, from <http://sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf>
8. Chambers, D. A., Pearson, J. L., Lubell, K., Brandon, S., O'Brien, K., & Zinn, J. (2005). The science of public messages for suicide prevention: A workshop summary. *Suicide and Life-Threatening Behavior*, 35(2), 134-145.
9. Ibid., p. 137.
10. National Institute of Mental Health (NIMH). (2001). Reporting on suicide: Recommendations for the Media. Retrieved on October 7, 2011, from www.nimh.nih.gov/health/topics/suicide-prevention/pdf-recommendations-for-rporting-on-suicide.pdf
11. Alberta Health Services (2009). What's in a word? The language of suicide. Retrieved on October 7, 2011, from <http://www.albertahealthservices.ca/MentalHealthWellness/hi-mhw-sps-language-of-suicide-1p.pdf>
12. Chamber et al. op. cit., p. 137.
13. Klimes-Dougan, B., Yuan, C., Lee, S., & Hour, A. K. (2009). Suicide prevention with adolescents: Considering potential benefits and untoward effects of public service announcements. *Crisis*, 30(3), 128-135.
14. Chambers et al. op. cit.
15. SPRC (2006). Developing and Marketing your suicide prevention message. Retrieved on October 7, 2011, from www.sprc.org/library/strategicmessaging.pdf
16. Cialdini, R. B. (2003). Crafting normative messages to protect the environment. *Current Directions in Psychological Science*, 12(4), 105-109.
17. Chambers et al. op. cit., p. 136.
18. Cialdini, R. B. op. cit., p. 105.
19. Manitoba Suicide Line. www.reasonstolive.ca
20. Chambers et al. op. cit.
21. Cantor, P. (1999). Can suicide ever be eradicated? In D. G. Jacobs (Ed.), *The Harvard Medical School Guide to Suicide Assessment and Intervention*. (pp. 239-248). San Francisco: Jossey-Bass.
22. Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., and Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, 36(3), 255-262.
23. Suicide Intervention & Education Centre (2002). Suicide common warning signs. Retrieved on October 7, 2011, from suicideinfo.ca/LinkClick.aspx?fileticket=ldEqkdmjigw%3d&tabid=532
24. Canadian Association for Suicide Prevention (CASP) (2010). Warning signs. Retrieved on October 10, 2010, from www.suicideprevention.ca/about-suicide/warning-signs/

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25. Canadian Coalition for Seniors' Mental Health (2010). Suicide Assessment and Prevention for Older Adults. Retrieved on February 25, 2011, from www.ccsmh.ca/pdf/CCSMH_suicideBrochure.pdf
 26. Fekete, S., & Schmidtke, A. (1995). The impact of mass media reports on suicide and attitudes toward self-destruction: Previous studies and some new data from Hungary and Germany. In B. L. Mishara (Ed.), *The impact of suicide*. (pp. 142-155). New York: Springer.
 27. De Leo, D. (2002). Struggling Against Suicide: The need for an integrative approach. *Crisis*, 23, 23 – 31.
 28. Gould et al. (2003). op. cit., p. 1275.
 29. Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, P., Haas, A., et al. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association*, 294, 2064–2074.
 30. CASP (2010). Risk and Protective Factors. Retrieved on September 30, 2010, from www.suicideprevention.ca/about-suicide/risk-factors/
 31. Corrigan, P.W., River, L.P., Lundin, R.K., Penn, D.L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., Goldstein, H., & Kubiak, M.A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, 27, 187-195.
 32. See Me: Scotland's anti-stigma mental health campaign (2002). Retrieved on February 25, 2011, from www.seemescotland.org.uk/home
 33. Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review*, 84, 191-215.
 34. Etzersdorfer, E., & Sonneck, G. (1998). Preventing suicide by influencing mass-media reporting. The Viennese experience 1980-1996. *Archives of Suicide Research*, 4, 67-74.
 35. Mindframe (2011). Issues to Consider: Suicide and Mental Illness in the media. Retrieved on January 14, 2011, from www.mindframe-media.info/client_images/361884.pdf
 36. CASP (2010). Media guidelines and social marketing. Retrieved on October 11, 2010, from www.suicideprevention.ca/media-guidelines-2/
 37. Neimeyer, R. A. (2000). *Lessons of Loss: A Guide to Coping*. Key Stone Heights: PsychoEducational Resources, Inc.
 38. Centre for Suicide Prevention (2006). Fighting the stigma of suicide. Retrieved on October 7, 2011, from suicideinfo.ca/LinkClick.aspx?fileticket=txC_gmTwbx4%3d&tabid=538
 39. Fekete, S. & Schmidtke, A. op. cit.
 40. Canadian Psychiatric Association (CPA). (2009). Media guidelines for reporting suicide. Retrieved on April 10, 2010, from publications.cpa-apc.org/media.php?mid=733&xwm=true
 41. Fekete, S. & Schmidtke, A. op. cit.
 42. SPRC. (2004). *After a Suicide: Recommendations for religious services and other public memorial observances*. Newton, MA: Education Development Center Inc., p.9. www.sprc.org/library/aftersuicide.pdf
 43. Sonneck, G., Etzersdorfer, E., & Nagel-Kuess, S. (1994). Imitative suicide on the Viennese subway. *Social Science and Medicine*, 38(3), 453-457.
 44. Mann et al. op. cit.
 45. NIMH. op. cit.
 46. CASP op. cit.
 47. Recommendations for Reporting on Suicide. (2011). Retrieved on April 12, 2011 from reportingonsuicide.org/

48. Siehl, P.M. (1990). Suicide postvention: A new disaster plan. What a school should do when faced with a suicide. *School Counselor*, 38(1), 52-58.
49. Centres for Disease Control (CDC). (1988). Recommendations for a community plan for the prevention and containment of suicide clusters. Retrieved on April 6, 2010, from wonder.cdc.gov/wonder/prevguid/p0000214/p0000214.asp
50. The National Institute for Trauma and Loss in Children. (2004). School memorials: Should we? How should we? Retrieved on October 7, 2011, from www.tlcinstitute.org/memorials.html
51. American Foundation for Suicide Prevention. (2011). After a Suicide Loss: A Toolkit for Schools. Retrieved on April 26, 2011 from www.afsp.org/files/Surviving/toolkit.pdf
52. Mann et al. op. cit.
53. SPRC. (2004). op. cit. www.sprc.org/sites/sprc.org/files/library/aftersuicide.pdf
54. CDC. op. cit.
55. The National Institute for Trauma and Loss in Children. op. cit.
56. CDC. (1994). Suicide contagion and the reporting of suicide: Recommendations from a national workshop. Retrieved on April 23, 2010, from www.cdc.gov/mmwr/preview/mmwrhtml/00031539.htm
57. Gould, M. S. (1990). op. cit.
58. CDC. (1994). op. cit., p. 5.
59. SPRC. (2004). op. cit., p. 10.

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Links and Resources

- After a Suicide: A practical and personal guide for survivors www.klinic.mb.ca/docs/booklets/After_a_Suicide_-_A_Practical_and_Personal_Guide_for_Survivors.pdf
- American Association for Suicidology www.suicidology.org
- American Foundation for Suicide Prevention www.afsp.org
- Canadian Association for Suicide Prevention www.suicideprevention.ca
- Find a Crisis Centre within Canada www.suicideprevention.ca/in-crisis-now/find-a-crisis-centre-now
- Canadian Coalition for Senior's Mental Health www.ccsmh.ca
- Canadian Mental Health Association www.cmha.ca
- Centre for Suicide Prevention www.siec.ca
- Distress Centres of Ontario www.dcontario.org
- International Association for Suicide Prevention www.iasp.info
- Kids Help Phone 1-800-668-6868 www.kidshelpphone.ca
- Mental Health Commission of Canada www.mentalhealthcommission.ca
- Manitoba Suicide Line 1-877-435-7170 www.reasonstolive.ca
- Quebec Association for Suicide Prevention www.aqps.info
- Suicide Prevention Resource Centre www.sprc.orf
- SZ Magazine www.mentalwellnesstoday.com
- Working Minds: Suicide Prevention in the Workplace www.workingminds.org
- World Health Organization www.who.int

